National Human Rights Commission

# Mental Health Care and Human Rights

National Institute of Mental Health and Neuro Sciences

# Mental Health Care
# and
# Human Rights

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# Editors and Contributors

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# Foreword

Mental health is an important component of the overall health of any individual. This was long recognized in ancient India, where in addition to the medical dimension, philosophical, religious, moral and ethical dimensions shaped and provided the ground for normal mental health and contributed to an integrated healing and welfare system for mental illness. The Vedic times provided a broadly conceptualized model of mental health and illness, supported by an ethos of nurturance, support, caring and family responsibility in treatment and rehabilitation of these mental disorders.

During the early Twentieth Century, care of mental ill became mainly limited to institutions which were rife with abuse and discrimination. The attention of both mental health professionals and the courts were drawn to human rights abuses of mentally ill persons within institutions. This led to Judicial interventions awakening of the administration to the needs of the mentally ill.

The approach to people with disabilities both nationally and internationally, has, for far too long, been built on charity and the assumptions that disability is an individual pathology, a condition grounded in the psychological, biological or cognitive impairment of the individual. In the last few decades, the world in general and India in particular has seen a shift towards a rights based approach to mental illness. The Universal Declaration of Human Rights in 1948 proclaimed the basic human rights for all people, including people with any kind of infirmity. The zenith of the inclusive human rights approach has been the Convention on the Rights of Persons with Disability whose aim is to promote, protect and ensure the full enjoyment of human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity. Persons with disability include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. The policy and legislation for improving mental health care and services, without political will, adequate resources, appropriate functioning institutions, community support services and well trained personnel will be of little significance.
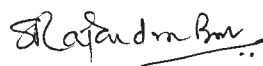
Since its inception, the National Human Rights Commission has been

playing the role of a catalyst to ensure direct action for the protection of the rights of vulnerable sections of society, including the mentally ill. NHRC took up an important project on quality assurance in mental health which was entrusted to the National Institute of Mental Health and Neuro Sciences at Bangalore. This project raised several seminal issues regarding the concerns and care of the mentally ill, particularly in institutions. It highlighted the need for a comprehensive range of services in the community for persons with mental illness. Since the release of that report in 1999, the NHRC has been actively involved in the monitoring of several psychiatric hospitals throughout the country and ensuring that the rights of the mentally ill in such institutions are protected. Besides the active involvement of the Chairpersons, Members and Staff of NHRC, our Special Rapporteurs have worked relentlessly, established regular dialogue with key functionaries in State Governments and constantly sought change and improvement.

There are definite winds of change. The improvements in mental health care in many parts of the country are testimony to such initiatives of the NHRC. We are witness to a strategic shift towards strengthening community care facilities for persons with mental illness. The changing economic world order with the impact of globalisation, peer pressure, professional tensions, diminishing family values or institutions are resulting in tremendous mental stress or disorders over a period of time. Focus has to be on rights of people suffering from a mental disability. We have realized, probably even more than before, the toll that current stresses and strife can take on our mental health and the need to nurture and promote the mental health and the need to nurture and promote the mental health of all needy citizens. The NHRC will constantly endeavour to make this possible.

This publication represents a timely review of developments in mental health care in India since the initial involvement of the NHRC through the 1999 quality assurance report. It will undoubtedly give us an opportunity to review the developments and examine the lacunae in mental health care in our country and the direction we will have to travel in the decades to come. I hope this publication will prove useful to mental health professionals, NGOs, State Human Rights Commissions, academics and others.

(Justice S. Rajendra Babu)

# Preface

In the modern age, we are now living with increasing stress owing to various factors. In the times to come, the stresses and strains will be further accentuated, thereby making mental health a very significant issue.

Morbidity on account of mental illness is set to over take cardiovascular diseases as the single largest risk in India by 2010. According to NIMHANS, there are over two crore persons in our country who are in need of treatment for serious mental disorder and about five crore people who are affected by common mental disorder. About 30 to 35 lakh persons need hospitalization at any time for mental illness. In contrast. there are about 29,000 beds available. This huge treatment gap, with 50-90% people not able to access services, is a serious human rights issue. Stigma-related discrimination faced by persons with mental illness also makes it a matter of deep concern to the National Human Rights Commission.

In India, the provisions of Article 21 of the constitution have been judicially interpreted to expand the meaning and scope of the right to life to include the right to health and to make the later a guaranteed fundamental right which is enforceable by virtue of the Constitutional remedy under article 32 of the Constitution. It is therefore, imperative that the mentally ill persons receive good quality mental health care and human living conditions not only in institutions but also in their homes.

The National Human Rights Commission (NHRC), very early after its inception, was asked by the Supreme Court to monitor the mental hospitals at Agra, Gwalior and Ranchi. Subsequently, on its own initiative, the NHRC commissioned a project to review the mental health situation in the country particularly in the mental

hospitals. The project publication has been lauded as a landmark report and brought attention to the neglected area of mental health.

The NHRC has taken up several issues related to hospital and community mental health care. The commission and its representatives have made several visits to many of the hospitals in the country. It has initiated dialogue with State authorities and constantly reviews the ground situation to make sure that its recommendations on the quality assurance in mental health are implemented both in letter and spirit.

With a view to protect the rights of persons with mental illnesses, there is a need to focus on preventive, curative and other dimensions of mental health. The National Human Rights Commission is of the view that institutionalization alone is not the answer but it is essential to move towards community-based treatment and social rehabilitation.

The objective of this publication is to lay down minimum standards for mental health care with a view to protecting the rights of mentally ill persons and to enable their monitoring by all concerned authorities. The Commission also wishes to raise awareness of authorities, academics, NGOs and the general public on the rights of mentally ill through this publication.

(A.K. Jain)

# Editors' Introduction

At the National Institute of Mental Health and Neuro Sciences (NIMHANS), we are deeply committed to providing quality mental health care. NIMHANS has been actively involved in developing and demonstrating sustainable models of mental health delivery. It has played a pivotal role in making evidence based recommendations for policy change in mental health. The institution has been cited as a model psychiatric centre worthy of emulation by the apex court of the country.

NIMHANS forged a memorable collaboration with the National Commission for Human Rights in the country through the "Quality Assurance in Mental Health" project. The recommendations of this project became a benchmark for assessment of care in government psychiatric institutions in the country.

NIMHANS has long advocated community care as a sustainable and cost effective model. It developed a district model for mental health care in the 1980s. More recently, it has been closely involved with the Government of India in re-strategising and expanding the National Mental Health Programme. The main objective of this programme is to provide accessible, affordable and acceptable care to the community.

The NHRC has continued to associate with NIMHANS in its efforts to improve mental health care. Two collaborative initiatives in this year included a national seminar on mental health and human rights (along with the National Law School of India University of Bangalore) and a consultative meeting of health secretaries and state mental health authority representatives. The current publication "Mental Health Care and Human Rights" is another result of this fruitful collaboration.

In this book, we have focused on human rights perspectives to mental health. The preliminary chapters focus on the right to

equitable and quality mental health being a fundamental right of every citizen. The judiciary and the NHRC have played a pivotal role to ensure the rights of the severely mentally ill. The specific interventions are discussed.

In subsequent chapters, the authors discuss the sobering findings of the NHRC/NIMHANS quality assurance project of 1999 with respect to psychiatric care in mental hospitals and the encouraging improvements in mental health care after a decade.

It is very clear that we must move from institutional care towards community care. The re-strategised National Mental Health Programme of the Government of India is an important step in this direction. The rationale, scope and strategies of the NMHP are discussed in detail. A major practical problem is the acute shortage of human resources. Short-term and long-term measures to address this important issue have been recommended.

A rights-based approach actively involves users and their families. Their perspectives, concerns and potential role in ensuring access to quality mental health care are discussed. Mental health professionals alone cannot handle the vast and complex issues of mental health care in the country. Public-private partnerships are crucial, and non-governmental organisations also play a crucial part. Illustrative examples of such initiatives are provided. These can be valuable insights for state governments while planning mental health service delivery for their constituents. Chronic mental illness imposes a significant financial burden. Access to health insurance will help to alleviate this burden. However, insurance for mental illness is either not available, or extremely restricted in its coverage. These issues are further discussed in a separate chapter.

Service providers in the health and social sectors, law makers, users and their families must all network to provide comprehensive mental health care services. This is a theme which emerges again and again in different chapters.

A review of this magnitude requires the co-operation of several individuals. We are grateful to the NHRC for providing this opportunity, and particularly thank Ms Aruna Sharma, Joint Secretary, NHRC, for her support. We thank the authors of the individual chapters. Professor Kiran Rao provided significant input towards chapterisation and valuable editorial advice which we gratefully acknowledge.

The impetus for this effort came from the initial NHRC/NIMHANS collaboration in 1999. Justice Malimath from the NHRC, Professor SM Channabasavanna and an enthusiastic multidisciplinary team from NIMHANS was involved in the initial project. During subsequent review meetings, heads of departments and faculty from the department of psychiatry, as well as from the departments of mental health and social psychology, psychiatric social work and nursing played a pivotal role in co-ordinating efforts. We express our heartfelt thanks to them.

This publication is a further expression of our commitment to the promotion of mental well being and providing effective treatment for mental disorders. We hope that it will be useful for people concerned with mental health care from diverse disciplines. We hope it will bring them together to evolve a comprehensive and effective mental health care system in India.

Bangalore
October 2008

**D Nagaraja**
**Pratima Murthy**

# Human rights in mental health care: an introduction

## Lakshmidhar Mishra

### Introduction

The Right to Life is the most primordial of all rights as also the most pre-eminent. The very first couplet of the Ramayan by Maharishi Valmiki espouses lucidly and forcefully the essence behind protection of all lives – man or animal alike. To quote from the English translation:

> *"O hunter! Please do not kill this pair of beautiful hawks immersed in an act of pure love. What lasting fame would you attain if you wantonly kill them?"*

In the Bheesma Parva of Mahabharat, the grandsire of the Kuru dynasty utters words that reinforce the primacy and centrality of that philosophy of the sacrosanctity of human life. Bheesma had fallen on the tenth day of the battle of Kurukshetra and was lying stricken on a bed of arrows, writing in physical and mental anguish. Yudhistira approached him along with his four brothers and asked him: 'O Pitamaha! Please enlighten us at this hour as to what is the ultimate truth of life'. Quick came the reply from the quivering lips of the grandsire:

> *"Let it be known by you and others, O Yudhistira, that human beings are the finest and best in creation. There is nothing greater than man".*

The Mahabharat of Vyasa is a product of his rich imagination and creativity. Yudhistira and all others are nothing but imaginary characters in the great epic. The central message underlying the beautiful lines of Bheesma Parva as quoted above is, however, important.

It is this:

> "*Protect, preserve and promote human life and its essence and do not destroy it (or its essence) for once destroyed it cannot be recreated*".

It also means the following:

Every human body and mind has an integrity which is inviolable. Every human being has certain irreducible barest minimum needs such as right to air, potable water, food, clothing, health, medical care and treatment, clean and hygienic conditions for living accommodation, environmental sanitation, personal hygiene and so on. Deprivation of any one of these amounts to violence to the person.

## Definition of Human Rights

If human life is the finest and best in creation what exactly are human rights?

The simplest way of defining human rights is that they are about balancing the inalienable rights of all of us as human beings within the community regardless of differences in birth, social origin, gender, physical differences, faith and belief, ideology, nationality and so on. There can be no disagreement with the universally acclaimed truth that human dignity is the quintessence of human rights. Every human being is entitled to be treated with dignity, decency, equality and freedom regardless of the fact that we are born differently, grow differently, are different in our mental make up, thought proceses and life-style. Negation of this would mean negation of human rights.

A person with mental illness is entitled to treatment with the same dignity and decency as any other human being. A mentally ill person does not become a non person merely on account of certain disabilities. His human rights flow from the fundamental right to life as in Article 21 of the Constitution which includes:

- Right to living accommodation, food, potable water, education, health, medical treatment, decent livelihood, income, a clean and congenial existence

- Right to privacy, speedy trial (if involved in any criminal offence), information and means of communication.

# International Treaties, Declarations and Guidelines

A series of international human rights treaties and other instruments have been in place since 1945. The UN provided an ideal forum for the evolution and adoption of these instruments. The international human rights law today comprises treaties, declarations, guidelines and principles – more than 100 in number.

The member States of the UN have reposed and reaffirmed their abiding faith in fundamental human rights, in the dignity, integrity and worth of every human being as a person and in the matter of equal rights of women and men as also in certain special rights for children.

Some of the international treaties, declarations, guidelines and principles which have affirmed and reaffirmed the human rights of every mentally ill person like any other human being are summarised in the accompanying table:

**International Treaties, Declarations and Guidelines affirming/ reaffirming rights of persons with mental illness**

|  | Year adopted |
|---|---|
| The Universal Declaration of Human Rights | 1948 |
| The International Convention on the Elimination of all forms of racial discrimination | 1965 |
| The International Covenant on Civil and Political Rights (ICCPR) | 1966 |
| The International Covenant on Economic, Social and Cultural Rights (ICESCR) | 1966 |
| The Declaration on the Rights of Mentally Retarded Persons | 1971 |
| The Declaration on the Rights of Disabled Persons | 1975 |
| The Convention on the Elimination of all forms of Discrimination |  |
| Against Women (CEDAW) | 1979 |

| | |
|---|---|
| The Convention against torture and other cruel, inhuman or degrading treatment or punishment | 1984 |
| The Declaration on the Right to Development | 1986 |
| The Convention on the Rights of the Child | 1989 |
| International Conventions on the Protection of the Rights of all Migrant Workers and members of their families | 1990 |
| UN Principles for the protection of persons with mental illness and improvement of mental health care | 1991 |
| The Declaration of Caracas | 1990 |
| The Declaration of Madrid | 1996 |
| The WHO Technical Standards (Mental Health Care Law: Ten Basic Principles and Guidelines for the Promotion of Human Rights of Persons with Mental Disorders) | 1996 |
| The UN Convention on the Rights of Persons with Disabilities | 2006 |

The UN principles for the protection of persons with mental illness and the improvement of mental health care (1991) recognise the enjoyment of the highest attainable standard of physical and mental health as the right of every human being.

In 1996, WHO developed the *Mental Health Care Law: Ten Basic Principles* as a further interpretation of the MI Principles and as a guide to assist countries in developing mental health laws. The WHO also developed *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, which is a tool to help understand and interpret the aforementioned UN principles 1991 (known as MI Principles) and evaluate human rights conditions in institutions.

| Mental Health Care Law: Ten Basic Principles |
|---|
| 1. Promotion of mental health and prevention of mental disorders |
| 2. Access to basic mental health care |
| 3. Mental health assessments in accordance with internationally accepted principles |
| 4. Provision of least restrictive type of mental health care |
| 5. Self-determination |
| 6. Right to be assisted in the exercise of self-determination |
| 7. Availability of review procedure |
| 8. Automatic periodic review mechanism |
| 9. Qualified decision-maker (acting in official capacity or surrogate) |
| 10. Respect of the rule of law |

WHO 1996

The principles with respect to the treatment of persons with mental illness can be summarised as follows:

- The aim of psychiatry is to treat mental illness and promote health to the best of his or her (*psychiatrist's*) ability, consistent with accepted scientific knowledge and ethical principles;

- Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solicitude and respect due to the dignity of all human beings;

- The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, cooperation and mutual responsibility;

- The psychiatrist should inform the patient of the nature of the condition, therapeutic procedure including possible alternatives and of the possible outcome;

- No procedure shall be performed nor treatment given against or independent of a patient's own will, unless because of mental illness, the patient cannot form a judgment as to what is in his or

her best interest and without which treatment serious impairment is likely to occur to the health of the patient or others;

- As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent;

- The value of positive mental health for every human being and the rights of all persons with mental disorders and with disabilities as full citizens of their countries should be recognised;

- All recipients of mental health services, regardless of age, gender, ethnic group or disorder must be treated in the same manner as other citizens in need of health care and their basic human rights and freedoms should be respected;

- The World Medical Association and its member associations have always sought to advance the cause of human rights for all people and have frequently taken actions endeavouring to alleviate violations of human rights;

- Members of the medical profession are often amongst the first to become aware of violations of human rights;

- Medical associations have an essential role to play in calling attention to such violations in their countries.

The UN Convention on the Rights of the Persons with Disabilities (2006) marks a "paradigm shift" in attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free, and informed consent as well as being active members of society. It has proposed a comprehensive definition of persons with disabilities as 'all those who have long-term physical, mental, intellectual and sensory impairments (Article 1). The Convention calls upon nations to take specific actions to protect the rights of people with mental disability.

# Protecting the rights of the mentally ill

Availability, accessibility, acceptability and quality are the core obligations and elements of the right to health. A mentally ill person is in need of special care and attention both at home and in the hospital for the simple reason that he/she is unable to fend for himself/herself. The responsibility for special care and attention also lies with the care givers and includes the following:

*At home:*

- Treating the mentally ill person with dignity, decency, kindness and compassion;

- Not suppressing the information that someone at home has been affected by mental illness;

- Recognising that time is of the essence, and taking the ill person to a mental health facility for evaluation and admission, if considered necessary by the treating mental health professional ;

- Furnishing accurate postal address of the admitted individual to the hospital authorities at the time of admission;

- Not suppressing any information about relationship with the individual and about the nature of ailment;

- Volunteering to stay with the admitted relative in the family ward/ open ward, as the case may be;

- If it is not convenient to stay with the person for personal and family reasons, interacting with him/her at the hospital at frequent intervals as necessary;

- Ensuring that after the person has been effectively treated and fit for discharge, he/she is taken home, treated kindly and given the best care and attention, ensuring strict and timely compliance with the medicines prescribed;

- Taking the person to the hospital for follow-up as advised;

- Infusing hope, faith and confidence in the mind of the recovering person all the time that he/she can be effectively treated, cured and can resume a normal life like in any other illness;

- Extending cooperation to the psychiatric social worker during follow-up home visits.

*In the treatment setting:*

- No individual should be handcuffed or tied with ropes while being brought to the hospital or as an inpatient;

- There should be facilities for sedating disturbed individuals in the outpatient (OPD) setting;

- The OPD should comprise a large hall with sufficient number of chairs to seat persons seeking consultation and accompanying family members;

- The OPD hall should be well lit and ventilated with provision of potable water, toilet, newspaper stand and a television;

- A hospital canteen should be available nearby as waiting in the OPD may go up to 2 to 4 hrs depending on the average turnout of patients and the number of treating professionals available;

- At the OPD there should be sufficient number of registration counters to cater to the needs of people in different age groups (adults, adolescents, elderly and the children) as also women and men;

- The people at the registration counter should be given orientation and training to be civil, courteous, considerate to everyone seeking care, particularly the elderly;

- No mentally ill person or their caregivers should be subjected to any abuse or offensive treatment or treatment that borders on cruelty or torture; instead they should be treated with utmost civility, courtesy and consideration;

- No person seeking help for mental distress or illness should be refused examination at the OPD on any ground whatsoever;

- Similarly, no patient should be refused admission as an inpatient if the same is considered absolutely necessary by the physician examining him/her.

   Once a decision is taken that a patient requires inpatient care, certain other rights accrue to the admitted person such as:

- Right to wholesome, sumptuous and nutritive food according to certain prescribed scales;

- Right to potable water;

- Right to environmental sanitation including clean toilets;

- Right to personal hygiene;

- Right to books, journals, periodicals and newspapers in their language;

- Right to recreation (television in the room, dance, drama, music, other cultural activities, games and sports);

  Right to food is further elaborated.

## Right to Food

This includes:

- Preparation of food in the kitchen in a neat, orderly and tidy manner;

- Serving food courteously;

- Ensuring that the food is wholesome and nutritious;

- Making the hospital self-sufficient by developing a farm/kitchen garden to minimise dependence on market and ward off scarcity.

*Preparation of food:*

Food in hospital must be prepared in a modern kitchen which may be centralised or decentralised depending on the size of the hospital, number of beds and occupancy rate. The kitchen should have adequate space, ventilation, and lighting. This includes providing exhaust fans and chimneys. Glazed tiles should be fitted upto 1.5 metres height to ensure cleanliness in the kitchen with provision for regular cleaning of the tiles. There should be separate platforms for washing, cutting, cleaning and storing of vegetables meant for cooking. Adequate mechanisation must be encouraged, for example, providing electric kneader and chapatti-making machine. Care must be taken to check the food quality, and to ensure that it is neither undercooked or burnt. On no account should vegetables be cut on the floor or chapattis be made on the floor as is the practice in many hospitals. Cooked food should be properly stored and served as soon as possible.

*Transportation and serving of food:*

- Cooked food should be transported by a trolley and not manually as in the case in most of the hospitals. For this, proper paving of the roads inside the hospital should be done;

- Food should not be exposed or served in an open space. Dining facilities should be available, designed to ensure that there is no over crowding and that it is not too far from where the inpatients reside and that the service is smooth and prompt;

- The utensils should be made of stainless steel and not aluminium as the latter gathers dust and dirt and is no longer recommended;

- The timing for breakfast, lunch, evening tea and dinner should be such that the gap between two consecutive meals is not too long;

- The menu should be prepared for the whole week but should be altered daily to ensure variety. There should be separate menu for those not doing any physical activity and those engaged in physical activity in the occupational therapy units;

- The dining room and tables should be kept clean and free of flies and cockroaches;

- Soft music could be played at the time of serving food.

*Ensuring that the food is wholesome and nutritious:*

- Services of a dietician should be engaged to verify and attest that the food being served conforms to a minimum of 2500 kilo calories for women and 3000 kilo calories for men;

- The diet should be balanced and contain adequate nutrients as per established and recommended standards. The dietician must be sensitive to local preferences and food habits. The Indian Council of Medical Research (ICMR) has prescribed certain nutrient requirements and recommended dietary allowance (RDA) for able bodied adults (women and men).

## Other Rights

In a similar fashion, the right to potable water requires ensuring that:

- There is sufficient water for drinking, washing, bathing, cooking and cleaning;

- Arrangements for distribution of water is made to all parts of the hospitals;

- Adequate state of the art technology is used to store and provide potable water;

- Regular checks to prevent contamination are carried out.

*Right to personal hygiene* includes providing adequate toilet facilities, adequate laundry facilities with mechanisation, clean and hygienic kitchens.

*Right of access to information* for the relatives includes ensuring arrangements for the relatives to visit their admitted relatives regularly, or make regular telephone calls. Such calls should be attended by trained and courteous attendants. There should be a computerised database for all outpatients and inpatients, to facilitate further treatment. A proper record system must be maintained with individual files for each individual seeking treatment. Strict confidentiality of such records must be maintained. While research scholars may have access to these records for academic purposes, procedures for such use must be clearly established.

*Right to read and to recreation* involves having access to reading material in the vernacular, opportunities to express one's creativity through fine arts, exploration and enhancement of inherent potentials in every individual.

*Right to ventilate and redress grievances* must include institutional mechanisms for such ventilation, time limit for redressal and communication of the decision regarding the grievance to the aggrieved.

## Right to speedy trial of mentally ill undertrial persons

In Hussainara Khatoon (No.1) vs. Home Secretary, Bihar, it was held by the Apex Court that "*right to a speedy trial, a fundamental right, is implicit in the guarantee of life and personal liberty enshrined in Article 21 of the Constitution*". Speedy trial is the essence of criminal justice. These principles were reiterated in Abdul Rehman Antuley vs. R.S. Nayak in which detailed guidelines for speedy trial of an accused were laid down even though no time limit was fixed for trial of offences.

These notwithstanding, a number of cases have come to light where mentally ill persons who have been facing trial for an offence have been undergoing incarceration for long periods till their plight and predicament

surfaced through public interest litigations and much needed relief was provided by the Apex Court.

## Supreme Court and human rights for persons with mental illness

In the case of Chandan Kumar Bhanik vs. State of West Bengal (1988) the apex Court observed: "*Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues*".

In the case of Sheela Barse vs. Union of India and others the apex Court observed as under:

- Admission of non-criminal mentally ill persons in jails is illegal and unconstitutional;

- All mentally ill persons kept in various central, district and sub jails must be medically examined immediately after admission;

- Specialised psychiatric help must be made available to all inmates who have been lodged in various jails/sub jails;

- Each and every patient must receive review or revaluation of developing mental problems;

- A mental health team comprising clinical psychologists, psychiatric nurses and psychiatric social workers must be in place in every mental health hospital.'

In the judgment of the apex Court in Rakesh Ch. Narayan vs. State of Bihar certain cardinal principles were laid down by the apex Court. These are:

- Right of a mentally ill person to food, water, personal hygiene, sanitation and recreation is an extension of the right to life as in Article 21 of the Constitution;

- Quality norms and standards in mental health are non-negotiable;

- Treatment, teaching, training and research must be integrated to produce the desired results;

- Obligation of the State in providing undiluted care and attention to mentally ill persons is fundamental to the recognition of their human right and is irreversible.

## Role and intervention of NHRC in mental health and human rights

In W.P. (Criminal) No. 1900/81 Dr. Upendra Buxi vs. State of U.P. and others the apex Court requested the NHRC to be involved in the supervision of mental health hospitals at Agra, Ranchi and Gwalior. The Commission on its part conceptualised and translated to action a Project on Quality Assurance in Mental Health Care in the country with Justice Shri V.S. Malimath, ex-Member, NHRC as Project Director and Dr. S.M. Channabasavanna, former Director and Vice Chancellor, National Institute of Mental Health and Neuro Sciences (NIMHANS) as the Principal Investigator along with a team of specialists as investigators. 'Quality Assurance in Mental Health' emerged as the end product of this marathon action research project with the following outputs:

- Existing status of mental health hospitals, failings and inadequacies;

- Comprehensive recommendations to achieve the object of ensuring quality mental health care in the country.

The NIMHANS team took enormous pains to visit and intensively review the functioning of 37 mental health hospitals all over the country. The review ended with a series of recommendations including steps to improve physical facilities, treatment and care of patients, occupational therapy as a tool of rehabilitation, training and research, and community outreach programmes.

The recommendations in a capsule form are:

- Immediate abolition of cell admissions;

- Gradual conversion of closed wards into open wards;

- Construction of new wards of shorter capacity (not more than 20) for use as open wards;

- Streamlining admission and discharge procedure in accordance with provisions of the Mental Health Act, 1987;

- Upgradation of investigation facilities;

- Inservice training of all staff members;

- Providing each patient a cot, mattress, pillow, bedsheet and adequate clothing for change;

- Improving supply of water and electricity;

- Ensuring supply of nutritive food of 3000 kilocalories per day to each patient;

- Developing occupational therapy facilities;

- Improving recreational facilities;

- Developing rehabilitation facilities including day care centres.

Since June 1999, when the 'Quality Assurance in Mental Health' report was released, the Chairperson, Core Member in charge of mental health and other members as also Special Rapporteurs have been regularly inspecting and reviewing the activities of all the 37 mental health hospitals including GMA, Gwalior, IMHH, Agra and RINPAS, Ranchi. A number of qualitative changes and improvements in the overall work environment, management and quality of treatment in these hospitals have taken place as a result of these visits, inspections and reviews. This runs into a long list and it will be difficult to recount all these changes and improvements.

The human rights dimension of mental health has occupied the pride of place in all these visits, reviews and inspections.

The NHRC can only play the role of a promoter, facilitator and catalytic agent as also a watch dog; it cannot, however, substitute the primary role or mandate of State Governments to ensure mental health as a matter of human right to every individual. Besides, it is not one department but a host of departments and agencies who are stakeholders in the process. NHRC has, however, adopted a totally open, transparent and participative style of monitoring the pace and progress of activities in the hospitals keeping the human rights dimension uppermost in view. It has hitherto used monitoring as a tool of correction and promotion of human rights of the mentally ill persons.

## What is the ground level situation?

While cardiac arrest at present is the major health concern, according to

the WHO Projection, by 2020, depression will be the main cause for worry. The proportion of total global burden of disease attributable to mental, neurological disorders and substance abuse is projected to rise from 11.5% in 1998 to 15.5% by 2020. Increasing suicides/attempted suicides is yet another major cause for worry.

*Why is this so?*

There are multiple contributory factors responsible for increase in mental problems year after year. Unplanned urbanisation, unregulated migration, within and across States and borders, naked expropriation and exploitation at the worksite, and vulgar consumerism are major problems today. Breakdown of the joint family system, emergence of nuclear family structures, neglect of children in childhood, marital discord, breakdown of relationships, emergence of more and more distrust and suspicion among couples all lend to significant mental health problems. Collective social resistance to inter-caste and inter-religious marriages, intense discrimination between siblings by parents at home, emergence of adversarial relationship amongst castes, classes and sects gives rise to mindless violence, hatred and intolerance in a highly stratified society. Extreme fads, taboos, obscurantist ideas and practices, unrealistic parental expectations and pressures on school and college going children to prove themselves and rise to heights drives children to desperation. Neglect of the old by the young results in throwing the old by the wayside. A callous and insensitive society and State, footloose governance without any semblance of transparency and accountability are also factors which might be behind some of the mental problems.

All this constitutes a terrible source of uneasiness for any civilised human being or right thinking person. This is on account of the fact that mental illness affects health, freedom, security and well-being of individuals, families, entire communities and of the society and the nation. It inhibits the individual's ability to cope with stress. If the patient is a young and productive adult, it leads to a colossal waste of this most precious human resource.

Children, women and the elderly constitute the most vulnerable groups. Article 39(f) of the Constitution says that children should be given opportunities and facilities to develop in a healthy manner in conditions of freedom and dignity and that childhood and youth are protected against exploitation, against moral and material abandonment. In case of children

who are afflicted with mental problems, the petals of childhood wither away in wilderness before blossoming to flowers of youth and adulthood.

In case of adolescents and adults, mental illness substantially cripples the productive and reproductive phase of life. For women, good mental health is intrinsically important as they are the care givers and would not be able to play this role effectively when they are afflicted by mental illness. A woman is the most important resource for the family and mental illness robs her of the vitality and strength as well as the stability and strength for the family.

In case of the elderly, their plight and predicament on account of old age associated with seclusion, helplessness and abandonment by the young gets compounded by mental illness. Depression among the elderly often goes undiagnosed. It is associated with chronic physical illness; symptoms of depression are also a common side effect of prescriptive medications including anti-hypertensive drugs. Suicide rate is one measure of depression which is higher among people over 65.

With lower birth rate and high longevity, the number of elderly people in the world is increasing rapidly. In India (where there are 76 million elderly persons at present) the number is likely to go up to 100 million by 2013 and 200 million by 2030. The elderly need our special attention and care as they are in the twilight zone of their life.

Our public health system often ignores elderly people who are mentally ill and such negligence is a form of elder abuse. Elderly people in poor health are 3 to 4 times more likely to become victims of abuse than those who are in good health. Beds are not easily available to them at the time of hospitalisation, residential care is denied to them and community services are often wanting for this group. They turn out to be victims of the worst forms of neglect and violation of human rights.

## Promoting human rights in mental health: what we have and what we do not

Internationally we have a series of treaties, customs, declarations, guidelines and principles some of which have been referred to earlier. Together they have set the international human rights standards. The primary responsibility for ensuring respect for the human rights of persons, however, rests with the Member States of the UN.

At the national level the old Lunacy Acts of 1912 and 1977 have been repealed and replaced by the Mental Health Act, 1987. The National Mental Health Programme was launched in 1982 which was reviewed and re-strategised in 2003. Successive judgements of the Supreme Court between 1986 and 1997, some of which have been referred to earlier, have clearly brought out the human rights dimension of mental health and need for a proactive approach to mental health and a humane approach to the patients. The meagre allocation of Rs 28 crore in the Ninth Plan was stepped up to Rs 190 crore in the Tenth Plan and has been further stepped up to Rs 1000 crore in the Eleventh Plan which has since been approved by the NDC in December, 2007. The emphasis in the revised NMHP is on:

- Integrated approach to treatment, training, teaching and research;

- Community outreach programmes;

- Destigmatization of mentally ill persons for acceptability and reintegration into the mainstream of society.

In terms of structures we have mental health advisory bodies at the Central and State levels. We have the District Mental Health Programme extended to 125 districts. We have Departments of Psychiatry in 271 of the 283 Medical Colleges (both government and private) in addition to 41 mental health hospitals. The Indian Psychiatry Society (IPS) has since its inception contributed significantly by way of action research. NIMHANS has been a trend and pace setter in both psychiatry and neurosciences and a number of institutions like 'Friends of NIMHANS' have come up under the umbrella of NIMHANS. A number of models of close collaboration between GOs and NGOs in providing rehabilitation and reintegration to mentally ill persons have also come up such as Medico Pastoral Association which set up the first half way home. The Institute of Human Behaviour and Allied Sciences (IHBAS) together with NIMHANS rendered yeoman service in providing psychological rehabilitation to those who were hit by natural calamities (earthquake, supercyclone, and tsunami).

The gap between the resources – human, material and financial needed on account of the growing demand for mental health services and the available resources is our major concern. According to established norms we need the following resources:-

- psychiatrists 1.0 per 1,00,000 population; one for every 10 inpatients;

- clinical psychologists 1.5 per 1,00,000 population; one for every 25 inpatients;

- psychiatric social workers 2.0 per 1,00,000 population; one for every 25 inpatients;

- psychiatric nurses 1.0 per 3 patients in a teaching hospital and one for every 5 in a non teaching hospital.

Going by the norms as above, we would need:

| | |
|---|---|
| Psychiatrists: | 9698 |
| Clinical psychologists: | 13,259 |
| Psychiatric social workers: | 19064 |

We have 61,521,790 major and minor mental disorders for which we have only 20,893 beds in government sector and 5096 beds in the private sector.

The gap is huge and unless timely action is taken to bridge the gap and the same is fully or substantially bridged, we will be no where in translating the human rights dimension to a concrete fulfilment; it will only remain an unrealised dream.

Simultaneously, a number of proactive steps will have to be taken in the following directions:

- All archaic structures must be dismantled giving rise to new modern, well lit, ventilated and aesthetically pleasing structures with a sylvan surrounding;

- Leaking roofs, eroded floors, overflowing toilets and broken doors must be made a thing of the past;

- All irrational practices (like lock up and dinner at 5.30 pm before lock up, treating patients not returning from leave and absconding patients as discharged, bringing patients to hospitals in ropes or fetters) must be completely abolished;

- Right to food, right to potable water, right to personal hygiene, right to sanitation, right to recreation and right to privacy must be fully respected; these are non-negotiable;

- All the walls of the hospital must be splashed with good quality information, education and communication materials which would breathe a new hope, faith and conviction among mentally ill persons and their relatives that nothing is lost and life can be started afresh;

- We must react to the observations contained in the WHO report, 2001 about status of mental health care institutions in India with sufficient sensitivity and concern.

## Towards community care

Community care involves the care and treatment outside an institution of people who have or who are recovering from a mental illness. It is coterminus with de-institutionalisation (which does not necessarily mean total dehospitalisation) which means a policy of caring for the people with mental illness in the community instead of only (or mainly) in hospitals or psychiatric units. The rationale for community based mental health care has its origin from 3 sources, namely:

- Treatment of mentally ill persons in mental hospitals has its severe limitations;

- Institution-based psychiatric treatment through trained professionals (who are also limited) can be very expensive;

- Para professionals with short and simple orientation and training could deliver reasonably satisfactory mental health care.

Without the network of community based services and support systems it is difficult to integrate people from the hospital wards into the community.

The concept of community care includes:

- Arrangement for the care and support of families;

- Care and treatment for the significant proportion of people with mental illness who have never been admitted to a psychiatric facility and who may never need to be if they are provided with appropriate care, support and treatment in their own environment.

Community care also includes issues affecting people who may need occasional inpatient care as well as community care. They may manage well in their usual environment for a substantial period of time but may

periodically require hospital admission for treatment and stabilisation when an acute episode occurs.

The irony of the situation which we face in India is that substantial resources are allocated to institutional care, leaving very little to promote or sustain community care. This is what has resulted in conspicuous absence of comprehensive community services linked with mental health. Attempts have been made to launch a few community satellite clinics but there are formidable problems in its successful operationalisation. There is no campaign or movement for involvement of the entire community in mental health.

## Conclusion

To sum up, human rights are not the exclusive preserve of any individual and group. They are neither owned by anyone nor can be doled out as a gift by one to another. They belong to all of us – individually and collectively. They are universal and indivisible. I conclude by quoting from the Vienna Declaration and Programme of Action adopted at the close of the World Conference on Human Rights:

> "*All human rights are universal, individual, inter dependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis. While the significance of national and regional peculiarities must be borne in mind it is the duty of the States regardless of their political, economic and cultural systems to promote and protect all human rights and fundamental freedoms*".

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# Human rights initiatives in mental health care in India: historical perspectives

## G. Venkatasubramanian

## Introduction

> "All human beings are born free and equal in dignity
> and rights. They are endowed with reason and
> conscience and should act towards one another in a
> spirit of brotherhood."

<div align="right">[United Nations Universal Declaration of Human Rights]</div>

Human rights encompass the "basic rights and freedoms to which all humans are entitled". This covers a broad range of rights related to civil and political issues, such as the right to life and liberty, freedom of expression, right to equality before the law and social, cultural and economic rights, including the right to participate in culture, the right to food, the right to work, and the right to education. The importance of human rights also reflects the progress that has been achieved by mankind in many of the above mentioned spheres. Undoubtedly, these advances have occurred due to a better understanding of the evolution of the human brain and mind. It is critical that the rights of human beings in the event of an "unsound" mind or mental illness are contextualised and examined with careful consideration.

Mental illness is a unique problem in that it affects the very basic faculty of human beings and can pose potential adverse impacts on both the suffering person as well as others. Thus, in the context of psychiatric disorders, while rights of mentally ill people should ensure them their due privileges in the community, it should also ensure protection against infringement of the rights of others (1).

| Rights of the Mentally Ill |
|---|

The rights of the mentally ill include the following (2):

- The fundamental rights as their fellow citizens, including the right to a decent life, as normal and full as possible.

- Legal safeguards against abuse

- Right to appeal

- Right to necessary treatment in the least restrictive set up and as far as possible to be treated and cared for in the community

- Right to rehabilitation

- Right to personal autonomy, privacy, freedom of communication

- Right to education

- Right to training

- Right to economic and social security

- Right to family and community life

- Right to employment

- Right for protection against exploitation and discriminatory, abusive or degrading treatment

- Right for assistance, including legal, for protecting their rights

## Human Rights and Indian Psychiatry

Major phases and revolutions have been described in relation to the history of psychiatry (3). The initial phases were predominated by the belief that sin and witchcraft were responsible for mental illness; mentally ill people were restricted to jails and asylums. Later, specific theoretical schools explaining the pathogenesis of psychiatric disorders from their respective perspectives created an impact in psychiatry. Further developments were related to the initiation and consolidation of community psychiatry that led to the integration of mental health care in the community.

While the historical roots of Indian psychiatry have been traced to periods as early as that of King Ashoka (3), spirituality has always been a pervading factor in understanding as well as treating psychiatric disorders in India. It

is noteworthy that descriptions of mental health have given consideration towards human rights even in earlier days of modern psychiatry in India (3). This chapter attempts to review the various historical perspectives with relevance to the human rights initiatives in mental health care in India.

## The Bengal Enquiry (1818)

One of the earliest descriptions referring to human right issues of the mentally ill was reported in the Bengal Enquiry of 1818 (2). This followed the select committee revelations on the regulations of psychiatric care in England in 1816. The enquiry indicated that the mental health care settings were sub-optimal – "the buildings are low and damp and not half-large enough for the number of patients, to which must be attributed the numerous deaths which occur". Inadequacies were observed in various domains like food supplies, staff handling of the mentally ill persons, issues related to restraining unmanageable patients and many other similar aspects. The recommendations suggested that the asylum had to ensure humane and caring behaviour of the staff towards the patients; also, with relevance to restraints, it was emphasised that "un-necessary coercion should never be used and that heavy iron chains should not be applied except in extreme cases where light leg chains may be used".

Some specific descriptions of the asylum followed: The asylum at Murshidabad was regarded as wholly unfit, the building altogether a wretched place even in its best state. The Rasapagla asylum in Calcutta was described in a worse situation. The asylum at Patna was said to labour under disadvantages greater even than those pointed out existed in Murshidabad. It was erected on a low ground close to the breeding ground of miasmas and was provided with poor quality water. This probably resulted in a high death rate of 52%. There was overcrowding in the Bareilly asylum, 105 patients were accommodated in 29 cells, with four persons often confined in a cell not bigger than 80 sq. feet. The Benares asylum was "*on a scale so contracted and insufficient and in appearance bore more resemblance to a prison than of an asylum for lunatics*"(2).

Diet supplies were also noted to be insufficient. Significant lacunae were observed in the handling of mentally ill persons in these asylums. Ernst summarised the 1818 inquiry as leading to "*only moderate control of gross abuses, rectification of the institution's physical defects whenever*

*practicable, and strongly expressed avowals to humane and moral treatment, proper gender segregation and classification of lunatics".*

## Investigations into the state of 'Native Lunatics in Bengal' (1840)

The second evaluation pertaining to mental health care issues was reportedly the investigation on the state of native lunatics in Bengal in 1840. This followed the suspicions of the European Superintendents' alleged corrupt practices as well as the highly divergent cure and death rates in the asylums. The summary of the findings emphasised the varying quality of conditions, influence of each superintendent's individual style of functioning, management and their individual commitment to patient care.

Consequent to this enquiry, the asylums in Benares, Delhi and Bareilly were condemned to be re-built. Around this time, it appeared compelling that basic amenities like diet and other factors like occupation for patients and the interest of the treating doctors were all vitally important. It was a paradoxical observation that at around the same time, surgeon Paton in Delhi was practicing what he considered a very effective approach of enforcing discipline and industriousness through 'food restriction' as punishment, which was reflected in a not altogether favourable cure; on the contrary, it resulted in increased death rates.

An overview of these early inquiries suggested that while they focussed on the responsibilities of the administrators, the Indian assistants and the role of the head keepers were never attached attention in the English documentation of Indian asylums (2).

## Developments during the early 1900s

This period was described as the 'third phase' of development during which time the mental hospitals that were till then under the charge of the Inspector General of Police, came under the charge of civil surgeons. The posting of specialist psychiatrists as full time officers in these asylums became a requirement. The centralised supervision of all asylums was planned in 1906 and was implemented formally under the Indian Lunacy Act of 1912.

Berkeley Hill, the then Superintendent of the Central European Hospital at Ranchi made a significant contribution to an attitudinal change towards

these institutions. He persuaded the government to change the names of the lunatic asylums to mental hospitals. Also, he highlighted the need to involve social scientists with the care of the psychiatric patients and the first efforts to train psychiatrists and psychiatric nursing personnel began during this period.

An Association of the Medical Superintendents of mental hospitals was also established and a manual for superintendents of mental hospitals was formulated in 1930. This manual described the procedures for care, administration, and treatments, as well as the roles of different levels of staff.

## Mapother's Report of 1938

The Mapother's report is considered as a significant step in elucidating the needs of the mental hospitals in India (2). This report compared the state of psychiatric services in London and India. The contrasting perspectives of the mental health scenario were evident in this report. While the psychiatric bed ratio was 1:200 in London, the same was 1:30,000 in India. Five out of 8 beds for medical diseases were for the psychiatrically ill in London, in contrast to 1 out of 7 in India.

There was significant overcrowding noted in the mental hospitals. For example, Yerawada had 29% overcrowding and Madras had 93% overcrowding. Due to overcrowding, there was an annual death rate of 123 / 1000 in Agra mental hospital. Mapother cited that "*indifference was stated commonly as a reason but this must be fought against*". He was very critical of the medical services in India, "*the Indians have been unable to exercise the authority to enforce change … the only thing they knew is to lock up the worst patients*".

Mapother was extremely critical of the state of the mental health hospitals and compared them on a scale of "badness". According to him, "*most mental hospitals are desolate wastes, based on the conception that the insane are indifferent to ugliness and are destructive*". Mapother mentioned Madras as the 'best' of the 'typical' mental hospitals in India. He described the mental hospital in Pune as 'inspired by the public work department concept of lunatic', with 'open air cages'. He advocated a comprehensive programme for re-organizing mental health services in India.

The re-organisation programme suggested by Mapother comprised the following:

- Admission Procedures:
    - Brief detention / observation exists but no short admission beds;
    - Voluntary admission exists but no beds in public wards.
    - India is not ready for non-volitional order on account of corruption.
    - Every case should be seen by a magistrate before and after admission for detention.
    - Certification for detention should be limited to experts with recognised qualifications.
- Visiting Committees needed to be set up.
- Deputy to Public Health Commission with knowledge of psychiatry to be appointed
- Institutional facilities to include:
    - Increase in beds irrespective of all pressures
    - Specialised services especially for the criminal, mentally retarded and involuntary patients
    - Classes of service to include – psychiatric clinic in Government hospitals and beds for mentally ill persons
    - Short treatments lasting for 1 month
- Improvements of conditions for chronic patients
- Increase in undergraduate education in mental health
- Diplomas to be started
- Teachers / researchers to have a stint of training abroad
- Well-trained staff and mental health nurses required
- Need to introduce social workers in mental hospitals
- Organised occupation of patients and training of those who supervise them is crucial
- Survey and public propaganda as to the true incidence of mental illness and whether certain illnesses could be prevented.

# Moore Taylor's Report

In 1946, Col. Moore Taylor, Superintendent of the European Mental Hospital at Ranchi and member of the Health Survey and Development Committee (Bhore Committee) was asked to survey mental hospitals and his report was based on his observations of 19 mental hospitals. His observations and recommendations were summarised as follows: "the majority of mental hospitals in India are out of date, and are designed for detention and safe custody without regard to curative treatment. The conditions of many hospitals in India today are disgraceful and have the makings of a major public scandal".

Many of Taylor's observations concurred with the earlier observations by Mapother. The following were the recommendations of the Moore Taylor's Report (2):

- Qualified and trained psychiatrists to head mental hospitals;

- Need for adequate staffing;

- Post-graduate training courses with adequate emphasis on prophylaxis and prevention in line with the principles of modern preventive medicine;

- Uniformity in undergraduate training in psychiatry;

- Mental hospitals should be teaching institutions and attached to medical colleges;

- Need for a mental health service, with improvement in the status, pay and conditions of service of the medical staff, with increased opportunities for purely professional work;

- Urgent necessity for better trained nurses;

- Increase in the number and quality of ward personnel;

- Theoretical and practical instructions for both nurses and ward personnel;

- Need for a more systematic and better conceived plan of work therapy and diversional therapy;

- Special homes for patients with physical problems (medical or nursing) under the supervision of the Medical Services (It was

observed by Moore Taylor that more than 50% of the patients in mental hospitals could be cared for in such homes);

- Need for outdoor clinics in mental hospitals;

- Services addressing mental health issues in schools, child guidance clinics, juvenile homes and remand homes;

- Psychiatry should not be segregated, but form links with other medical specialties. Nonetheless, Taylor cautioned that to open psychiatric units in general hospitals before there are trained personnel to conduct them would be sub-optimal. Once this was achieved the general hospital could bear its share of mental illness treatment and prevention activities;

- Need to create goodwill about mental hospitals by *"letting the community know that the mental hospital has a real service to be given; convincing people that they need what it has to offer; making it easily obtainable; making people glad they can have what the institution has to offer"*.

The onus of improvement of mental health services was placed on the government. Taylor mentioned that "*this is a suitable time for Government to take stock, overhaul resources, and rechart the course for the next 30 years*".

## Bhore and Mudaliar Committees

The description as well as the recommendations of the Bhore Committee have been summarised in the compilation – *Mental Health – An Indian Perspective* (4). The Bhore Committee divided mental ill-health conditions into two groups, i) mental disorder and ii) mental deficiency. *Mental disorder may be either inherited or acquired, and very often is both. No age is exempt from mental disorder although the types may be different at different age periods. A large proportion of them are amenable to modern methods of treatment. Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring just before or soon after birth.*

The Bhore Committee commented that the present position in India is extremely unsatisfactory. It mentioned that chronic starvation or under-nutrition, tropical fevers, anaemia and frequent childbirth in women who are unfit for motherhood are responsible for the large numbers of mental breakdown in India. The report estimated the requirement of beds for

mentally ill at that time to be about 800,000. Only a little over 10,000 beds were then available for these patients. Given the deficiencies of mental health care in India, the Bhore Committee came out with the following proposals which can be summarised as below (4).

The Bhore Committee recommendations (1940) for mental health, based on Moore Taylor's report, called for improvements in mental hospitals and the need for medical and ancillary mental health personnel. It was also instrumental in the formation of the National Institute of Mental Health and Neurosciences (then known as the All-India Institute of Mental Health) in Bangalore.

The committee suggested that the most important step to be taken was the formulation of a mental health programme for the country after a preliminary investigation of the needs of individual provinces. "*Such a programme should aim at providing for the community, in successive stages, a modern mental health service embracing both its preventive and curative aspects. As a part of the implementation of such a programme two of the most urgent needs that should be met are (1) an improvement and augmentation of existing institutional facilities for the treatment of mental ill-health and (2) provision for the training of different types of mental health workers, including doctors and ancillary personnel*". With these objectives in mind, the following recommendations were made by the Bhore Committee for a short-term programme (4):

a) Creation of mental health organization as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;

b) Improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;

c) Provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India; and

d) Establishment of a Department of Mental Health in the proposed All-India Medical Institute.

Importantly, there had been a mention about the promotion of positive mental health, "*the pursuit of which requires the harmonious development of man's physical, emotional and intellectual equipment*". The Bhore Committee recommended that apart from provision for the

prevention and cure of specific forms of ill-health, physical and mental, many of the proposals by the Committee, for example, those dealing with health and physical education, the social aspects of programmes for mothers and children, for the school going population and for industrial workers, the removal of slums and the creation of parks and other facilities for promoting community life should also help to raise the level of mental health in the community.

The Mudaliar Committee envisaged the development of psychiatric units in all district hospitals in the subsequent ten years. The Medical Council of India mandates the setting up of Departments of Psychiatry at all medical colleges.

## Medical Superintendents' Workshops: Summary of the proceedings

Four workshops on the improvement of mental hospitals in the country were conducted over a period of 30 years between 1960 and 1990. These included the first conference of Superintendents of Mental Hospitals in India held in November 1960 at Agra, WHO workshop on "Mental Hospitals in India: Present Status, resources and future needs" at Ranchi in February, 1986, Workshop on Mental Hospitals in India held as part of the NMHP implementation at NIMHANS, Bangalore in March 1988, and a WHO workshop on Future Role of Mental Hospitals in Mental Health Care in India held at IHBAS, New Delhi in December 1990.

The following were the themes of focus at all these workshops:

- Improvement of living conditions;
- Improvement of hospital infrastructure and function;
- Definition of role of various personnel;
- Training of staff in mental hospital;
- Provision of outpatient and emergency services;
- Provision of daycare and rehabilitation services;
- Extended role of mental hospitals in teaching and training;
- Need for special services (child, old age, drug and alcohol, criminal mentally ill);

- Need for development of GHPUs;
- Need for development of alternative services and linkage in the community for mental health care;
- Undergraduate and postgraduate training and refresher courses in psychiatry for other professionals;
- Mechanisms for internal and external monitoring.

While the workshops were well attended and these above-mentioned recommendations were formulated by mental health professionals, only a few of them had resulted in visible changes (2).

## Quality Assurance Project in Mental Health

While the last few decades of the 20th century witnessed significant growth of private psychiatric institutions for the mentally ill, general hospital psychiatry, initiation of the National Mental Health Programme with focus on community psychiatry as well as the enactment of the Mental Health Act of 1987, the issues related to the care of the mentally ill with relevance to human rights needed comprehensive review. There was a need to be proactive in ensuring that the basic rights of the mentally ill were protected. Also, there was a need for the standards of mental health care to be reviewed. This led to conceptualisation and implementation of the project on quality assurance in mental health care (2). The details of this project are discussed in further chapters.

## Minimum standards of care in mental hospitals

The Central Mental Health Authority recommended the development and implementation of a set of minimum standards of care in all the mental hospitals in the country. Guidelines for minimum standards of care were prepared after consultative meetings of medical superintendents and state health secretaries in February and June 1999 (5).

## The National Mental Health Programme

The National Mental Health Programme which was initiated in 1982 (6), was re-energised in 1996 and the District Mental Health Programme was initiated in different states in a phased manner. Under the 11th Five Year Plan, this programme was restrategised and strengthened based on guidelines formulated at a national consultative meeting held in 2006 (7). This is detailed in subsequent chapters.

# Conclusion

Review of the historical perspectives on human rights initiatives in mental health suggests that there has been a continued emphasis on ensuring the ensuring the provison of human rights of the mentally ill. While these reports highlighted the inadequacies in the older and existing mental health setup, they have suggested important recommendations to correct these lacunae.

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# Mental health legislation: an Indian perspective

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## Introduction

People with mental disorders are particularly vulnerable to abuse and violation of their rights (1). If a protective mechanism is not in place, they can be susceptible to abuse by anyone in society including family members, spouses, caregivers, professionals, friends, fellow citizens and even law-enforcing agencies. Legislation is an important mechanism to ensure appropriate, adequate, timely and humane health care services. It also helps in the protection of the human rights of the disadvantaged, marginalised and vulnerable citizens. Ensuring human rights of these groups is reflective of a civilised society that respects and cares for its disabled and marginalised citizens. This, in turn, clearly reflects high values, morals, attitudes, culture, traditions, customs, aspirations and practices.

In a country like India, mental health care is not perceived as an important aspect of public health care. Hence, mental health legislation will play a very important role in upholding the rights of the mentally ill (2). The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens. In the undeniable context that every society needs laws to achieve its objectives, mental health legislation is no different from any other legislation (1). It also plays a vital role in dictating the terms and conditions of mental health care and protecting the human rights of people with mental disorders.

## Principles of mental health care law

The World Health Organization (1996) prescribes ten basic principles for 'Mental Health Care Law' (3) that has been outlined in Chapter 1.

Mental health legislations were initially drafted with an aim or safeguarding members of the public from dangerous patients and isolating them from the public when there was no treatment or minimal treatment available. A paradigm shift from custodial care to community care has occurred because of the following reasons: a) Proactive legislation; b) advances in

medical technology in assessment and treatment of mental disorders; c) human rights movement; d) WHO's definition of 'health' (4) and e) promotive, preventive, curative, rehabilitative approaches and mitigation of disability. This shift has given a new perspective to the care of mental disorders and has led to the review of mental health legislation (5).

*Preventing discrimination*

The available laws should address not only curative but also preventive, promotive and rehabilitative aspects. Legislation is needed to prevent discrimination against persons with mental disorders (1). Discrimination takes many forms, affects several fundamental areas of life and is pervasive. Discrimination and stigma may impact access to adequate treatment and care as well as other areas of life, including employment, education, marriage and shelter. The inability to integrate into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn, aggravate mental disorder. The presence of mental health legislation, however, does not in itself guarantee respect and protection of human rights (1) until there is commitment from political and social structures as also the people concerned in implementation.

# Mental Health Legislation in India

Worldwide, mental health legislations are concerned mainly with: (i) rights of the mentally ill (right to care and human rights), (ii) quality of care, (iii) the use of administrative and budget control measures, and (iv) consumer participation and involvement in the organisation and management of mental health care services (6). There have been significant advances with respect to mental health legislation in India. These achievements include legislations and case laws. The purpose of this chapter is to briefly review important legislations of India. Legislations that come under the purview of mental health in chronological order include:

1. Narcotic Drugs & Psychotropic Substances Act, 1985 (NDPS 1985)

2. Mental Health Act, 1987(MHA 1987)

3. Rehabilitation Council of India Act, 1992 (RCI 1992)

4. Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995(PWD 1995)

5. Juvenile Justice (Care and Protection of Children) Act, 2000 (JJA 2000)

6. National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (NTA 2001)

7. Protection of Women from Domestic Violence Act, 2005 (DMV 2005)

All the above legislations have one common objective, which is providing dignified living, protecting human rights, and addressing the promotive, preventive and curative aspects of mental health. Almost all the above acts have excellent vision and many positive aspects. We discuss below the main features of the act and focus on their shortcomings and possible remedies.

## Mental Health Act 1987 (MHA 1987)

As this is the primary act relating to mental health, it is discussed first and in relatively more detail.

**THE MENTAL HEALTH ACT (7)** was enacted in 1987, and came into force in 1993, replacing the Indian Lunacy Act, 1912. It has been described as *"An Act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto".*

MHA is divided into 10 chapters consisting of 98 sections (7). The following are the chapters - I-Preliminary, II-Mental Health Authorities, III-Psychiatric hospitals and psychiatric nursing homes, IV-Admission and detention in psychiatric hospital, or psychiatric nursing home, V-Inspection, discharge, leave of absence and removal of mentally ill persons, VI -Judicial inquisition regarding alleged mentally ill person possessing property, custody of his person and management of his property, VII-Liability to meet cost of maintenance of mentally ill persons detained in psychiatric hospital or psychiatric nursing home, VIII-Protection of human rights of mentally ill persons, IX Penalties and procedure and X-Miscellaneous.

To summarise, the objectives of MHA are to:

1. Establish a Central Authority and State Authorities for Mental Health Services.

2.   Regulate the minimum standards for establishing, licensing and controlling psychiatric hospitals and psychiatric nursing homes for mentally ill persons.

3.   Regulate the procedure of admission and discharge of mentally ill persons to the psychiatric hospitals or nursing homes either on voluntary or involuntary basis.

4.   Protect the rights of such persons while in custodial care.

5.   Protect society from the violent mentally ill persons.

6.   Provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their property.

7.   Provide free legal aid to mentally ill persons at state expense in certain cases.

8.   Avoid offensive terminologies (like lunacy, asylum, wandering lunatics and so forth) and to use neutral terms (Mental hospital, mentally ill patient, wandering mentally ill patient) thus upholding the dignity and respect of mentally ill persons.

MHA has its own merits and demerits. The present MHA gives an easy-to-use approach for admission and discharge procedure of mentally ill persons. However, some of the provisions in the MHA need review and amendments.

*Hospital Standards*

MHA is a proactive legislation to achieve the ideal minimum standards of mental hospitals but is difficult to implement pragmatically because of acute shortage of manpower resources. MHA excludes government mental hospitals from obtaining licenses, as they are under the direct supervision of the Central and State Mental Health Authorities (Chapter 2, sections 3 and 4). The issues relating to government hospitals have been taken up by the National Human Rights Commission (8) and state mental health authorities and state administrations have become actively involved in monitoring the functioning of the government psychiatric hospitals.

Psychiatry units in general hospitals are kept out of the purview of the MHA. This is an essential and positive step for two reasons: it encourages voluntary treatment of persons with serious mental disorders; common mental disorders like anxiety and depression, which do not come under the purview of the MHA are effectively treated in these settings. Proper

utilisation of general hospital psychiatric services can decrease discrimination and stigma, and increase utilisation of mental health services.

*'Convalescent home' vs 'psychiatric hospital'*

A convalescent home is a facility for the care of individuals who do not require hospitalisation and who cannot be cared for at home. This is similar to the concept of a 'halfway home' – a rehabilitation centre where people who have left an institution, such as hospitals are helped to readjust to the outside world. However, in the, MHA, definitions of 'convalescent home' and 'psychiatric hospital' and 'psychiatric nursing home' are clubbed together and both the terms are equated for legal purposes. The definition (7) of 'psychiatric hospital' or 'psychiatric nursing home' means a hospital, or as the case may be, a nursing home established or maintained by the Government or any other person for the treatment and care of mentally ill persons and includes a convalescent home established or maintained by the Government or any other person for such mentally ill persons. This implies that the minimum standards applicable to psychiatric hospitals which deal with acutely disturbed patients with severe illness also apply to convalescent homes, where the focus is on rehabilitation and reintegration into the community. This has lead to an outcry among private convalescent homes and rehabilitation centres operated mainly in the non-governmental sectors whose aims and functions are distinct from psychiatric hospitals. It is a matter of debate whether these organisations should be brought under the purview of the Mental Health Act, or whether their monitoring should be brought under alternative Acts like the Rehabilitation Council Act.

The MHA sets minimum standards for institutional care. Lack of standards and monitoring mechanisms can give rise to disasters, best exemplified by the horrific incident at Erwadi in Ramanathapuram (9). Ensuring adequate standards of care both in institutions and in the community requires active public-private linkages, as only governmental agencies cannot comprehensively shoulder the responsibility of the care of the mentally ill. Epidemiological data suggests that 6 to 7% of mentally ill persons need active professional mental health assistance at any point in time (10).

*Choice of treatment*

MHA has clearly laid down the procedures of admission and discharge of mentally ill persons. However, when it comes to intervention, the Act is

silent regarding the choice of treatment, consent for treatment, and the method to be adopted when a severely ill patient refuses well established treatments like medication or modified electroconvulsive therapy (ECT). Some psychiatric hospitals continue to use unmodified ECT, without the consent of the patients or the legal guardian. This is common in situations when a patient is admitted to a mental hospital in a closed environment and family members are not available to give informed consent on behalf of the patient. Some hospitals have evolved standardised protocols for patients unable to provide consent for ECTs. One method has been to obtain the opinion of two independent psychiatrists and the consent of the hospital RMO or superintendent who acts as a surrogate guardian.

Available evidence clearly documents the efficacy of ECT. Hence, this treatment continues to exist in many developed and developing countries. The debate is whether to consider modified ECT (under anesthesia) or unmodified ECT (without anesthesia). While modified ECT is preferred over unmodified ECT, non-availability of anesthetists poses a practical difficulty as does the relatively greater cost of ECT (Rs 300 to Rs 900 more per patient per ECT). Overall, the cost difference for one course of ECT is approximately Rs 2500 to Rs 7000. The issue of anaesthetist unavailability has led to some facilities continuing with direct ECT. The issue of cost should not be a factor for considering unmodified ECT treatment which, even if effective is inhuman. Consider the same issue in a different perspective: if it were proposed to conduct a surgical operation without anesthesia, how many would consent to it? Use of unmodified ECT has resulted in severe stigma attached to this potentially useful treatment. Considering the well established efficacy of modified ECTs and from a human rights, perspective, modified ECT's should be mandated, unless specifically contraindicated (in situations of hypersensitivity or delayed recovery from the pre-ECT drugs used).

*Psychiatric Emergency Services*

De-institutionalisation, ie., minimising custodial care and encouraging treatment of the patient in the community is a wonderful concept, but can only occur if community outreach services and resources are strengthened. There are many helpless families requesting emergency ambulance services to escort or shift a violent patient to psychiatric hospital. Unfortunately, there are no guidelines or provisions under MHA for crisis intervention to help these families. There are many instances in which helpless family members have approached the nearest police station seeking help to

transfer a disturbed person to the hospital. These requests are ignored without any thought of helping them. Finally, helpless family members are sometimes forced to file complaints against the individual for petty crimes like violence, assault, property destruction and so forth. Under such circumstances, law-enforcing agencies file an FIR for the petty crime, arrest the the mentally ill person and have him/her referred to a psychiatric hospital. It is ironic that there should be such a complicated approach and the, accusation of a petty crime be thrust on a mentally ill person just to provide emergency treatment!

## Rehabilitation of mentally ill persons

Though MHA elaborates on the admission and discharge procedures, there are no provisions available for rehabilitation/aftercare of the mentally ill persons under this Act. This requires to be addressed because treatment of mentally ill persons does not end with hospitalisation and medication. They require social and vocational rehabilitation.

## Placement of mentally ill persons

There are many mentally ill who are admitted to hospital and later abandoned by their family members. Their discharge is difficult and they are detained indefinitely inside the hospital. Often, especially in the case of women, they cannot be sent home alone. There are no provisions in the Act for placing these treated and stable persons in other social welfare institutions. This issue calls for inter-sectoral coordination between the Departments of Health, Women and Child Development, and Social Welfare.

## Dumping of the mentally ill

Psychiatric hospitals have become 'dumping grounds' for families to abandon their mentally ill members. This occurs either due to economic reasons or because of a lack of understanding and awareness of mental illness. The ill individuals are kept in hospitals for longer periods than required by their family members. MHA does not discuss about the placement and rehabilitation of these cured mentally ill persons. It should also state that family members must also shoulder the responsibility of care along with the necessary help, support and guidance from the state.

## Death and mental illness

Mental illness carries an increased risk of mortality when compared to

general population. On an average mental health problems like depression or schizophrenia are associated with higher rates of suicide (approximately 10% with these illnesses commit suicide) when compared to the general population. However, the issue of death during custodial care of a mentally ill person is not addressed in MHA (11).

The following factors can contribute to increased mortality (8):

a) Known risk of mortality in mentally ill persons;

b) Lack of manpower (Doctor/nurse/attendent to patient ratio) to monitor persons at risk;

c) Absence of training of the other (non-medical) staff on how to restrain a violent individual;

d) Greater vulnerability of mentally ill persons to physical illness;

e) Disease outbreaks in hospitals;

f) Non-availability of life-saving medicines and general medicines;

g) Poor protective clothing especially in adverse climatic conditions;

h) Violence among in-patients;

i) Suicide or deliberate self-harm.

Many of the mental hospitals in India do follow good clinical practice by conducting a postmortem to ascertain the cause of death. Good clinical practice should be fostered without undue threat to the existing staff of possible legal action. Otherwise they may adopt defensive practices as are sometimes seen in private hospitals, where serious cases/patients are referred to other centres.

## Substance Dependence

There is a provision for establishment of separate psychiatric hospitals and psychiatric nursing homes for *children,* those who are *addicted to alcohol or other drugs which lead to behavioural changes* and *convicted persons.* It is not uncommon to get repeated requests from the family members of substance users for admission and treatment against the consent of the users. However, MHA remains silent on the issue of admission and treating persons with substance dependence *without any behavioural changes* who refuse consent for treatment.

## Mentally ill Prisoners

Such persons can be admitted and detained at psychiatric hospitals under MHA, Sec 27 (7). However, no provisions have been made for a baseline assessment (during induction into prison) and periodic examination of all the prisoners for mental illness. Many international studies have shown a high prevalence of mental disorders among prisoners. There are many public interest litigations regarding the issue of detaining mentally ill persons in jails. Unfortunately, only a few prisons in India have attending psychiatrists. This issue of mental health examination and assessment of prisoners requires to be streamlined and a system should be developed in which a copy of the FIR and charges framed against the referred mentally ill prisoner are made available to the treating psychiatrist. This will not only help the psychiatrist in understanding the mental condition of the prisoner during the crime, but also enable proper precautions to be taken with regard to his/her treatment and care. Another important issue from a human rights perspective is fitness to stand trial. If an accused is suffering from mental illness at the time of trial, the presiding judge will not be able to proceed with the case until the accused becomes mentally fit to stand trial. There is no clear provision in the MHA with regard to further proceedings if a patient is chronically ill, treatment resistant and never likely to be fit to stand trial. For such mentally ill prisoners arrested for crimes for which they will never be fit to stand trial, there must be provisions in law for further care outside the prison setting.

The National Institute of Mental Health and Neuro Sciences, Bangalore in collaboration with the Department of Prisons of Karnataka has recently launched a project titled "Mental Health: Assessment and Approach in Prisons", with financial support from the Karnataka State Legal Services Authority, Bangalore. One of the expected outcomes of this project is the development of minimum standards for mental health care in prisons and guidelines for the assessment of prisoners (12).

## Poor knowledge and implementation

Some of the judiciary and law-enforcing agencies have limited knowledge of the existence and provisions of the Mental Health Act leading to its poor implementation and utilisation. It is the duty of the police officer in-charge of a station to take into protection any person within the limits of his station whom he/she has reason to believe to be dangerous by reason of mental illness and to make necessary arrangements to admit wandering

mentally ill persons to a psychiatric hospital. In the absence of comprehensive awareness-raising activities, there is little scope for the scenario to change in the near future. MHA implementation and human rights for the mentally ill will remain a distant dream if the judiciary and executive are not adequately sensitised.

*Media and mentally ill persons*

Media including television, cinema and newspapers use mental illness as a means of publicity, sensationalism or misplaced humour. This includes caricaturing mentally ill persons by portraying them as dangerous, violent, serial killers, criminal or objects of ridicule. Such depictions continue to contribute to stigma and negative attitudes among the public. This negative depiction of mentally ill persons should be actively discouraged. There is no provision to take action against such human right violations of the mentally ill.

*Guardianship for persons with mental illness*

A person of unsound mind may not be capable of managing his affairs and property. The MHA has provision for appointing a guardian for care and a manager for management of property of mentally ill persons. However, this provision is rigid and cumbersome. This aspect requires simplification at least for the natural guardian on the lines of the procedure outlined in the National Trust Act 1999.

# Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation) *(PWD Act 1995)*

Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full Participation) 1995 (Act 1 of 1996) was unanimously passed by both the houses of Parliament on 22nd December 1995, but came into force only on February 7, 1996 (13).

This Act consists of 14 chapters and 74 sections (13). Each section is further divided into several subsections. I – Preliminary, II - The Central Coordination Committee, III - The State Coordination Committee, IV - Prevention and Early Detection of Disabilities, V – Education, VI – Employment, VII - Affirmative Action, VIII - Non-Discrimination, IX - Research and Manpower Development, X - Recognition of Institutions

for Persons with Disabilities, XI - Institution for Persons with Severe Disabilities, XII - The Chief Commissioner and Commissioners for Persons with Disabilities, XIII - Social Security and XIV - Miscellaneous

*Salient features of the Act*

This Act is an important landmark and is a significant step in the direction of ensuring equal opportunities for people with disabilities and their full participation in nation-building. The Act provides for both preventive and promotional aspects of rehabilitation. Areas covered include education, employment, vocational training, job reservation and research and manpower development. It seeks to create a barrier-free environment, rehabilitation of persons with disability, securing unemployment allowance for the disabled, providing special insurance scheme for disabled employees and establishment of homes for persons with severe disability.

*Poor knowledge of the Act*

The Disability Act of 1995 defines 'disability' as (i) blindness; (ii) low vision; (iii) leprosy-cured; (iv) hearing impairment; (v) locomotor disability; (vi) mental retardation, and (vii) mental illness. There was much ignorance among policy makers and administrators about mental illness as a disability, but this is slowly changing. Comprehensive awareness-raising activities regarding the Act must be undertaken. Though the Act came into force in 1996, the disability assessment for mental illness was procedurised only in 2001. The Indian Disability Evaluation and Assessment Scale (IDEAS) (14) was accepted and published in 2002.

*Representation for mentally ill persons*

There have been no representatives or representation for persons with mental illness in the Central Coordination Committee. Sufferers and users of services must be included in such committees to ensure fair and equitable delivery of mental health care (15).

*Discrimination with regard to employment*

The disability associated with chronic mental illness is invisible and the impact on family members and the community is enormous. Most of the welfare work with regard to mentally ill persons has been undertaken as a 'knee jerk reaction' to certain situations or public outcry. There is a wrong notion that a person with mental disability is incapable of working. Hence,

mentally disabled persons are either discouraged or not allowed to apply for a job. This is a delicate issue which needs to be debated.

*Rehabilitation of mentally ill persons*

Community Based Rehabilitation (CBR) has been advocated by WHO and by many international agencies for more than two decades. CBR improves self-esteem, empowerment, self-reliance and social inclusion, which improves the quality of life of persons with disabilities. Despite this, the majority of government psychiatric hospitals or medical colleges do not offer rehabilitation facilities for mentally ill persons. Though chapter IV (Prevention and Early Detection of Disabilities) and chapter VII (Affirmative Action) discusses promotion and prevention, the curative and rehabilitative aspects are missing. Unfortunately rehabilitation of mentally ill persons, which is highly essential, has been ignored. This aspect has not been captured either in MHA or PWD Act. Development of halfway homes, vocational training centres, social-skill training centres, cognitive retraining centres, day-care centres and long-stay centres requires advocating and initiating at regional levels.

*Indian Disability Evaluation and Assessment Scale (IDEAS)*

The Rehabilitation Committee of the Indian Psychiatric Society evolved an assessment tool called the Indian Disability Evaluation and Assessment Scale (IDEAS) (14, 16). This has been field-tested in eight centres in India. This instrument is simple and comprehensive in quantifying mental illness. It assesses disability on five dimensions, namely, 'Self-Care'; 'Work' ;'Interpersonal Activities', 'Communication and Understanding'; and 'Duration'. Initially IDEAS was devised and advocated for four important psychiatric disorders: Schizophrenia, bipolar disorders, obsessive compulsive disorders and dementia. However, as per the gazette notification, disability certificates can be issued for all mental disorders.

The Ministry of Social Justice and Empowerment, Government of India gazetted it in 2002 after certain modifications in the scale (14, 16), with respect to duration of illness. The original version had a simple method called MY 2Y (16) – months of illness during the last two years. For certification it was necessary that the total duration of illness should be at least two years. The original IDEAS adopted 'duration of continuous illness' rather than 'duration of illness' as a criterion to determine disability. In its modified form, it becomes difficult to compute total duration of illness for episodic disorders.

*Temporary Disability certificate*

The PWD Act makes a provison for providing temporary disability certificates in certain situations. The treating professional can indicate the duration for which the certificate is valid, and may suggest periodic re-evaluation. When not specified, it is assumed that such a certificate is valid for five years. This information is not widely known, and in several instances such certificates have not been honoured by concerned administrators, and patients have been denied their rights.

*Quantification of disability*

The disability scores for mental retardation are expressed in terms of mild, moderate, severe and profound disability as follows (14): Mild Disability (d"40%), Moderate Disability (40-70%), Severe Disability (71-99%) and Profound Disability (100%). Although these ranges have been notified in the gazette, in many cases, administrators still insist on a specific percentage (above 40%) to provide benefits. They need to be educated about the provisions. An alternate option would be for persons providing certification to express the calculated score in median percentage rather than on a range.

*Travel concession*

While knowledge of travel concession benefits for mental retardation is more widely known, that persons with mental illness are also eligible for the same concessions is little known. This concession will greatly help people who often have to travel long distances for consultation.

PWD Act 1995 is a milestone in the history of Indian legislation. This legislation has moved beyond the concept of charity for the disabled by rewriting it into their individual rights. However, the main weakness of this legislation is the absence of a strong monitoring and implementing system.

## National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 *(NTA 1999)*

NTA 1999(17) provides for the constitution of a national body for the welfare of people with autism, cerebral palsy, mental retardation, and multiple disabilities. The Act mandates: a) promotion of measures for their care, b) protection of persons with these disabilities in the event of the

death of their parents, c) procedures for appointment of guardians and trustees, and d) support to registered organisations to provide need-based services in times of crisis to the families of the disabled (18). This Act also encourages and supports the formation of Parent's Associations where persons with intellectual, severe and multiple disabilities are themselves unable or unwilling to engage in self-advocacy.

One of the criticisms that the National Trust Act has been facing is regarding the appointment of guardians for taking care of and making proxy decisions on behalf of the disabled. This, it is argued, defeats the very purpose of empowerment, equality, rights and full participation goal. Asserting that each individual should make their own decisions does not mean that each individual does not need help, assistance and support in doing so. It should rather be a 'shared decision' making or 'assisted decision' making or 'informed decision' making. The combination of ownership (patients) and responsibility (guardians) is most empowering.

Recognising and responding to the need to provide facilities to persons with disability help them live with their own families in the community, providing protection/care/support when family members are unavailable is definitely a boon to mentally ill persons and their family members.

## Rehabilitation Council of India Act 1992 (RCI 1992)

The RCI (19) is responsible for standardising, regulating and monitoring training courses for rehabilitation professionals, granting recognition to institutions running courses, and maintaining a Central Rehabilitation Register of rehabilitation professionals. The RCI Act was amended in 2000 to give RCI the additional responsibility of promoting research in rehabilitation and special education (20). This Act contains only three chapters, I-Preliminary, II-Rehabilitation Council of India & III-Functions of the Council.

A person possessing the necessary qualification has certain rights and can practice rehabilitation (Sec 13). The Act regulates the standard of education, training and examination (Secs 14, 15). Recognition of the Institution (21) can be withdrawn if it does not fulfill requirements as specified in the Act (Sec. 17). Infamous conduct or any illegal practice done by such a person may cause the removal of his/her name from the register (Sec. 21) (21).

## The Protection of Women from Domestic Violence Act 2005 (DMV 2005)

As per the DMV 2005 Act **(22)**, domestic violence is defined in terms of mental, physical, sexual, verbal, emotional and economic abuse. This legislation recognises a woman's right to live free from violence (23) and is critical to a person's mental health.

Disputes, differences of opinion, economic difficulties, criticisms and gender differences occur in every family. Previously, a majority of these problems were solved by families themselves or by the elders of the family. Now, these family differences and difficulties have reached new legal dimensions. DVA may help many women who are silently undergoing domestic violence to get help. The Act if utilised in a proper manner, can prevent domestic violence and can be a boon for Indian women. For example, a lady lodged a case against her husband for beating her with an umbrella, as a result of which she sustained injuries on her face. This violent act took place when the man demanded money from her for alcohol and on her refusal, decided to punish her. This man was arrested under DVA and subsequently referred for counseling (24).

There are many instances during which the Anti Dowry Act has been misused and then the whole family has been punished. This new legislation leaves the male members unprotected in circumstances of a woman mounting an attack on men. On the contrary, this Act may be misused in situations where family ties have weakened (for example, between brother and sister), because of greed for property or just to harass, punish or blackmail a family member.

In domestic violence, the weaker gender requires more than just legislation. Victims will need shelter, food, social support, emotional support, legal aid, financial aid and above all, safety. The important question which requires to be answered is whether we have a system to support and empower women.The government should work towards improving the social, health, economic, educational and occupational status of all women. This will lead to true empowerment.

As with any law, there will always be a possibility of its misuse. All members of society need to look at this Act from a different perspective. This Act will provide relief and support to millions of abused women.

# Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS ACT 1985)

Drug abuse has become a major social, economical, health and crime related issue. It destroys not only the individual, the family, and society but also adversely affects the economic growth of the country. Drug use is no more an individual problem but a global issue. To combat this problem, the Indian Government took a first step by enacting the Narcotic Drugs and Psychotropic Substances Act, 1985, also known as the NDPS Act (25). Under this Act, the cultivation, production, manufacture, possession, sale, purchase, transportation, warehousing, consumption, inter-state movement, trans-shipment, and import and export of narcotic drugs and psychotropic substances is prohibited, except for medical or scientific purposes. The NDPS Act focuses on three different categories of persons liable for prosecution. They are:

a) Drug manufacturers / Cultivators

b) Dealers / Traffickers /Transporters

c) Consumers (Substance users / addicts)

Under section 27 of the Act, who so ever consumes any narcotic drug or psychotropic substance shall be punished (26). This clear prohibition and penalty for personal consumption raises important issues in terms of mental health treatment and rehabilitation. The legal implication when a person comes to a rehabilitation centre directly for treatment reporting that he/she was consuming banned drugs is unclear. Should the mental health professional treating him/her inform the law-enforcing agencies? If mental health professionals start informing law-enforcing agencies, then the people who seek voluntary treatment will decline rapidly. The Act has partially addressed this issue by providing once in a life-time immunity against conviction for undergoing de-addiction treatment if he/she is willing to execute necessary bond prescribed under the Act.

This Act does not differentiate between the offender groups. The first two groups (manufacturers and traffickers) have monetary motives, whereas the third group (consumers) is a drug dependent group, which does not have any profit-making motive but requires treatment. Research has proven beyond doubt that substance dependence is an illness and requires treatment for long duration.

Section 27 of the NDPS Act states that individuals found to be in illegal possession of drugs in a small quantity for personal use are liable to punishment up to six months of imprisonment or fine or both, which, in case of hard drugs like heroin would be up to one year's imprisonment or fine or both. Section 27 of this Act requires amendment because of the following reasons:

a) Substance dependence syndrome is a life-long illness like diabetes and hypertension. In substance dependence, relapse is a rule rather than an exception. Hence, provision like once in a life-time immunity for treatment is simply not practical.

b) Treatment is made available only after executing a necessary bond in the court as prescribed under the Act. Seeking courts' permission before treatment is impractical. It also goes against the concepts of right to health and confidentiality.

c) NDPS Act may itself act as a deterrent for people seeking treatment when they relapse.

d) The quantity fixed is so small that it may not suffice for even a single use and such provisions make it difficult for persons with addiction to openly seek medical help and rehabilitation.

The NDPS Act should act as a facilitator for treatment for persons with substance use. Amendment of Sec 27 is necessary to facilitate treatment especially for users. In practice, this section is rarely seen in operation. This Act's emphasis should be on stringent action against people involved in manufacturing and trafficking of drugs.

## The Juvenile Justice (Care and Protection of Children) Act, 2000

The JJ Act 2000 (27) came into force in Feb 2001, repealing the earlier Act of 1986. This Act focuses on two different types of child populations: a) juveniles in conflict with law (law offending children) and b) children in need of care and protection (neglected children). This Act ensures protection, proper care and treatment by catering to the developmental needs of this population. This Act also promises a child-friendly approach in the adjudication and speedy disposition of matters in a newly formed juvenile jurisprudence. In this Act, every human being below the age of 18 years is treated as a juvenile and this group is exempt from death penalty and degrading punishment.

This Act has a serious drawback of falling back on the same old custodial centres. Instances of children being ill-treated, physically and even sexually assaulted by the staff or by older residents (seniors) of these institutions, are not uncommon. This issue needs to be addressed seriously. However, there is provision in the Act for social reintegration through restoration (back to home), adoption, foster care, sponsorship and sending the child to after-care organisations. It also attempts to develop a greater co-ordination and collaboration through joint ventures between the governmental and non- governmental agencies, families, corporate and other stake holders.

The JJA 2000 provides for the rehabilitation and social integration of children in conflict with law as well as children in need of care and protection (27). There should have been more emphasis on investing in the establishments of institutions governed under JJA. Many of the institutions established under this Act only provide some shelter but have no quality of care is missing. This ultimately defeats the very purpose of the Act to protect and promote the rights of children by providing safe, protective, rehabilitative and social reintegration for full participation.

## Conclusion

People with mental disorders are one of the most vulnerable populations in society. They are often isolated, stigmatised, discriminated, humiliated and marginalised. They often end up in unhygienic and inhumane living conditions either in the community or in the mental hospitals with increased likelihood of human rights violation. Hence, mental health legislation acts as an important means of protecting the rights and dignity of persons with mental disorders. It also provide a legal framework for addressing issues such as admission, treatment, care in institutions and discharge; civil, political, economic, social and cultural rights; and implementation of mental health policy and programmes. Ultimately, objectives of all the mental health legislations are to ensure equal access to mental health services, protection of human rights and reintegration of person with mental disorders into the mainstream of society.

Significant changes in Indian mental health legislations have occurred over the last two decades. Though there may not be a single comprehensive legislation, various acts have addressed many critical issues of mentally ill persons, like provision for treatment, protection against discrimination, providing equal opportunities, promoting mental health of high risk population groups like women and children, prevention and regulation of

narcotics and psychotropic substances and providing guardianship. Human right issues of persons with mental illness have, however, not been covered comprehensively in any of the acts.

A majority of the Indian legislations have focused on institutional treatment but failed to address community-based mental health care. Provision to address vital issues in the promotion of mental health and prevention of mental disorders is almost absent. Similarly, our legislation has failed to emphasise that 'family of mental ill persons' and 'caretakers' (including the state) assume major responsibility for looking after people with mental disorders.

There is no doubt that the Indian mental health legislative framework is comparable to the legislative framework of a developed country. However, due to ineffective implementation, the measures taken have not been effective to realise the envisaged vision. Much more can be achieved by rigorously implementing the existing laws than prematurely looking for amendments or new laws. Hence, the rule of thumb should be '*implementation first, amendments should follow next*'. Although there are a number of laws that are made to protect persons with mentally illness, no law will help unless each and every citizen is educated about legal provisions. Nonetheless, implementation, monitoring and regulation of mental health legislation remain an important challenge.

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# Judicial interventions and NHRC initiatives in mental health care

## Pratima Murthy & D Nagaraja

## Introduction

Mental illness represents a range of diverse conditions where serious infringement of human rights can occur from deprivation of a person's dignity and right to life, to complete denial of the right to lead a fulfilling life. If the rights of the mentally ill are to be assured and protected, several players from diverse areas of society need to play an active role. In this chapter, we examine the specific role of the judiciary in addressing some of the critical mental health care needs of the country and highlight the landmark role of the National Human Rights Commission (NHRC) in addressing and being a part of mental health change in the country.

## Mental health as an integral part of health

The Right to Health is a fundamental right of every citizen in the country. Courts in India have repeatedly extended that there lies a positive duty on the part of the government to promote health in the society. Mental health is an integral and inseparable part of health. Hence the ancient Roman proverb, 'mens sana in corpore sano', meaning, 'a **healthy mind in a healthy body**'. This philosophy was the bedrock of the Bhore Committee report of 1946 (1) and the basis of formulating the National Mental Health Programme, way back in 1982 (2).

## Judicial involvement in mental health: three eventful decades

Unfortunately, mental health took a backseat and was largely ignored. The first well known involvement of the judiciary with mental health issues was with the jailing of the non-criminal mentally ill, leading to mental health reform. There have been numerous Supreme Court and State High Court decisions that have exposed illegal detention and institutionalisation of women, unlawful use of reception orders to detain a family member or

spouse and housing of the mentally ill. The book *Legal Order and Mental Disorder* by Amita Dhanda (3) provides a detailed description of many of these issues. In this chapter, we confine the discussion to issues related to mental health service delivery in the country.

## The Mentally ill in prisons

In Bihar, a number of undertrials had been kept in jail for long periods without trial. The Supreme Court, in the Hussainara Khatoon vs State of Bihar (4) held that speedy trial was an essential and integral part of the fundamental right to life and liberty enshrined in Article 21 of the Constitution. Soon after, in a public interest litigation (PIL), that of Veena Sethi vs State of Bihar case in 1982 (5), the court was informed through a letter that some prisoners, who had been 'insane' at the time of trial but had subsequently been declared 'sane', had not been released due to inaction of the state authorities, and had remained in jail for 20 to 30 years. The court directed them to be released forthwith, considering the requirements of protection of right to life and liberty of the citizen against the lawlessness of the state.

## "Unlocking the padlock"

The often cited Sheela Barse vs Union of India and Others (6), was filed in 1989. This case was with regard to the illegal and unconstitutional practice of locking up non-criminall mentally ill persons in jails of West Bengal. Following the PIL, there was a series of affidavits and counter affidavits. The court appointed a commission in 1992 to evaluate the situation. The commissioners Srinivasa Murthy and Amita Dhanda, in their report highlighted the problems in providing effective mental health services to the mentally ill in jails: lack of human resource, lack of supervision of care, absence of a mental health team, and absence of adequate range of treatment services. It suggested various remedial measures, including setting up managing bodies for all the mental hospitals in West Bengal, formulating schemes to improve conditions of care, establishment of state level rehabilitation centres and association with voluntary agencies. It recommended the moving out of the mentally ill in prisons to the nearest place of treatment and care.

In its judgement, the Supreme Court held that such a practice (of keeping the non-criminal mentally ill in prisons) contravened Articles 21 and 32 and ordered that such persons be examined by a mental health

professional/psychiatrist and on his advice sent to the nearest place of treatment and care (7). It directed the state government to take immediate action and issue instructions for implementation. The state government was also asked to take immediate steps for upgradation of mental hospitals, set up psychiatric services in all teaching and district hospitals and integrated mental health care with primary health care. The Calcutta High Court was requested to appoint a committee and submit a report with detailed recommendations.

It is worth mentioning that there are now a large number of NGOs working in the area of mental health in West Bengal. One such organisation, 'Paripurnatha' was founded to rehabilitate mentally ill women in Kolkata prisons (8).

## Denouncing inhumane treatment of the mentally ill

In the Chandan Kumar vs State of West Bengal (9), the Supreme Court heard of the inhuman conditions in which mentally ill persons were held in mental hospital at the Mankundu Hospital in the Hooghli district. The Court denounced this practice and ordered the cessation of the practice of tying up the patients who were unruly or not physically controllable with iron chains and ordered medical treatment for these patients. Despite this directive, the tragedy of Erwady occurred.

## Erwady and its consequences

On 6 August 2001, in Erwady in the Ramanathapuram district of Tamil Nadu, 26 mentally ill patients kept chained in a thatched shed in a dargah were charred to death in a fire. Following this shocking incident, the Supreme Court took suo moto notice of the incident in the form of a PIL (CWP No 334 of 2001). Notices were issued to the Union of India and to the state of Tamil Nadu. Subsequently, the court directed the Union of India to "conduct a survey on an all-India basis with a view to identify registered and unregistered '*asylums*' (italics added by authors) as also about the state of facilities available in such '*asylums*' for treating mentally challenged" (10).

Meanwhile, more PILs followed Erwadi. The Delhi-based NGO 'Saarthak' filed a PIL in October 2001 (11) calling for a ban on the practice of physical restraint and administering 'unmodified' or 'direct' ECT, i.e. ECT without anaesthesia. ACMI, an advocacy organisation for families caring for

family members with mental illness filed another PIL (12) before the court emphasising the importance of family members and their underrepresentation in decisions regarding the care of the mentally ill. This PIL highlighted the need for a short-term emergency plan for mental health care in view of the gross mental health manpower deficits, need for a psychiatrist to man district level services, short-term training in psychiatry for general practitioners, integrating the family and community model into institutional care, due representation to families in processes of revising mental health legislation, due weightage to families in decisions regarding treatment, safeguarding the rights of the mentally ill, addressing issues of guardianship, inclusion of mental illness under the PWD Act and RCI Act and formulation of guidelines for research involving the mentally ill.

The order of the Supreme Court in the Erwady case included a mental health needs assessment in all states. It ordered that licenses be issued to private homes looking after the mentally ill, mandated a district monitoring committee for periodic inspection of the facilities, directed that destitute recovered mentally ill be admitted in government or non-government facilities. It strictly advocated that all the recommendations of the NHRC and SHRC be 'implemented scrupulously'. It directed increased budget outlay for the DMHP in Tamil Nadu and that psychiatrics be posted in all the districts. Further, both the Central and State Governments were directed to undertake a comprehensive awareness campaign with a special rural focus to educate people as to provisions of law relating to mental health, rights of mentally challenged persons, the fact that chaining of mentally challenged persons is illegal and that mental patients should be sent to doctors and not to religious places such as temples or dargahs.

Among other things, the Supreme Court also ordered that each state government establish at least one mental health hospital. It is retrogressive to continue to think of newer, centralised facilities, when the country has a huge responsibility to develop its primary and secondary mental health care services. Further, bringing NGOs running rehabilitation centres under the MHA can increase bureaucratic hurdles and impede the smooth functioning of these organisations. This issue is discussed further in the chapter on rehabilitation.

In response to the court's directive to assess the situation of mental health services in the country, the Ministry carried out a survey of the government-run psychiatric hospitals, as well as other mental health services, or the lack of such services, which helped to provide inputs to formulating a re-

strategised national mental health programme in the 10<sup>th</sup> Five Year Plan (13). Further expansion of the DMHP occurred in the 11<sup>th</sup> plan.

## Financial obligation of a welfare state

In a leading case, that of State of Gujarat and Another vs. Kanaiyalal Manilal and others (14), the Court referred to the provisions of cost maintenance to be borne by the Government in case of mentally ill person under Section 78 of the Mental Health Act. The Court opined that in a welfare state like India, it is not merely a matter of grace, but a *statutory obligation* of the State Government to bear the cost of mentally ill persons.

## Specific Supreme Court interventions in government institutions

On the basis of two public interest litigations (B.R. Kapoor and Anr. vs. Union of India (UOI) and Others (15) and PUCL vs Union of India (16), both relating to functioning of the hospital for mental diseases, Shahdara, Delhi, the Supreme Court instructed the New Delhi administration to take immediate steps to set up a mental hospital-cum-medical college with sufficient autonomy to bring about quality changes in patient care. This led to the formation of the Institute of Human Behaviour and Allied Sciences, IHBAS.

The LGB Institute of Mental Health was taken over by the North-Eastern Council on 17th February, 1999, in pursuance of the order of the Gauhati High Court (17). This Institute was under the Government of Assam and was administered by a Board of Administrators, appointed by the High Court. The Institute was then registered as LGB Institute of Mental Health, Tezpur, on 11th March, 1999. It is presently an autonomous institution and designated as a regional institute.

Several of the High Courts of different states have, at various times, also expressed serious concern about the conditions in the mental hospitals in their states.

The other interventions of the Supreme Court which also involved the National Human Rights Commission are discussed later.

## Legal aid and relevance to mental illness

Article 39A of the Constitution of India provides that State shall secure

that the operation of the legal system promotes justice on a basis of equal opportunity, and shall in particular, provide free legal aid, by suitable legislation or schemes or in any other way, to ensure that opportunities for securing justice are not denied to any citizen by reason of economic or other disability. Articles 14 and 22(1) also make it obligatory for the State to ensure equality before law and a legal system which promotes justice on a basis of equal opportunity to all. Legal aid strives to ensure that constitutional pledge is fulfilled in its letter and spirit and equal justice is made available to the poor, downtrodden and weaker sections of the society (18).

In 1987, the Legal Services Authorities Act was enacted to give a statutory base to legal aid programmes throughout the country on a uniform pattern. This Act was finally enforced on 9th of November, 1995 after certain amendments were introduced therein by the Amendment Act of 1994.

Section 12 of the Legal Services Authorities Act, 1987 prescribes the criteria for giving legal services to the eligible persons, and includes mentally ill persons, those coming under section 2 of the Juvenile Justice Act 1986 or in a psychiatric hospital or psychiatric nursing home within the meaning of clause (g) of section 2 of the Mental Health Act 1987 (18).

## The National Human Rights Commission

The National Human Rights Commission was constituted on October 12, 1993, by virtue of the Protection of Human Rights Act 1993.

The NHRC is mandated under Section 12 of the Protection of Human Rights Act, 1993 to visit Government run mental health institutions to 'study the living conditions of inmates and make recommendations thereon.' Besides discharging this specific responsibility, the Commission has been, right from its inception, giving special attention to the human rights of mentally ill persons because of their vulnerability and need for special protection. The Commission's role is complementary to that of the judiciary. The Supreme Court has referred a number of important matters to the Commission for monitoring while the Commission has also taken specific cases of violation of human rights to the court.

## Monitoring of the hospitals at Ranchi, Gwalior and Agra

The management of the mental hospitals at Ranchi, Gwalior and Agra

had come under the scrutiny of the Supreme Court through writ petitions No 339/86, 901/93, 448/94 and 80/94. Vide its order of 8 September 1994, the apex court, had, after considering the report submitted by the Union Health Secretary, ordered a number of measures for improving the overall functioning of these institutions by raising the standard of infrastructural facilities, professional services, administration and management, care and treatment of the patients and welfare of the staff. The court had directed that these institutions must be run as autonomous bodies, managed by a Management Committee, headed by the Divisional Commissioner. The NHRC was requested to monitor these hospitals (19).

The sorry state of affairs at the Ranchi Manasik Arogyashala was highlighted in the Rakesh Chandra Narayan vs the State of Bihar and others (Writ Petition No 339 of 1986) (20). This resulted in a number of positive directions from the apex court and brought about a few qualitative changes and improvements in the management of the RMA, including the change of name to RINPAS and an autonomous status for the institute, a directive to the NHRC to monitor, supervise and co-ordinate the functioning of the institute from November 1997.

Upon being entrusted this work, the Commission examined the scope and objectives of the remit of the Supreme Court, as also the manner in which the Commission should set about fulfilling the responsibilities assigned to it. It constituted a Central Advisory Group (CAG) for the purpose of advising the Commission on the nature of the duties and responsibilities envisaged by the order of the Supreme Court and the various steps to be taken to achieve these objectives.

## Specific NHRC initiatives in mental health

The NHRC undertook several initiatives since 1997 which are summarised in the accompanying box. This has involved regular monitoring of hospitals under the Supreme Court Directive, dialogue with central and state health secretaries and administrators concerned with the hospitals, visits to these hospitals and monitoring in detail the implementation of the recommendations, dialogue with secretaries of ministries involved with rehabilitation, extending the mandate of supervision to other hospitals in the country (hospitals at Agartala, Indore, Tezpur and Amritsar).

# The NHRC quality assurance in mental health report

The Supreme Court had ruled that maintenance and improvement of public health is one of the obligations that flow from Article 21 of the Constitution. Threat to this precious right warrants appropriate remedial measures. This prompted NHRC to take up the issue of quality assurance of mental health care in the country. Justice Malimath, member of NHRC undertook this project and assigned the National Institute of Mental Health and Neuro Sciences (NIMHANS) Bangalore, to execute the work. The project report (21) is discussed in detail in chapter 5. Shri L.K. Advani, then Union Home Minister, formally released the report on 11 June 1999 and it was disseminated to all mental hospitals and state health secretaries for follow-up action.

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### Interventions of the NHRC in assuring quality assurance in mental hospitals in India

#### A summary

**November 1997**: NHRC entrusted with the supervision of the three major mental hospitals in Ranchi, Agra and Gwalior by the Supreme Court of India

Central Advisory Group of the NHRC constituted, headed by the Chairperson

**1997-1999**: The NHRC commissioned NIMHANS to carry out the project on Quality Assurance on Mental Health in India. The report was disseminated by NHRC to all the mental hospitals and the state health secretaries for follow-up action

**July 1999** – A Sub-committee of CAG was constituted including NHRC member as Chairman, Secretary General NHRC, Secretaries of Ministry of Social Justice and Empowerment, Department of Women and Child Welfare, Department of Human Resource Development as members to advise on steps to rehabilitate persons with mental illness.

**May 2001**: NHRC meeting with Directors and Chairpersons of the Management Committees of the hospitals, Health Secretary, Government of India and the 3 state Health Secretaries to review progress.

**2000-2005**: NHRC visits to mental hospitals at Ranchi, Agra and Gwalior.

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NHRC also undertook monitoring visits to hospitals at Agartala (2004), Indore (2004), Amritsar (2005), Tezpur (2005). The Commission also visited hospitals in other states.

**2006-2008:** NHRC rapporteurs visited many of the mental hospitals in the country.

**April 2008:** NHRC, in collaboration with NLSIU and NIMHANS, Bangalore, organised a national conference on mental health and human rights.

**May 2008**: NHRC conducted a review meeting of state health secretaries, state mental health authorities, health secretaries and their representatives. Many directors/medical superintendents of mental hospitals attended this meeting.

In a review meeting in 2001 (22), NHRC met with the Directors and Chairpersons of the three hospitals at Ranchi, Agra and Gwalior, along with the concerned health secretaries. Discussion revealed the following improvements in the working of these institutions and in their management and administration:

- The admission and discharge of patients were streamlined.

- The number of involuntary admissions had registered a steep decline.

- Diagnostic and therapeutic facilities had been upgraded and their impact was visible in the rate and recovery of patients.

- All three institutions were engaged in expanding mental health services at the community level.

- Some of their doctors were making significant contributions to research and training.

However, NHRC noted that a great deal remained to be done in the field of occupational therapy. Also, for want of required infrastructure, all the institutions had not started regular training courses, though re-orientation programmes had been conducted and students from medical colleges were being trained for short duration. The Commission noted that efforts were underway to start professional and para-professional training activities in Ranchi and Agra in the field of psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. The Commission also noted

the slow evolution of the autonomous nature of these institutions, particularly at Agra and Gwalior, although this issue had been agreed in principle and formalised by the issue of several notifications. It was also particularly concerned about the rehabilitation of cured patients who were destitutes and had been abandoned by the families. Specific changes in each hospital visited are discussed under each hospital.

As per the memorandum of action taken on the annual report of the Commission for 2001-02, it was noted that the government had sent the views of the Commission to the States/ Union Territories. While few states reported follow-up action, regrettably, there had been no enthusiastic response from other states 'despite persuading them from time to time'.

Because of the poor response, the Commission was in the process of launching its own monitoring programme through the State Human Rights Commissions (SHRCs) and its special rapporteurs. It was then found that the Ministry of Health and Family Welfare had already constituted three appraisal teams under their scheme of upgradation/modernisation of mental health institutes within the country.

The NHRC CAG also spelt out an action plan to undertake counseling and rehabilitation of cured patients at these hospitals with the assistance from Action Aid. This included sensitisation workshops for the staff of the hospital, rebuilding daily living, social and community skills of patients and providing a healing, lively and recreational environment in the hospital.

The specific reports of the NHRC rapporteurs visits to the different hospitals are discussed in detail and referenced in Chapter 6.

## NHRC Interventions against instances of abuse

Just as the Supreme Court took serious exception to the inhuman practice of chaining patients, so did NHRC, well before the Erwady tragedy. On a petition received in August 1998, alleging that persons with mental illness were being kept in chains, and confined to a space where it was difficult for them to move about, in the Sultan Alayudeen Dargah at Goripalayam near Madurai, the Commission had sought a report from the District Collector of the area (23). The Collector had confirmed that about 92 mentally ill persons were staying in the Dargah, having been brought by their relatives who had faith in the curative powers of the Dargah. The Collector, however, denied any mistreatment of the patients. The Commission had the case investigated in February 1999 by the then

Director General (Investigation) of the Commission. According to the DG (I)'s report, about 500 patients/devotees were staying inside the campus of the Dargah. Three-fourths of them were Hindus and the others were Muslims. About 100 patients were found to be chain. The patients were kept in thatched sheds and in verandahs. The report highlighted that similar places/Dargahs also existed in other areas of Tamil Nadu where mentally ill persons were chained and kept in the hope of a faith cure.

On considering the above reports, the Commission directed the State Government to get the entire matter examined by a body of experts. The report of the group of experts, however, stated that the complaint was exaggerated and added that there was no evidence of torture or compulsion by the Dargah authorities. The inmates had expressed faith that their mental illness would be cured in the Dargah even though some of them had been kept in chains.

The Commission then decided that it was essential to have the matter examined in greater detail by a Committee headed by Dr K.S.Mani of Bangalore. The Committee recommended that:

- Patients cannot and should not be treated as cattle. Responsibility for admission and discharge must be in the hands of a qualified psychiatrist and cannot be left to the Dargah.

- There should be strict supervision of drug intake by the patients.

- Institutionalisation should be only for brief periods and facilities should be ensured for rehabilitation programmes, with emphasis on adequate social inputs from family members.

- Family members should not be allowed to leave patients in the Dargah and walk away, instead there should be health education of the family and explanation about the nature of illness.

- The living conditions in the Dargahs need vast improvement, without which they should not be allowed to continue.

- There should be facilities for early diagnosis and regular treatment of mental illnesses in these areas of the State.

On 3rd January 2001, the Commission considered and accepted the report of the Committee and directed the Government of Tamil Nadu to implement the recommendations forthwith and send its compliance report at the

earliest. The NHRC was awaiting the Tamil Nadu Government's compliance.

*The Erwadi incident occurred in August of the same year, in the very same State.*

## NHRC interventions for mentally ill undertrials

The landmark interventions by NHRC in this connection is in the case of 72 year old CS, who had been detained for nearly 20 years as an undertrial, as his physical and mental condition did not permit him to defend himself at trial (24). His relatives had abandoned him. The NHRC moved a Criminal Writ Petition (Cr. W.P. No. 1278/04) to cancel the criminal proceedings against him and suggested a set of guidelines to deal with undertrials in similar situations. The Delhi High Court by its order dated 4th March 2005 quashed the proceedings and asked the local government to evolve an appropriate scheme based on the suggested guidelines. The court in its order also incorporated the recommendations made by NHRC regarding dealing with the cases of those who are mentally ill and in jail. Some of the suggestions were:

1. Psychological or psychiatric counseling should be provided to prisoners for early detection and to prevent mental illness.

2. Central and District jails should have facilities for preliminary treatment of mental disorder. All jails should be formally affiliated to a mental hospital.

3. Services of a qualified psychiatrist in every central and district prison who should be assisted by a psychologist and a psychiatric social worker.

4. Not a single mentally ill individual who is not accused of committing a crime should be kept in or sent to prison. Such an individual should be taken for observation to the nearest psychiatric centre or Primary Health Centre.

5. If an undertrial or a convict undergoing sentence becomes mentally ill while in prison, the State must provide adequate medical support.

6. When a convict has been admitted to a hospital for psychiatric care, upon completion of the period of his prison sentence, his status in all records of the prison and hospital should be recorded

as that of a free person and he should continue to receive treatment as a free person.

7.  Mentally ill undertrials should be sent to the nearest prison having the services of a psychiatrist and attached to a hospital, they should be hospitalised as necessary. Each such undertrial should be attended to by a psychiatrist who will send a periodic report to the Judge/Magistrate through the Superintendent of the prison regarding the condition of the individual and his fitness to stand trial.

8.  All those in jail with mental illness and under observation of a psychiatrist should be kept in one barrack.

9.  If a mentally ill person, after standing trial following recovery from the mental illness is declared guilty of the crime, he should undergo his term in the prison. Such prisoners, after recovery, should not be kept in the prison hospital but should remain in the association barracks with the normal inmates.

10. The State has a responsibility for the mental and physical health of those it imprisons.

11. To prevent people from becoming mentally ill after entering jail, each jail and detention centre should ensure that it provides

    i)   a conducive environment with physical and mental activities for prisoners that reduce stress and depression;

    ii)  a humane staff that is not unduly harsh;

    iii) effective grievance redressal mechanisms;

    iv)  encouragement to receive visitors and maintain correspondence;

    v)   overseeing bodies should have members from civil society to ensure the absence of corruption and abuse of power in jails.

Similar intervention was also carried out in Tezpur (25). The Commission has issued notices to the IG (Prisons) and Chief Secretary, Assam asking them to submit reports of five undertrial prisoners presently lodged at the LGB Regional Institute of Mental Health, Tezpur, Assam, who had been kept in the hospital for anywhere between 32 and 54 years.

The NHRC observed that similar practice of mentally ill being in prisons was prevalent in many other states, in gross violation of the provisions of the Mental Health Act 1987. The Chairperson of NHRC requested the Chief Ministers of all States in February 2000 to instruct the respective Chief Secretaries to immediately end this practice (26).

Thus, in the last one and a half decades of its existence, NHRC has been involved in several diverse issues related to the care of the mentally ill. But as one of the rapporteurs has remarked, NHRC can only 'play the role of a promoter, facilitator and catalytic agent, as also a watchdog. It cannot, however, substitute the primary role or mandate of State Governments to ensure mental health as a matter of human right to every individual'.

## Conclusion

There have been several Supreme Court interventions largely in response to PILs focusing on the problems of the mentally ill in prisons and focusing on the care in psychiatric hospitals. The NHRC has been playing a pivotal role in improving the standards of mental health care in both institutional and community settings. There is a great need presently for legal literacy about mental health issues to be more widespread even among the judiciary. Responsive central and state administrations, a committed judiciary, human rights advocates and watchdogs and an informed public which demands mental health care need to work together to further enhance mental health reform.

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# Quality assurance in mental health– a blueprint for change

## Kiran Rao

## Introduction

The year 1982 is a significant year in the history of mental health care in India. It saw the birth of the National Mental Health Programme, an ambitious endeavour to provide minimum basic mental health care to reach all sections of society and the first of a series of public interest litigations (Veena Sethi vs State of Bihar) against the deplorable conditions in which treatment was provided in many of the mental hospitals in the country.

Right to health and the right to live with human dignity are fundamental rights enshrined in Article 21 of the Constitution of India. The public interest litigations and media exposure highlighted that there were gross violations of human rights. Beginning in the 80's, the Supreme Court issued a series of progressive judgements and directed that some of the mental hospitals, notably those at Delhi, Ranchi, Gwalior, Agra and Tezpur, be completely revamped in structure and function on the lines of the National Institute of Mental Health and Neuro Sciences (NIMHANS) located at Bangalore. The National Human Rights Commission (NHRC), New Delhi was entrusted with the responsibility of monitoring the status of these hospitals. There were other legal initiatives: The Indian Lunacy Act of 1912 was replaced by the Mental Health Act in 1987, and rights of persons with disability were ensured protection in the Persons with Disabilities Act in 1995. The housing of non-criminal mentally ill persons in jails was declared unconstitutional in 1993. Despite these steps, mental health care in the country was still a far cry from meeting the minimum standards.

It was in this context that, in 1997, the National Human Rights Commission (NHRC), New Delhi, requested NIMHANS to initiate a project on Quality Assurance in Mental Health. The project was executed by a 10 member multi-disciplinary team led by Dr S.M. Channabasavanna, Professor of Psychiatry and former Director, NIMHANS and faculty from the departments of Psychiatry, Clinical Psychology, Psychiatric Social Work, Psychiatric Nursing and Mental Health Education. The present chapter

attempts to provide a brief overview of some of the significant findings of the project. The interested reader is, however, encouraged to read the original report (1) to obtain a detailed account of the conditions prevailing at the time.

# The Project

## Objectives and Methodology

The main objectives of the project were i) to examine the structure and functioning of 37 Government run mental hospitals in the country, ii) to sensitise the administrators, professionals and staff in these facilities to the rights of the mentally ill and iii) to make suggestions for improvement in the care provided.

During the project, the scope was further enlarged to include some of the private psychiatric institutions and the general hospital psychiatric units in the country. However, since the coverage was not comprehensive, these findings are not included in the present summary.

The project was implemented in three phases. In the first phase, a comprehensive assessment of the conditions of the mental hospitals was carried out. Initially, a detailed questionnaire was mailed to the administrative heads. This was followed by onsite personal visits by members of the project team. Each hospital was visited by two members of the team. During these visits, the information provided in the proforma was clarified and verified. In addition, physical inspection of the structure and functioning was carried out. It is important to emphasise that the purpose of the visits was not inquisitorial, but to get a first hand understanding of the prevailing conditions in the hospitals, as well as develop a dialogue with the hospital staff and concerned authorities. Interactive meetings were held with various stakeholders including all levels of the staff, users, family members and non-governmental organisations. Wherever possible, the team members also met the chairperson of the State Mental Health Authority and or the health secretary/ representative. Press conferences and press releases were issued to create awareness about the project and highlight various issues related to human rights of the mentally ill.

In the second phase, a series of 7 workshops of one-week duration were conducted to sensitize and train personnel from each of the hospitals.

Middle level staff from the administrative and clinical services were identified and deputed for the training. The focus of the training was to inform the participants regarding the protection of rights of the mentally ill, provide a feedback on the existing conditions in the hospitals and to generate solutions for some of the problems. A total of about 125 persons underwent training in these workshops.

In the third phase, the findings of the project were documented in two parts. In the first part, the historical milestones in mental health care, an overview of the background to the project and its methodology and the overall findings and general recommendations were outlined. In the second part, detailed reports with specific recommendations were presented statewise for each hospital.

## Findings of the project

The survey proforma was returned by all the 37 mental hospitals and 33 of these hospitals were personally visited by the team. The main findings are presented in this chapter.

### Beginnings

It is not clear as to what factors determined the location of the 37 mental hospitals. They were clearly not influenced by the geographical size of the state or the density of the population. This explains the unequal distribution of both the number of hospitals and the bed strength in each state (Tables1-3). While there were 6 hospitals in West Bengal, 4 each in Gujarat and Maharashtra, 3 in Kerala and Uttar Pradesh, 2 each in Andhra Pradesh, Bihar, Karnataka and Madhya Pradesh and one each in Assam, Delhi, Goa, Jammu & Kashmir, Nagaland, Orissa, Punjab, Rajasthan and Tamil Nadu, there were none in the remaining States. Some were started by the British, a few by considerate Indian Maharajas and private individuals. The oldest hospital in Chennai was established in 1794, while the latest addition at the time of the survey, was the hospital at Purulia (West Bengal) established two hundred years later, in 1994. Fourteen hospitals were started before the year 1900, 11 were established after 1900, but before independence, and 10 hospitals after independence (no information was available for 2 hospitals). Bed strengths varied widely. The smallest in Bhuj (Gujarat) had 16 beds and the largest in Pune (Maharashtra) had 2,540 beds with the total number of beds available in mental hospitals being about eighteen thousand (18,024). Interestingly, while most were built exclusively for

patients with mental illness, a few like the hospital in Thiruvananthapuram (Kerala) and the Pavlov Hospital (West Bengal) were built as isolation facilities for patients with mental illness, tuberculosis and leprosy.

## Architecture

Fourteen (38%) of the 37 hospitals were built with custodial type architecture, with one of the hospitals ( MH Murshidabad, West Bengal) originally being a jail. Sixteen (43%) hospitals still had cells at the time of the survey. Twenty-one (57%) of the hospitals had high walls. Most hospitals, at the time of the construction, were built at a considerable distance from the centre of the city to keep the mentally ill away from public view. The prison-like appearance and the distant location served to perpetuate the stigma attached to persons with mental illness. It is ironic (and befitting) that today, the cities have grown to make the hospitals the centre of the city. Most hospitals have adequate land holdings ranging from 5 acres to 500 acres and the land is now prime property!

## Basic living facilities

Nineteen hospitals (51%) had only closed wards, while the remaining had both open and closed wards. Open wards are those in which the family caregiver can stay with the patient for the duration of the treatment. Sixteen hospitals (43%) had private wards on payment. Patients with criminal charges and mental illness were being admitted in 20 (54%) of the hospitals, but separate facilities were available only in 15 of these centres. As a result, in the remaining hospitals, movement of all patients was grossly restricted. In many of the hospitals, the criminal wards were in worse conditions than even jails (e.g. Goa). Separate facilities for children with mental illness were present in just 4 (11%) hospitals. In gross violation of the Mental Health Act, children were being admitted in closed wards (e.g. Pune and Vishakapatnam). There was overcrowding in several hospitals, notably in Kozhikode, Thiruvanathapuram and Thane (Tables 2 & 3).

Overall, the living condition in these wards was quite poor. The average ratio of cots to patients was 1:1.4 indicating that floor beds were a common occurrence. Toilets and bathing areas were inadequate in most places, with the absence of proper sanitation or running water rendering them unusable. Conditions were particularly deplorable in Varanasi (UP), Indore (MP), Murshidabad (WB) and Ahmedabad (Gujarat) where male

patients had to urinate and defecate in the open. Electric supply was adequate in 27 (73%) hospitals, and erratic in Indore (MP), Agra (UP), Bihar, Vishakapatnam (AP) and Calcutta (WB), partly reflective of the power situation in the states. However, lighting in the wards was inadequate in about a third of the hospitals (14, 38%); while in a majority, the campuses were poorly lit, resulting in safety issues and instances of assault, robbery and rape being reported. Although ceiling fans were available in most hospitals, this was inadequate with an average ratio of one fan for every eight patients. Many of the hospitals (even those located in cold places) did not provide hot water for bathing or have heating facilities. Patients were found to be lying on cold, damp floors with scanty clothing.

Most hospital buildings (32, 87%) were being maintained by the Public Works Department (PWD) and very few hospitals had maintenance staff available on the campus. As a result, leaking roofs, overflowing and clogged toilets, worn out floors, broken cots, windows and doors were a common sight. While conditions were poor in Indore, Varanasi, Amritsar and Vishakapatnam, the hospital at Murshidabad reflected the worst possible scenario. In the latter, the walls were covered with lice and all the patients had to suffer from lice infestation and scabies.

*Diet*

The quality and quantity of food provided to the patients varied widely across hospitals. Only in 20 (54%) hospitals, information regarding caloric value of food provided was available and this ranged from 1200 to 3322 calories. Cost per day for food/ per patient ranged from a paltry Rs 5 a day in Chennai to Rs 30 per day in Assam and Bihar. However, in many places misappropriation of provisions and pilferage during food distribution, as well as dietary services being outsourced, ensured that what was ultimately provided to the patients was substandard. On the other hand, many hospitals, e.g. Ahmedabad, had innovatively supplemented the meagre budget through donations and sponsored meals for patients. Drinking water was also not available readily in most hospitals. Patients would often have to drink water from the tap in the bathroom or from water kept in an open bucket. Patients had complaints that food was not served with dignity, and that the food was served all in one big mass. In most places, three meals a day was the practice with dinner being served between 5 and 7 pm. Patients complained of feeling hungry and irritable, having nothing to eat for almost 14 hours, till breakfast the next morning.

In general, it was felt that it would be better to make annual budget provisions for diet on the basis of caloric value rather than per day costs, to ensure that patients get sufficient and nutritive food.

## Clinical services

### Out-patient services

It is heartening to note that majority of the hospitals (N=36, 97%) provided daily outpatient services. On an average, about 100 patients were seen per day. Amenities like waiting halls with adequate seating and interview rooms were available in most places. Free drugs were dispensed in 32 (82%). However, investigation facilities were inadequate and no psychosocial treatments were offered. Overall, only in 14 (38%) hospitals did the concerned authorities rate their own services as adequate, indicating that there was scope for further improvement.

### Admission and Discharge

Twenty-six hospitals (70%) reported that admissions were governed by the Mental Health Act. However, two hospitals were found to be using the Indian Lunacy Act (1912), while seven were using both the ILA and the MHA. Although involuntary admissions continued, a definite positive trend was the increase in voluntary admissions across all hospitals, except in Indore. The provision for "admission under special circumstances" in the MHA was rarely used. Hospitals in West Bengal had a cumbersome procedure of having each admission ratified by the Directorate of Health Services. Court admissions were found to be easier in Maharashtra and favoured by the family members as it ensured free treatment.

Majority (N=33, 89%) of the hospitals reported maintaining separate case files for each patient. However, a few reported different inpatient and outpatient files for the same patient leading to confusion. Storage of records and retrieval were difficult in most cases, further compounded by the lack of adequate staff.

### In-patient services

In-patient services comprised mainly pharmacotherapy in all the hospitals. In overcrowded and understaffed hospitals, patients often received less than the optimum dose. Supervision of medication and periodic review was not present in many places. Modified electroconvulsive therapy (ECT)

used for management of acutely ill and violent patients was available in only about half the hospitals. Routine basic investigations such as blood and urine tests were present in 29 (78%), but not available round the clock. Other investigations such as VDRL, serum lithium estimation, screening for HIV and hepatitis and EEG were present in about 14 (38%) hospitals on the average. Overall, investigations needed to make crucial decisions about routine treatment did not meet the required standard.

Even though 20 (54%) hospitals reported that they had psychological test material, the use of psychological testing for diagnostic purpose, evaluation of cognitive functions (including neuropsychological assessment) for certification purposes and assessment of personality and interpersonal relations was almost absent.

Psychoeducation to patients and their families was reported in 24 (65%) hospitals, counseling services in 29 (78%), Behavioural interventions in 18 (49%) and rehabilitation services in 20 (54%). Rehabilitation facilities and services are dealt with in more detail in a separate chapter in this book. Overall, evidence based practice guidelines indicate that psychosocial interventions when combined with drug treatment increase the efficacy of outcome by almost 30%. These treatments were available in only about two-thirds of the hospitals. Majority of the patients did not receive the benefit of these treatments. This may have also contributed to increasing the disability of patients and further rejection by family members resulting in longer stay in hospital. The non-availability of these treatment approaches was a combination of lack of availability of trained personnel and the absence of a multidisciplinary team approach.

*Casualty and Emergency Services*

Emergency services were reported by 22 (59%) hospitals. However, short stay wards for brief hospitalisation and acute care was reported by only 12 (32%). Ambulance services were reported by 22 (59%) hospitals, but in actual practice were not available when needed. Routine bed-side investigations, telephone services, doctor and other support staff on duty were all inadequate.

*Staff pattern and related issues*

Quality of care in the delivery of mental health services is directly related to the availability of trained personnel. Overall, a majority of the hospitals

(N=30, 81%) reported that the staff positions in their hospitals was inadequate. With the exception of the hospitals at Gwalior and Jamnagar, all other facilities had at least one psychiatrist, with the average number of psychiatrists being about 4. However, relative to the bed strength, the numbers were grossly inadequate. Very often a lone psychiatrist would also be the medical superintendent and be bogged down with administrative responsibilities. Many existing posts were lying vacant.

Majority of the hospitals had large number of medical officers, often with specialisations in other branches. Hence, they were poorly motivated to work in a psychiatric institution. Those who did get trained or gathered some experience would soon get transferred. Despite the availability of medical officers, even routine medical care was often not provided to the patients. Majority of the hospitals did not have a panel of visiting consultants for attending to medical problems. Patients had to be referred to local general hospitals, when necessary. Transporting the patient and taking care of him/her in the event of admission in the general hospital posed problems. Service of an anesthetist to administer modified ECTs was also difficult in most places.

When it came to other mental health professionals the picture was even more dismal. There was no post of a clinical psychologist in 8 (22%) hospitals, 18 (49%) had a post that was lying vacant and 10 (27%) hospitals had one clinical psychologist. In 11 (30%) hospitals there was no post of a psychiatric social worker and 9 (24%) had one post. In many places the post was that of a 'social worker' with master's level qualification but inadequate exposure to work with persons with psychiatric illness. Nineteen (51%) hospitals did not have a post of a psychiatric nurse. The in-patient care in hospitals which had a trained psychiatric nurse was qualitatively superior. However, the survey revealed that 3 (8%) hospitals [Agra, Bareilly (in UP) and Kohima (Nagaland)] did not have a single nurse. It is indeed difficult to imagine a hospital without nurses!!

Most of the posts of administrative staff and laboratory technicians were filled and services were commensurate with existing facilities. Majority of the hospitals had a disproportionately large number of staff at the ministerial level (Group D). There were complaints about the behaviour of these staff with the patients, disciplinary problems, union issues, etc. On the flip side, the staff reported several problems at work such as risk of handling violent patients, especially at night, without support from nurses or doctors, and

burnout because of having maximum contact with the patients. Overall, across all categories of staff, burnout was high. It was evident, that there was a need to improve service conditions and provide ongoing training to prevent burnout. Human resource development and capacity building related issues are dealt with in another chapter in this book.

## Rights of patients

The information provided in the earlier sections indicates that the rights of patients were not accorded the highest priority. On the contrary, there are several areas wherein these rights are grossly violated. In most hospitals, neither the staff nor the patients were aware of what constituted human rights.

Patients were unaware of their rights vis-a-vis admission and discharge procedures. The lack of adequate toilets and designated bathing areas has already been mentioned. Although, 27 (73%) hospitals reported that patients could wear their own clothes, in practice, most of the patients across all hospitals wore uniforms. In about 80% of the hospitals, patients had a daily bath and were allowed change of dress once in 2 to 3 days. In one hospital in Kerala, suicidal patients were kept naked for fear of self-harm if clothes were provided. Shaving of the head to manage lice infestations was routine for men (70%) and common for women (46%). Facilities for patients to keep their personal belongings was available only in 21(57%) of the hospitals.

## Budget expenditure

Examination of budget allocations across hospitals reveals that in most cases, the sanctioned budgets were very low. The budget expenditure was mainly for staff salaries, leaving hardly any money for patient care. Figure 1 gives a graphic presentation of the average percentage of budget expenditure across hospitals under different heads of account. In the small-sized hospitals, on an average, 64% of the budget was spent on salaries, 5% on drugs, 12% on diet and 19% on other expenses. In the medium-sized hospitals, 68% of the budget was spent on salaries, 6 % on drugs, 13 % on the diet and 13% on other expenses. In the large hospitals, 70% of the budget was spent on salaries, 3 % on drugs, 11 % on the diet and 16% on other expenses. The expenditure under various budget heads was also very variable across hospitals, not reflected when the figures are averaged. Budget details were not available for the hospitals in West

Bengal and IOP, Calcutta reported that there was no fixed budget for the hospital. This clearly indicates that budget allocation needs to be done, as in the NIMHANS pattern, separately for recurring expenditure (non-plan budget) and for new developments and activities (plan budget), so that there is a constant effort to improve existing facilities and services.

*Grading of hospitals*

The hospitals that were personally visited were graded on a 4-point scale from 1 (very poor) to 4 (good), in order to provide a relative comparison (Table 4).

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### Summary of the Findings

In 1997, the National Human Rights Commission (NHRC) New Delhi initiated a project on Quality Assurance in Mental Health. It entrusted NIMHANS with the task of executing this project. A ten-member, multidisciplinary team carried out a comprehensive survey of the 37 mental hospitals in the country, through a comprehensive questionnaire and personal visits. A number of sensitisation workshops with regard to human rights were also conducted with various stakeholders.

The project revealed that physical infrastructure and living arrangements were inadequate in most hospitals. Patient's rights with respect to privacy and dignity were grossly violated. Hospitals did not have adequate number of professional staff. Medical management was the mainstay of intervention, with psychosocial treatments almost absent. Compliance with the Mental Health Act (1987) was not uniform across the States. Policy makers, professionals and users were not aware of human rights and related issues. Overall, mental heath care in the mental hospitals was custodial rather than therapeutic.

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The hospitals that fell in the very poor category with a rating of 1 were MH Indore, Varanasi, Bareilly, Amritsar, Kozhikode, Murshidabad and Mankundu. The hospitals in the poor category with a rating of 2 were MH Thane, Pune and Nagpur, Jamnagar, Vadodara, Ahmedabad, Chennai and Vishakapatnam. The hospitals in the average category with a rating of 3 were MH Hyderabad, Ratnagiri, Agra, Dharwad, Gwalior, Thrissur, Thiruvananthapuram, Jaipur and Pavlov Hospital, Lumbini Park Hospital and IOP in Calcutta. The hospitals in the good category with a rating of 4 were those in which the basic living conditions were adequate, but were

still deficient in terms of the overall quality of service delivery. These hospitals were MH in Jammu, Tezpur, Goa, RINPAS and CIP in Ranchi and IHBAS in Delhi. NIMHANS being a multidisciplinary teaching hospital with a different pattern of structure and functioning was left out of the rating.

## Conclusion

Overall, the project highlighted that care in the mental hospitals was largely custodial rather than therapeutic. The hospitals monitored by the NHRC were better than the others. However, in most hospitals, patient's rights were not adequately protected. The project acted as a catalyst for change and a few proactive States started to implement some of the recommendations soon after the visit of the project team; others did so when the State-wise recommendations were sent to them by NHRC. This in itself was a positive step in the right direction. However, it was the Erawadi tragedy in 2001, and the judicial intervention by the Supreme Court that followed, that became the real impetus for change. Most of the States now realised that the NHRC-NIMHANS report was a blue-print for change and sought to implement the recommendations. These changes have been documented in another chapter in this book.

In the two decades since the project was completed, the National Mental Health Programme has made generous budget allocations to improve the infrastructure of the mental hospitals. It is heartening to note, that in most cases, this budget has been utilised. There has been considerable improvement in the physical infrastructure and living arrangements, so that at least basic minimum comfort is provided to those utilising the services. Laboratory facilities and availability of drugs are other areas which have improved. However, changes in functioning have not kept pace with evidence-based practices. This is largely due to the fact that adequate numbers of trained mental health professionals are still not in place, due to both delays in recruitment and financial remuneration and service conditions not being attractive enough. Mental health services rely on the competence and motivation of its personnel and hence, human resources are its most valuable asset.

The Quality Assurance in Mental Health project focused on mental hospitals. It is evident, however, that with about 20,000 beds, these hospitals address the needs of only a small percentage of the population with psychiatric illness. The most recent revision of the National Mental Health Programme recognises that the challenge is to make minimum and

quality mental health care community based so that it is available and accessible to those who need it the most. Improvement in mental health service delivery would necessitate better Centre-State dialogue and cooperation, as well as linkages with various other sectors such as education, social justice and empowerment, women and child welfare and the judiciary. The specific changes that have taken place are documented in another section of this book.

## Acknowledgements

To Justice V.S. Malimath, NHRC, for commissioning the study, to Dr S.M.Channabasavanna for leading the team as Principal investigator and to my co-investigators: Dr Mohan Isaac, Dr C.R.Chandrashekhar, Dr Mathew Varghese, Dr Pratima Murthy, Dr K. Redemma, Dr K.Sekhar and Dr T. Murali for making the project a memorable one.

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Table 1: Bed strength, average occupancy and budget allocation of small size(less than 250 beds) mental hospitals (figures for 1996)

| Name | Year established | Bed strength | Average Occupancy | Budget (in Lakhs) |
|---|---|---|---|---|
| HMH Bhuj | 1957 | 16 | 20 | 14 |
| IOP Calcutta | 1817 | 36 | 06 | NA |
| TMH Calcutta | 1932 | 180 | 180 | NA |
| MH Cuttack | NA | 60 | 60 | 37 |
| GMA Gwalior | 1935 | 212 | 180 | 387 |
| MH Indore | 1930 | 155 | 150 | 65 |
| PDH Jammu | 1964 | 75 | 75 | 7 |
| HMH Jamnagar | 1959 | 50 | 50 | 19 |
| MH Kohima | NA | 25 | 25 | 24 |
| MH Murshidabad | 1980 | 230 | 230 | 140 |
| IMH Purulia | 1994 | 80 | 80 | NA |

Table 2. Bed strength, average occupancy and budget allocation of medium size (250 to <500 beds) mental hospitals (figures for 1996)

| Name | Year established | Bed strength | Average Occupancy | Budget (in Lakhs) |
|---|---|---|---|---|
| HMH Ahmedabad | 1863 | 317 | 250 | 194 |
| MH Bareilly | 1862 | 408 | 280 | NA |
| CPH Calcutta | 1966 | 250 | 250 | NA |
| LPMH Calcutta | 1940 | 200 | 200 | NA |
| KIMH Dharwad | 1845 | 375 | 250 | 184 |
| IOP Goa | 1957 | 300 | 250 | 280 |
| PC Jaipur | 1952 | 312 | 312 | 116 |
| GMH Kozhikode | 1872 | 474 | 780 | 148 |
| RMH Ratnagiri | 1886 | 365 | 200 | 118 |
| GMH Thrissur | 1889 | 361 | 280 | 85 |
| HMH Vadodara | 1898 | 300 | 300 | 104 |
| MH Varanasi | 1809 | 331 | 331 | 65 |
| GMH Vishakapatnam | 1863 | 300 | NA | 125 |

Table 3. Bed strength, average occupancy and budget allocation of large size (more than 500 beds) mental hospitals (figures for 1996)

| Name | Year established | Bed strength | Average Occupancy | Budget (in Lakhs) |
|---|---|---|---|---|
| AMA Agra | 1859 | 718 | 447 | 185 |
| VGMH Amritsar | 1950 | 811 | 500 | NA |
| IMH Chennai | 1794 | 1800 | 1700 | 800 |
| IMH Hyderabad | 1907 | 600 | 580 | 194 |
| RMH Nagpur | 1904 | 910 | 750 | 299 |
| RNH Pune | 1907 | 2540 | 2300 | 728 |
| CIP Ranchi | 1918 | 643 | 400 | 406 |
| RINPAS Ranchi | 1925 | 600 | 580 | 439 |
| LGH Tezpur | 1876 | 500 | 400 | 127 |
| RMH Thane | 1901 | 1880 | 2000 | 508 |
| MHC Thiruvanathapuram | 1817 | 507 | 800 | 54 |
| IHBAS1966 | 400 | NA | 800 | |
| NIMHANS | 1937 | 650 | 500 | 1954 |

Figure 1. Average percentage of budget expenditure on salaries, drugs, diet and other expenditures in mental hospitals in India (figures for 1996)



Break-up of Budget expenditure
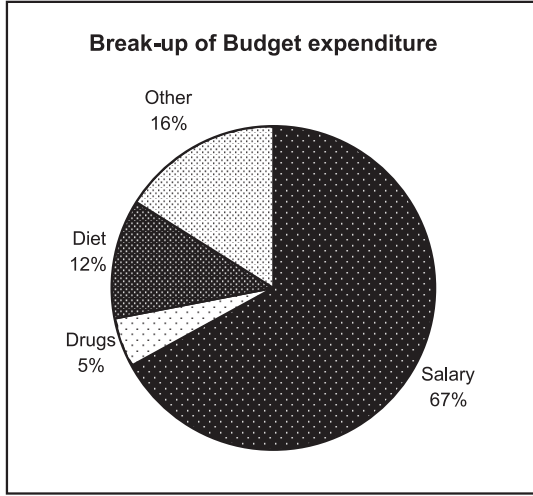
Table 4. Grading of the hospitals (1999)

| Sl.No. | Name of the hospital | 1 Very poor | 2 Poor | 3 Average | 4 Good |
|--------|---------------------|-------------|--------|-----------|--------|
| 1 | VGMH Amritsar | + | | | |
| 2 | MH Bareilly | + | | | |
| 3 | MH Indore | + | | | |
| 4 | GMH Kozhikode | + | | | |
| 5 | MH. Murshidabad | + | | | |
| 6 | TMH Calcutta/ Mankundu | + | | | |
| 7 | MH Varanasi | + | | | |
| 8 | HMH Ahmedabad | | + | | |
| 9 | IMH Chennai | | + | | |
| 10 | HMH Jamnagar | | + | | |
| 11 | RMH Nagpur | | + | | |
| 12 | RMH Pune | | + | | |
| 13 | RMH Thane | | + | | |
| 14 | HMH Vadodara | | + | | |
| 15 | GMH Vishakapatnam | | + | | |
| 16 | AMA Agra | | | + | |
| 17 | GMA Dharwad | | | + | |

| Sl.No. | Name of the hospital | 1 Very poor | 2 Poor | 3 Average | 4 Good |
|---|---|---|---|---|---|
| 18 | MH Gwalior | | | + | |
| 19 | IMH Hyderabad | | | + | |
| 20 | PC Jaipur | | | + | |
| 21 | IOP, Calcutta | | | + | |
| 22 | Lumbini Park Hospital, Calcutta | | | + | |
| 23 | Pavlov Hospital, Calcutta | | | + | |
| 24 | RMH Ratnagiri | | | + | |
| 25 | GMH Thrissur | | | + | |
| 26 | MHC Thiruvananthapuram | | | + | |
| 27 | CIP, Ranchi | | | | + |
| 28 | IOP Goa | | | | + |
| 29 | IHBAS, Delhi | | | | + |
| 30 | PDH Jammu | | | | + |
| 31 | RINPAS, Ranchi | | | | + |
| 32 | LGH Tezpur | | | | + |

# A decade after the NHRC quality assurance initiative: current status of government psychiatric hospitals in India

Pratima Murthy & K Sekar

## Introduction

The current condition of government psychiatric hospitals in India has been a source of concern for more than a century. There were several eye-openers to the state of these hospitals, beginning with the Mapother Report in 1938, followed by the Bhore Committee report in 1946. The latter based its recommendations on Moore Taylor's observations of many of the mental hospitals in the country. Subsequently, medical superintendents of these hospitals met at four workshops at Agra (1960), Ranchi (1986), Bangalore (1988) and New Delhi (1990) and deliberated the ills of the hospitals and possible remedies. In spite of all these efforts, little change actually occurred. It was only after a spate of public interest litigations beginning in the 1980's that the attention of the highest court in the country, the Supreme Court, turned to the plight of the mentally ill and their treatment at these institutions. The Supreme Court directed the hospitals at Shahadra and Ranchi to become autonomous institutes, modeled on the National Institute of Mental Health and Neuro Sciences (NIMHANS) in Bangalore. The National Human Rights Commission (NHRC) was entrusted with monitoring the hospitals at Agra, Gwalior and Tezpur. With the help of NIMHANS, the NHRC initiated a project to evaluate the status of mental health in the country. A major part of this initiative was the evaluation of functioning of the mental hospitals.

## Background

These hospitals were reviewed between 1997 and 1999. The assessment was carried out through a detailed questionnaire sent to each psychiatric institution as well as visits to 33 of the 37 hospitals in the country. The findings from this assessment formed the core of the NHRC Quality

Assurance in Mental Health Report released in 1999 (1, 2), hereafter referred to as the NHRC/NIMHANS report. The highlights of this report were presented in an earlier chapter. This report was largely based on conditions during 1996-1997, the year prior to which the visits were conducted.

This was followed by the formulation of recommendations for minimum standards of care in mental hospitals in consultation with medical superintendents of the hospitals and state health secretaries (3).

In addition to the NHRC initiative, there was also an intermediate review of these facilities by the Government of India. Soon after the Erwadi tragedy in the Ramanathapuram district of Tamil Nadu, pursuant to the orders of the Hon'ble Supreme Court in CWP No 334 of 2001, the Government of India constituted a number of teams to inspect and report on the state of mental health services, with a special focus on psychiatric hospitals (4). The team visited all state capitals and government-run psychiatric hospitals during 2001 and 2002, and submitted a detailed report. This report is hereafter referred to as the DGHS report. Under the 10th 5 year plan, a modernisation grant was sanctioned for these hospitals.

Following the quality assurance report, the NHRC as well as the central and state government have focused considerable attention on mental hospitals. A review meeting organised by the NHRC in May 2008 brought together the health secretaries of the states, secretaries of the state mental health authorities (SMHAs) and some of the superintendents of the psychiatric institutions around the country. Several of the participants presented the positive changes that had occurred in the hospitals, as well as the activities undertaken under the District Mental Health Programme. Following this meeting, NHRC asked NIMHANS to prepare a document highlighting rights based issues in mental health care and to review in detail changes that had occurred following the NHRC/ NIMHANS report.

The present review, carried out between May and July 2008 attempts to capture the current status of the government run psychiatric institutions and document the changes that have occurred a decade after the earlier report.

# Present review

Two questionnaires were prepared for the review (see appendix, section 2). The first aimed at documenting the *qualitative changes* that occurred in each hospital after 1999. The specific emphasis was on whether the recommendations provided by the NHRC/NIMHANS for each hospital had been followed. A second questionnaire, abridged from the original questionnaire used in the NHRC/NIMHANS project, captured *specific issues* related to infrastructure, functioning, patient care and amenities, human rights of patients, staff strengths and budgetary allocation, as reported by each hospital. The findings were tabulated and compared on specific parameters to the earlier self report from the hospitals, as well as the NHRC/NIMHANS quality assurance report (1). A small team also reviewed the central government's intermediate report on mental hospitals (4), the reports of the NHRC rapporteurs to various hospitals (5-26) and the presentations made by health secretaries/mental health authorities at the NHRC national review workshop earlier this year (27). The overall current status of the hospitals is reviewed here. Specific changes pertaining to each hospital are separately discussed under individual hospitals in a separate section.

## Findings of the 2008 review

Only the first questionnaire was received from the Institute of Mental Health (IMH) Chennai, Hospital for Mental Health (HMH) Ahmedabad, Mental Health Institute (MHI) Cuttack and Mental Health Centre (MHC) Thiruvananthapuram. For these hospitals supplementary information was obtained from the official reports mentioned earlier (4-26). Though no questionnaire was returned by the Institute of Mental Health and Hospital (IMHH, formerly Agra Manasik Arogyashala or AMA Agra) comprehensive information from this hospital was reconstructed from the rapporteur's reports and the presentation made at the NHRC national review meeting (27).

The mental hospital at Mankundu in West Bengal, which in the 1999 report was rated as very poor, has closed down in the intervening period. The findings are thus restricted to 36 hospitals. Both questionnaires were returned by 32 hospitals.

New hospitals have been initiated at Rohtak, Haryana (Rajya Mansik Swasthya Sansthan), proposed to be completed in May 2009; Agartala (the Modern Psychiatric Hospital constructed in July 2006); Himachal

Pradesh (Himachal Hospital of Mental Health and Rehabilitation, Shimla, in 2004) and Bihar (at Bhojpur, under construction). The Government Psychiatric Hospital, Srinagar, was not part of the NHRC/NIMHANS 1999 review. These hospitals are discussed separately and do not form part of this review.

## Building and Infrastructure

All the 36 hospitals (100%) report changes in infrastructure with construction of new buildings for in-patient care. Except for 3 hospitals, the RMH, Thane in Maharashtra, the Lumbini Park Hospital and the Behrampore Mental Hospital (BMH) in West Bengal, the other 33 hospitals (92%) report infrastructure changes in the out-patient area. Twenty-six hospitals (72%) received funds from the central government under the 10th five year plan scheme for modernization of mental hospitals. Each hospital received variable amounts with a ceiling of Rs 3 crore for this activity.



The old Durvasa ward
at GHMC Vishakapatnam



The new wards at GHMC



The old Behrampore Mental Hospital,
Murshidabad, West Bengal



The new construction at the BMH

The old wards at MH Indore, MP



Architectural plans for a new building at the MH Indore

Some of the hospitals have moved to new locations. The erstwhile Institute of Psychiatry, Goa, moved to a new location in Bambolim, and is known as the Institute of Psychiatry and Human Behaviour (IPHB). It is affiliated to the Goa Medical College. Similarly, the Institute of Psychiatry in West Bengal has been converted to the Bangur Institute of Neuro Science and Psychiatry. The MH Indore has given a proposal for a new hospital. At Bhuj, the Hospital for Mental Health, which was destroyed in the 2001 earthquake has been rebuilt with a Member of Parliament Local Development (MPLAD) fund of Rs 70 lakh, in the vicinity of the collapsed hospital. Initially, the building was built on the lines of a half-way home and was to be handed over to the department of social defense, but now houses the hospital. A new hospital block has been built at the HMH Ahmedabad. The IMH Chennai has constructed a new administrative block, as well as three new wards, including one for mentally ill prisoners. The GMHC Vishakapatnam has constructed an entirely new building. This is part of the Andhra Pradesh programme of modernization of having a multispecialty medical facility at one place through a model of disinvestment/restructuring of fixed assets (4).

HMH Vadodara has built a new female ward and HMH, Jamnagar, a rehabilitation centre. A family ward and short stay ward has been built at IMHH, Agra, a new OPD block at GMA Gwalior and a new in-patient ward at Cuttack. At the RMH, Yerawada, 4 new dormitories have been constructed for indoor patients and one ward has been renovated as a family ward. New internal roads have been laid with central assistance.

Addition of new buildings has resulted in the start of new facilities. At the Psychiatric Centre, Jaipur, a new OPD block has resulted in the development of dedicated emergency services, improved facilities for visiting out-patients and relatives, canteen, out-patient laboratory, and separate out-patient and in-patient psychiatric services for children.

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At some of the hospitals built one or two centuries ago, additions of new buildings, while they provide a face-lift, have not been enough to shake off the custodial, prison-like appearance. Typical examples of these are the hospitals in Varanasi and Bareilly in Uttar Pradesh. Buildings that are 200 years old have inevitable problems of repair and maintenance, and if not attended to urgently, can give rise to serious human disaster. Other hospitals which have a run down, prison-like atmosphere are some of the hospitals of West Bengal, the MH Indore and the mental health centres in Kerala. The DGHS report (4) states that at the IMH, Chennai, despite many improvements, *'the vestiges of the old custodial legacy remains'*. The Mishra Report of 2007 (23) says that the present building of IMHH Agra is too old, with construction of most of the blocks dating to 1859.

## Out-patient and emergency services

Out-patient services are provided at all the hospitals. The NHRC/NIMHANS report (1) had recommended that the RMH Nagpur should start out-patient facilities and the same has since been started.

From the data available for 32 hospitals, there were a total of 3,62,793 new registrations and 13,18,237 follow-ups during the last year. Except the BMH and Lumbini Park hospitals in West Bengal and the RMH Thane, all other hospitals report new outpatient constructions.

More than 70% of hospitals now have emergency services (Figure 1). No emergency services are available at the hospitals at Ahmedabad, Jamnagar, Thane, Nagpur, Bareilly, and three of the hospitals in West Bengal.



Figure 1: Emergency and outpatient facilities
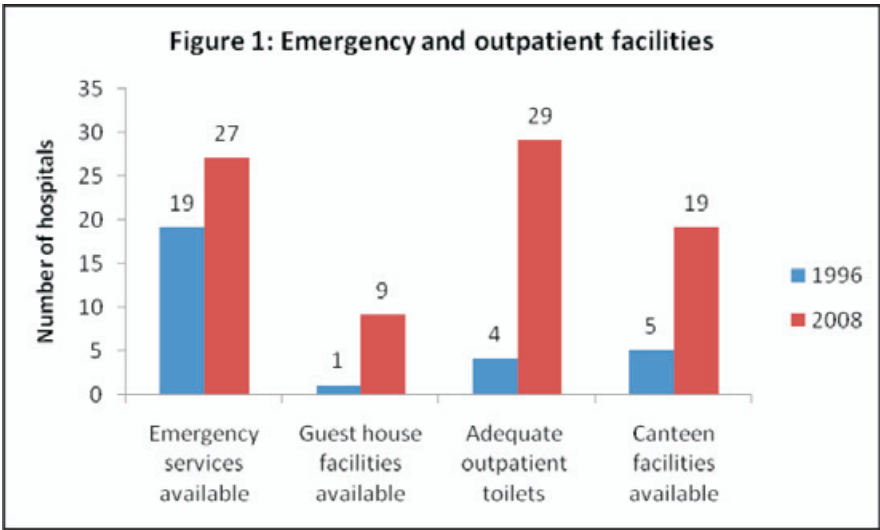
*Out-patient facilities*

Guesthouse facilities like dharamshalas have newly been set up at the MH Hyderabad, HMH Jamnagar, CIP Ranchi, KIMH Dharwad, GMA Gwalior, PC Jaipur, IMH Agra and the GMH Amritsar. Waiting halls for out-patients are present in three-fourths of the hospitals (Figure 1).



Waiting hall at the GMA, Gwalior, MP



OPD registration at the GHMC, Vishakapatnam

In the NHRC/NIMHANS 1999 report, 21 hospitals had reported having routine blood and urine tests, but only two hospitals considered their outpatient laboratory facilities as adequate. Laboratory services have substantially improved for out-patients since that survey, with more than half reporting adequate out-patient lab facilities presently. There are still no out-patient lab facilities at the hospitals in Bhuj, Jamnagar, Ratnagiri, Bareilly, Varanasi, Bangur Institute, BMH, Murshidabad and IMH, Purulia. Four of the other hospitals report basic but inadequate lab facilities (Figure 2).



Figure 2: Outpatient laboratory and medication supply

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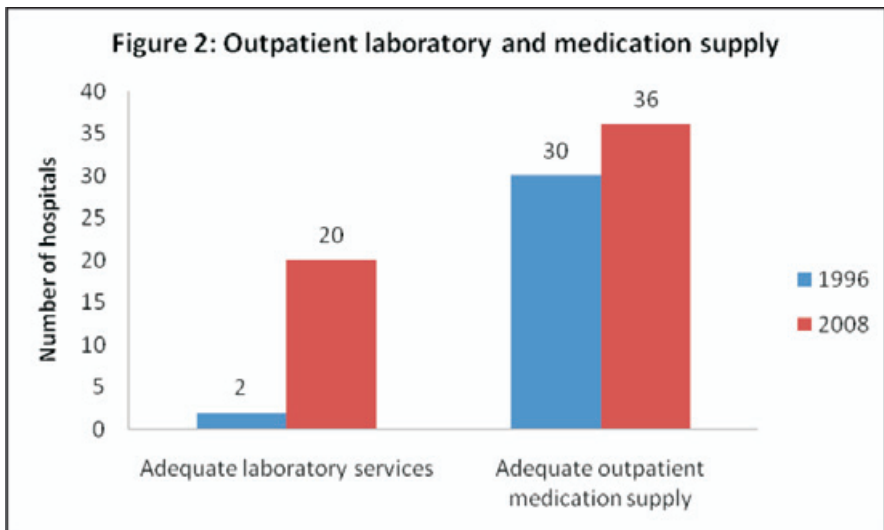
Medications supply was generally adequate even in the earlier review, and all hospitals presently report adequate supply of medicines in the out-patient.

## In-patient characteristics and services

This section examines issues of bed strength and occupancy, nature of admissions, services and amenities provided to the in-patients.

### Bed capacity

Some of the hospitals have reduced their in-patient strength (Table 1). A few hospitals have increased their beds, notably RMH, Nagpur from 910 to 940, HMH, Jamnagar from 50 to 70 and the Purulia Hospital from 80 to 190. The latter has had to accommodate the mentally ill in the local jails as well as from adjacent States. The RMH, Yerawada continues to maintain its sanctioned strength of 2540, but its bed occupancy is about 66%. The RMH, Thane has marginally reduced its bed strength from 1880 to 1850.

Table 1: Changes in bed strength

| Hospital | Previous bed capacity | Current bed capacity |
|---|---|---|
| LGB Hospital, Tezpur | 500 | 336 |
| IHBAS, Delhi | 400 | 180 (psychiatry) |
| IPHB, Goa | 300 | 190 |
| GPDH, J&K | 75 | 70 |
| RINPAS | 600 | 500 |
| VGMH, Amritsar | 850 | 400 |
| PC, Jaipur | 312 | 280 |

In the NHRC/NIMHANS review 1999 (1), three hospitals had revealed overcrowding, far in excess of the allocated beds (Figure 3). The hospitals in Kerala continue to have occupancy in excess of the sanctioned beds. The MHC, Thrissur, which did not show overcrowding in the earlier report has current occupancy of 390 against 361 alloted beds (108% occupancy). The RMH, Thane has brought down its occupancy significantly. The Pavlov

Hospital in Kolkata with a bed strength of 250 reported 280 in-patients as on 1 April 2008, indicating overcrowding. A similar situation is noted in HMH Bhuj, where the sanctioned strength is 16, and there were 34 patients. At Bhuj, the NHRC rapporteur has suggested the possibility of increasing the bed strength. The MH Cuttack, according to the Health Secretary's report, plans to increase its number of beds from 60 to 100, and start paying wards.

In Tamil Nadu, as a response to the NHRC/NIMHANS 1999 recommendation to decentralize psychiatric facilities within the state to prevent overcrowding at the IMH and improve quality of care, a comprehensive proposal to improve mental health services in the state has been submitted to government.



Figure 3: Bed strength/occupancy in previously overcrowded hospitals
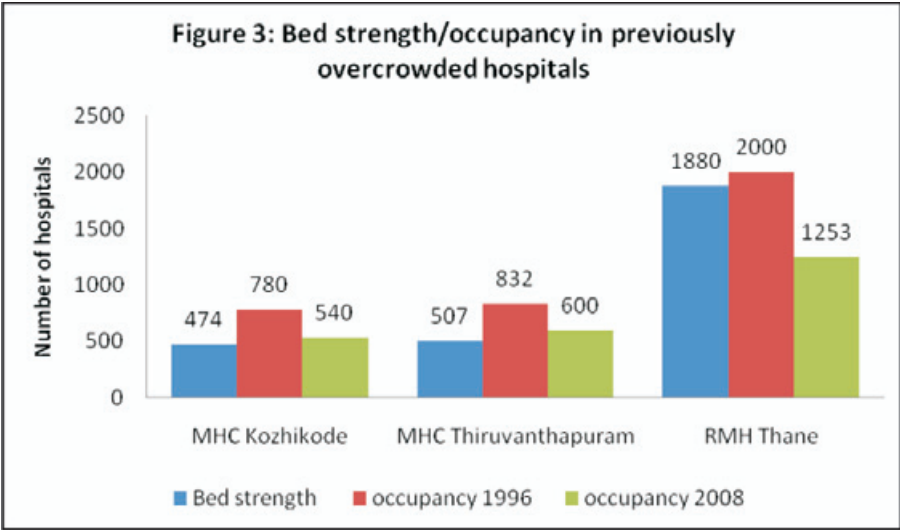
*Type of wards*

In the last decade, approximately half the hospitals had only closed wards. According to the 2008 review, 24 hospitals (67%) have open wards. RMH, Ratnagiri has started 8 open wards. RINPAS has reduced its closed wards. KIMH, Dharwad has created 8 open wards. PC, Jaipur has also increased its open wards. In contrast, in West Bengal, all facilities are still closed facilities. Many of the wards are primarily closed wards with little work carried out with families in GMHC, Vishakapatnam, IPHB, Goa, all the hospitals in Kerala, MH, Kohima, MH, Bareilly and Varanasi, IMH, Chennai, VGMH, Amritsar and the hospitals in Gujarat and Maharashtra.

A family ward at HMH, Vadodara (Gujarat)

*Ward facilities (Figure 4)*

Inpatient toilets were considered adequate if a minimum ratio of 1:5 was maintained. In 11 hospitals the recommended patient toilet ratio is not met.This is not necessarily a reflection on the maintenance and cleanliness of these toilets, which has overall improved across all the hospitals. Apart from the hospitals mentioned earlier, there were also no specific responses from the hospitals of Maharashtra and BMH, Murshidabad (new building under construction).

Running water availability has improved significantly and is adequate in 81% of the hospitals. Many of the hospitals have built new storage tanks. At IMH, Hyderabad, the Hyderabad Metro Water Supply and Sewerage Board has been contracted for construction of a reservoir and supply station in the hospital premises, with condition to supply water 24 hours for the next 20 years. At HMH, Jamnagar, a grant of Rs 9 lakh has been transferred to PWD for necessary work and the report states that work will start shortly. The hospital currently has 6 water coolers and 6 water purifiers. According to the hospital reports, availability of running water continues to be a problem at HMH, Vadodara and RMH, Nagpur. The Mishra report of IMHH, Agra (23) comments that the water supply system is old and has outlived its utility.

Figure 4: Ward facilities
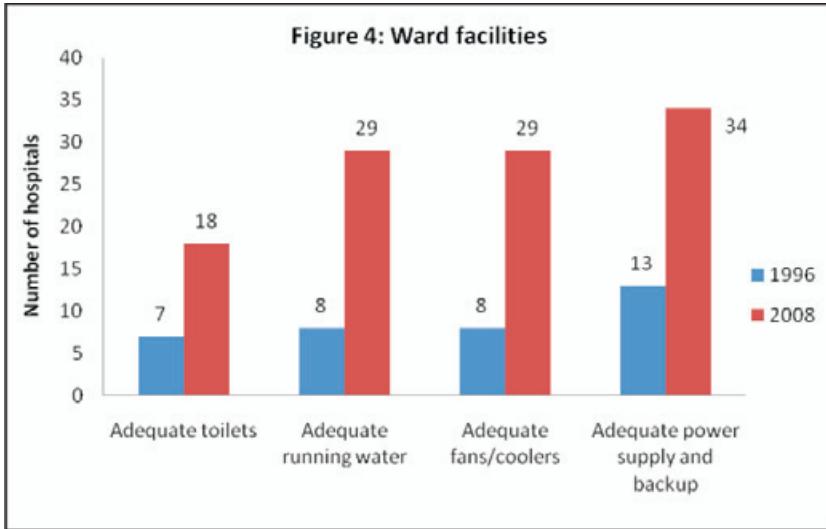
Fans and coolers have been installed in many hospitals and are now adequate in 81% of hospitals. These facilities are inadequate at the Bangur Institute at Kolkata, the BMH at Murshidabad, the IMH Chennai and the MH Nagaland.

Generators have been installed at many hospitals, particularly at the hospitals in Kerala. Electrification work and repairs were undertaken at MH Indore in March 2008. At RMH, Yerawada, the lighting within the hospital has substantially improved and generator back up has been provided for the campus.



Dining facilities at the IMHH Agra



Mechanised laundry at RINPAS Jharkand

Geysers and solar heaters have been installed at some hospitals.

The laundry has been mechanised at some of the hospitals. The IMH, Chennai presently has a modern laundry set up with the help of the Lion's Club. The RINPAS has a mechanical laundry, mineral water plant and incinerator to handle biomedical waste. The laundry has been outsourced

at GMA, Gwalior. The hospitals at Varanasi and Bareilly still have one or two washermen providing manual laundry services.

The MH, Nagaland still has no telephone.

Thirty-one hospitals (86%) presently report using only disposable needles and syringes. None of them reuse blades (for shaving etc). This information is not available for the hospitals that did not return the supplementary proforma.

## Diet

There has been a significant improvement in the dietary allocation across most hospitals (Figure 5). Presently, 26 (72%) hospitals provide food according to specified calories. Hospitals which have started providing diet as per caloric requirements after 1999 are the hospitals at Varanasi, Bareilly, Agra, Jaipur, Gwalior, Indore, Tezpur, Goa, Bhuj, the CIP Ranchi, the Lumbini Park Hospital and the Bangur Institute in West Bengal. A curious practice Has observed from MH, Cuttack, where general patients get a diet of Rs 10-Rs 20 per day and RINPAS patients get Rs 40 per day.



Figure 5: Average daily spending on diet
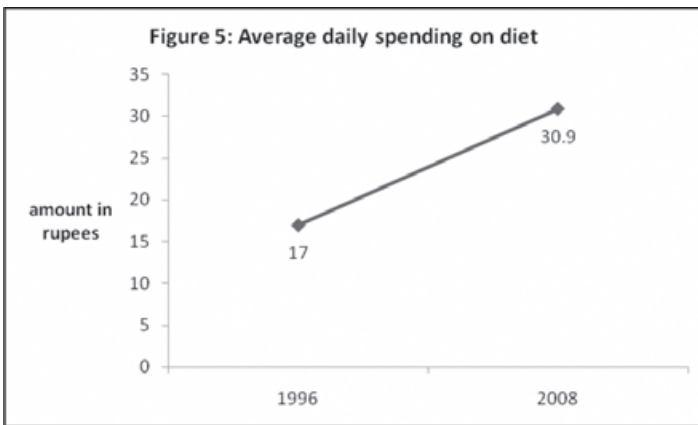
## Admission and discharge

A notable change across many hospitals is a marked reduction in the percentage of admissions through courts (Figure 6). The MH, Varanasi, AMA, Agra, VGMH, Amritsar, HMH, Vadodara and MH, Indore are striking examples where court admissions have substantially decreased. However, at some of the hospitals in West Bengal (BMH Murshidabad and Pavlov Hospital) and Maharashtra (RMH Thane and Nagpur) and HMH, Jamnagar, a majority of the admissions still occur through courts.

**Figure 6: Percentage of admissons through courts**
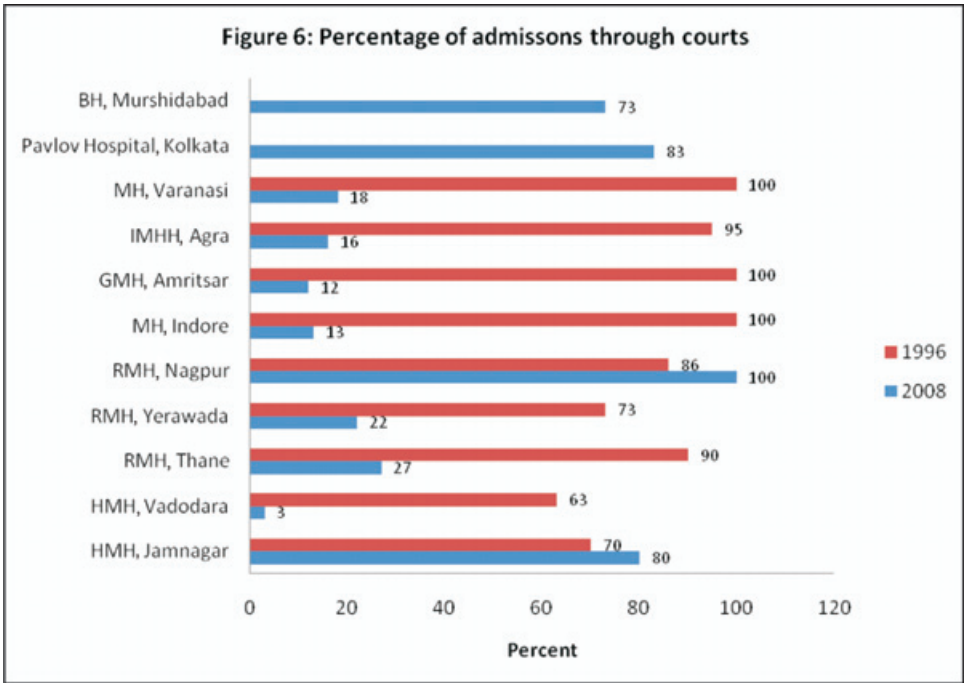
The NHRC rapporteurs have cautioned against the misuse of Section 19 (admission under special circumstances of the Mental Health Act) at the hospitals in Bhuj and Goa, where they noticed that patients were prematurely discharged after the stipulated period of 90 days or readmitted under the same section after discharge.

## Long-stay patients

The NHRC/NIMHANS report of 1999 (1) commented: "*Large institutions, inadequate psycho-social interventions, long distances and unavailable families all perpetuate chronicity*". In sharp contrast to the findings of a large number of long-stay patients at that time, many of the hospitals have successfully brought down the long stay by more than half (Figure 7). Efforts to this end include contacting families and reaching recovered patients back to them, active inputs of psychiatric social workers in the hospitals that have such staff, and the involvement of non-governmental organisations in this activity. At IMHH, Agra a number of long-stay patients have been restored to their families through special efforts of the staff and volunteers of Action Aid India.

The IMH Chennai raises some practical difficulties with rehabilitation of long-stay patients. "*50% of the long-stay patients have no social*

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*support or are not completely recovered. It has not been possible to rehabilitate them".*



Figure 7: Longstay patients in the hospital
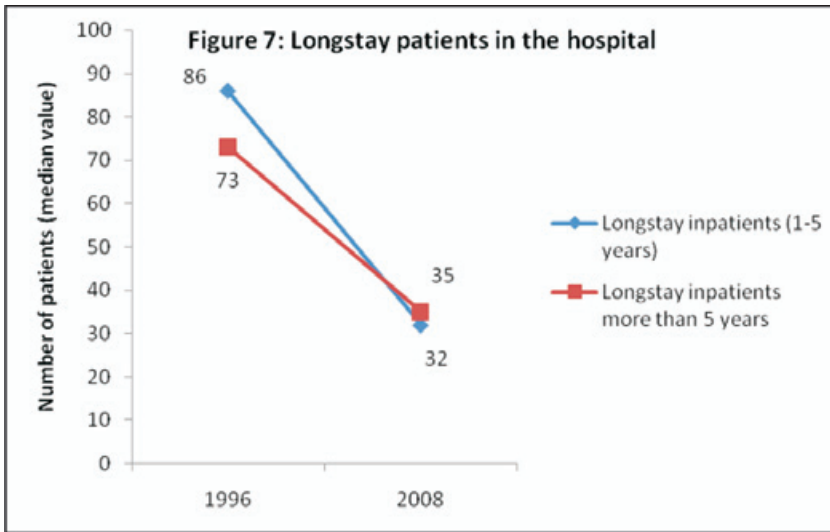
## Mortality

This data is available for 20 hospitals in 1996 and 31 hospitals in 2008. Annual deaths declined from a mean of 20.1(± 35) to 10.2 (± 16.2), and are mainly contributed to by the long-stay patients. Many of the hospitals now hold death meetings in such an event.

## Medical records section

According to the NHRC/NIMHANS 1999 report, 33 (89%) of the 37 hospitals maintained separate files for patients, but only 27 (75%) had a separate medical records section. Presently 31 hospitals (86%) maintain a separate records section. Four hospitals (RMH Thane, MH Kohima, MH Bareilly and IMH Purulia) report that they do not have a separate medical records section.

## In-patient investigation and medical treatment

In the earlier report, 29 hospitals had reported having routine blood and urine tests for inpatients, but his could be considered adequate then in 21 hospitals. Presently, in 25 (69%) hospitals laboratory services are adequate (Figure 8). Laboratory facilities do not exist at the five hospitals in Calcutta and Nagaland. They are reported as inadequate at HMH, Bhuj and MH, Bareilly. At MH, Bareilly, despite having a modern laboratory building, there

is neither the manpower nor equipment to start functioning. Proposals for equipment and creation of manpower are pending with the government. Radiological investigations, particularly imaging facilities are present only in few hospitals.

Medication is reported as adequate in all the hospitals. Many hospitals have adequate supply of mood stabilisers, atypical antipsychotics and SSRIs.



**Figure 8: Inpatient: adequate laboratory services and medication supply**
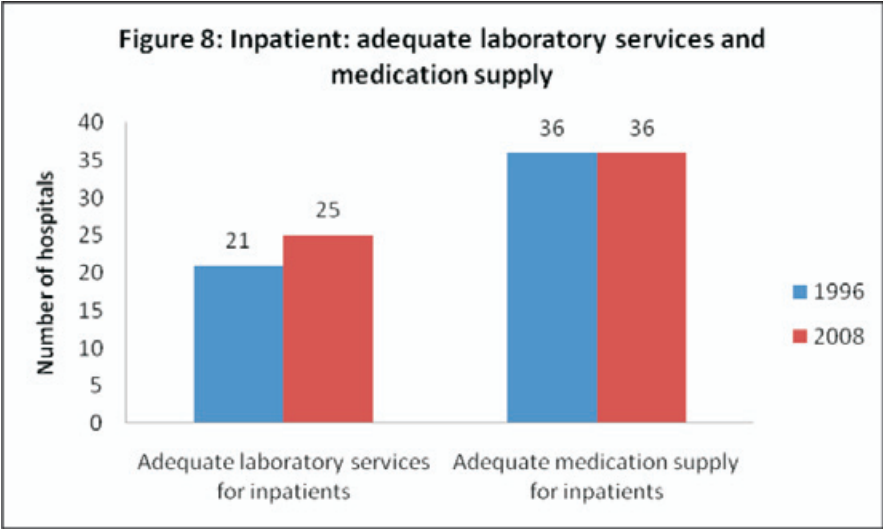


Well equipped laboratory at GMA, Gwalior

*Electroconvulsive therapy*

A majority of the hospitals actively use ECT as a treatment modality, and 21 hospitals provide only modified ECTs (58%) (Figure 9). RINPAS and CIP, Ranchi from Jharkand, IOP, Bangur and MH, Nagaland report using only unmodified ECTs. Two hospitals (LGBH, Tezpur and GMHC, Vishakapatnam) report using both modified and unmodified ECTs. While 2 hospitals (6%) reported not using ECTs in 1996(HMH Vadodara and IMH Purulia), 6 hospitals (17%) presently report not using this treatment modality (four hospitals of Kolkata and Varanasi). Although they have facilities for modified ECT, hospitals that do not record any ECT having been given in the past year are HMH, Ahmedabad, HMH, Jamnagar and the 3 hospitals in Kerala. Vacancy of anaesthetists is cited as a common problem.



Figure 9: Electroconvulsive therapy
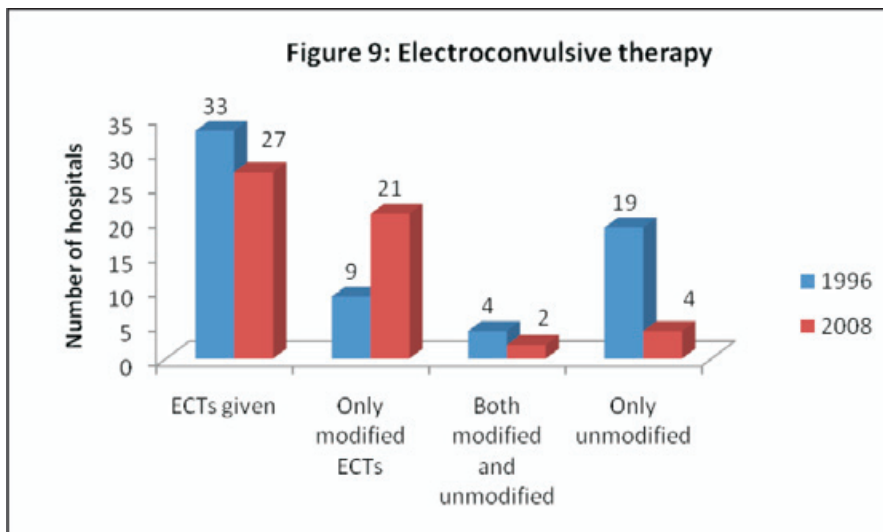
During the previous year, across 20 of the 26 centres which have provided information about the number of ECTs annually administered, a total of 43,343 ECTs have been given (range from 6 ECTs to more than 3000). Centres which use ECTs as an active treatment modality include GHMC, Vishakapatnam (5061 annual ECTs), IMH, Agra (6035), NIMHANS (5852), KIMH, Dharwad (4644), RMH, Yerawada (3244) RMH, Nagpur (3167) and CIP (3930).

*Psycho-social inputs*

With no psychologists in 14 hospitals (39%), no psychiatric social workers in 18 (50%) and no psychiatric nurses in 24 (67%), it is clear that little or

no psycho-social inputs like individual therapies, group counseling, family therapy, psychological testing, case work, etc occurs even now in most of the hospitals. The details of staffing and the consequences of human resource deficiency are discussed later. A specific comment made in the Chaman Lal Report in 2005 (17) that at the VGMH Amritsar, the extent of psychosocial inputs to diagnosis is still inadequate and needs to be increased, is applicable to many other hospitals. Therapy is even more inadequate.

*Recreation and Rehabilitation*

A major finding of the NHRC/NIMHANS report 1999 (1) was that in most of the hospitals, people were confined in closed environments, with little to do the whole day, and ill-prepared to lead productive lives following discharge. Chronic psychotic disorders often cause amotivation resulting in little interest in taking up activities. Amotivation, coupled with lack of supervised activity, can result in the individual becoming unproductive and unemployable.



Figure 10: Recreation and rehabilitation facilities within the hospital
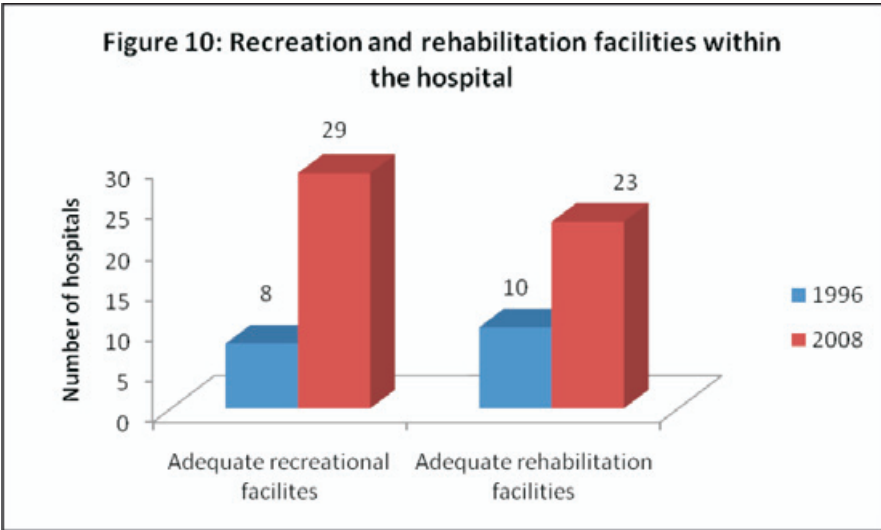
While basic recreational facilites were reported in most hospitals (31, 84%) in 1999, they could be considered adequate in only 8 hospitals. Presently, 29 (81%) of the hospitals have adequate recreational facilities for in-patients (Figure 10). This ranges from reading material, music, and sports activities. Regular exercises and occupational therapy are conducted by the nursing staff in some of the hospitals, while occupational therapists are present in a few hospitals. Only two hospitals–KIMH Dharwad and

IMH Bareilly report that recreational activities are inadequate. According to the DGHS report (4), "*a lot needs to be done at the MH Varanasi to bring the recreation and rehabilitation facilities closer to adequate*". The hospital report for 2008 suggests that things have since improved.



Recreation- vernacular reading material: HMH Ahmedabad (Gujarat)

With regard to occupational therapy, the L Mishra Report of 2007 (24) illustrates the refreshing change productive activities can bring about in hospitals. With reference to RINPAS, it states, "Visit *to both the male and female sections of the OT was indeed a treat. The following aspects in the functioning of the OT struck me most: Willingness, opportunity, responsibility and knowledge are the dominant motifs; there has not been a single occasion when there has been cessation of work on account of shortage of raw material or breakdown of power; the end products are both attractive and useful*".



Rehabilitation at RINPAS, Jharkand

While 20 hospitals reported some form of rehabilitation activity in the 1999 report, rehabilitation facilities could be considered adequate in only half the hospitals. Adequate rehabilitation services for in-patients are now

provided in 23 (64%) of the hospitals. While the recreation and rehabilitation facilities superficially may not seem to have increased (about two-thirds of the hospitals reported such facilities even in 1996), the range of rehabilitation services have improved in the hospitals offering such facilities. As part of the rehabilitation service, IMH, Hyderabad has started male and female quarter-way homes. The Andhra Pradesh State Mental Health Authority is formulating rehabilitation programmes for the mentally ill along with NGO collaboration. At LGBRIMH, Tezpur, a comprehensive centre is being newly built with funds from the central government. Trade instructors, occupational therapists and physiotherapists have been appointed and are in-charge of the rehabilitation activities. In Goa, the state government has approved a proposal to start a day care centre in the IPHB complex for rehabilitation of both admitted and outpatients. HMH, Ahmedabad provides occupational therapy, a day care centre, skills development, vocational training and job placement when possible. The hospital follows a community based rehabilitation model and closely works with several community NGOs. The HMH, Jamnagar has constructed an occupational therapy building in 2004 and a rehabilitation complex in 2008. Non-governmental organisations assist in recreational and rehabilitation activities. The HMH Vadodara currently has a half-way home and day care centre run by specialised staff under an occupational therapist. The HMH, Bhuj provides activities such as carpentry, machine sewing, embroidery and computer training. RINPAS has a sub-committee overseeing rehabilitation activity. KIMH, Dharwad has started a rehabilitation centre of its own, in addition to a centre run by an NGO. MHC, Thrissur has a rehabilitation centre functioning within its campus, but the DGHS report (4) suggests that rehabilitation services were inadequate here. The same comment was made of MHC, Thiruvanthapuram, but their 2008 report suggests that several rehabilitation units are currently functioning. At GMA, Gwalior, the Chaman Lal report of 2007 (26) indicates that half-way homes have been functioning under the supervision of NGOs of established repute. At IHBAS, trades such as tailoring/stitching/embroidery, envelope making, candle making, arts and crafts are available in occupational therapy. IMH, Chennai reports active NGOs involvement in rehabilitating the patients in the recreation therapy centre, occupational therapy centre and industrial therapy centre. At IMHH, Agra, according to the Mishra report of 2007(23), there are two occupational therapy units one each for male and female patients with separate instructors. RMH, Yerawada has submitted a proposal for a day care centre. Rehabilitation of long stay is under taken in the hospitals

at Lumbini Park, Pavlov and Murshidabad with the involvement of some well-known NGOs like Paripurnata, Sevac, Antara and Anjali. A two-storey rehabilitation centre constructed at BMH, Murshidabad is to be shortly inaugurated. However, in general, rehabilitation services are reported as inadequate at IMC Purulia, BINP, Bangur, BMH, Murshidabad, Pavlov Hospital, MH, Varanasi, MH, Bareilly, MHC, Cuttack, MH, Indore, all the Hospitals at Maharashtra and GPDH, Jammu.

## Specialised services (Figures 11 &12)

*Child mental health services*

In 1996, only 2 hospitals, IMH, Chennai and NIMHANS, Bangalore, reported *out-patient* facilities for children. Presently, IMH, Hyderabad, IHBAS, LGBRIMH, Tezpur, IPHB, Goa, HMH, Ahmedabad, RINPAS, PDH, Jammu, PC, Jaipur, AMA, Agra and BINP, Bangur report out-patient child psychiatric services. However, only 7 centres presently report specialised in-patient facilities for children (IMH Chennai, PC Jaipur, MHC Kozhikode, IMH Hyderabad, RINPAS, RMH Yerawada and NIMHANS). The RMH Yerawada presently reports having a 10-bed children's ward. The NHRC/NIMHANS 1999 report had observed with consternation that children were being admitted into adult wards in that hospital.

*Geriatric mental health services*

While only 2 hospitals earlier offered these services, IMH, Hyderabad, IHBAS, HMH, Ahmedabad, RINPAS, CIP, RMH, Thane, PC, Rajasthan, IMHH, Agra and NIMHANS presently offer out-patient geriatric mental health services but only 4 hospitals presently report specialised in-patient geriatric services (RINPAS, PC Jaipur, MH Agra and NIMHANS).

*Forensic mental health services*

A separate out-patient service is offered at IMH, Hyderabad, LGBRIMH, Tezpur, IHBAS, RINPAS, MHC, Kozhikode, MHC, Thrissur, VGMH, Amritsar, PC, Rajasthan and BINP, Bangur. Separate wards for the criminally mentally ill are newly provided at LGBRI, Tezpur, IHBAS, IPHB, Goa, PDH, Jammu, MHC, Thrissur, RMH, Thane, VGMH, Amritsar, PC, Jaipur, MHC, Thiruvanathapuram, MHC, Kozhikode and IMH, Chennai (they existed earlier at the hospitals of Andhra Pradesh, RINPAS, RMH Yerwada, and NIMHANS).

*De-Addiction Services*

In 1996, out-patient de-addiction services were reported from RMH, Nagpur, IMH, Chennai, PC, Jaipur and NIMHANS. These services have presently expanded to IMH, Hyderabad, IHBAS, HMH, Ahmedabad, IPHB, Goa, RINPAS, CIP, MHC, Thrissur, RMH, Yerawada and BINP, Bangur.

Inpatient de-addiction facilities are now available at 15 hospitals (42%). MHC, Thiruvanthapuram mentions that a de-addiction ward is under construction. Although the reports received from the hospitals of West Bengal apart from Purulia do not mention separate in-patient de-addiction facilities, at the presentation of the meeting of state health secretaries in May 2008, it was mentioned that five drug de-addiction centres had been opened in the hospitals at West Bengal with a total capacity of 60 patients. At Cuttack, the drug de-addiction building, which was lying vacant for 5 years, is presently being used.



Figure 11: Specialised out-patient services



Figure 12: Specialised in-patient services

Mental Health Care and Human Rights
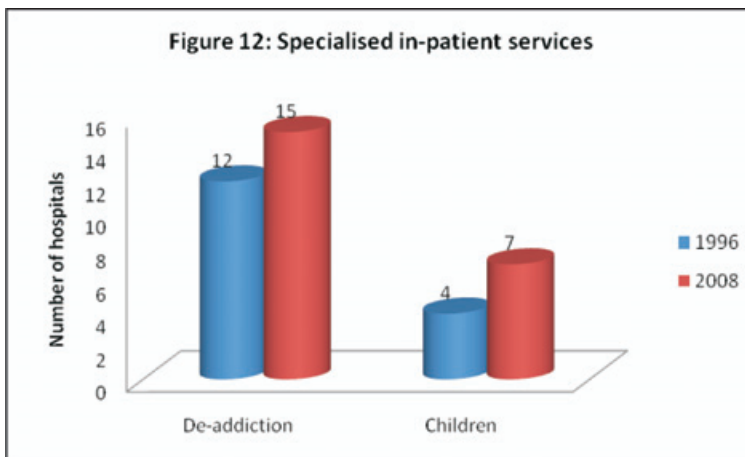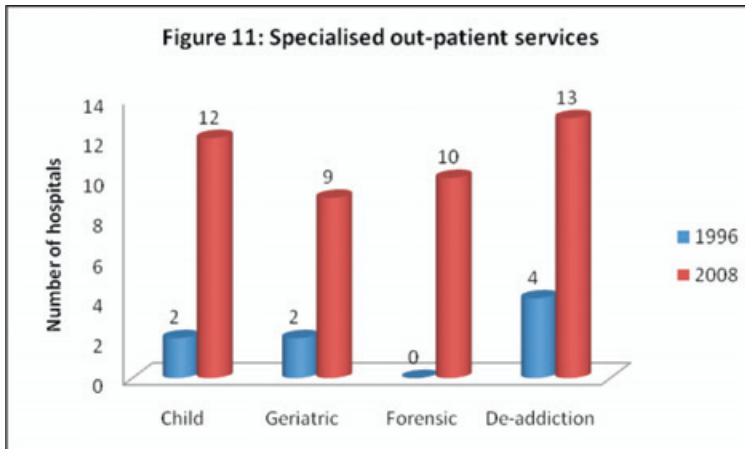
*Community programmes*

In the NHRC/NIMHANS report (1999), 59% of the hospitals had reported providing some form of community mental services, largely sporadic. Only 19% of them had regular community based programmes.



Figure 13: Regular community programmes conducted by hospital: 2008
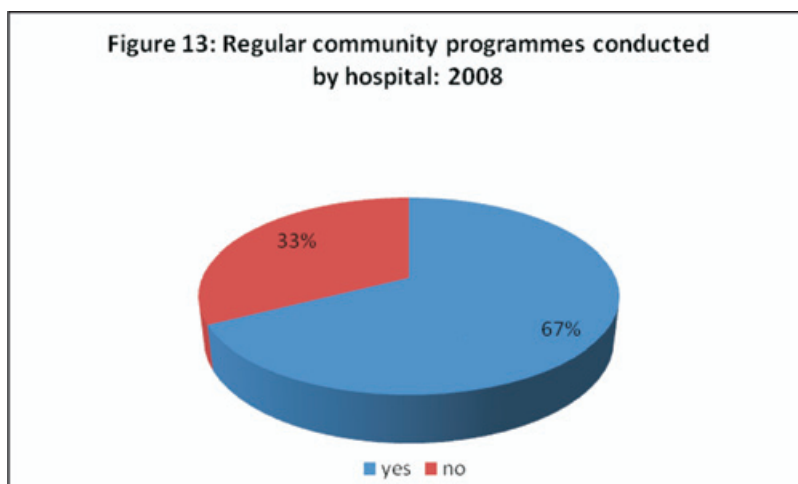
Presently, 24 hospitals (67%) offer regular community services (Figure 13). MH, Varanasi, MH, Bareilly, IMH, Purulia, BINP, Bangur, Pavlov Hospital, MHC, Cuttack, MH, Kohima, PDH, Jammu and MHC, Kozhikode do not report regular community activities.

IMH Hyderabad is implementing the DMHP at Medak and was involved with the WHO supported psychosocial interventions for the Tsunami affected districts. The IMH Vishakapatnam provides mental health services to several NGOs like the Mother Teresa home as well as the Central Prison. It is implementing the DMHP in the Vizianagaram district. The psychiatric hospitals in Gujarat are regularly involved in outreach programmes in the district and the DMHP. MH Indore is implementing the DMHP in Shivpuri, Dewas, Sehore, Mandla and Satana Districts. All the MHCs of Kerala are nodal centres for district mental health programmes in the state. IMHH, Agra provides mental health services to several NGOs, the Central and district jails. RINPAS is co-ordinating the DMHP at Dumka and two more programmes sanctioned at Gumla and Daltonganj. The IPHB Goa liaises with several NGOs as well as voluntary organisations.

Community awareness under the DMHP- a street play in Tamil Nadu

*Training of judicial officers*

It is very important to sensitise judicial magistrates and other officers about the nature of mental illness, the needs of the mentally ill, treatments available for mental illness and the laws pertaining to mental health and ill health. NIMHANS, RINPAS, Ahmedabad and KIMH Dharwad report conducting regular sensitisation programmes for the magistracy.

## Staff pattern and related issues

In general, there has been an overall increase in sanctioned posts across all hospitals, but the vacancies are striking and are a cause for serious concern. The situation in Varanasi is particularly appalling. This 331 bed hospital has only one qualified psychiatrist running the hospital, with 4 other posts vacant. There is no sanctioned post of general medical officer, clinical psychologist, psychiatric social worker, occupational therapist dietician or nurse.

In both the earlier review and in the present one, only 19-20 hospitals report having staff residential on the campus.

*Psychiatrists*

The number of psychiatrists relative to the bed strength was very low in 1996, the average number being about 4. The change in staff patterns was calculated for 1996 and 2008. NIMHANS has been excluded from this analysis because of its strong multidisciplinary emphasis and therefore different staff pattern. No information, or incomplete information was obtained from RMH, Yerawada, MHI, Cuttack, IMH, Chennai, IMC, Purulia

and MHC, Thiruvananthapuram. From information collated for 31 hospitals, the number of sanctioned posts between 1996 and 2008 reflects an increase from 179 to 293, an increase from an average of 5.8 to 9.5. Posts have been significantly enhanced at IHBAS (23 to 42), RINPAS (13 to 20), GMA, Gwalior (6 to 23), VGMH, Amritsar (6 to 22), PC, Jaipur (4 to 14) and IMH, Hyderabad (12 to 17). More modest increases are seen in the hospitals of West Bengal, Uttar Pradesh, Gujarat, KIMH in Dharwad, and the IPHB, Goa. Hardly any changes in the sanctioned posts are evident in the hospitals of Kerala and Maharashtra. Despite this positive move, the available specialist manpower continues to be short with there being 116 vacancies across the country, compared to 27 in 1996 (Figure 14). There are only one or two psychiatrists presently working in eight of the hospitals (HMH Bhuj, Jamnagar and Vadodara, RMH, Nagpur and Ratnagiri, MH, Varanasi and IMC, Purulia).



Figure 14: Mental health professionals: numbers of sanctioned posts and vacancies
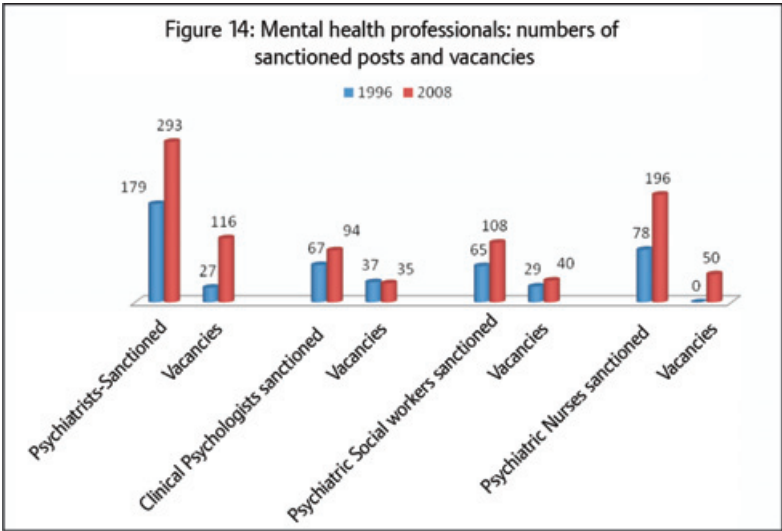
(Information on psychiatrists for 31 hospitals, other mental health professionals for 32 hospitals)

The staff scenario is even bleaker with respect to other mental health professionals, as was the scene during the earlier review.

*Clinical Psychologists*

There was no post of clinical psychologist in 8 hospitals (22%) at the time of the NHRC/NIMHANS 1999 review. Eighteen hospitals (49%) had a post that was lying vacant. In 2008, of 32 hospitals which have

provided the information, 14 (44%) hospitals have no clinical psychologist working presently. There is one clinical psychologist in 6 hospitals (19%), 2 in 5 hospitals (16%), and 3 or more in 8 hospitals (25%). While this represents a slight improvement from before, the situation is far from satisfactory, and about a third of the sanctioned posts are vacant.

*Psychiatric social workers*

During the earlier review, 11 (30%) of the hospitals had no post of psychiatric social worker and 9 (24%) had one post. According to the information provided by the hospitals in 2008, there are no psychiatric social workers in 12 of the 32 hospitals (37.5%). There is one psychiatric social worker in 10 hospitals (31%), 2 in 2 hospitals (6%) and 3 or more in 5 hospitals (16%). Hospitals which have 3 or more psychiatric social workers presently working include IPHB, Goa, RINPAS, CIP, IHBAS, KIMH, Dharwad, AMA, Agra, RMH, Nagpur and Thane. Although the number of sanctioned posts has increased more than 1.5 times over the decade, there are several vacancies across the hospitals, notably in the hospitals at Hyderabad (3), Tezpur (4), Agra (5) and at IHBAS (5) and RINPAS (10).

*Psychiatric Nurses*

In the last decade, 19 (51%) of the hospitals did not have a post of a psychiatric nurse. The situation was better in the hospitals in Maharashtra, where many nurses had been deputed for psychiatric training to NIMHANS. The CIP Ranchi also conducted psychiatric nursing courses. Thus the hospitals of Jharkand (formerly in the state of Bihar) have even earlier had psychiatric nurses. Although the sanctioned posts of psychiatric nurses have more than doubled, nearly 25% of the sanctioned posts are presently vacant. Most hospitals also have large vacancies of general nurses.

Three hospitals in the NHRC/NIMHANS report 1999 reported having no nursing staff at all. Of them MH, Nagaland, presently has 8 general nurses and MH, Bareilly has 4 general nurses. The sad story of MH, Varanasi was mentioned earlier.

*Anaesthetists*

While only 5 (14%) hospitals reported having an anaesthetist earlier, presently 18 (50%) hospitals report having an anaesthetist available for ECT services.

*Other staff issues and staff training*

Overall, 13 hospitals do not have a psychiatrist as medical superintendent. This includes all the hospitals of West Bengal. The reason cited is that the post of superintendent is within the WBPH & AS (a separate administrative cadre). This is being examined and rectified. The superintendents of the hospitals at Gwalior, Bareilly, Varanasi, Kohima, Thrissur, Jammu, Tezpur and IHBAS are also non-psychiatrists. The posts of both superintendent and deputy superintendent are vacant at RMH Yerawada.

The NHRC/NIMHANS report of 1999 (1) recommended in-service training to sensitise staff, including the ministerial staff, to the specific needs of the mentally ill, particularly the safeguarding of their human rights. This is particularly relevant to the ministerial staff, who have had little formal training and have a custodial approach to patients. While only 7 hospitals (19%) reported regular in-service training for staff earlier, 20 of the 33 hospitals (61%) that have responded to this question presently report regular in-service training for the staff.

## Post-graduate training



Figure 15: Post graduate training
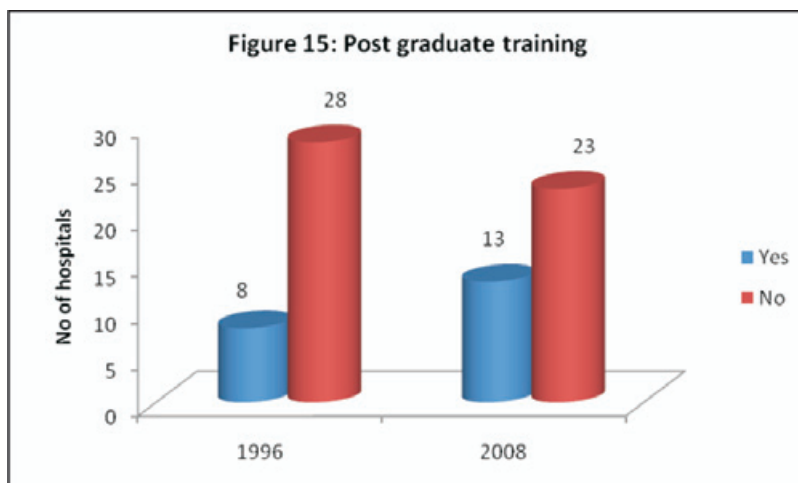
There has been a marginal improvement in the number of centres offering post-graduate training (Figure 15). However, a majority of the hospitals do not offer any post-graduate courses in any of the mental health disciplines. There are a few notable exceptions. At LGBHRIMH, Tezpur, there are presently 7 post-graduates pursuing their DNB psychiatry and 4 MSc psychiatric nursing. This institute is planning to start MPhil in psychiatric social work this year. Inspection by the Guwahati University

for starting an MD Psychiatry course has been completed in May 2008. RINPAS initiated courses of MPhil and PhD in clinical psychology in 2000 (6 and 2 seats respectively), and MD and DPM psychiatry courses in 2007. A proposal for MPhil in psychosocial rehabilitation and enhancement of the post-graduate seats in psychology is in the anvil. The KIMH, Dharwad has obtained the approval of the Indian Medical Council to start an MD course under the Karnataka Institute of Medical Sciences (KIMS), Hubli, to which the hospital is affiliated. Preparations to start post-graduate courses at GMA, Gwalior are underway. Six MD seats have been sanctioned at GHMC, Vishakapatnam and MCI clearance is awaited. IMH, Hyderabad is planning to start MPhil courses in clinical psychology, psychiatric social work and psychiatric nursing. At IPHB, Goa, nurses are being deputed for training, including for psychiatric nursing courses. PDH, Jammu provides a DNB Psychiatry course. MHC, Thiruvanthapuram has started a DNB course in psychiatry with 4 sanctioned seats each year.

Students of medical social work and psychology and general nursing have postings at this hospital, as well as the MHC Thrissur. MD Psychiatry students of the Calicut Medical College are posted to MHC Kozhikode. This also occurs in other hospitals.

## Custodial care indicators

The NHRC/NIMHANS report of 1999 (1) mentions that 16 hospitals have cells. However, upon recalculating the figures from individual hospitals it is seen that 20 (54%) used cells in 1999. This has reduced to 8 (22%) (Figure 16). Cells are still reportedly used at HMH, Ahmedabad, HMH, Jamnagar, MHC, Thrissur, MHC, Kozhikode, MHC, Cuttack, IMH, Chennai, BINP, Bangur and IMH, Purulia.

While uniforms are compulsory in 27 hospitals (73%) at the time of the earlier report, 21 hospitals (59%) presently report having uniforms (Figure 16). Even hospitals that have made significant improvement in many areas of patient care like RINPAS, LGBRI Tezpur, IMHH Agra, PC Jaipur, PDH Jammu still mandate uniforms. The hospitals of West Bengal, Uttar Pradesh, Madhya Pradesh and Maharashtra also mostly have uniforms. HMH, Jamnagar, CIP, Ranchi, MH, Kohima, GMH, Amritsar, which had compulsory uniforms earlier, have presently discontinued this practice.

Figure 16: Custodial care indicators
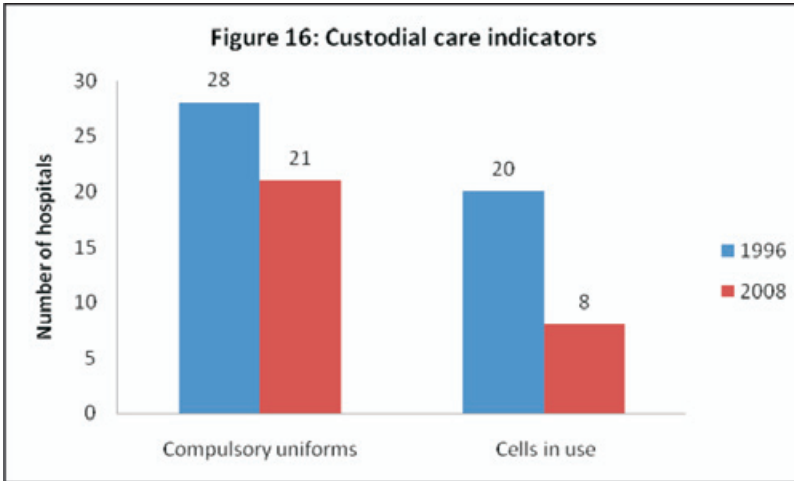
## Patient rights

While only the hospitals at Ratnagiri, Tezpur and the Pavlov Hospital in Kolkata reported displaying patient rights in the NHRC/NIMHANS 1999 survey, 15 hospitals (42%) presently report actively displaying such boards within the hospital. The Chaman Lal report of 2006 (20) particularly commends the IPHB Goa in this regard. The comment reads "*It is heartening to note that a Citizen's charter containing general information about the Institute, guidelines for availing of various facilities and mechanism for redressal of complaints and grievances has also been issued*".

## Board of Visitors

The Board of Visitors (BOV) is still required under the Mental Health Act 1987 for regular inspection and monitoring of hospitals. At the time of the earlier review, it was present in 23 hospitals (62%) but met on a regular basis in only 12 hospitals (32%). According to the 2008 review, 29 hospitals (81%) have regularly functioning BOVs.

## Disability Certification

Under the Persons with Disability (PWD) Act, the mentally ill can receive benefits upon disability certification. Nineteen (53%) of the 36 hospitals presently carry out disability assessment and certification. While 12 are not doing disability certification, there is no response to this question from 5 hospitals.

## Budgetary Issues



Figure 17: Budget increase between 1996 and 2008
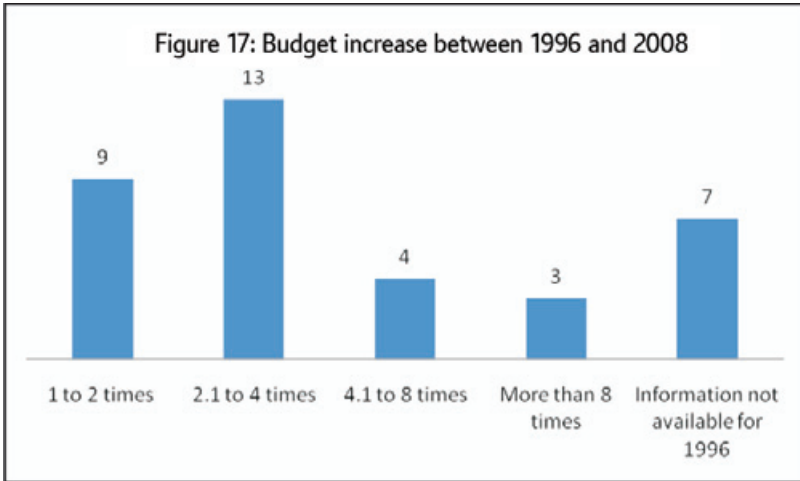
Fifty percent of the hospitals have had their budgets doubled or more than doubled between 1996 and 2008 (Figure 17). Hospitals which have only had a marginal increase (1.1 to 1.5 times) in their annual budget are HMH, Ahmedabad, RINPAS, KIMH, Dharwad, MHC, Kozhikode, GMA, Gwalior and IMH, Chennai. LGBH, Tezpur, BMH, Murshidabad and the PDH, Jammu have had huge increases in their total annual budget. GMA, Amritsar, which did not specify a budget for 1996 reports an annual budget of Rs 666.3 lakh for the current year. The 4 hospitals of West Bengal, BINP, Bangur, Lumbini Park Hospital, Pavlov Hospital and IMH Purulia, which did not specify any budget for 1996, now report annual budgets. One of the observations in the earlier report was that some hospitals had no separate budget and most hospitals did not have a bifurcation of plan and non-plan budgets. A large part of the budget was spent on salaries leaving little for developmental work and maintenance. During the current review, 28 (78%) have provided a break-up of plan and non-plan. Some of the hospitals do not indicate a plan budget this year, possibly because of the recent one time modernisation grant availed from the central government.

MH, Nagaland, which has received an annual grant of Rs 24 lakh, specifically reports inadequate budgetary allocation, which hardly meets even the staff salaries. The state government's ban on recruitment has prevented their filling up any vacancies in the hospital.

## Stigma

Several efforts of the various hospitals have helped in reducing stigma. IMH, Chennai reports revising its hospital code to avoid stigmatizing terms. However, it is still not uncommon to hear the hospitals referred to as 'pagal khanas', something that was still evident during a NIMHANS faculty visit to the hospitals in Uttar Pradesh. Though most custodial and stigmatizing terminologies have thankfully become obsolete, we still come across terms like 'barracks' for wards, 'wandering lunatics' and 'inmates' in reports. The latter terminology is surprisingly sometimes used even in official reports as well as in judicial pronouncements.

## Administrative Changes

Some of the hospitals have become autonomous (e.g. the hospital at Tezpur), some affiliated to medical colleges during the interim period (KIMH, Dharwad to KIMS, Hubli, IPHB, Goa to the Goa Medical College). Others have come under the medical education department (MH, Indore). In West Bengal, based on the recommendations of the NHRC/NIMHANS report (hospitals in a variable and mostly undesirable state except Pavlov), a separate mental health cell has been set up under the Directorate of Health Services. All the hospitals come under the control of the Department of Health and Family Welfare.

## Positive reflections

Some of the positive changes and the overall improvements can best be summarised by some of the interim reports of the NHRC and the DGHS. These are reproduced verbatim below:

*LGBRIMH, Tezpur*

 "*The dramatic improvement in the standards of mental health care at the LGBRIMH, Tezpur is something which the State can take pride in and which can be a role model for the other mental hospitals to follow… The Institute has been taken over by the North East Council and is being renovated gradually*" (4).

*IPHB, Goa*

"*Given the right kind of dynamic and imaginative leadership the IPHB can become a major centre for training mental health personnel including clinical psychologists, PSWs and psychiatric nurses*" (4).

Implementation of the recommendations of the Dr Channabasavanna Committee (1) is thus found to be generally good with promising signs of early completion of pending tasks….The institute has been performing commendably in the field of education and training in mental health and research activities" (20).

*PDH, Jammu*

*"Though the hospital was started as a mental hospital, it is now working as a psychiatric institute attached to a medical college. It has an open ward set up where family members can stay with the patient. This open ward system is an example of how a typical closed mental hospital can be transformed when it becomes an open system. This change has been facilitated by the attachment of a teaching hospital with postgraduate students. The effect of adequate staffing is evident from the better care that is available at this hospital l(4)".*

*RINPAS, Jharkand*

The Chaman Lal report (15) remarked that RINPAS had been making steady progress in achieving the objectives set by the Supreme Court while granting it autonomous status. *"Promising steps have been taken for developing training facilities for medical and para-medical personnel. The scope and reach of the community outreach programme has been expanded. The credibility of RINPAS in government and private circles is seen to have gone up. The institution is capable of making a still greater progress and realize its potential of becoming an outstanding hospital and a centre of excellence in the field of training and research provided the management committee boldly exercises its autonomy and strengthens the hands of the Director who has been working with great zeal and providing an inspiring leadership to a team of competent an dedicated workers".*

*HMH, Ahmedabad*

*"Although one of the oldest hospitals, is well managed. The new building will provide better infrastructure. The hospital has good potential not just for services but as a training centre"* (4).

## The negative side

Though all hospitals have shown change, the slow pace of change,

administrative apathy of the state government, and a lack of insightful leadership and innovation has led to some hospitals still presenting a dismal picture and overshadowing the positive changes that have occurred in most.

*GMA, Gwalior*

The Chaman Lal report of 2006 (22) concludes: "*In my opinion the intervention of the Supreme Court does not seem to have made any significant change in the efficiency and quality of services at the GMA. I do not think the Commission's continued involvement is likely to make any difference. I reiterate what I had recommended last year that we should bring all these matters to the notice of the Supreme Court and request the apex court to deal with this institution directly.*" Fortunately, things have improved in the subsequent years and the 2007 report has a more optimistic note (26).

*MH, Indore*

"The hospital is in a highly deplorable state in almost all aspects of human care as well as the conditions of the staff members. The overall scenario and atmosphere are highly regrettable. Evidence of chaining of patients, clinical abuse and active neglect are seen. Needs CRISIS RESPONSE (4). This hospital has made some changes, particularly in out-patient care, but still has several inadequacies, including several staff vacancies, including that of 40 general nurses.

*MH, Varanasi*

This hospital needs major improvements in buildings and maintenance, basic facilities for patients…… a lot is needed to bring the services closer to adequate. Needs CRISIS RESPONSE (4). A visit by a NIMHANS faculty in July 2008 shows that the problems are far from resolved. "*The construction plan needs to be executed by the state government at the earliest. Amenities need to be addressed in the planning…there is an urgent need for casualty and emergency services….here is an urgent need of personnel…supportive services need to be developed…*"

*The hospitals of Maharashtra*

Terming the conditions at the four government-run mental hospitals in Maharashtra as *'horrible' and 'shocking', the* Bombay High Court asked

the principal secretary (health) to file an action report within four weeks (28). Stating that people working in these hospitals seem insensitive to the plight of the '*inmates*' (italics added), the court said, "These places are worse than jails".

## Monitoring and its impact

Each hospital was asked about the number of visits from the NHRC after 1999, when the NHRC/NIMHANS report was prepared. Hospitals which reported 3 or more visits from the NHRC during the interval period were regarded for the purpose of the following analysis as 'NHRC monitored'(includes AMA, Agra, GMA, Gwalior, MH, Indore, VGMH, Amritsar, RMH, Ratnagiri, KIMH, Dharwad, LGBRHI, Tezpur, RINPAS, PC, Jaipur, MH, Varanasi and PDH, Jammu). Hospitals with fewer than 3 visits from the NHRC were regarded as non-monitored. The second category recorded no visits (five of the hospitals of West Bengal and MH Nagaland), one or two visits from the NHRC in the last few years. (hospitals of Gujarat, Andhra Pradesh, Maharashtra, Tamil Nadu, Cuttack, Goa, CIP, Ranchi, NIMHANS, RMH, Yerawada and MH, Bareilly)

On many of the parameters compared, we would like to emphasise that some of the hospitals monitored by the NHRC had been worse off than some of the better non-monitored hospitals at baseline. NIMHANS and IHBAS, which had better resources from the beginning, have been excluded from the calculations of budget as these two hospitals have both mental health and neurological services and facilities and hence very different patterns of funding.



Figure 18: NHRC monitored and non-monitored hospitals: Budget increase between 1996-2008
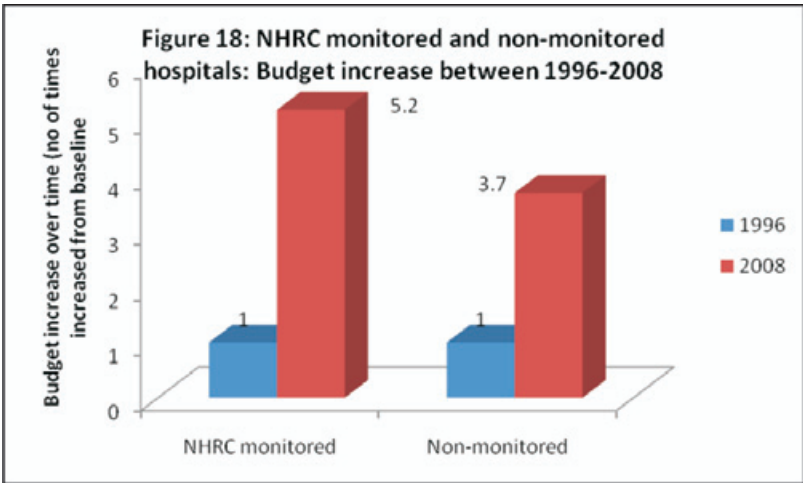
NHRC monitored hospitals recorded much higher increases in budget between 1996 and 2008 compared to the non-monitored hospitals (Figures 18 and 19). Consequently, the infrastructural changes have been more visible in the monitored hospitals.



Figure 19: Monitored and non-monitored hospitals: budget increase across time
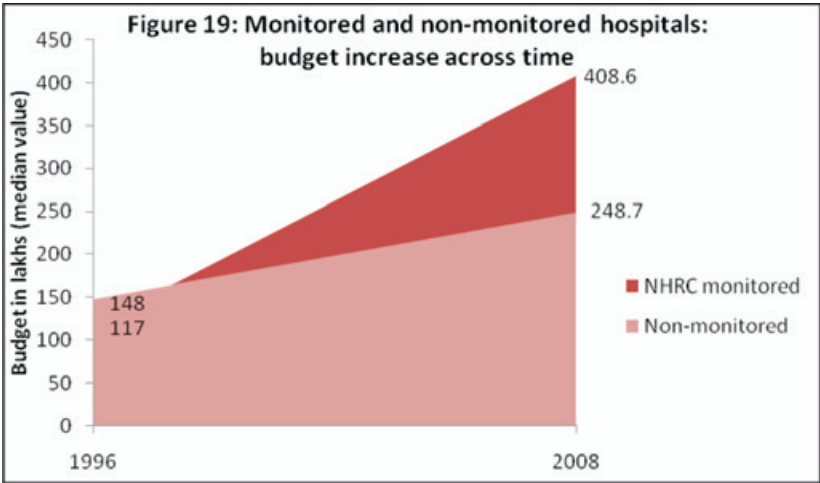
The monitored hospitals show a much greater reduction in the admissions through courts (Figure 20). The monitored hospitals have also made a more visible effort to improve recreation and rehabilitation facilities, dialogue with NGOs and improve the amenities and living conditions within the hospital.



Figure 20: NHRC monitored and non-monitored hospitals: court admissions over time
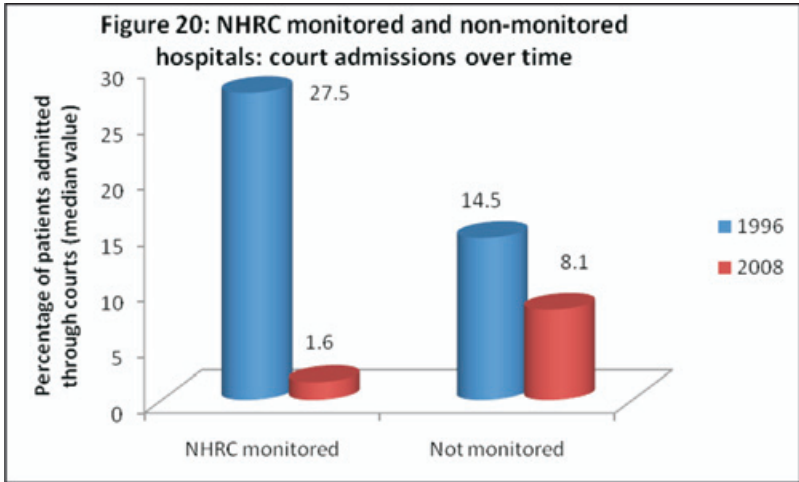
In monitored hospitals, the dietary allocation shows a greater increase than in the non-monitored hospitals (Figure 21).

**Figure 21: NHRC monitored and non-monitored hospitals: diet**

| Category | 2008 | 1996 |
|----------|------|------|
| Non-monitored | 2400 | 2500 |
| NHRC monitored | 3000 | 2450 |

Diet per patient in kcalories (median values)
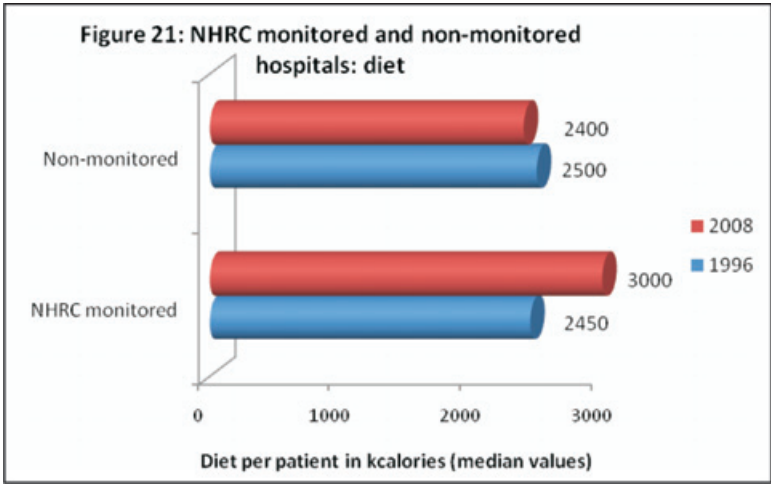
While both sets of hospitals have made significant improvements in providing basic amenities, the improvement on most parameters is greater in the monitored hospitals (Table 2). The patient-toilet ratio seems better in the non-monitored hospitals because of the strict consideration of 1:5 to determine adequacy. Many of the buildings in the monitored hospitals have been very old and remodified. With new facilities, the ratio would be better maintained.

## Table 2: NHRC monitored and non-monitored hospitals: improvements in amenities

| Services/ Amenities | NHRC monitored (N=11) | | | | Non-monitored (N=25) | | | |
|---|---|---|---|---|---|---|---|---|
| | 1996 | | 2008 | | 1996 | | 2008 | |
| | N | % | N | % | N | % | N | % |
| Emergency services present | 7 | 64 | 11 | 100 | 12 | 48 | 15 | 60 |
| Adequate drinking water in the OPD | NR | - | 9 | 82 | NR | - | 21 | 84 |
| Adequate toilets in the OPD | 2 | 18 | 10 | 91 | 2 | 8 | 19 | 76 |
| Guest house facility for relatives | NR | - | 5 | 46 | NR | - | 5 | 20 |
| Canteen facilities present | 0 | 0 | 7 | 64 | 5 | 20 | 12 | 48 |
| Adequate in-patient toilets (1:5) | 2 | 18 | 5 | 46 | 5 | 20 | 13 | 52 |
| Adequate running water in in-patients | NR | - | 11 | 100 | 8 | 32 | 18 | 72 |
| Adequate fans/coolers(1:5) | 1 | 9 | 11 | 100 | 8 | 32 | 17 | 68 |
| Separate dining hall facilities | 4 | 36 | 6 | 55 | 4 | 32 | 18 | 72 |
| Adequate in-patient laboratory facilities | 7 | 64 | 11 | 100 | 14 | 64 | 14 | 64 |
| Adequate power/backup | 4 | 36 | 11 | 100 | 9 | 36 | 22 | 88 |

**Limitations of the review**: Incomplete information from some of the hospitals on the two questionnaires is a major limitation of this review. Individual hospitals could not be visited to obtain an objective report of the current state. This was overcome by perusal of the interim reports of NHRC and DGHS visits. Despite the limitations, the findings provide a reasonable understanding of major changes that have occurred in the hospitals during the intervening decade.

## Summary and recommendations

To summarise, it would not be an exaggeration to say that more change has occurred in the government run psychiatric hospitals in India in a little over a decade than in the six decades following Mapother's report and in the five decades following the Bhore Committee report.

| Areas of positive change | Areas of poor progress |
| --- | --- |
| Reduction in court admissions | Staff inadequate. |
| Improved structural facilities | Created posts vacant |
| Living conditions | Psychosocial interventions still inadequate |
| Diet | Closed wards in many hospitals |
| Recreation and rehabilitation | Lack of post graduate training |
| Greater collaboration with NGOs | |
| Regular community level activities | |
| Improved budgetary allocation | |

The most likely reasons likely for the positive changes are the following:

- Improvements in funding, especially the central government grant for modernisation as well as greater financial investments from state governments;

- Separate budgets for these hospitals, many of which did not have any allocated budget earlier;

- Monitoring by different agencies–primarily the NHRC, in some instances SHRC and the State Mental Health Authority;

- Innovative and dynamic leadership. Despite financial resource enhancement, some hospitals without an able administrator and effective team have been able to do little;

- Greater focus on rehabilitation, networking with NGOs, enhancing community activities;

- Expanding and improving out-patient services;

- Involving families in care, active attempts in restituting recovered patients with their families.

Despite the involvement of NHRC, the progress has been slow at some hospitals. Some of the reasons attributable to a lack of change include:

- Large, unmanageable bed strengths;
- A largely closed set-up with little networking with academic institutions on the one hand and social organisations on the other;
- Lack of trained human resource;
- Insufficient involvement of the state government in matters relating to release of funds, filling of vacancies and lack of support to facilitate change;
- Lack of a motivated team and effective leadership.

The states of West Bengal, Kerala, Maharastra, Uttar Pradesh and Madhya Pradesh have showed relatively less and slower pace of change. This is ironic because many of these states have relatively more number of psychiatrists, though mostly in the private sector.

New hospitals have been started in the states of Bihar, Himachal Pradesh, Haryana and Tripura. This appears to have been in compliance with the order of the Supreme Court in Writ Petition (Civil) No 334 of 2001(27), which directed that "*with respect of State Union Territories that do not have even one full-fledged State government run mental hospital the Chief Secretary of the State Union Territory must file an Affidavit within one month from the date of this order indicating steps being taken to establish such full-fledged State government run mental hospital in the State/Union Territory and a definite time schedule for establishment of the same*" (29). Having more custodial care institutions is contrary to recommendations world over, where downsizing or closure of such institutions is recommended. Great care will have to be exercised to ensure that the new centres do not become custodial care institutions, but become full fledged training, research and development-oriented centres.

## Recommendations

The specific recommendations arising from observations of the government psychiatric facilities a decade after the NHRC/NIMHANS 1999 initiative are as follows:

- Continued monitoring efforts by NHRC or other agencies;

- Immediate downsizing of the large hospitals;

- Immediate attention to replacement of old and unsafe structures (hospitals of Madhya Pradesh and Uttar Pradesh);

- Conversion of most closed ward facilities to open wards;

- Immediate abolition of custodial practices still prevalent in a few hospitals (uniforms and cells);

- Further strengthening of OPD services;

- Provision of residential facilities for staff on campus;

- Initiation/enhancement of post-graduate training;

- Interim measures to address human resource shortage—short term training courses for mental health professionals, contractual employment of mental health professionals from the private sector;

- Active liaison with governmental and non-governmental organisations.

## Conclusion

The process of change in the government psychiatric hospitals after a decade is active and visible. The directions in which to proceed are clearer than before. The complete transformation of these psychiatric hospitals to therapeutic, training and resource centres while simultaneously developing primary and secondary mental health services in the community is the road map for the future.

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# Health as a fundamental right: the national mental health programme initiative

## D Nagaraja & Suresh Bada Math

## Introduction

Health is one of the important indicators of economic development of any society. Health is defined in the preamble of the World Health Organisation (WHO) and in Article 25 of the Universal Declaration of Human Rights. This states that everyone has the right to medical care. Medical science, the humanities and international conventions all recognise mental health as an integral part of health care. This chapter elaborates on the evolution of health as a fundamental right and role of human rights in improving mental health care in India. It also attempts to highlight the important innovations in improving mental health care through the National Mental Health Programme, which seeks to provide easily accessible and acceptable mental health care in the community.

## International development

The right to health has evolved rapidly under international law, and its normative clarification has significant conceptual and practical implications for health policy. The preamble of the WHO Constitution, adopted in 1946, proclaims that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (1). Since then, right to health has been recognised in a wide range of international and regional human rights legislation.

The concept of health has moved from a narrow medical model to a broader and holistic social view. The constitution of WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1). Mental health thus is an integral part of health care. This evolution of defining health from a social context and the emergence of health as a public issue has changed the perspective and dimensions of health. This paradigm shift was further confirmed in the

Declaration of Alma-Ata on Primary Health Care 1978, in which states pledged to progressively develop comprehensive health care systems to ensure effective and equitable distribution of resources for maintaining health.

## National Development

The Constitution of India guarantees Fundamental Rights under Chapter III. One of these rights provided under Article 21 reads as follows 'Protection of Life and Personal Liberty': No person shall be deprived of his life or personal liberty except according to the procedure established by law (2). The Constitution of India also has provisions regarding the right to health. They are outlined in the Directive Principles of State Policy- Articles 42 and 47, in Chapter IV (2). Article 42 states that; "Provision for just and humane conditions of work and maternity relief" and Article 47 states, "Duty of the State to raise the level of nutrition and the standard of living and to improve public health" Further there are sufficient case laws on the issue of right to health. Our judiciary has interpreted the right to health in many ways and also in a number of instances, through public interest litigation as well as litigation arising out of claims that individuals have made on the State, with respect to health services.

Although it is not listed as a fundamental right in the constitution, the Supreme Court has almost accepted the right to health as a fundamental right in *Vincent Vs Union of India* (3) reflected in the statement "A healthy body is the very foundation for all human activities". Hence the adage 'Sariramadyam Khalu Dharam Sadhanam'. In a welfare state, therefore, it is the obligation of the state to ensure the creation and sustenance of conditions congenial to good health". Similarly, Article 21 imposes an obligation on the State to safeguard the right to life of every person.

The role of courts nowadays is no more only as the protector and custodian of the indefeasible rights of the citizen. They have also been empowered to go a step further and give compensatory relief under public law jurisdiction. The first landmark in the Indian human rights jurisprudence was articulated by the Supreme Court in *Rudul Shah Vs State of Bihar* (4) in which it was held that the compensatory jurisprudence for the infraction of article 21 occurred. In *Bandhua Mukti Morcha Vs Union of India* (5), the Supreme Court has held that the Right to life includes the right to live with dignity. The recognition that the right to health is essential for human existence and is, therefore, an integral part of the right to life, is

laid out clearly in *Consumer Education and Resource Centre Vs Union of India* (6).

In *Francis Coralie Vs Union of Delhi* (7), it was held that the right to life does not mean a mere animal like existence but a more meaningful life, a life of physical and mental integrity. Further, in *State of Punjab and Others vs. Mohinder Singh* (8) it was also stated that right to health is integral to right to life. The state government has a constitutional obligation to provide health facilities and denial of medical aid due to non-availability of beds in government hospital amounts to violation of Article 21. This issue of adequacy of medical health services was articulated in *Paschim Banga Khet Mazdoor Samiti vs State of West Bengal* (9). Preservation of human life is thus of paramount importance. The government hospitals run by the State and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his/her right to life guaranteed under Article 21. Further, the Court ordered that primary health care centres be equipped to deal with medical emergencies. It has also been held in this judgement that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation. Similarly, in *Mahendra Pratap Singh vs State of Orissa* (10), a case pertaining to the failure of the government in opening a primary health care centre in a village, the court held, "In a country like ours, it may not be possible to have sophisticated hospitals, but definitely villagers within their limitations can aspire to have a Primary Health Centre". The necessity for timely intervention by medical professionals has been clearly stated in *Parmanand Katara vs Union of India* (11). It states that every doctor whether at a government hospital or otherwise has the professional obligation to render medical services when it is required during an emergency situation, with due expertise for protecting life. Now the doctor's ethical duty to treat the patient (professional and ethical obligation) has become a legal obligation.

From the above discussion it is clear that the Constitution of India incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health. Right to Life means the right to lead a meaningful, complete and dignified life. It is something more than just surviving or leading an animal existence. As far as Personal Liberty is concerned, it means freedom from physical restraint of the person by personal incarceration or otherwise and it includes all the varieties of rights other than those provided under Article 19 of the Constitution. The Right

to Health includes availability, accessibility, acceptability and equality (2). Non-discrimination and equal treatment are among the most critical components of the right to health. The concept of right to health translates in practice to the right to health services.

## Mental health as a fundamental right

A human rights approach to health is critical to address growing global health inequalities, poverty, violence and establishing accountability for protection of rights (12). Human rights refer to the freedom and entitlements concerned with the protection of the inherent dignity and equality of every human being. They include civil, political, economic, social and cultural rights. Human rights are inspired by moral values, such as dignity, equality and access to justice. However, they are more than moral entitlements: they are legally guaranteed (13). The international community has accepted the position that human rights are universal, indivisible, inter-dependent and interrelated (Vienna Declaration and Programme of Action, 1993) (14). Human rights and health are connected in a number of ways (15). The mentally ill person deserves the same privileges as enjoyed by any other human being. This includes a right to better and more accessible care, to good recovery and increased hopes of reintegration into society (16). The National Human Rights Commission (NHRC) is mandated under section 12 of the Protection of Human Rights Act 1993 to visit government run mental hospitals to study the living conditions of the admitted persons and make recommendations thereon.

Health professionals' practice, typically governed by ethical codes, may benefit from human rights guidelines. Human rights approaches include holding States and other parties accountable, developing policies and programmes consistent with human rights, and facilitating redress for victims of violations of the right to health and human rights. A human rights approach to health is critical and has been advocated wherever there is inequity in health and poor access to health care (2).

Mental health care has always received the least or almost no priority among health needs. Lack of insight, lack of recognition of the seriousness of mental illness, lack of understanding about the benefits of treating mental disorders and stigma **have all led to the** discrimination of mental health and mentally ill persons. This attitude not only exists among health professionals but also among policy makers, the judiciary, insurance companies, various other organisations and the public at large.

People afflicted by mental disorders are vulnerable to violations of their human rights, including the right to health, life, non-discrimination, privacy, work, education, and the right to enjoy the benefits of scientific progress. Such vulnerability is obvious in the Indian context. In *Sheela Barse vs Union of India* (17) pertaining to the admitting of non-criminal mentally ill persons to prisons in West Bengal, the Supreme Court has held that admission of non-criminal mentally ill persons to jails is illegal and unconstitutional. The judicial magistrate will, upon a mentally ill person being produced, have him or her examined by a mental health professional/psychiatrist and if advised by such MHP/psychiatrist, send the mentally ill person to the nearest place of treatment and care. In many instances, members of the judiciary have neither known about nor utilised the provisions of the Mental Health Act of 1987. Many of the law enforcement agencies are ignorant of the special admission and treatment procedures under this Act. In many instances, mentally ill persons are arrested by the police and detained in custodial care for petty crimes (creating public nuisance, destruction of property, trespassing, assault etc). They are then lost in the judicial procedure, do not receive psychiatric treatment, and have prolonged incarceration for what was a petty crime. In a recent incident, an undertrial prisoner Mr. ML, had been languishing in the mental institute in Tezpur, Assam for 54 years. Detained at the age of 23, he could secure his release only when he was 77 years old, only after the intervention from the Honourable Supreme Court of India (18)

There was also the shocking inhuman incident involving the death of 25 mentally ill persons in *Erwadi, Ramnathapuram District* (19) as they were chained to poles or beds and could not escape from a fire that broke out. Following this incident, the Supreme Court directed the state to implement the provisions of the Mental Health Act, and also undertake a survey of all institutions that provide mental health facilities to ensure that they are maintaining certain minimum standards of care.

The general public is unaware that health is a fundamental right and that 'mental health' is an integral part of health. Protection and provision of this right rests upon the state. Each citizen has a right to be listened to, to request and demand access to appropriate, acceptable and affordable comprehensive health services. This knowledge gap will narrow with increasing social and economic empowerment through awareness, education and rights legislation. Promoting the right to health care involves reorganisation, reorientation and redistribution of health care resources on a societal scale. Enjoyment of the human right to health is vital to all

aspects of a person's life and well-being, and is crucial to the realization of many other fundamental human rights and freedom.

## Mental health burden

A meta-analysis of 13 epidemiological studies on mental illness in India reported a psychiatric morbidity of 58.2 per 1000 general population (20). Similarly, another meta-analysis of 15 epidemiological studies reported a total morbidity of 73 per 1000 general population (21). When we consider prevalence of individual mental disorders and add the overall prevalence rate will be approximately 115-130/1000 population (22). Even if we consider (average of above two meta-analysis) 65/1000 population as the prevalence rate for mental illness, about 6.5 crore of persons require professional help. If each patient requires INR 300 per month for treatment, the total cost required per month will be 1,950 crore, which translates to 23,400 crore INR per year. If we do not address this issue by investing in mental health, the indirect costs in terms of loss of wages from the person's illness and consequent disability and the intangible costs of social isolation, burden, stigma and psychological strain will be enormous (22).

## Barriers in help seeking

Even in situations where treatment is available, patients get the benefits 6 to 24 months after the onset of the severe mental disorder. Nearly 50% of patients with schizophrenia remained never treated in a taluk that had a practicing psychiatrist from the private sector. The main reasons for non-treatment included low levels of help seeking, perceived stigma, poverty, ignorance, illiteracy, non-availability of mental health facilities, lack of insight into the illness, lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of treatment.

Psychiatric hospitals continue to carry stigma. Most patients who seek psychiatric consultation approach general hospitals for psychiatric consultation. However, more than 70% of the developing world's population in rural areas still depends on complementary and alternative systems of medicine (23). A majority of the mentally ill in rural areas still go or are taken to faith healers and other alternative systems. Hence, emphasis should be on training faith healers and professionals in alternative medicine for identifying mental illness and referring them (24). At the same time, emphasis should also be given to improving the manpower that can

cater to the needs of the referred cases at the general hospital. This can be achieved only by proper training of undergraduate medical professionals in treating common mental disorders. Ultimately, initiatives like integrating mental health care with general health care at primary health care and the development of general hospital psychiatry units in each district hospital through the National Mental Health Programme will yield desired results of taking basic mental health care to the doorstep.

## Innovative steps: The National Mental Health Programme

**The National Mental Health Programme (NMHP)** for India was initiated in 1982. NMHP was operationalised as the **District Mental Health Programme** (DMHP) and pilot tested in the district of Bellary, Karnataka to understand the feasibility and logistics of providing mental health care by NIMHANS.

Objectives of the NMHP were a) To ensure availability and accessibility of minimum mental health care in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population, b) To encourage application of mental health knowledge in general health care and in social development, c) To promote community participation in mental health care development in the country and to stimulate efforts towards self-help in the community.

Over a period of time, NMHP has undergone a complete review and re-orientation. A major achievement has been the increase in funds. The budget allocated for comprehensive mental healthcare delivery during the $9^{th}$ Five-Year Plan was Rs 28 crore and Rs 190 crore during the $10^{th}$ Five-Year Plan. For the current $11^{th}$ Five Year Plan, the allocation has made a quantum jump to Rs 1000 crore. Various innovative approaches adopted in the current NMHP include rural and urban mental health, school mental health, adolescent mental health, suicide prevention and public private partnership. Following are the salient features of the revised NMHP:

1. **The District Mental Health Programme (DMHP)**

   This programme was developed as an approach to deliver mental health care through primary health care for the entire district. Based on the mid-term review and two national consultative meetings, the existing DMHP programme is being strengthened by adding the adolescent mental health programme that includes health promotion for high school students, intervention for students with

emotional problems, counseling for out of school children and college based counseling services Apart from continuing the existing programmes, in the present five-year plan, it is envisaged that 443 more districts will be brought under the DMHP activities. Urban Mental Health Programme (UMHP) is a new addition to the NMHP.

## 2. Preparatory phase

This is a new concept introduced in the 11th plan. Each State should map the mental health resources in the private and public sector before applying for the project. The state has to identify the nodal officer and programme officer and get their written consent. They should undergo sensitisation and the programme officer should undergo training for three months before the total grants are released.

## 3. Adolescent and School Mental Health Programme

This involves health promotion through life skills education for development of psycho-social competence. This model, using teachers as trained resource staff has been approved as an accepted strategy internationally both in developing and developed countries. It is envisaged that 500 rural blocks and 100 urban blocks will be taken up for the adolescent mental health programme that includes life skills education for adolescents and intervention for emotional problems in the 11th plan. Adolescents' mental health programme for out of school adolescents in both rural and urban districts in the country is also envisaged. Networking with department of youth and sports, NGOs and other voluntary organisations will be established to provide appropriate interventions for this population. This programme will cater to 30,000 schools covering 1,00,00,000 adolescents.

## 4.  College mental health programme

Emotional distress, adjustment and substance use problems are significant issues in college students that need attention. Trained teachers can effectively handle such problems within the context of the college. It is planned to cover all the pre-university and degree colleges in all the districts in the country. One hundred college teachers in each of the 500 rural districts and 300 college teachers

in each of the 50 urban districts will be trained to provide counseling services in the college. The programme will cover approximately 2, 65, 65,312 college students (seventh education survey India 2002).

5.  **Improvement in health manpower status:** During the 11th Five-Year Plan, it is envisaged to support the development of 11 regional Institutes of Mental Health with a one time grant of Rs 30 crore for infrastructure development. It is also proposed to equip 30 medical colleges to start/strengthen their post graduate programme in mental health. The running cost for 5 years will be met in addition to the initial support for infrastructure development.

6.  **Research and mental health**

    This may be implemented under the following headings:

    a.  Biology of mental disorders

    b.  Early intervention for mental disorders

    c.  Improving long-term outcomes in drug and alcohol dependence

    d.  Social factors / support systems to minimise disability in chronic psychosis.

    e.  Health behaviour research

    f.  Psychological and social factors contributing to mental disorders and disability

    g.  Interventions to improve functional outcome, reduce disability and stigma

    h.  Interventions for prevention of illness and promotion of mental health.

    i.  Levels and limits of mental health care by primary care doctors.

    j.  Outcome of mental disorders treated in primary care settings.

7.  **IEC activities**

    Under this head, the following issues require to be addressed:

    a.  Development of public awareness material such as video clippings, posters radio/ TV messages and wall writings. Projects may be awarded for developing such material with an

incentive of a cash prize for the best product. Scientific methods to evaluate the impacts of these on the public have to be initiated.

b. Training material for under-graduate/post-graduate training in the form of video, interactive CD for use on the net/distant education have to be developed.

## 8. Support money for implementation of the Mental Health Act 1987

It is proposed to allocate separate funds to assist both the Central and the State Mental Health Authorities.

## 9. Public-Private Partnership

This is a key concept. Government alone is inadequate to realise all the goals of NMHP. The role of NGOs and related organisations in all components of NMHP has been recognised. Appropriate linkages between NGO activities as well as NMHP components by matching them can increase efficiency. A substantial part of NMHP can be contracted to established NGOs/private bodies of standing. For example, the entire life-skill programme (school mental health) can be run by NGOs with checks and balances and monitoring from the professionals; this would also apply to the components of IEC. NGOs can be involved in spreading awareness about mental disorders, organisation of self-help groups, day care centres, support for families and conduct of mental health camps.

## 10. Monitoring

Monitoring the implementation of DMHP in the country is very critical to plan mid-course correction. This aspect is a new addition in the 11th Plan. It is proposed that a Central and State level monitoring committee be formed to monitor DMHP on a monthly basis.

## 11. Suicide prevention

Suicide is a growing cause of premature morbidity. The causes include psychiatric disorders as well as socioeconomic reasons. Recognition of any underlying psychiatric disorder and early

treatment has the potential to prevent suicide. Several vulnerable populations require life skills training and/or counseling to prevent suicides – school and college populations are two examples. Varied social factors need to be addressed that are regionally relevant. Several other sectors have to be linked for networking resources for suicide prevention. Special IEC activities will target specific populations. Each state's nodal officer will be responsible in implementing suicide prevention programme in one or two chosen districts and the state in this plan period (first phase). The budget is proposed for 50 districts (one or two in each state). If the state needs to implement this in more districts, the same may be done through grants for NGOs or state's own resources.

## 12. Stress management

Stress is a physiological response of the body to changes within and outside an individual. It is important to recognise that stress responses are an inevitable part of human existence. Stress affects people irrespective of their age, gender, socio-economic, occupational and educational status. Many empirical studies have established the relationship between stress and illness. Studies based in the United States report that 80-90% of all illnesses are stress related. It is also estimated that 7-8 out of every 10 individuals who consult general practice doctors, do so because of stress and anxiety related symptoms. Studies conducted in India regarding prevalence of psychological distress suggests that nearly one third to one half of executive officers report symptoms of psychological distress and nearly one in four of them suffer from stress related disorders like diabetes, hypertension, arthritis, various skin and respiratory disorders. It is important to note that prevalence of psychological distress is distinctly more in women compared to men. This difference in psychological distress seems to be related to cultural factors, ability to verbalise emotions, willingness to reliably report symptoms rather than differential vulnerability. It is encouraging to find that a small proportion of individuals have made initiatives to start incorporating life-style changes to limit damages due to stress. Most often, the individual makes life style changes after the onset of illness but not before it. Hence, it is clear that the need for stress management is beyond doubt-but the crucial question is the conviction to incorporate and to adopt necessary specific life-style changes.

# Realising the goals of NMHP

In India, the number of formal treatment facilities is far too few. Mental health care can best occur in community settings. The current development of implementing national mental health programme in a phased manner is indeed very positive. Developing a mechanism to monitor the programme and institutionalise the process so that the local district authorities carry on the task is an important outcome of this activity. DMHP seeks to implement mental health care using the public approach. The most important aspect of the DMHP is to train doctors, multi-purpose workers and other functionaries in task oriented mental health skills. The doctor is expected to evaluate patients attending his/her clinic, diagnose and treat the referred cases from the field. The multi-purpose workers are expected to follow up the treated patients, monitor the side effects of medication as the case may be, educate the families about the nature of the illness, support the family during crisis. The doctor is expected to actively support and encourage the multi-purpose workers to visit the field and carryout the above mentioned tasks. The District Mental Health Programme officer is available to provide clarification and support to the primary care physician as needed. The primary care physician can refer a case for opinion or inpatient care to the district psychiatrist.

Thus, a paradigm shift in strategy from institutional treatment to a holistic community approach has been adopted in the NMHP keeping the aims of promotion, prevention, early detection and treatment. Such an approach would also minimise disability.

# Conclusion

Community care of persons with mental illness has moved a long way from the institution to community settings. This has been possible because of the commitment on the part of the government, professionals, institutional policies, legislations and, in some instances, judicial activism. Community is not a cheap alternative to a hospital but a realistic alternative to fill the wide treatment gaps that exists.

Community care has been accepted as the most suitable and realistic alternative to care for the mentally ill all over the world. Most of the mentally ill are being treated at the level of general hospital practitioners and primary health care settings in the community so that patients get the benefit of being in the community and avoid custodial care in mental hospitals, which have their own demerits, especially from the human rights perspective.

NMHP promises to provide easy access to mental health care without any discrimination. Realised into action, it will reduce disability, lower family distress and burden, and reduce the stigma of mental illness. Ultimately, it will integrate mental health care with primary health care a main objective of the National Mental Health Programmeme. Taking basic and free mental health care to the doorstep of every member in our society will realise the vision of health as a fundamental right.

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# Realising the objectives of the national mental health programme: a look at states and innovations

## Kishore Kumar & Pratima Murthy

## Introduction

Mental health care must be easily available, affordable and accessible to everyone in the community. While the National Mental Health Programme (NMHP) suggested this in 1982 (1), it was only in 1996 that a strong recommendation was made for the activation of the NMHP. This expansion occurred across the 9th and 10th five year plans. Under the 11th five year plan, the NMHP has been re-strategised and strengthened (2). The need to mainstream mental health has never before been felt so strongly.

It is the right time therefore, to take stock of the situation as well as innovative approaches across States, so that we may have ideas to develop a road map for a truly integrated, multiple level, easily accessible, mental health care delivery system in the country.

## Mental Health Care Resources

Table 1 indicates the health care facilities and specialised mental health resources within each State (3). It is immediately apparent that specialised mental health services are extremely deficient in comparison to the general health care facilities.

## Table 1: State-wise health care and specialised mental health resources

| Resources | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical College | 36 | 25 | 18 | 32 | 39 | 8 | 16 | 13 | 4 | 9 | 8 | 3 | 4 | 8 | 7 | 5 | 2 | 1 | 3 | 3 | 0 |
| District Hospitals | 24 | 29 | 14 | 20 | 35 | 47 | 74 | 25 | 14 | 15 | 25 | 20 | 32 | 28 | 20 | 9 | 11 | 2 | 22 | 21 | 11 |
| Referral Hospitals | 57 | 100 | 0 | 0 | 0 | 0 | 0 | 409 | 0 | 0 | 70 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| City Family Welfare Centre | 2 | 104 | 0 | 0 | 0 | 0 | 0 | 106 | 0 | 0 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Rural Dispensaries | 176 | 1421 | 0 | 0 | 0 | 0 | 0 | 8347 | 0 | 0 | 366 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Ayurvedic Hospitals | 122 | 9 | 124 | 8 | 51 | 34 | 1768 | 48 | 2 | 4 | 11 | 1 | 8 | 99 | 15 | 10 | 24 | 1 | 1 | 8 | 0 |
| Ayurvedic Dispensaries | 589 | 32 | 740 | 620 | 490 | 1427 | 340 | 493 | 265 | 295 | 311 | 393 | 624 | 3496 | 507 | 148 | 1105 | 11 | 122 | 472 | 0 |
| Unani Hospitals | 13 | 1 | 0 | 6 | 5 | 3 | 204 | 0 | 3 | 1 | 4 | 0 | 0 | 3 | 0 | 2 | 0 | 0 | 0 | 1 | 0 |
| Unani Dispensaries | 51 | 21 | 1 | 193 | 25 | 50 | 49 | 0 | 235 | 3 | 144 | 1 | 9 | 92 | 35 | 25 | 3 | 0 | 30 | 19 | 0 |
| Homeopathic Hospitals | 20 | 0 | 35 | 6 | 44 | 21 | 1 | 14 | 0 | 1 | 11 | 3 | 0 | 5 | 6 | 2 | 1 | 1 | 2 | 1 | 0 |
| Homeopathic Dispensary | 42 | 43 | 580 | 283 | 0 | 146 | 1482 | 216 | 0 | 1220 | 179 | 75 | 603 | 147 | 107 | 98 | 14 | 3 | 54 | 20 | 0 |
| Number of DMHPs | 4 | 16 | 5 | 6 | 6 | 6 | 12 | 8 | 4 | 4 | 0 | 6 | 8 | 1 | 3 | 5 | 2 | 1 | 3 | 3 | 0 |
| Number of government psychiatric hospitals | 2 | 1 | 3 | 2 | 5 | 2 | 4 | 7 | 2 | 7 | 0 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 3 | 1 | 1 |

1= Karnataka, 2= Tamil Nadu, 3= Kerala, 4= Andhra Pradesh, 5= Maharashtra, 6= Madhya Pradesh, 7= Uttar Pradesh, 8= Gujarat, 9=Jammu and Kashmir, 10= West Bengal, 11= Bihar, 12=Assam, 13= Orissa, 14= Rajasthan, 15= Punjab, 16= Delhi, 17=Himachal Pradesh, 18=Goa, 19= Jharkhand, 20= Haryana , 21= Nagaland

## Psychiatrists : a precious commodity

The mental health resource mapping in India (2) calculated that there were 2219 psychiatrists available in 2002, as against a required 9696 professionals. The more recent figures reveal a marginal increase in the total number to about 2800. In chapter 8, it has been suggested, that after counting in many different ways, the total number is still less than 3000. This small number shows an inequitable distribution across the country, with the South having a much larger number despite the smaller geographical spread, the metropolis having many more psychiatrists than non-metropolis and the private sector having a relatively larger number of professionals compared to the government sector (Tables 2 and 3)

## Table 2: Regional distribution of psychiatrists

| North | 560 |
|-------|------|
| East | 390 |
| West | 725 |
| South | 1125 |
| Total | 2800 |

Source: Doctors of India 2007 (4)

## Table 3: State-wise distribution of psychiatrists and government/ private ratio

| | Name of the State /UT | Number of psychiatrists* | Ratio of government/private psychiatrists** |
|---|---|---|---|
| 1 | Andhra Pradesh | 250 | 1:5.2 |
| 2 | Assam | 20 | 1:0.68 |
| 3 | Bihar | 125 | 1:5.3 |
| 4 | Goa | 46** | 1:14** |
| 5 | Gujarat | 125 | 1:7.5 |
| 6 | Haryana | 46 | 1: 3.2 |
| 7 | Himachal Pradesh | 10** | 1: 0.1 |
| 8 | Jammu & Kashmir | 12** | 1:1.4 |
| 9 | Jharkand | 44** | 1: 1.3 |
| 10 | Karnataka | 350 | 1:1.5 |
| 11 | Kerala | 150 | 1:4.9 |
| 12 | Madhya Pradesh | 125 | 1:2.0 |
| 13 | Maharashtra – Mumbai | 200 | 1:9.6 |
| 14 | Maharashtra – Rest | 275 | |
| 15 | Orissa | 20 | 1:1.7 |
| 16 | Punjab | 108 | 1:3.9 |
| 17 | Rajasthan | 60 | 1:2.5 |
| 18 | Sikkim | 3** | All in govt |
| 19 | Tamil Nadu – Chennai Tamil Nadu- Rest | 150 225 | 1:3.8 |
| 20 | Uttar Pradesh | 250 | 1:3.3 |
| 21 | Uttarachal | 4** | 1:0.3 |
| 22 | West Bengal –Kolkata West Bengal – Rest | 150 75 | 1:5.1 |

| 23-28 | North-East (excluding Assam) | 26[**] | 1:0.4 |
|---|---|---|---|
| 29 | Andaman & Nicobar | 2 | Both in govt |
| 30 | Chandigarh | 34 | 1:1.6 |
| 31 | Dadra & Nagar Haveli | 0 | 0 |
| 32 | Daman & Diu | 0 | 0 |
| 33 | Delhi | 175 | 1:2.8 |
| 34 | Lakshadweep | 0 | - |
| 35 | Puducherry | 8 | All in govt |

based on *Doctors in India (4) ; **Directory of the Indian Psychiatric Society 2007(5), ***website of Goa Psychiatric Society (6).

Given the scenario of psychiatrists and their distribution in the different States and regions, each State government will have to evolve a policy of how it will provide mental health care to its constituents.

## Pragmatic Response

The shortage of trained mental health human resources will be addressed in detail in the chapter on human resources. Integrating basic mental health care into the diverse health care facilities available appears to be the pragmatic direction ahead.

## The District Mental Health Programme

The District Mental Health Programme was first pilot tested in the District of Bellary in Karnataka, way back in 1980. Although the feasibility and usefulness of decentralised mental health care was demonstrated in the Bellary DMHP programme, there was a long lull for nearly 15 years. Subsequently, following a meeting of the Central Council of Health in 1995, and the Workshop of all the health administrators held in February 1996 at Bangalore, the activation of the National Mental Health programme was recommended. A District Mental Health Programme was to be implemented at each State/UT (7).

The objectives of the DMHP as reformulated in 1996 were to:

- Provide sustainable basic mental health services to the community and integrate these services with other health services;

- Early detection and treatment of patients in the community itself;

- See that patients and relatives do not have to travel a long distance to government hospitals or facilities in cities;

- Take the pressure off the mental hospitals;

- Reduce stigma attached to mental illness through change of attitude and public education;

- Treat and rehabilitate mental patients discharged from mental hospitals in the community.

Between 1996 and 1997, the DMHP was launched in four districts, one each in Andhra Pradesh, Assam, Rajasthan, and Tamil Nadu.

## Mid-course evaluation of DMHPs

A team of experts from NIMHANS evaluated the DMHP being carried out in 27 districts in 2003. The report (8) concluded that programmes were functioning at different levels of efficiency contributing to different levels of outcome. Many of the DMHPs in most states had shown satisfactory progress at various stages of implementation. Where the programme had been successful, the objectives of decentralising mental health services from the cities to the district level, from the mental hospitals to the medical college hospital and partial integration of mental health services with general health had been achieved; the possibility of early detection of mental illness in the community had been enhanced; distances that patients and families had to travel had reduced; there were indications to suggest that the case-load of mental hospitals where the programmes were being implemented was declining. It attributed the success of the programme to the motivation and commitment of the nodal officer and programme staff, the interest and support of the administrative staff and senior state health authorities.

The report also expressed concern about the lack of any meaningful work in a few districts. It emphasised the need for an effective central support and monitoring mechanism. It highlighted that funds were not a constraint, but accessing funds was.

# The restrategised National Mental Health Programme

The Government of India held a national consultative meeting (9) in June 2006 at NIMHANS to expand the scope of the NMHP under the 11th Five Year Plan. This meeting was attended by 29 mental health professionals from different states, the government and private sectors and representatives of professional bodies. The recommendations at this meeting included managing the DMHP under the public health system, having a nodal officer at each state, short-term training of medical officers in mental health at PG training centres, adequate public private partnership for all components of the DMHP, separate budget allocation for the NGO sector, regional training institutions on the model of NIMHANS, attention to special populations under the DMHP, a dedicated central monitoring cell, a common minimum education (IEC) kit, separate funding for an urban mental health programme and earmarked grants for research in the NMHP.

Table 4: Sites of the DMHP

| Sl. No | States | Year of Initiation | District |
|---|---|---|---|
| 1. | **Andhra Pradesh** | 1996-97 | Medak |
| 2. | | 2000-01 | Vizianagaram |
| 3. | | 2004-05 | Cuddapah |
| 4. | | 2004-05 | Prakasham |
| 5. | | 2006-07 | Nalgonda |
| 6. | | 2006-07 | Mahaboob Nagar |
| 7. | **Arunachal Pradesh** | 1997-98 | Naharlagun |
| 8. | | 2006-07 | East Siang |
| 9. | **Assam** | 1996-97 | Nagaon |
| 10. | | 1999-00 | Goalpara |
| 11. | | 2004-05 | Darrang |
| 12. | | 2004-05 | Morigaon |
| 13. | | 2004-05 | Nalbari |

| 14. |  | 2004-05 | Tinsukia |
|-----|--|---------|----------|
| 15. | **Chandigarh** | 1999-00 | Chandigarh |
| 16. | **Chhattisgarh** | 2004-05 | Bastar |
| 17. |  | 2004-05 | Bilaspur |
| 18. |  | 2004-05 | Dhamtari |
| 19. |  | 2006-07 | Raipur |
| 20. |  | 2006-07 | Raigarh |
| 21. |  | 2006-07 | Durg |
| 22. | **Dadra Nagar Haveli** | 2006-07 | Silvassa |
| 23. | **Daman & Diu** | 1998-99 | Daman & Diu |
| 24. | **Delhi** | 1999-00 | Chhattarpur |
| 25. |  | 2006-07 | North –West District |
| 26. |  | 2007-08 | West District |
| 27. |  | 2007-08 | South West District |
| 28. |  | 2007-08 | North District |
| 29. | **Goa** | 1998-99 | South Goa |
| 30. | **Gujarat** | 1998-99 | Navsarai |
| 31. |  | 2004-05 | Amreli |
| 32. |  | 2004-05 | Godhara |
| 33. |  | 2004-05 | Surendranagar |
| 34. |  | 2006-07 | Dang |
| 35. |  | 2006-07 | Porbander |
| 36. |  | 2006-07 | Junagarh |
| 37. |  | 2006-07 | Banaskantha |
| 38. | **Haryana** | 2004-05 | Gurgaon |
| 39. |  | 2004-05 | Hissar |
| 40. |  | 1997-98 | Kurukshetra |

| 41. | **Himachal Pradesh** | 1997-98 | Bilaspur |
|-----|----------------------|---------|----------|
| 42. | | 2004-05 | Kangra |
| 43. | **Jammu & Kashmir** | 2004-05 | Jammu |
| 44. | | 2004-05 | Kathua |
| 45. | | 2004-05 | Rajauri |
| 46. | | 2004-05 | Udhampur |
| 47. | **Jharkhand** | 2004-05 | Dumka |
| 48. | | 2007-08 | Daltonganj |
| 49. | | 2007-08 | Gumla |
| 50. | **Karnataka** | 2004-05 | Chamrajnagar |
| 51. | | 2004-05 | Gulbarga |
| 52. | | 2004-05 | Karwar |
| 53. | | 2004-05 | Shimoga |
| 54. | **Kerala** | 1998-99 | Thiruvananthapuram |
| 55. | | 1999-00 | Thrissur |
| 56. | | 2004-05 | Idukki |
| 57. | | 2004-05 | Kannur |
| 58. | | 2006-07 | Wayanad |
| 59. | **Madhya Pradesh** | 1997-98 | Shivpuri |
| 60. | | 2003-04 | Dewas |
| 61. | | 2003-04 | Sehore |
| 62. | | 2004-05 | Mandla |
| 63. | | 2004-05 | Satna |
| 64. | **Maharashtra** | 1997-98 | Raigard |
| 65. | | 2003-04 | Amravati |
| 66. | | 2003-04 | Buldhana |
| 67. | | 2003-04 | Parbhani |

| | | | |
|---|---|---|---|
| 68. | | 2004-05 | Jalagaon |
| 69. | | 2004-05 | Satara |
| 70. | Manipur | 1999-00 | Imphal East |
| 71. | | 2003-04 | Imphal West |
| 72. | | 2003-04 | Thoubal |
| 73. | | 2007-08 | Churachandpur |
| 74. | | 2007-08 | Chandel |
| 75. | Meghalaya | 2003-04 | Jaintia Hills |
| 76. | | 2003-04 | West Garo Hills |
| 77. | Mizoram | 1999-00 | Aizwal |
| 78. | | 2006-07 | Lunglei |
| 79. | Orissa | 2003-04 | Mayurbhanj |
| 80. | | 2003-04 | Puri |
| 81. | | 2004-05 | Balangir |
| 82. | | 2004-05 | Dhenkanal |
| 83. | | 2004-05 | Karaput |
| 84. | | 2004-05 | Keonjhar |
| 85. | | 2004-05 | Khandhamal |
| 86. | | 2004-05 | Khurda |
| 87. | Punjab | 1997-98 | Muktsar |
| 88. | | 2006-07 | Sangrur |
| 89. | | 2006-07 | Hoshiarpur |
| 90. | Rajasthan | 1996-97 | Seekar |
| 91. | Sikkim | 2001-02 | East Gangtok |
| 92. | Tripura | 2001-02 | West Tripura |
| 93. | | 2003-04 | North Tripura |
| 94. | Tamil Nadu | 1996-97 | Trichy |

| 95. | | 2000-01 | Ramanathapuram |
|---|---|---|---|
| 96. | | 2000-01 | Madurai |
| 97. | | 2003-04 | Kanyakumari |
| 98. | | 2003-04 | Theni |
| 99. | | 2004-05 | Dharampuri |
| 100. | | 2004-05 | Erode |
| 101. | | 2004-05 | Nagapattinam |
| 102. | | 2007-08 | Kancheepuram |
| 103. | | 2007-08 | Thiruvallur |
| 104. | | 2007-08 | Cuddalore |
| 105. | | 2007-08 | Perambalur |
| 106. | | 2007-08 | Virudhunagar |
| 107. | | 2007-08 | Thiruvarur |
| 108. | | 2007-08 | Namakkal |
| 109. | | 2007-08 | Chennai |
| 110. | **Uttar Pradesh** | 1997-98 | Kanpur |
| 111. | | 2004-05 | Azamgarh |
| 112. | | 2004-05 | Banda |
| 113. | | 2004-05 | Faizabad |
| 114. | | 2004-05 | Gazipur |
| 115. | | 2004-05 | Ghaziabad |
| 116. | | 2004-05 | Itawah |
| 117. | | 2004-05 | Mirzapur |
| 118. | | 2004-05 | Moradabad |
| 119. | | 2004-05 | Muzaffarnagar |
| 120. | | 2004-05 | Raibareli |
| 121. | | 2004-05 | Sitapur |

| | West Bengal | 1998-99 | Bankura |
|---|---|---|---|
| 122. | | 2003-04 | Jalpaiguri |
| 123. | | 2003-04 | West Midnapur |
| 124. | | 2006-07 | South 24 Parganas |

Currently the DMHP has been extended to 124 districts. Under the 11th Five-Year Plan (2007-2012), it will be extended to another 200 districts. It is expected that in the 12th Five-Year Plan (2012-2019) the remaining districts of the country would be covered.

The DMHP is one of the components of the restrategised NMHP. The NMHP also looks at strengthening general hospital departments of psychiatry and the existing government hospitals. Other components include adolescent and school mental health programmes, college mental health programmes, improving mental health human resources, IEC activities, public-private partnerhips, research in mental health, suicide prevention and stress management.

Given the fact that many of the specific components and activities in the scope of NMHP will involve public-private partnerships, it will be useful to summarise some of the innovative approaches to community mental health care that have occurred in the country. Some of these have occurred in the government sector, some in the non-governmental sector and some illustrate partnerships in mental health care.

## Innovations/Initiatives in mental health in India

There have been several innovative community mental health care approaches in different parts of India. In this section we present some illustrative examples. These examples are limited and do not necessarily represent all the initiatives that may be present on the ground, but they help to provide an idea of the range of services that can be provided by the community, and considered under the NMHP programme by the States. It must be emphasised that these initiatives are few and concentrated in a few regions. Many of them have sustained because of human commitment. They are described under certain broad areas.

# Children and Adolescents

## Life skills education in schools – NIMHANS experience (Karnataka)

Health promotion in schools using life skills approach needs trained manpower resources. Teachers become the most important resource for this activity.

Life skills education was institutionalised into the education system in four Districts of Karnataka (10-12). The approach used was a cascading model where master trainers were trained by mental health professionals for one week. The master trainers are expected to train teachers in their respective District Institute of Education and Training (DIET) in a three-day training programme. The training is participatory and activity oriented.

## School mental health – (Delhi)

A school mental health programme "Expressions" is being successfully run in Delhi schools since past six years (13). A team from Child Development and Adolescent Health Centre, VIMHANS, New Delhi started this programme. They have already conducted over 200 workshops in NCT region of Delhi schools and in a few satellite towns of Northern India (Amritsar, Ludhiana, Agra, Jodhpur, Banaras, Sikkim) for children and adolescents. The programme consists of a three-part module on comprehensive school mental health, and is entirely experiential in nature. The programme also evaluates the teacher's own mental well-being and stress levels, which can influence their professional output.

## College mental health programme (Karnataka)

NIMHANS, Bangalore has developed many community-based prevention and promotion programmes to reduce mental morbidity and to improve mental well being of people. College students are a high-risk group to develop mental health problems. This programme involves college teachers in counseling students and they act as referral agents and support providers for those students with psychosocial problems and mental distress.

In 1995, the Department of Collegiate Education of Govt. of Karnataka and NIMHANS, Bangalore launched a short-term training course in students counseling for volunteer teachers. During 1995 to 2006, 661 teachers from all over the State of Karnataka underwent training in 26 batches of teachers.

### Protecting children's mental health (Goa)

The Sangath Centre for Child Development and Family Guidance was started in Goa in 1997(14). The centre deals with diverse issues such as scholastic backwardness, family violence, postnatal depression and all areas of behavioural, developmental and emotional health of children, through a community mental health service. The organisation also works with schools as well as parents.

## Children with intellectual difficulties

There are several organisations working with children with serious intellectual difficulties throughout the country. Many of them have done pioneering work in this area and are now well established in service provision, training and advocacy. A more detailed discussion of these organisations is outside the scope of this review.

### Parents as change agents for children with learning disabilities– the ALDI (Kerala)

The Association for Learning Disabilities, India, (ALDI), was formed at Thrissur in 1990 (15) by two parents searching for help for their child with a learning disability - this resulted in the coming together of a few professionals (two psychiatrists, and a clinical psychologist), teachers and parents who had an interest in starting such services. Activities of this organisation has included conducting awareness programmes in schools, developing community based services for children with dyslexia and involvement in the Kamakshi Grama Panchayat programme to help children with scholastic backwardness through remediation.

### Empowered, Enabled, Effective–the Samadhan approach (Delhi)

The operational strategy of Samadhan is based on the concept of the Self-Help Group but with a difference (14). They employ a Self-Help Group, whether mothers, women from the community or persons with mental handicap or other disabilities can take home a regular income each month. The women are also trained to function as community workers and home intervention workers to help families with mentally handicapped children.

### Services for destitute children with mental illness (Tamil Nadu)

Anbaham (16) is a project of TERDOD, which is a registered public

charitable trust. Anbaham's mission is to provide shelter for mentally ill orphans, rehabilitate them through proper medication, training and reuniting them with their long lost families wherever possible, thus helping them to lead normal lives. Between 1999 and May 2006, Anbaham provided shelter to more than 300 individuals with mental health problems and has reunited 275 of these individuals with their families.

## Counseling Services

### Listening with the Heart–Helping Hand (Karnataka)

Helping Hand (17), founded by a housewife in Bangalore, welcomes any one who is interested in working for fellow humans. Volunteers range from 18 to 80 years of age. While a few are themselves medical professionals or psychologists, the vast majority are lay people from unconnected fields. There are many retired persons, a number of housewives, and also many busy professionals who desire to spend a few hours in the week giving back to society.

All the volunteers were initially trained in the basic skills of being non-judgmental listening and empathizing. There are many who have a special interest in learning how to deal with particular types of people. They are encouraged to get training and exposure in their area of interest. There are volunteers who work with alcohol and drug other drug addiction, others who assist families of mentally ill, and some who spend time with terminally ill cancer patients. Some of the volunteers befriend disabled children, while others work with battered women. Many of them work in government hospitals.

### Helping with stress: Prasanna Counseling Centre (Karnataka)

Prasanna Counseling Centre was founded by an engineer. He took up social work as his lifetime job. In the beginning, the centre started with providing support to persons who had attempted suicide. More than 600 hundred lay volunteers have been trained over the past 26 years in Bangalore city. Hundreds of people who are psychologically distressed seek help from this centre.

### Preventing suicide: Sneha (Tamil Nadu)

Sneha was started by a psychiatrist in 1986. A chosen band of volunteers were trained to run the centre. It uses the concept of "Befriending" to help

persons in crisis (14). This is done by trained lay people and is directed more towards addressing the feelings experienced (anger, fear, disappointment, hopelessness, etc.) rather than offering suggestions and advice, in attempting to solve their problems.

### Crisis intervention centre: Aasra (Maharashtra)

Aasra (18) is a crisis intervention centre for the lonely, distressed and suicidal. Aasra functions as a unit of Befrienders India / Samaritans and is registered as a Public Charity under the Bombay Charity Act, 1960.

### Emotional support for distressed persons: Maithri (Kerala)

**Maithri** is a voluntary organisation working to provide confidential emotional support to distressed persons, who may be in danger of taking their own lives (19). Maithri operates in Kochi (Cochin), in Kerala, which has a high suicide rate.

## Services for the elderly

### Utilising Senior Citizens as Effective Volunteers: The Dignity Foundation (Maharashtra)

Dignity Foundation was set up as a charity to promote "productive ageing" (20).

Various services are offered to the senior citizens and in each service delivery, another senior citizen plays a vital role. Activities include Dignity *Dialogue* (a monthly magazine), issue of senior citizens ID card to more than 4 lakh senior citizens, a help line offering a social support system for the elderly, dementia day care, companionship for the elderly and counseling and enrichment centres for the elderly. The Foundation helps 83 police stations through its senior citizen members. Some senior citizens offer voluntary service at banks and form vigilant groups.

### Care for dementia (Kerala)

**Alzheimer's and Related Disorders Society of India (ARDSI)** is a registered, national, non-profit, voluntary organisation dedicated to the care, support, training and research for people with dementia (14). ARDSI was formed in 1992 by affected family members, interested professionals and social workers. It aims to improve the quality of life of people with dementia as well as the caregivers through support services, awareness

campaigns and a variety of other projects. ARDSI has 14 chapters spread across the country with its headquarters in Kerala. Through this network ARDSI implements a number of services like day care, home care, memory clinic, respite centre, helpline and training of community geriatric care workers. One of its important objectives is to empower people in the community to cope with the challenges caused by the illness.

## Providing treatment for alcoholism through rural camps: The TTK Hospital (Tamil Nadu)

The TTK hospital in Chennai has a long tradition of providing care for alcohol dependence through rural camps conducted in six locations in Tamil Nadu since 1989 (14). The organisation works with voluntary agencies in the community, prepares the community for the camp, identifies potential participants and has a structured counseling programme. It offers comprehensive treatment for the 15-day camp duration. Follow-up is organised with the local community.

## NGOs in training in alcohol and drug dependence rehabilitation

The National Centre of Drug Abuse Prevention under the Ministry of Social Justice and Empowerment has identified 8 NGOs with strong technical capabilities to provide training and information at regional levels, monitor programmes and implement the Drug Abuse Monitoring System. These NGO's are Galaxy Club (Manipur), Kripa Foundation (Maharashtra), The Calcutta Samaritans (West Bengal), Mizoram Social Defence and Rehabilitation Board (AP), Muktangan Mitra (Maharashtra), Society for Promotion of Youth and Masses (Delhi), the TT Ranganathan Clinical Research Foundation (Tamil Nadu) and Vivekananda Education Society (West Bengal).

# Primary Care Initiatives in Mental Health

## Multiple purpose workers in mental health care (Karnataka)

For mental health care to become accessible despite resource constraints, the primary care model allows a tremendous opportunity. It has many advantages. It provides an opportunity for early diagnosis and treatment, which has a better outcome. It is less stigmatizing. Being more accessible, it is likely to be more frequently utilised. It is less expensive for both service seekers and providers. Training primary health care staff in mental health care is both a challenge and an opportunity. There have been several studies

demonstrating the feasibility of training of health workers to undertake a limited amount of mental health tasks, as part of their routine health work (21-26).

## Mental health care through Ashagram (Madhya Pradesh)

The mental health unit of Ashagram was initiated in 1996 (14) using an eclectic multi-disciplinary model, which emphasised enhancing awareness and providing accessible services relevant and acceptable to local people. Ashagram has demonstrated that trained mental health workers drawn from the community can deliver high quality care for chronically mentally ill.

## An important role for Anganwadi workers (Delhi)

Community outreach clinics are being carried out by the Institute of Human Behaviour and Allied Sciences (IHBAS), Delhi since the year 2000 under the District Mental Health. Anganwadi workers from Chattarupur village were involved to address the high rates of dropout of patients from follow-up. They were imparted knowledge about the common mental disorders (CMDs) including depression and anxiety disorders, drug and alcohol abuse, mental retardation and epilepsy. As they are well versed with the local geographical area, the mapping of the community became easier for carrying out the programme in an extensive manner.

## Lay persons as partners in mental health management (Maharashtra)

The Schizophrenia Awareness Association (SAA) was founded in 1998 by a few individuals with compassion for persons with mental illness and their caregivers (27). Its objectives are to create awareness about schizophrenia and other mental disorders among the community, to promote self-help groups for patients (shubhartis) and their caregivers and to network with other NGOs offering mental health care. This group exchanges information about illness, members provide mutual moral support and instill hope of recovery in the carers. The group also provides a forum to professionals to share their expertise with the user group.

# Care giver Initiatives

## A care giver initiative (Maharashtra)

MANAV was started by the caregiver of a daughter with learning disability who went on to develop schizophrenia (28). Shocked at the dearth of

rehabilitation services, she set up the Manav Foundation in 2004. The Manav rehabilitation centre provides treatment support and care to persons with a mental illness, personality disorder and/or a mental condition that has rendered them non-functional, provides support to caregivers, offers counseling to distressed adults with emotional problems and encourages involvement of the community.

### The KSHEMA Family: AMEND and ACMI (Karnataka)

The Association for the Mentally Disabled (AMEND) was initiated in 1992 (14). The KSHEMA project was started as a family to family peer sharing activity. Client families are provided awareness about mental illness and its treatment, encouraged to understand mental illness as a disability and supported through education, empowerment and enablement. An offshoot, 'Action For Mental Illness' (ACMI) is an advocacy initiative that was started in 2003. The ACMI adopts a four dimensional strategy–social, political, legal and media advocacy. This organisation has been able to get disability certification protocols into action, obtain income tax rebates for persons with mental illness and their family members. It filed a PIL in both the Karnataka High Court and Supreme Court to bring to attention the discrimination of persons with mental illness in the PDA Act, lack of a rights based legislation and political inertia in the implementation of the NMHP.

## Rehabilitation for serious mental illness

### The Richmond Fellowship Society (India) (Karnataka)

The RFS (14) provides care and psychosocial rehabilitation for persons with mental health needs in India and also for those in the neighbouring countries. It delivers its services through Asha, a halfway home functioning since 1989, Jyoti, a group home for persons with chronic psychiatric illness, Chetna, a day care centre with vocational training facilities and Pragathi, a community based rural multidisciplinary mental health project in the Kolar district of Karnataka.

### Medico-pastoral association (Karnataka)

The medical pastoral association was founded in 1967(14). It was a movement initiated by volunteers to promote mental health and care in the community. During the initial period, the MPA volunteers provided counseling for persons with alcohol or drug problems, emotional problems,

psycho-social problems and suicidal patients. It started the AA groups in 1969 at NIMHANS and suicide prevention squad in 1971.

It developed a half way home in 1975 in response to needs of person with mental health problems. The growth of MPA is an ideal example of collaboration between an NGO and a governmental agency like NIMHANS. The Navajeevan hostel for working persons with mental health problems was developed in 1988 and a long-term care centre was established in 1997.

## The SCARF Experience (Tamil Nadu)

Schizophrenia Research Foundation (SCARF) is a voluntary organisation based in Chennai (14). It was founded in 1984 by a group of philanthropists and mental health professionals. SCARF is one of the very few NGOs in the world to be named as a Collaborating Centre with the World Health Organization (WHO) for Mental Health Research and Training.

It was the first voluntary agency to provide rehabilitation free of cost for persons with severe mental disorders. It has a day care centre, residential rehabilitation centre, long-term care, child support programme and a community mental health programme. This organisation is also actively involved in research into the biological, social and psychological aspects of schizophrenia, enhancing public awareness about the disorder, conducting academic programmes on various aspects of mental health and lobbying for mental illness care and treatment.

## Anand Rehabilitation Centre (Maharashtra)

This is a project of Prompt Care International Foundation (PCIF) and was established in 2002, because PCIF saw a growing need for "psycho-social rehabilitation for schizophrenia and a lack of such services in the western region of the country" (29). ARC's work is funded by its user fees. In 2007, it began providing outpatient services. This building also houses the Anand Care Centre, which is for individuals with Parkinson's disease, Alzheimer's disease, or dementia.

## Chaitanya Mental Health Care Centre (Maharashtra)

Chaitanya Mental Health Care Centre (Chaitanya) was started in 1999 (30). It offers residential facilities to persons with a variety of mental health problems. Chaitanya's goal is to help people to regain the skills that they

lost during hospital stay so that they can be integrated back into society. This is done by providing medicine and a structured environment with a routine of activities such as art therapy and cultural activities. The average length of stay is nine to twelve months, but the period may be extended according to the need.

### 'Ashadeep'– the first NGO in Mental Health in the NE Region

The first initiative of this family based organisation was a day care centre in 1996 (31), with a stress on vocational activity. It conducts family support group meetings. Its sheltered workshop for recovering members now offers both day care and residential facilities. It has been conducting monthly outreach programmes along with another local NGO, Satra.

### Paripurnatha (West Bengal)

Psychosocial rehabilitation of the mentally ill women in prisons of west Bengal was the main reason behind the founding of Paripurnatha (14). Its objectives were to start a half way home for non-criminal mentally ill women, to rehabilitate the women, to educate family members, to train its residents in gaining financial independence and encourage community participation in the care of the mentally ill. The most valuable contribution of Paripurnata is in demonstrating that it is possible for people with mentally illness to get back to the mainstream of society. It has provided a model for many mental hospitals in the country to work in partnership with the community to rehabilitate and reintegrate persons with mental illness into society.

## Services for the Homeless Mentally ill

### The Banyan Story (Tamil Nadu)

The Banyan was established in 1993 (14) by two just out of college young women concerned for the care of the mentally ill. The Banyan cares for and rehabilitates homeless women with mental illness found in the streets of Chennai at its home, Adaikalam. It provides shelter, medical care and a supportive environment for recovery and also supports the return of the women after recovery to their families and community, or helps them start a new life. It has taken a strong role in lobbying for the rights of the homeless mentally ill in order to facilitate localised access to mental health care.

## Mental health care for the homeless mentally ill (Karnataka)

The department of psychiatry, NIMHANS, Bangalore and the Ministry of Social welfare, Government of Karnataka initiated a collaborative effort to address the needs of the destitute men and women in Bangalore city. The warders and the support staff including the superintendent of the destitute centre have been trained in mental health skills to provide basic mental health care in the centre. The local government was requested to hand over the nearby primary health unit to Karuna Trust, a non- governmental organisation headed by right livelihood awardee Dr.H.Sudharshan (32). The department of psychiatry, NIMHANS provided technical support to manage person with mental health problems, substance abuse problems and other brain disorders. The primary health care team implements case management plan for persons with severe mental health problems in the centre. Collaboration between two government departments and an NGO has been working well to provide mental health care for the destitutes in Bangalore.

# Advocacy for Mental Health

### Research advocacy support and help for the mentally ill (Delhi)

This organisation, RASHMI, holds regular public meetings to make people aware of problems related to mental health and advances in the area, family carers' meetings to provide support, address the problem of exclusion and stigma on account of mental illness. RASHMI played an important role in the formation of the National Federation for Mental Illness (NAMI). It presently works with the Department of Psychiatry at the Ram Manohar Lohia Hospital to provide care giver support.

### Nodal alliance for mental illness

NAMI INDIA is a registered trust with the Charity Commissioner, Mumbai (33). It aims to provide help in the reduction and treatment of mental illness in India by integrating and involving consumers, mentally challenged people, doctors, healthcare workers, Government and other sections of society. It seeks to improve awareness on mental illness, conduct courses, network with support groups, set up an India-centric website on mental illness, serve as a nodal agency that interacts with government and NGOs in the area and to advocate better health care delivery systems for the mentally ill in the country.

### The Bapu Trust (Maharashtra)

The Bapu Trust is engaged in social science and feminist research in the area of mental health (14). It attempts to convert academic work into ground level policy, social and legal activism. It is committed to bring about changes in societal attitudes to mental illness and fight for the rights of people with mental health difficulties, especially in terms of their right to good quality care. Its platform for action is "Enabling user assertion in mental health". It has set up a Centre for Advocacy in Mental Health (CAMH)

## Other Activities

### Rationalist Society (Punjab)

The Taraksheel Society was formed with the primary aim of developing a scientific temperament among people in 1984 (34). This society has been actively involved in creating awareness about mental illness and providing guidance to persons in need of psychiatric care.

### ROSHNI (Punjab)

Roshni has been in existence since 2003 at Ludhiana in Punjab. It was formed by a group of like-minded persons who decided to come together to make a difference in the lives of persons who were undergoing extreme stress leading to a deterioration in their mental health. It works with the victims of domestic violence and has set up a 'Crimes against Women' police counseling cell at Ludhiana (35). A lot of domestic violence and crimes against women was seen to be associated with alcohol/drug abuse by their male family members. The counseling process and police protection together has helped in alleviating the emotional problems experienced by women and their children.

### A club for women from slums (Chandigarh)

The Gangadevi Club (36) was started as an activity of an NGO under the project Atam Vishvas in 2004. The purpose is to provide a samuh (club) for the underprivileged women of the area, particularly the abandoned, old sick, needy and neglected women.

### Notes from Jammu and Kashmir

The state of Jammu and Kashmir has undertaken serious measures for

capacity building for medical officers, paramedical workers, nurses, schoolteachers, volunteers and significant others to ensure psychosocial and mental health care for the affected population in partnership with NIMHANS. An outstanding example of networking is collaboration between mental health professionals and NGOs. Young mental health professionals have initiated mental health care services in the far-flung and remote areas of Kashmir region with help from Action Aid India and MSF (Doctors without borders). The professionals have been able to establish childcare centres in different locations of Kashmir region.

The police department in the Kashmir region has been able to establish a de-addiction centre in the police hospital, providing treatment to many young people with drug problems. This activity is entirely funded by the police administration. The medical and paramedical personnel associated with the police hospital manage the deaddiction services. The treating team receives periodic support from the faculty of the medical college, Srinagar.

## Conclusion

In this section, we have highlighted the need to integrate mental health care into primary health care and traced the development of the district mental health programme. Given the much wider scope of the restrategised National Mental Health Programme and the focus on public private partnerships, we have provided some illustrative examples of work done by organisations in the community, hoping that these will provide ideas for community based, integrated and comprehensive mental health care. Each State will have to carefully understand its mental health care needs, map its resources for mental health care delivery, and plan programmes aimed at improving mental health and ameliorating mental health problems among its constitutents.

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# Human resource development in mental health care

B.N. Gangadhar

## Introduction

Psychiatric disorders are widely prevalent. They affect all sections of the population irrespective of the sex, age group and social class. It is estimated that close to ten percent of the population would need some form of psychiatric intervention (1, 2). In the days when modern psychiatric drugs were not available, these unfortunate individuals were confined to asylums or at best were provided a variety of traditional treatments. The scenario has changed over time. Psychiatric patients can receive modern treatments as well as some of the proven traditional treatments in this country. However, the scene is far from satisfactory.

## Mental health manpower

The Indian Psychiatric Society (2007) enlists less than 3000 registered psychiatrists in this country. When equitably distributed, this translates to one psychiatrist for every three-lakh population. This is in stark comparison to other countries like Australia which have 50-fold more psychiatrists per unit population. Hence there is a need to define the optimal psychiatrist to population ratio for our country. A recent report proposed one psychiatrist for every hundred thousand population (3). This means the number of psychiatrists must increase to three-folds of what exists at present. The issue of scarcity of psychiatrists is compounded in recent years with some affluent countries recruiting even senior psychiatrists from India. Financially lucrative job offers have led to draining of human resources from India. This has been seen as 'brain robbery' (4).

Not only is there an acute shortage of psychiatrists, but even this small number is not equitably distributed. Seventy-five percent of the psychiatrists are located in urban areas and only the remaining 25% cover the rural areas that account for 75% of the population. Apart from psychiatrists, psychologists, social workers and nurses who have special training in

mental health also provide services for the mentally ill. The number of these paramedical professionals is even smaller. Hence there is a need to look at the human resource development angle while planning services for the mentally ill.

## Hospital treatment

Since decades, service delivery for persons with mental illness has been through mental hospitals (formerly asylums). In these hospitals, procedures of admission and discharge did not differentiate those who may have a chronic course of illness from those who remitted after one illness episode and/or those with cyclical courses. Therefore, many recovered mentally ill continued to languish in mental hospitals. Yet another consequence of this development was overcrowding of these hospitals. Overcrowding affected the patients' living status adversely in several aspects that attracted the intervention by courts and the National Human Rights Commission.

Nearly all states have either just one or two mental hospitals. Patients from far off places were unable to reach these hospitals and hence remained untreated. Mental hospitals are even today associated with stigma. This too discouraged patients from reaching such treatment centres. The mental hospitals were generally situated in places that were once remote from general hospitals and teaching hospitals. Rarely did medical students, PGs and other specialists come in contact with these hospitals and the doctors who work there. This too carried adverse consequences. Doctors working in a mental hospital were also discriminated. Many doctors saw this as a source of discouragement and burn out was a consequence. Absence of post-graduate trainees seriously hampered the doctor: patient ratio. Together these could have affected the quality of care that patients received.

There is hence a shift of care from mental hospital–based service delivery. In principle, mental disorders should receive care on the lines of any other medical disorders in the health system. Thanks to the advent of potent psychotropic drugs, this approach is eminently possible for psychiatric disorders in the present day. There is, however, a serious limitation in making this a success–lack of trained personnel. This issue needs to be addressed separately for medical and paramedical professions in mental health.

# Medical manpower training for mental health

## Medical Council of India

Psychiatrists, medical specialists in the field of mental health, obtain their qualification after successfully completing one of the three courses (a) MD, (b) DPM or (c) DNB in Psychiatry. MD in Psychiatry is a three-year course after MBBS in an MCI (Medical Council of India) recognised teaching centre. DPM is a two-year diploma course in a similarly recognised centre. Doctors who possess a DPM qualification can go on to complete MD in a 2-year course. MCI recognition is a statutory requirement. There is a minimum standard that any teaching centre should fulfill to be permitted to provide MD and/or DPM training. The teaching hospital should have a thirty-bed psychiatric unit that is supported by three psychiatry faculty members of whom two should be PG teachers. A PG teacher is one who has a MD degree from a recognised centre with 7-years of teaching experience following MD. In addition to psychiatrist–teachers, the unit would also have psychologist and psychiatric social work teachers. Each such teaching unit gets eligibility to admit two MD and one DPM students each academic year. By 2008 MCI has accorded recognition for admitting 104 DPM trainees and 157 MD trainees for each academic year to different training centres all over the country.

## National Board of Examinations

There is yet another process of producing medical specialists in psychiatry. This is the National Board of Examinations (DNB). Each year just under 50 become DNB qualified within the country. Although the standards of training needed to obtain this qualification are comparable to that needed for MD, the latter is considered the gold standard and most preferred. DNB is hence offered in centres that do not have MD courses. In recent years, with the stipulation of one-to-one teacher-PG ratio, the teaching centres would rather prefer to provide a MD seat instead of a DNB. The centres that train DNBs too often prefer those with DPM as their students. Most DNB trainees are hence already psychiatrists with DPM. As a consequence, this course is not likely to add to the number of qualified psychiatrists produced significantly. Similarly, a small but sizeable number of DPM-trained psychiatrists choose to do MD Psychiatry.

The net effects of all these processes result in the generation of about 250 psychiatrists each year. This number must be seen in the background

of the current need, three times the number of existing psychiatrists. This means we need to add another 7000 psychiatrists. With all other numbers not changing (least likely) we can achieve this only in the next 30 years. It is hence clear that a psychiatrist alone cannot shoulder responsibility of providing medical care to needy patients. This calls for a need to deprofessionalize psychiatry to a certain extent. How can this be achieved? One can envisage short-term and long-term strategies that need to be launched simultaneously to meet this challenge. Successful attempts have been made in both areas.

## Training medical officers

The National Mental Health programme that was launched in 1982 had realised the shortage of specialists. Also for other advantages (not elaborated here for the sake of brevity), psychiatric care needs to be provided as far as possible through public health system and other general hospitals. Earlier experiments have demonstrated that primary care doctors can be reliably trained in simple skills of detection and treatment of some of the psychiatric disorders that occur commonly and are amenable to medical intervention with inexpensive and safe drugs (5-9). The experiments at Chandigarh and Bangalore supported these observations. As a consequence, the district mental health programme was developed. The programme entails training of primary health care physicians for periods from six months to as short as three days. 'Booster' training sessions are also designed once in six months. These doctors identify as well as treat selected psychiatric disorders and when needed, take over follow-up care for those sent by specialists. Training modules that were standardised in these centres are available. NIMHANS Bangalore also produced a brief curriculum for this training and easy-to-use reference manual for the primary care doctors (10). This module has been incorporated in the district mental health programme which the central health ministry has implemented.

## Novel training initiatives

MCI as a regulatory body ensures quality and minimum standards for manpower training in medical specialties. These standards naturally exclude several centres from PG training. There are very few PG teachers in psychiatric centres, though these centres have abundant clinical material for learning. Therefore, universities with psychiatry department can design training programmes using these centres. In this regard, the Mental Health Act under section 2(r) has made a provision to allow the state government to designate a medical doctor as psychiatrist after the required training.

On these lines, NIMHANS developed a one-year training module for primary care doctors to empower them with required skills. These skills will allow these doctors to provide primary care psychiatric services. They also have the skills to manage the district mental health programme. One batch of such doctors each for the states of Jammu & Kashmir and Karnataka has been trained in the last year at NIMHANS.

## Strengthening undergraduate training

This is another important area that has been hitherto neglected. However, professional bodies have recognised this need and have conducted meetings to sensitise the administration as well as the departments of medical education in this regard (11-13). As a result, over the years, undergraduate training has been strengthened with respect to psychiatry. However, unlike other subjects such as pediatrics and ophthalmology, psychiatry has not been included as an exam-subject at MBBS level. There should be a clinical case examination in psychiatry during the annual examination (11, 14). The training in social and behavioural science areas for medical doctors at undergraduate level has been emphasised by several authors (15, 16). It is heartening to note that to recognise medical college for undergraduate medical training, MCI demands that the college has a department of psychiatry with faculty. Writing an editorial on this issue, Bhaskaran (17) noted that an average psychiatrist is trained in a mental hospital setting. If posted as a teacher in a medical college that is attached to a general hospital the psychiatrist should become familiar with general hospital psychiatry. In a workshop (1989) at NIMHANS, training was given to medical college teachers to be able to function as good undergraduate teachers.

## Training of GPs

Presentation of psychiatric disorders at primary care is close to 50%. They may present either as a *de novo* psychiatric disorder or the one that co-occurs with medical disorders (18, 19). Patients may have preference to visit the family doctor for their health care needs. They may also not prefer the consultation with a psychiatrist for fear of being stigmatized. The availability of psychiatrists too is infrequent. Gautam et al (20) demonstrated that once a month seminars over two years changed the attitudes of GPs, positively towards mental health. Shamsundar et al (21) demonstrated the feasibility of training GPs in lecture/demonstration classes that are conducted as a weekend activity or in courses that need

attendance once in a week. These sessions included lecture classes as well as case presentations. A pre-post assessment revealed significant gains in knowledge and skills. These positive results were later confirmed in two independent studies. One of these two studies was an ICMR-supported multi-centre study (22, 23). Such 'in service' training does not interfere with their busy clinical practice schedules.

## Higher education in psychiatry

Apart from training of human resources in psychiatry, the trained personnel too need special attention. This helps to prevent burnout. This can be visualised in two dimensions; Super-specialty career options to psychiatrists and continued medical education. More and more knowledge is accumulating as regards practice of psychiatry. This is overwhelming and particularly so in training institutions where the specialist psychiatrist is focusing on select areas of research. Two distinct examples are addiction medicine and child psychiatry. The clientele for these two areas are different from adult general psychiatry. Though addiction disorders co-occur with certain common psychiatric disorders, the line of approach to the former is different from the latter. Also addiction disorders need interface with other medical disciplines much more than average general psychiatry. Likewise, the settings under which the services are offered for addiction disorders are different from adult psychiatric disorders. Public health consequences are also different. Similarly, children with psychiatric disorders and/or with mental retardation clearly need a different approach than mental disorders in the elderly. Psychosocial intervention but less of biological intervention has a place in the treatment of children. Child psychiatry needs significant interface with pediatrics and neurology. Recognising these differences, the All India Institute of Medical Sciences at New Delhi and NIMHANS, Bangalore have proposed a DM degree (super specialty training) in addiction medicine and child psychiatry respectively.

## Continuing medical education

Following successful qualification, the psychiatrist may join PG training centres or work as a freelance practitioner. All cannot have adequate touch with the modern developments. The practice of psychiatry is dynamic and is rapidly catching up with that practiced world over. Introduction of assessment tools and revised diagnostic systems, newer treatment approaches, legal provisions as well as developments in the rest of the medical profession comprise the knowledge that a practicing psychiatrist

should become aware of. Professional bodies, for example the Indian Psychiatric Society, through its specialty sections, provide symposia and seminars on selected areas for the benefit of its members. PG training centres too offer such academic programmes. Some centres periodically conduct orientation programmes or refresher courses in child psychiatry, addiction medicine, family psychiatry to name a few. Such programmes update the knowledge in practicing psychiatrists. Apart from such CME activities scientific conferences at the national or regional levels by professional bodies augment the practitioner's knowledge.

## Recommendations for training medical personnel in psychiatry

(a) Existing mental hospitals may be upgraded to facilitate PG training in psychiatry either independently on the model of NIMHANS or in conjunction with a nearby medical college of the state. It may be noted that the 11th Five-Year Plan of National mental health programme envisages setting up of regional PG centres in selected mental hospitals. The MCI must relax its minimal standards at least for a period of 10 years.

(b) Medical colleges must be encouraged to start PG training in psychiatry. Where needed, funds may be provided to upgrade the infrastructure. The National Mental Health Programme in the last and current plans, provide such funding to several state-run medical colleges to upgrade the infrastructure of psychiatry departments. The State Governments may complete the other formalities to help these colleges meet MCI requirements to start PG courses.

(c) Periodic reviews of curriculum in undergraduate training may be conducted. Special gold medal exams in psychiatry outside the university purview may be encouraged. Many a students may be attracted to go through these exams and as a result this will add to their skills in psychiatric practice. Professional bodies should bring pressure on the departments of medical education to have psychiatry as a part of MBBS qualifying examination.

(d) Novel but structured training programmes may be developed to meet the existing challenge – to have one psychiatrist for every 1,00,000 population. Certificate courses with brief supervised internship may be developed both for MBBS doctors and even other specialists, for example pediatricians, physicians etc.

(e) Psychiatric centres may develop super-specialty courses or newer courses in branches of psychiatry to meet the growing need for expert teachers. Areas like addiction medicine, child psychiatry, and geriatric psychiatry are some examples.

(f) A 'credit' system may be built in to encourage all practicing psychiatrists to go through continued professional development. Incentives may be provided to such psychiatrists who meet certain minimum credits of CMEs.

(g) Newer methods of training like tele-education must be introduced.

## Training and other health manpower in psychiatric care services

Human resources are the most valuable asset of a mental health service delivery system. Mental health care is best delivered by a multidisciplinary team with an interdisciplinary approach. Integral part of the service includes psychological and social work inputs. Postgraduates completing the degree in psychology or social work have the option today to obtain a higher degree (formerly a diploma) such as MPhil that trains them to become psychologists specialised in mental health or psychiatric social workers.

## Psychologists specialised in mental health

The role of the psychologist includes evaluation, psychological testing for cognitive and neurocognitive functions, personality and interpersonal relations and diagnostic clarification; and psychological interventions in the form of individual, couple, family and group therapies. Evidence based practice guidelines in the delivery of mental health services clearly indicate that psychological interventions are as effective as pharmacotherapy in many conditions, help in relapse prevention in others and overall, significantly improve the quality of life of persons with mental illness, disability, stress related conditions and emotional difficulties.

The number of centres offering such training should be increased immediately. The training programmes could be located in the university departments with active liaison with institutes of mental health, as well as in teaching departments of psychiatry. As psychologists are involved in the assessment of IQ and certification of disability of the mentally challenged, the training of psychologists working in mental health has been brought under the purview of the RCI. This is inappropriate as their role

goes far beyond that of rehabilitation (24). It would appear more appropriate if the training and supervision of psychologists could be brought under the MHA or under a separate council of psychologists.

## Psychiatric Social Workers

The scope of psychiatric social work involves providing psycho-social intervention and rehabilitation, through individual, group and family approaches. Community organisation and mobilising community support, working with marginalised populations; liaison and networking with community based organisations for social action are other important areas of psychosocial intervention. Many schools of social work presently provide some psychiatric social work exposure.

These two professionals have the skills to offer non-pharmacological, yet potentially very effective interventions in minor as well as major psychiatric disorders.

The report on quality assurance in mental health care (25) clearly highlights that treatment of mental illness has been mainly in the form of medical management and that there has been an inadequate emphasis on psychoeducation, counseling and other psychosocial interventions. This is largely due to the lack of psychologists and social workers with mental health specialisation.

In the 11th Five-Year Plan, the National Mental Health Programme is being implemented in each district in the country. This necessitates a psychologist and social worker specialised in mental health care in each district to be part of the mental health team. NIMHANS has developed a 3 month training module specifically for this purpose. However, there may be a need to develop more focused modules depending on the setting or the needs of the community, for example, school/college mental health, crisis or suicide prevention centres, rehabilitation, etc. The psychologist and social worker at the district level could also be used to train a large group of volunteer counsellors and mental health workers at the grass root level. The role of the latter personnel would be to bridge the gap between users and service providers. Their role would be to educate and inform the community, identify persons with mental disorders and emotional problems, provide initial care, motivate users to seek appropriate help and assist them in reintegration in the community.

# Recommendations for training in psychosocial interventions

As there is a significant human resource shortage of psychologists and social workers, specialised in mental health care, in addition to augmenting higher education in these disciplines, clinical training to provide psychosocial interventions can be provided at the post-graduate level of education. This should be followed by a mandatory clinical internship of six months.

## Training lay counsellors

A sizeable number of individuals are exposed to the risk of progressing into a fully developed psychiatric disorder when faced with domestic or other forms of stresses. Emotional support at the onset of this disturbance is unavailable in modern family system associated with urbanisation. Lay counselors with minimum skills in listening to and being emotionally supportive to such distressed individuals can prevent progression into a disorder. Some experiments have demonstrated their efficacy. For example NIMHANS has been offering a course in collaboration with an NGO (26). These trainees' spend their evening hours twice a week or more often over a period of six months to one year to learn these counseling skills. Chatterjee et al (27) was able to demonstrate the efficacy of health volunteers' intervention in schizophrenia. The lay counselor model has been utilised in training school and college teachers. These trained teachers can recognise minor, stress-related aberrations in their students' behavior and offer intervention. NIMHANS has developed a manual for teachers to help them acquiring such counseling skills (28).

## Training of health workers

Community health workers form another potential human resource that should be capitalised for enhancing psychiatric care in the community. They can increase awareness in the community, recognize the disorder early, and motivate them to seek treatment, provide support and ensure follow-up of treatment that is prescribed by the doctors. Their outreach is widening. Coming from the same socioeconomic strata, their role is more acceptable to the community. Modules of training health workers have been standardised and manuals have been developed (29).

# Training Nurses in Mental Health Care

Qualified nurses often receive training in exclusive medical/surgical settings and may not have any exposure to psychiatry. Also, mental health nursing in hospitals is different from general medical nursing. The nurses' role is not just medication and related physical monitoring, but also a role in offering education to patients and families as well as providing required counseling in select cases. Nursing Council of India recognises specialised nursing courses in mental health. These include Diploma in Psychiatric Nursing and Masters in Psychiatric Nursing. These professionals increase the quality of care in the hospitals and also provide human resources as trainers. The National Mental Health plan in its district programme includes a nurse as an integral part of mental health team. Modules for training general medical nurses in mental health for effective role in the DMHP have been successfully developed. Elegant experiments have demonstrated the role of training nurses in providing inexpensive follow-up care (30-33) in urban areas too.

## Conclusion

Human resources are the most valuable asset in any effective mental health care delivery system. The need for adequate specialised mental health manpower is undisputed. However, we also need a very large pool of professionals in the health care and the social sector equipped to provide basic mental health care to the community.

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# Psychiatric Rehabilitation in India

## T. Murali & Prashant K Tibrewal

## Introduction

Interventions that focus directly on functional impairments related to mental illnesses come under the rubric of psychiatric rehabilitation (1). Patients with mental disorders have been increasingly helped by rehabilitation services to achieve functional independence. Rehabilitation is a comprehensive and multi-disciplinary treatment. It involves a wide variety of interventions. These interventions help the patient to integrate into the mainstream of society and improve his/her quality of life (2). Modern psychopharmacology, the assertion of patient rights and the positive results of the effectiveness of psychosocial rehabilitation have all contributed to the recent growth of this discipline (3).

Severe mental disorders figure among the 10 leading causes of disability and burden in the world (4). The treatment of these disorders, especially in the recent era of psychopharmacology has centred on the amelioration of the acute phases of the illness. By their very nature, mental illnesses are chronic and relapsing and require a broad range of services, beyond just pharmacotherapy. Psychosocial intervention uses a combination of learning procedures and environmental supports in a holistic and integrated manner, to provide life-long care for persons with mental illness.

Unfortunately, in our country, a vast majority of patients still do not have access to any form of psychosocial intervention, let alone a well-integrated psychiatric rehabilitation service. In this chapter we have tried to provide a brief overview of the services and concerns related to psychiatric rehabilitation in India.

## Psychiatric rehabilitation in India

Psychiatric rehabilitation in India is in a dynamic phase of growth and can best be considered in three different sectors, namely, hospital-based initiatives, initiatives by non-governmental organisations (NGOs) and community and consumer initiatives. While the activities in many of these sectors were started on a largely experimental basis, some of them have

been found to be sustainable and replicable. Organised structured programmes with adequate human resources and budgeting for psychosocial rehabilitation (PSR) are still scarce in government psychiatric hospitals and in the NGO sector. Government initiatives remain largely on paper and have not reached the field. Issues related to norms, guidelines, staff pattern, infrastructure and linkages remain unattended. With this background let us examine the current status of PSR in the three different sectors.

## Hospital-based initiatives

These were initially confined largely to the government mental hospitals, re-christened as mental health centres or institutes of mental health. The NHRC report (1999) stated that 63% of the government mental hospitals had some form of rehabilitation services (5). Though rudimentary, they were in existence. These were largely on the lines of occupation therapy. They were mainly ward-based activities, some of which were productive but largely confined to the needs of the hospital. Staff nurses generally carried out a majority of these activities. Formal vocational training and placement were not very common. Hospital work like cleaning, assisting nurses and group D staff was very common in all the hospitals.

Following the recommendations of NHRC in 1999, there were improvements in some of the hospitals. Notable improvements are at the hospitals in Gujarat, Kerala and Madhya Pradesh. These states have NGOs and varying levels of community participation.

There has been a gradual shift from simple occupational activities towards productive and purposeful activities leading to income generation. Patients have started getting incentives for their work. Many of the mental health centres have started attached day care centres and halfway homes in their premises. Different levels of staff are also employed in these facilities. While PSR activities are becoming strengthened at some centres, unfortunately, in a few well-known centres, these activities have actually declined, e.g. at the CIP, Ranchi. This centre was once the Mecca of PSR in India (6).

Day care centres, especially those attached to psychiatric hospitals, tend to be used more by chronic patients with greater disability and those from the lower socio-economic strata (7). Poor work performance is often related to the persistence of residual symptoms of mental illness (8). However, the use of activity therapy, behaviour modification techniques

and monetary incentives for work helps to reduce the behavioural problems and improves the social and occupational functioning of the patient (9, 10). Cognitive remediation can be used to improve the quality of life (11).

With a reduction in the duration of hospitalisation at most of the psychiatric hospitals, and a decrease in long-stay patients resident in the hospital, it is important at this stage to extend PSR from just within the hospital to the larger community. The expanded district mental health programme (DMHP) provides an ideal opportunity for this movement.

## Non-governmental organisation initiatives

A recent survey of non-governmental organisations provides an interesting scenario of psychosocial rehabilitation efforts in the Indian context. There are different types of organisations involved in a variety of rehabilitation measures for the mentally ill. A major group are the registered societies or trusts. These organisations have reasonable infrastructure, adequately trained professional staff and structured programmes. Their clientele are people who have recovered from the acute illness and who are on maintenance medication. While a majority of the centres have a residential facility, some of them have only a day-care facility as illustrated below.

Figure 1
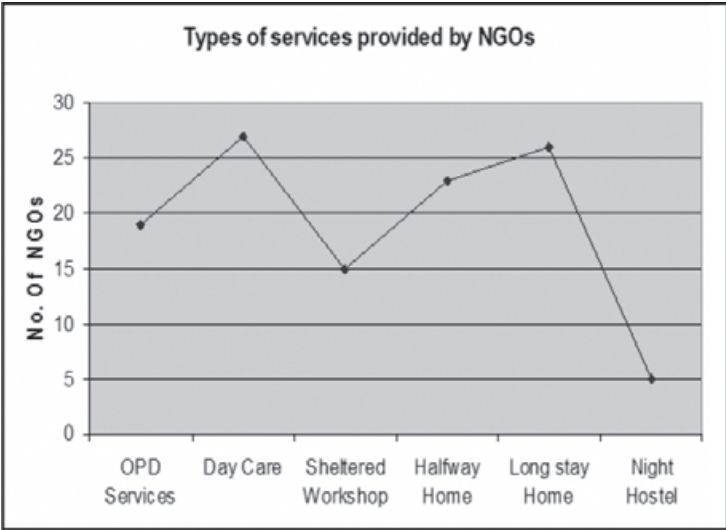
## Residential facilities

Well-known residential facilities, which mostly provide shared accommodation, include the Medico Pastoral Association in Bangalore, the Richmond Fellowship Society with branches across India, the Schizophrenia Research Foundation (SCARF) at Chennai and the Atmashakthi Vidyalaya, Bangalore. These organisations have developed halfway homes with a maximum duration of stay of 1 year, after which the person returns to his/her family. These centres generally accept patients with psychotic illnesses. They offer very well structured programmes for the whole week with an adequate mix of daily living skills, communication, appropriate behaviour, etc. as components. Adequate professional staff, either clinical psychologists, or psychiatric social workers, are employed to supervise the programmes. Among these centres, the Medico Pastoral Association has a unique feature of house parents, who are an elderly couple who function as surrogate parents. Food and medicines are provided in the centres. The charges at these centres range from Rs 3000 to Rs 7000 per month.

These centres have also started long stay facilities as well as day-care facilities in their premises. The long-stay facility is provided after taking a lumpsum from the families. All these facilities provide non-medical aftercare services. However, these organisations are presently required to obtain a license under the Mental Health Act (the same required to run a mental hospital/psychiatric nursing home). This is a misinterpretation of the Mental Health Act as these are not active treatment facilities for the acutely mentally ill. It poses a major hindrance for such organisations and moreover, is a disincentive for newer organisations interested in starting psychosocial rehabilitation. . Their monitoring could be more appropriately done under the Persons With Disabilities (PWD) Act 1995, under the Disability Commissioner.

## Day-care facilities

There are over 25 day-care facilities in India spread over Kerala, Karnataka, Tamil Nadu, Goa, Maharashtra, Gujarat, Madhya Pradesh, New Delhi, Assam and Meghalaya. Special educators or vocational instructors primarily manage these day-care centres. They generally cater to persons with psychosis, mental retardation, and mental retardation with epilepsy. They all emphasise on vocational training that is locally relevant. Most centres have productive activities and patients do get a stipend or

remuneration depending on their work performance. Once they are trained, they are assisted to get a placement in the community. Duration of the stay varies according to the individual's disability. There are no formal certificate courses or any specific yardstick to assess employability or competence.

In the district of Malapuram, Kerala, as a part of the DMHP, small community day-care centres have been operational where 10-15 patients are engaged in daytime activity. These day-care centres increase the self-esteem of the patients, gives them some time away from the family. This gives family members an opportunity to attend to their work, making them less pressurised and better able to support the mentally ill family member. Day-care centres can be developed anywhere in the country, they help to reduce stigma, have low professional manpower requirements, and ensure good drug compliance. The difficulties include the need for transportation from home to the centre, and that the family members of the patient need to pack lunch sometimes very early in the morning.

This form of care is popular and can be easily established even in rural areas, as illustrated by Thanal Chavakkadu in Trichur district of Kerala or the day-care centre run by Deshbandhu Club, Silchar, Assam.

## Long-stay facilities

Certain families simply cannot accommodate the mentally ill person. Examples include situations when the patient is severely disabled, when there is a very high degree of family pathology, or when there is no immediate family member available to provide care. Cadabams in Bangalore provides this facility, but the costs make it affordable for only a few. Non-governmental organisations and private entrepreneurs must come forward to develop such facilities. Usually they take a lumpsum payment and do not charge any monthly fees. There is a growing demand for such centres and we may see more such centres come up in the private sector, as they may offer more economically viable models of long-term care. A criticism of these centres is that they may become like private asylums.

## Home for the homeless

There have also been relatively less visible community initiatives for the mentally ill. Several individuals and families in Kerala have been involved in providing food, clothing, shelter, medicine and occupational therapy free of cost for the destitute mentally ill. These are largely charitable efforts

sustained by the active support of the local community in cash and kind (12).

A novel approach has originated in Kerala. The homeless mentally ill are taken from the streets and provided shelter, clothing and medicine by ordinary families. There are about 60 such centres spread across Kerala; all of them are registered under the orphanage control board. These were started in 1993 and slowly spread across the state. The families, which run these centres are from the low and middle socio-economic strata and are driven by religious faith. A few of these centres are managed very well with adequate infrastructure and good care. The expenditure for running these centres are through donations by the local community and other well wishers. A large number of volunteers are also engaged to care for the patients. These volunteers as well as the care giver's families do not have formal mental health qualification or training. In 2001, a State level workshop of these centres was organised. It was found that some of them do not provide any medication. Hence, a training programme was started and today, a majority of the centres are aware of the principles of care for the mentally ill and they all have visiting psychiatrists providing medication. National Institute of Mental health and Neuro Sciences (NIMHANS), Bangalore, has taken a lead in these programmes. Once the patients are taken to these centres, they are given personal grooming and provided with psychiatric and medical consultation. Once they recover, their families are traced and they are sent back. Those who are not accepted by the families remain at the centre. One such centre has an orchestra and drama troupe comprising recovered persons and has completed more than 300 stage shows. These centres also do a lot of public awareness programmes.

Such centres are also present in Tamil Nadu. Two well-known centres in this state are the Banyan and Udagum Karangal in Chennai. There are a few centres in Karnataka as well. These centres need support from the government for infrastructure and medicines. Models such as the above are worth nurturing and enable healthy community participation. Community involvement in such centres will reduce the stigma associated with mental illness.

## Consumer and Community Initiatives

Psychosocial rehabilitation in India has also seen meaningful community participation, primarily from users, family care givers and others who have

taken this as a mission. There are families of the mentally ill who have also taken up psychosocial rehabilitation. Ashadeep in Assam, Aasha in Tamil Nadu are examples of day-care centres started by family care givers. Schizophrenia Awareness Association in Maharashtra is a user initiative. Family Federation of India is a group of different family associations working for the cause of the mentally ill. The World Association of Psychosocial Rehabilitation has provided a significant contribution towards conducting awareness programmes and providing technical assistance for psychosocial rehabilitation. Any interested individual can become a member and work for the cause of the mentally ill.

## Psychosocial rehabilitation for non-psychotic disorders

This chapter has catered primarily to issues of psychosocial rehabilitation for persons with mental illness, mainly psychosis. Psychosocial rehabilitation is also a popular and well established therapeutic approach for the long-term treatment of alcohol and drug de-addiction. The Ministry of Social Justice and Empowerment funds NGOs to carry out psychosocial rehabilitation for alcohol and drug dependence. The regional centres identified under this scheme also provide training in rehabilitation of persons with dependence. Many of these agencies have demonstrated the effectiveness of community based and workplace prevention and rehabilitation programmes. The approach and treatment modalities for this group are distinct (13).

## Conclusion

Psychosocial rehabilitation is spreading across the country slowly but surely and there is a gradual growth in agencies offering these services across the country. There is a need for a user-friendly rehabilitation policy at both the central and state government levels. The issue of psychosocial rehabilitation and the regulation of different centres offering this service must come under the purview of the PWD Act 1995 rather than under the Mental Health Act. There is a need to develop trained human resources at different levels to provide therapeutic interventions at these centres. Alternate manpower development programmes can be taken up by the Rehabilitation Council of India in association with other mental health professionals' bodies like the Indian Psychiatric Society, Indian Association of Social Psychology, Psychiatric Social Work, World Association of Psychosocial Rehabilitation, etc. The Indian Psychiatric Society has developed a scale for quantification of disability which has been accepted

by the Ministry of Social Justice and Empowerment and is being widely used across the country for certification of disability in mental illness (14). This is a good example of government working in tandem with professional associations. Once these policy changes are implemented and translate into user friendly services, mentally ill persons can have a better life of dignity, individuality and honour.

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# Human rights in the community: user perspectives and the role of NGOs

## Nirmala Srinivasan

## Introduction

The 21st century witnessed radical changes in perspectives about mental illness (MI) and persons afflicted by it. These changes were mainly characterised by shift in the paradigm of care from custody to community; from asylum to household; from isolation to integration. The shift was attributed mainly to pharmacological advances in drug therapy for MI, social and political sensitivities to human rights concerns and finally inclusion of mental health as part of the general health agenda in many countries (1). The grand culmination of these diverse historical forces in the last two centuries witnessed the birth of the UN Convention for Rights of Persons with Disabilities, or "CRPD" (also known as the "Convention") (2) . Domesticating the Convention involves legal reforms and changes in the existing laws to incorporate the broad principles and ensure that there is no conflict of interests between CRPD and the local laws.

## Limitations of institutional models

Historically, human rights activism for persons with MI in India was the initiative of the Supreme Court of India and was concerned with the incarceration of mentally ill prisoners without treatment (3). NHRC commissioned a survey of mental hospitals in the country and exposed the plight of many recovered patients in mental hospitals that led to the study on quality assurance in hospital services (4). The institutional model of State sponsored human rights activism had no relevance for users in family care who constitute around 90% of users in the country as a whole (5, 6).The Mental Health Act 1987 (herein after known as MHA) was inadequate to protect the interests and rights of patients outside the institution.

## Rights based perspective to mental health care

Until the passing of the Persons with Disabilities Act (hereinafter known

as PDA) in 1996, the participation of Mental Health NGOs (MHNGOs) (7) and User advocacy groups in policy lobbies was negligible (8). On 26th July, 2007, Action for Mental Illness (ACMI, an NGO of which the author is Director and trustee) was invited by the Ministry of Health and Family Welfare, GOI for a presentation on the legislative reforms in MHA thus breaking years of silent stonewalling. Unlike other disability lobbies or even the victims of TB, Cancer or HIV/AIDS, mental health users were unknown, unseen and unheard. This representation for user groups is a desirable shift. The UN Convention marks a shift in orientation from welfare to human rights by mainstreaming of persons with mental and intellectual disabilities, firstly within the disability scheme and then within the broad human rights agenda (9). It embodies the 21st century thinking on human rights as an undivided holistic package of rights covering all aspects of life, health, civil, economic, social, political, etc. More details on MHA, PDA and CRPD and their implications are discussed in the subsequent sections.

> "Mental Illness is not so much about loss of sanity, but of self respect"- *user from Bangalore.*

This paper seeks to a) examine the Rights perspectives of mental health users or MHUs, including the current debate about the definition of Users and the description of their rights perspectives. b) illustrate NGOs' role for facilitating rights based community initiatives using the Public Private Partnership (PPP) strategies currently in vogue.

## Definition of Users and Rights

"User" is a misnomer in India because it implies users or consumers of mental health services whereas nearly 80% of the 20 million requiring mental health care are believed to be outside the purview of psychiatric treatment until the recent revival of the NMHP under the 11th Plan (10). Popular reference to Mental Health Users (MHUs) as 'mental patients' has an illness connotation, used mostly in clinical settings and in government health departments. In day-to-day parlance, they are still referred to as "mad persons" or "lunatic" in the vernacular. Of late, reference to MI persons in the context of rehabilitation is "mentally challenged or mentally disabled persons". In legal parlance, they are identified as persons of "unsound mind" (in the MHA and in Indian Contract Act). The idea of such apparently crude descriptions of the users in Law is to protect their rights in case they are being taken advantage of. Identity of the MHU in India is presently

reduced to a sane-insane dichotomy. Unlike the three-decade old consumer movements in the West, the decade old Indian user activism is still to emerge as an organised and independent pressure group (1).

The reasons for a lack of synergy in this area are many. MHU is an ambiguous sociological entity. Many persons with severe mental illness live in rural India. Besides the rural- urban divide, there are three broad categories of users in India. These are the users within or requiring institutional care, those in family care ((this terminology is a more realistic description than community care. In urban areas, there is really no community that helps a family in distress. Existing community care facilities run by the voluntary sector are expensive and inadequate). Thirdly, there are the homeless persons living on the streets (who though legally entitled to all the rights under the CRPD are literally "non-users"). MHU is a broad category that primarily includes current users, potential users and even treatment dropouts as well those who fall under the clinical category of persons with major MI. We believe that the users must include all those persons suffering from MI; irrespective of medical status, all are entitled to rights under the Law of this land; and are also capable of independent articulation of their rights within the limitations posed by their disabling illness. It is learnt that in some states, disability certificates are not issued to destitute MI persons residing in long-stay homes because they are unable to give their home address. The 'significant others' who are involved in the everyday life situations of the affected MI persons like the family, service providers, Mental Health NGOs (MHNGOs), medical professio-nals and the local community, have a strong influence on the MHU rights perspectives. In fact, the emotional, physical and social proximity of the family as care provider has given rise to doubts whether the users have any independent views of their own at all? So much so that many believe that the category of users also includes the family, irrespective of its clinical profile of MI.

## User vs Family or User and Family?

Commenting on User groups, WHO finds that "*Opinions vary among consumers and their organizations about how best to achieve their goals. Some groups want active cooperation and collaboration with mental health professionals, while others want complete separation from them. There are also major differences as to how closely to cooperate, if at all, with organizations representing family members of patients*" (1). Since the majority of Indian users are under the family care

model, their perception of rights, just like the perception of themselves and their illness, is likely to be deeply influenced by family- centric decision making style. Shankar and Rao claim that "…*The experiences and interpretations of psychiatric conditions by* **users- families and patients**- (emphasis added by the author) *have a substantive role to play in the development of meaningful health delivery systems as only those services that are perceived as compatible with the users beliefs are likely to be utilised*" (11). Accordingly, any understanding of User rights is inevitably linked with the existential context of the family so much so that it is empirically difficult to delineate User rights as an independent variable. They (patients) *may* experience that "*their choices can be very limited compared to others around them. Further, decisions affecting their life choices are taken for them and without reference to them*" (12).

The apparent conflict of interest seen in the Family-User relationship has raised an important question about the role of family- is it a barrier or facilitator for Users rights? The bias against family probably has its origins in the fifties theories of psychiatry or anti-family ideology of some human rights advocates under the influence of the West. These are at best tendentious arguments not warranting generalisations beyond a point. Protagonists of the family as Users argue that "*Mental illness is not about one individual but the entire family. Life is never easy for a care-giver. The health care provider may, at best, show the way but the burden of decision rests solely with the care-giver*", observes the author of *Sepia Leaves* who discovered life as a child care giver (13). The exclusion of family from the definition does not mean its exit from the rights agenda of consumer movements.

NGOs such as Ashadeep (Assam), AMEND (Bangalore), Aasha (Chennai), SAA (Pune), NAMI India (Mumbai), Turning Point (Kolkata) illustrate the emergence of family support groups as community care providers to supplement the acute shortage of care facilities. Hence it is simplistic to take a negative view about the family only based on its overwhelming presence. Phenomenological insights of taking the Users "for granted" by the family, are necessary but not sufficient to dismiss the Indian User as passive or an oppressed recipient of services.

At the same time, any definition of MHU that includes the family contradicts the very basic principles of human rights and social justice advocated in the CRPD. As stakeholders, family is not to be identified with Users because it is necessary to delink the two for validating User advocacy for

rights. Our view is that the family is a critical resource, with proper guidance and education can turn out to be a positive change agent. MHU as an independent category of advocacy, delinked from the family, are in line with the national and international legal norms. Adopting a legal definition of Users helps to understand the social dynamics underlying their position for self advocacy and peer advocacy. So we take the view that Users have their own autonomous role in exercise of their rights, not clubbed together with the family but related to it in terms of dialectics of care, control, and interdependence.

## Varying User perspectives

The second major factor that gives limited scope for fostering independent User perspectives is the unstable nature of the illness, social attitudes, denial by the users, stigma, lack of disability doles that support such causes elsewhere in the world etc. User perspectives of illness vary too. "*For example, some are happy to accept the idea that they suffer from illnesses such as schizophrenia; or affective disorders; they accept the language of psychiatry. Others reject the notion of mental illness completely, and are incensed that they might be forced to take medication and have their liberty taken away because their distress is interpreted in terms of illness; these people reject the language of psychiatry. Other groups lie somewhere between these extremes. Despite their differences, they share a common belief in their right to interpret their experiences in their own way, and to receive help accordingly.*" (14) Commenting on consumer advocacy movements , WHO observes that "*Among the strongest themes that have emerged are: the right to self-determination; the need for information about medication and other treatment; the need for services to facilitate active community participation; an end to stigma and discrimination; improved laws and public attitudes, removing barriers to community integration; the need for alternative, consumer-run services; better legal rights and legal protection of existing rights; and an end to keeping people in large institutions, often for life*" (1).

Cross-cultural variations in User perspectives is only a matter of degree, depending on the quality of life parameters in their respective countries. "*If one talks to mentally ill people, it is easy to realize that they have the ability to make decisions necessary to carry out development work in their own communities, and that they must be accorded their rightful place in society. In the process of development, one can assume with*

*a fair degree of certainty, that the pursuit of basic needs will also slowly lead to the achievement of basic rights"* (13).

## Some NGO approaches to ensure user rights

The logical culmination of the argument that unmet needs are unfulfilled rights seems the most appropriate yardstick for understanding user perspectives – be it from MHUs themselves or by their "significant others". A care giver-cum-service provider states, "At Aasha we have broken down the principles to which we adhere, in simple Do's and Don'ts:

| The Aasha approach (15) | |
|---|---|
| Treat them (patients) like adults | DO NOT look down at them |
| Treat them as equals | DO NOT treat them like school children |
| Tell them CLEARLY as to what decisions they can take and what they must refer to the supervisor | DO NOT force them to do what they don't wish to |
| Treat them professionally - be firm when firmness is required, reward them when they do well. Train them in pre-determined modules - little each day. | |
| If they were accountants before being stricken by the illness, they may want to do accounting work only. ENCOURAGE this trend. | DO NOT look over their shoulders when they are working. |

Instead of explicit and elaborate references to human rights, Aasha's principles reflect a sense of implicit respect for the selfhood of the user that finds its brilliant expression in the CRPD. Echoing the same view, another care giver turned NGO believes that "*To me, it appeared that it is the 'human right' of the person concerned to stay and continue his treatments within the family.... The Human Rights workshop helped the beneficiaries at Turning Point....to fight for their remunerations in an assertive way"* (16).

Fourth Sector NGOs are initiatives by individuals who have been deprived of equal opportunities either due to social barriers or due to setbacks like

disability that motivates them into positive action. The Fourth Sector is a shift from the institutional and community to family and Individual as the basis and agent of change. Fourth sector NGOs like Aasha, AMEND and Turning point show the change from a medical mindset to a rights based worldview (17) .

Others like CAMH view the linkage of needs and rights as a dichotomy giving freedom and personal liberty greater priority than treatment rights (18). Holistic cure and alternative medicine are advocated as more humane than forced treatment. "....*Psychological sciences have made no effort to surmount patient recalcitrance through expertise. Instead they have opted for convenience and stream rolled patients into submission with the force of law*." (19)

## Resolving the divide

The resultant schism within MHU has led to the polarisation of the rights dialogue into a service model as against the advocacy model. Most MHNGOs are in the former and in fact, shy away from any rights based advocacy dialogues as superfluous in the light of utter lack of services in the community. Human rights, no doubt are an end in itself, but in the course of achieving it, we must not compromise on the means. NGOs in the development and disability sector can play a decisive role to narrow down the gaps between the two models as is seen from the following approach to family advocacy by ACMI. (This was described in chapter 8)

## Incompatibility between MHA and community care principles

User rights have also faced major handicaps due to incompatibility between MHA and the principles of community care. The MHA is not rights oriented on account of its institutional bias and dyadic mindset about the users as either *sane* or *insane*, and nothing in between. Official preoccupation with MI prisoners or custodial confinement of recovered patients made no sense to the problems in family care posing a major hurdle for the exercise of rights by Users or by family members on their behalf. The case history of "X" (Box 1 below) is a classic illustration of the manner in which the complex process of Law can obstruct the course of social justice in the community.

| BOX 1MHA: Case history of X | |
|---|---|
| 1989 | X is a well built Karate expert, shows signs of emotional disturbance |
| 1991 | Diagnosed as suffering from Schizophrenia. Treatment starts by regd. Govt Psychiatrist of a leading mental health hospital. |
| 1991-2007 | Intermittent discontinuation of medicines by X. He gets violent during these phases and admitted to Govt Hospital with police help . |
| 2007 | Stops taking medicine and becomes aggressive towards mother and sisters. He wants them to leave the house. They live in fear. |
| March 2008 | X becomes highly symptomatic. Refused to go to the hospital. Letter from Govt Psychiatrist to the Magistrate for Reception Order because Police refuse to help without Reception Order. Mother files affidavit for Reception Order in court and starts running around to court for multiple hearings. All prescriptions since 1991 are also produced for Magistrate's reference. |
| April 08 | X gets more hostile and threatens "bloodbath". More delusions follow. |
| May 08 | Magistrate directs X to be produced on 19 May 2008 |
| 16 May | X assaults his two sisters without any provocation, threatening to kill them. Mother, sisters and grandchildren run out of house. Police called. X threatens them also. Police advise the family to stay elsewhere for their safety, they run out without even a change of clothing. |
| 17 May | FIR lodged. They (Police) register a case of assault against X. . |
| 19 May | X is presented before magistrate on 21st May because it was dismissed on 19th May |
| 22 May | Magistrate dismisses the Reception Order case on 22 May. Family runs to Human Rights Commission. They |

| | |
|---|---|
| | direct the police to assist the family to admit him in the hospital. |
| 23-25 May | Police not available due to inauguration of BLR new airport 23th and Karnataka elections on 24th. They say that X can be picked up only on the basis of the assault case and MI. |
| 26 May | Finally Police arrest X on assault case, produce before Magistrate and he directs him to Custody in Central Jail instead of admission as a patient. X is now a criminal and not a patient! |
| 28 May | Medical Authorities at Central Jail understand that X is mentally ill and he is taken to the same Govt hospital where he was treated. He is presently admitted in the prison ward of the hospital. |
| Till 3 rd week of Jun | X is administered counseling & treatment in the Govt Hospital for about 3 weeks. After this he is sent back to the Central Jail and treatment and counseling continues there by the prison psychiatrist. |
| Early 1st week July | Prison psychiatrist is comfortable with the improvement of X. Family contemplates bringing X back home rather than risk him spending long time in jail. What if X stops medicine or gets violent again? There is no doorstep service to help X overcome his criminal record. |
| Later1[st] week | X is back home and is doing well but unfortunately with a criminal record. |

*Written by a relative of X and edited by the author*

ACMI is in the forefront of legislative activism with the MoHFW for recognising family as "enablers" rather than as "enemies" of the Users that is implicit in the present Law (ACMI's correspondence with the Health Ministry was initiated in Sept 2006 and continues till date). Few cases of family abuse are exceptions and not the rule; by making the exceptions into rules in the name of protecting the user rights, the genuine cases like that of X (in Box-1 above) suffer untold misery. Among other things our demands include simplification of admission procedures, information on rights to patients and families, self rights and rights of natural guardians for nomination of legal guardians, review of closed wards, police

intervention to be supplemented by crisis and emergency management services; Sec 37 wherein the composition of Board of Visitors to include user and family groups, consumer lobbies, Rotarians, other disability advocacy activists , representation from professional bodies etc. Minimum standards to be worked out in facilities with resident MHU keeping user rights and needs in mind , not based on the availability of resources alone. The positive response of the Ministry is already felt at the State level wherein Rule 22 has been amended (under sec 94 of the Act) to include the above recommendations. With the advent of CRPD, knowledge of the law by families and NGOs is indispensable to ensure full and free participation of MHU in the exercise of their rights.

## Moving forward

The MHU perspectives underwent significant changes in the last twenty years. The passing of the PDA, and the recognition of MI as one among the disabling mental disorders, marked a paradigm shift from service orientation to the broader context of rights in civil society. AMEND, the first autonomous SHG in the country, actively lobbied for inclusion of MI persons in the Persons with Disabilities Act (17). It circulated information booklets in English and Kannada, prepared with the help of faculty of NIMHANS. SAA from Pune used visual media by making the film "Devrai" to convey the merits of positive family support. Third sector NGOs like Aasha and Cadabams developed job skills of the users by opening shops catering to the community. User advocacy issues range from "challenging psychiatrist driven mental health programme", advocated by CAMH (18) to demand for social security benefits and life-long pension for MI persons above 45 years and safe property rights by NAMI India (21). In 2000, AMEND got the disability certification protocols into place in the state of Karnataka. In association with other MHNGOs in the country, AMEND and ACMI succeeded in obtaining income tax rebate for persons with MI and their family providers. The office of Disability Commissioners at State levels handled cases of violation of PDA at State levels.

## Disability certification for mental illness

The integration of mental disabilities into the overall disability sector gave rise to CBR initiatives in rural areas by NGOs such as Basic Needs, a CBR Forum in Bangalore (Karnataka). SCARF (Chennai) organised workshop on disability caused by mental disorders in 1999 where attention was drawn to the question of measurement of disability in MI. Further research on this

resulted in the designing of IDEAS that was formally recognised by the GOI in 1996. ACMI's first legal literacy workshop on Law and MI for the family and user lobbies in May 2006 put forward an eighteen point demand that laid the foundations of dialogue with the Ministry of Health about amendments to MHA and certification of rehabilitation centres under the PDA instead of the present license system under MHA. Tamil Nadu has already put this into practice. Political inertia regarding NMHP, lack of a rights based mental legislation, and discrimination towards MI in PDA prompted ACMI to file affidavits in the Supreme Court (10) and Karnataka High Court. (22). Bapu Trust organised a series of national consultations and brought out a Charter of Rights (18).

## Federation of MHNGOs

An all-India federation of MHNGOS was formed in 2003 as an umbrella organisation to work for the cause of persons with MI. It demanded job opportunities for MHUs in the private sector by giving incentives to the employers. In 2006, ACMI in association with Torchbearers, Delhi joined the NGOs led by Lawyers Collective to protest against the new Patent Ordinance (23).

By drawing the MI lobbies out of the medical orientation to one of social justice, the PDA brought about some attitudinal change towards persons with MI. Networking with other disabilities led to greater awareness and acted as a stigma buster in a limited way. PDA was not a comprehensive rights based law as far as MI was concerned. Starting with the definition of MI (copied from MHA), denial of Job quotas to MHU (Ch VI), the very language of the text loaded in favour of physical disabilities and the failure of the government to amend the Act were hurdles that the MHU is yet to be overcome. MHNGOs across the country have protested against the neglect of mental disabilities and their rights in PDA. The advent of the UN CRPD is forward step towards realisation of the rights missed out by PDA.

## From national to global Integration

The UN CRPD is a radical departure from all previous disability policies applicable in the country. Besides allowing room for State Parties to adopt definitions that are culturally, socially, financial and legally acceptable to their localised scenarios, this broad and inclusive approach results from strategic and active campaigning by the civil society participants of the Ad

hoc Committee (AHC), collectively called the International Disability Caucus (9). On 30 March 2007 India also joined the community of 82 countries to have signed the UN CRPD on the very day it was adopted and opened for signature and ratified it on October 1st 2007. Since May 5th 2008, India is bound by the international charter of human rights universally applicable to all disabilities recognised by PDA.

Domesticating the Convention involves legal reforms and changes in the existing laws to incorporate the broad principles and ensure that there is no conflict of interests between CRPD and the local laws. *"Article 12 embodies the foundation for a whole new vista of rights for persons with mental and intellectual disabilities. .....* The language of Article 12 of the Convention was hotly debated up until the 7th and 8th sessions of the AHC (*Ad hoc* Committees) reflecting an ideological divide within the civil society groups (9). Concern among many MHNGOs and mental health professionals was about the consequences of full legal capacity for the MI in symptomatic phase of the illness that could have fatal consequences such as the one that was witnessed in Virginia Tech campus in USA (25). The issue here is not protecting the civil society from the *client patient*; on the contrary, it is one of supporting him/ her with timely 'enablers' **to cherish freedom without fear of Law**. Finally it was resolved "by qualifying legal capacity to imply, (a) recognition of legal capacity of all persons with disabilities; (b) introduction of the tailor-made supported decision making model in place of replacement/ substitution by personal representative; and (c) proportionality of the support provided. (9) ACMI in association with SCARF, Chennai based MHNGO conducted a brainstorming workshop on the implications of CRPD for the rights of MHUs. Reports have been submitted to MoHFW and MoSJE.

## NGOs in Rights-based interventions: PPP model of advocacy

Public Private Partnership is the "mantra" in India's for strategic resource management to overcome the inefficiencies in public services today. Illustrative examples of such PPP models are emerging from different parts of the country and have been provided in chapter 8. The ACMI in Bangalore worked with the Disability Commissioner to negotiate a crisis ambulance service through a PPP model involving the State Mental Health Authority, government department of health, the Rotary Club and the police.

# Conclusion

The CRPD is a broad human rights framework to fit other laws of the land. It is the overall responsibility of the civil society to "make it happen". The Health Ministry and NHRC must throw open its doors to consumer representatives in all policy making initiatives rather than adhering to non-participatory decision making process. Critical among these are attitudinal changes and communication skills (especially listening skills) for "significant others" including mental health professionals as a symbol of respect for user lobbies and MHUs. It is time we think on the lines of setting up an autonomous and nodal agency such as a National Mental Health Corporation to oversee the transition from the medical to human rights model in a manner that coordinates the work of the two ministries involved in the cause.

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# Insurance and mental illness - concerns and challenges

## S Kalyanasundaram

## Introduction

Mental health disorders and mental illness can be found all around us. These conditions afflict people from all walks of life, from the homeless on our streets, the stressed colleagues in our work places, to immediate members of our own families. If mental illness was understood and treated in the same way as physical illnesses, the financial burden for sufferers would be considerably alleviated. What is pertinent for modern society is an understanding that mental illness is as significant as physical illness.

## Mental Illness

*Mental illnesses are physical brain disorders that profoundly disrupt a person's ability to think, feel and relate to others and the environment* (1)

It is estimated that at least 20% of a given population will experience mental disorders of some kind during their lifetime: mental illness cuts across age groups, gender and socio-economic barriers. Unfortunately, the stigma attached to mental illness significantly worsens the quality of the life of the already unwell sufferer, who is not infrequently regarded with contempt.

Mental illness is not as diametrically different to physical illness as it may seem at first. Whilst physical changes in the brain coupled with mental disorders can signify potential biological origins of illnesses, some mental health advocates propose switching from 'illness' to less stigmatised terms, such as behavioural ill-health, brain disorder or brain illnesses to describe these conditions. For some in society, mental illness is not traceable to a legitimate medical condition but is the outcome of the sufferer's 'wrong' actions, decisions and preferences. They are blamed and led to believe that their illness is all in the mind. Some even believe that mental illness is a sign of weakness or laziness.

It is crucial both for the understanding of society as a whole as well as for those suffering from mental illnesses that we challenge the way we talk about mental health. The general practice of transposing mental illness onto the individual, for example, by referring to the sufferer as a 'schizophrenic', rather than as someone who suffers from schizophrenia brings up profound political issues around the human rights of mental illness sufferers. This mode of defining them through their illness lays the foundation for the very discrimination that mental health professionals seek to oppose. Separating the individual from their illness should lie at the heart of a greater social awareness that does not simultaneously label and dismiss those will mental ill health. By seeing the illness as a condition the individual may be suffering from rather than as a determining factor in their identity, not only is their humanity preserved in ethical terms, but on a political level their civil liberties are safeguarded.

## Complexities of mental health problems

Some of the issues that might compound the problem are:

Mental health problems are not always easily identified, remaining unrecognised and thus untreated for long stretches of time if at all (2). The stigma attached to mental illness and the discrimination faced by those who suffer from it, acts as a significant disincentive to accepting that there is a health problem and seeking help.

a.    It has been demonstrated that people suffering from mental illness have more physical ill health than the general population. Studies have identified that people with mental illness are at a greater risk of having a concurrent physical illness, and of that physical illness going undiagnosed and untreated. There are also indications that mortality rates amongst the mentally ill are 2.5 times higher than in the general population, yet hospitalisation rates are considerably lower for many conditions. This is compounded by the fact that the mentally ill are more likely to engage in high-risk behaviour, such as smoking, alcohol or drug abuse, and sexual promiscuity.

b.    The mentally ill are also less likely to engage in health-promoting activities, such as good diet and exercise. In addition to the illness itself working as a barrier to these activities, the additional expense and side effects from medication, also prevent such engagement.

c.    Additional stress, anger and frustration due to lack of services, the stigma around mental illness and persistent discrimination have an

adverse effect on sufferers. Attitudinal barriers from the health workforce can result in health professionals refusing to provide treatment to the mentally ill due to lack of understanding of mental illness, fear and prejudice.

d.    The mental health workforce itself is characterised by high turnover and burnout rates – a situation that does not bode well for those charged with the mental well-being of the vulnerable.

e.    Additionally, the needs of family carers are generally unmet. Since health services often fail to meet the needs of consumers, family carers are put under enormous pressure and end up placing their own needs last. The lack of services available for family carers themselves is also a significant problem: as a result their health (both physical and mental) and quality of life are severely affected. This raises serious concerns about the wellbeing of family caregivers.

f.     One of the greatest concerns identified amongst caregivers, particularly those in the ageing population is the fear of what will happen to their charge when they die. We regrettably do not have the systems and services available in the community to provide care for those who depend on a family member. The situation has now reached a crisis point with many carers are "afraid to die" because they fear for the fate of their loved ones.

Insufficient support for caregivers can have physical and mental knock-on effects. There are also flow-on effects to children of parents with mental illness and other family members.

Significantly, individuals at risk of mental health disorders are more likely than the rest of the population to leave a job that provided insurance, which risks disruption of care.

The unemployment rate for the mentally ill population is normally three to five times higher than for the rest of the population.

Loss of insurance usually results from loss of employment, which often provides private cover. Parity in insurance coverage can provide protection against the financial costs of mental illness to the extent that they are equivalent to those of other medical disorders. However, serious mental illness has many other costs, representing the services of non-traditional providers.

# Insurance

Broadly defined, the term 'insurance', represents an agreement in which two parties agree to a sharing of risk. The client pays a sum of money - the 'Premium' and in turn the insurance firm commits to pay a predetermined sum of money to meet the customer's claims. A Health insurance policy is a contract between an insurance company and an individual. The contract is usually renewable annually and Premium is the monthly amount the policy holder pays to the health plan to purchase health coverage. Health insurance will protect a person and his/her dependants against any financial constraints arising on account of a medical emergency (3).

The term **health insurance** is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance programme, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits which pay for medical expenses may also be provided through social welfare programmes funded by the government. Health insurance works by estimating the overall risk of healthcare expenses and developing a routine finance structure (such as a monthly premium or annual tax), which will ensure that money is available to pay for the healthcare benefits specified in the insurance agreement.

Historically, the concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, "accident insurance" began to be widely available, which operated much like modern disability insurance.

Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents.

While there were earlier experiments, the origins of coverage for sickness in the US effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911.

Before the development of medical expense insurance, patients were expected to pay all costs related to health out of their own pocket under what is known as the <u>fee-for-service</u> business model.

Today, most comprehensive private health insurance programmes cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this has not always been the case.

Insurance companies use the term '<u>adverse selection</u>' to describe the tendency for only those who will benefit from insurance to buy it. More specifically, when talking about health insurance, unhealthy people are more likely to purchase health insurance in anticipation of large medical bills. Consequently, those who consider themselves to be reasonably healthy may decide that medical insurance is an unnecessary expense.

The basic concept of insurance is that it balances costs across a large, random sample of individuals – or what is known as a '<u>risk pool</u>.' For instance, an insurance company has a pool of 1000 randomly selected subscribers, each paying 100 units per month. One person becomes very ill while the others stay healthy, allowing the insurance company to use the money paid by the healthy people to pay for the treatment costs of the sick person. However, when the pool is self-selecting rather than random, as is the case with individuals seeking to purchase health insurance directly, adverse selection is a greater concern.

An important issue facing the community and people living with mental health issues is the entitlement to appropriate insurance coverage, including income protection insurance and life insurance. However, it remains difficult to obtain health insurance for the mentally ill. Most insurance companies across the globe do not offer insurance for the mentally ill, despite the unstinting efforts made by family members and advocacy groups.

Health insurance is available in only in a few countries, while the mentally ill are deprived of any form of health insurance in most nations. Even when available, health insurance for mental health services is often less generous in terms of both the breadth of services covered and the depth of coverage. The financial barriers to accessing mental health services are a grave policy concern in many health systems.

Below are the current policies in various countries with respect to health insurance coverage for the mentally ill.

# USA

Most people in the US do not have good insurance cover for mental illness. Their main sources for care are State funded mental clinics and State funded insurances. However, the USA is moving towards equal treatment for the mentally ill.

American mental health advocates and policy analysts believe that the collective power needed to bring mental health parity to private health insurance could be harnessed. Former President Bill Clinton ordered such equal coverage for federal workers in 1999, and these changes took effect in 2001. Under this policy - known as parity - insurers were unable to charge higher co-payments or impose stricter limits on psychiatric care or treatment for alcohol and drug abuse (4-5).

In 1996, Congress passed the "Mental Health Parity Act." This landmark legislation prohibited insurers from imposing lifetime and annual-benefit limits on mental health services that they do not impose on services for physical health. Prior to this, a typical insurance plan might cap lifetime mental health benefits at $50,000, but cap benefits for physical health services at $1,000,000. Once the act was passed, insurers were no longer able to impose a different limit on mental health benefits if both kinds of benefits were part of the health insurance package. Maryland, Minnesota, Maine, New Hampshire, and Rhode Island, among other states, have passed laws which require coverage for mental illness services to be on par with services for physical health. Several other states are considering similar legislation (6).

Thus, up until the time the parity act goes into effect, a family with both physical and mental health insurance coverage in one policy can incur catastrophic costs associated with the mental illness of a family member. However, they will avoid financial hardship if a physical illness strikes. This is because the latter situation is more generously covered, while mental health coverage is typically subject to low annual and lifetime spending limits.

The Mental Health Parity Act takes an important step toward ending discriminatory coverage of mental health services. But it is only a first step. Under the act, even those insurers who offer both physical and mental health services can still impose other coverage limits on mental health benefits. These could include co-payment and other co-insurance requirements that are higher than those for physical health care as well as

treatment limits that restrict patient access to adequate mental health treatment (e.g., session limits) (7-9).

Members of the National Alliance for the Mentally Ill (NAMI) showed that health insurance coverage continues to be a source of much stress and inequity for people with mental illness in America. Health insurance is a lifeline for many people with mental illness, as expensive medications and numerous visits to doctors are commonly needed to manage the illness.

A web-based survey of visitors to the NAMI website in August 2003 confirms that private health insurance coverage is critically important to many people living with a serious mental illness (10). Out of 50% people who responded to questions on health insurance, 57% were individuals with a mental illness and 36% were family members or friends of sufferers. The majority, 56%, were covered by private health insurance provided through an employer, either part- or fully-paid, and an additional 18% had self-paid private health insurance. Almost one in five respondents had no insurance at all (11).

Although most of the respondents had private health insurance, the survey data reveals major problems with this industry. One quarter of respondents said they, or their loved one, had been denied private health insurance because of a mental illness, and of those that had private health insurance, only 17% said that it adequately covered the cost of mental health treatment. Disturbingly, 25% of respondents also said that they had been deterred from employment or moved to public health insurance programmes, such as Medicaid, because of the lack of private health insurance coverage for mental illness treatment. Clearly discrimination in the field of private health insurance is a major problem within this nation's troubled mental health system. Advocacy organisations such as Mental Health America and the National Alliance for the Mentally Ill, along with direct-to-consumer marketing and improved access to information through the Internet, have all contributed greatly to the public's heightened awareness of mental illness and its understanding that mental disorders are not a flaw in the person who has them, or indeed their fault. According to supporters, the newly proposed Mental Health Parity Act of 2007 is far from perfect, but its passage would mark an important milestone in the struggle to provide equitable coverage of mental illness and substance abuse treatment. Enactment would force health plans to eliminate the use of barriers to care and extend parity to deductibles, out-of-pocket expenses, co-payments, co-insurance, hospital stays and outpatient visits.

Studies show that mental health parity, when combined with managed care, improves benefits without increasing total costs (12-13).

A new study examining health benefits for federal employees demonstrates that providing insurance coverage for <u>mental illness</u> equal to that provided for physical illness does not drive up the cost of mental health care as many insurers feared. The new study of those changes, published in *The New England Journal of Medicine* concludes that if mental health care is properly managed, expanding the coverage for it "can improve insurance protection without increasing total costs" beyond those paid by insurers that do not offer parity (14). Whilst providing equal coverage for treatment of mental disorders did not increase the use of mental health services under the federal employee programme, it did lead to "significant reductions in out-of-pocket spending" for many government workers and retirees.

## Canada

Canada's public health insurance system fully covers medically necessary hospital and physician services, but it does not cover community-based non-physician mental health provider services or prescription drugs (15-16). It has been found that having private supplemental insurance significantly increases the odds of using medications for mental illness, with particularly large increases for anti-psychotic and mood-stabiliser medications.

## United Kingdom

Insurance for mental illness is covered by the Disability Discrimination Act (DDA) 1995. This Act makes it illegal to provide goods, facilities and services to a disabled person (including people with mental health problems) on terms which are unjustifiably different from those given to other people. Since 1990, the DDA has made it illegal to refuse insurance or charge higher premiums unless the company can demonstrate statistically higher risks as a direct result of a specific mental health condition (17). When deciding whether to insure someone, an insurance company should carry out a risk assessment which should include a statistical analysis examining whether the person presents "a higher than average risk". In order to assess risk, insurers should ask a number of questions about one's history of mental illness. Health problems, which tend to recur, may present difficulties. If there is discrimination based on a mental health

problem, the case can be taken to the County Court under the Disability Discrimination Act 1995.

## Australia

Private health insurance is different with most other types of insurance offered in Australia in that it is community rated, not risk rated. This means that a person 'should not be discriminated against in obtaining or retaining insurance coverage'. That is, 'in setting premiums or paying benefits, funds cannot discriminate on the basis of health status, age, race, gender, sexual orientation, religious belief, use of hospital, medical or ancillary services or claiming history'. Funds must accept all applicants within certain membership categories (18-20). In principle, this means that 'private health insurance policies (and premiums) are the same for people who need mental health care as for those needing any other type of health care. In reality however, people with mental illness, or even people with an incidence of mental illness in their family history, are frequently refused insurance products such as life insurance, health insurance, and travel insurance.

## South Africa

**Health care discrimination against the mentally ill is very common** in South Africa. The Bill of Rights of the Republic of South Africa specifies people with disability as one of the groups that may not be discriminated against. It goes on to state 'National legislation must be enacted to prevent or prohibit unfair discrimination.' Psychiatric disorders are included among these disabilities. Section 10(1) of the recently approved Mental Health Care Act of South Africa states: "A mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status" (21). Despite these legal safeguards, discriminatory practices continue unabated. Despite the emphasis in the constitution on equality, private healthcare providers in South Africa do not provide adequate benefits for the treatment of mental disorders. Health professionals, in conjunction with consumer advocacy groups, are required to address this issue as an issue of utmost priority.

## India

The World Health Organisation (WHO) reports that 450 million people worldwide are affected by mental, neurological or behavioural problems at any time (22). Furthermore, according to WHO, most middle and low-income countries devote less than 1% of their health expenditure to mental

health. Consequently, mental health policies, legislation, community care facilities, and treatments for people with mental illness are not given the priority they deserve. Barriers to effective treatment of mental illness include the lack of recognition of the seriousness of mental illness and the lack of understanding about the benefits of services. Policy makers, insurance companies, health and labour policies, and the public at large – all discriminate between physical and mental problems. The Disability Rights movements in India have achieved laudable aims on various fronts, but their greatest drawback has been a neglect of the rights of persons with mental illness.

The Government of India has passed two acts, the Mental Health Act 1982 and the Persons with Disability Act 1995 in order to protect rights of persons with mental illness, thus theoretically, at least, mainstreaming these people into society (23 -24). Notably, mental illness is formally recognised as a disability according to Section 2 of the PWD (Persons with Disability Act 1995). However, persons with mental illness are still not treated as disabled persons as per this definition, not having benefited by social security benefits like concessions, educational scholarships etc. as compared to other groups of disabled people (25).

In India, there is no insurance for mentally ill people. There are many private insurance companies offering health insurance. However, in addition to the 'General Exclusions' listed in the policies they offer, these insurance companies do not cover mental, nervous or emotional disorders or rest cures.

One important barrier to this changing in India is widespread discrimination against the mentally ill. For example, Insurance schemes do not recognise the parity between physical and mental illness and reimburse expenses for the former, not the latter. The problem is huge in a country of this size. India needs more public awareness and collaboration among politicians, policy makers, NGOs working in health and the disability sectors, and advocacy groups if we wish to ensure that the mentally ill are not sidelined by discriminatory insurance policies. Only then will there be some hope of realistically protecting the human rights of persons with mental illness in this country.

## Counter point

Controversially, others have conversely argued that there are two significant ways in which mental illnesses are NOT like other illnesses. The first is

that mental illness is not an illness at all. Mental health supporters have yet to produce a scintilla of scientific evidence that ANY mental illness is biologically determined. Psychiatrists have not conclusively proven that any mental illness is, in fact, a chemical imbalance of the brain (the latest in a long line of psychiatric theories).

Unsurprisingly, psychiatrists have also been unable to produce a single physical test, which can definitively detect any mental illness (26). People who have been diagnosed with a mental illness have either not been physically tested or their physical tests have shown they are in fact healthy according to every bodily test known to modern medicine, thereby proving there is no physical basis for their illness.

The second problem is that psychiatrists are the only medical doctors whose practice rests on the use of force on unwilling "patients." While psychiatrists regularly hospitalise mental patients and treat them against their will, no other doctors do this. And the use of force in psychiatry has been increasing, not decreasing. More people are involuntarily committed now than 50 years ago, and many released patients are forced to take psychiatric drugs for years on end. But while this may be an issue for the profession of psychiatry, it does not change the discrimination against the mentally ill found in societies across the globe.

## Conclusion

It is well-known that people with mental illness, or even people with an incidence of mental illness in their family history, are frequently refused insurance products such as life insurance, health insurance, and travel insurance. Compared with the general population, individuals with mental health problems experience exclusion in their health insurance status.

Insurance companies have found that paying for pills is both cheaper and simpler than paying therapists to address the interpersonal causes of suffering - especially since general physicians are able to dispense most of the prescriptions normally required. Patient advocates have realised that defining mental illnesses as a brain disease has reduced the stigma attached to depression and psychoses - a patient can hardly be blamed for having an organic disease.

Discrimination in insurance for mental health services must end if the mentally ill are to receive truly fair and equitable health care. **Health care reformers would require insurers to provide equal treatment in**

**serious cases, as l**ack of insurance can be disastrous for families already burdened with attempting to deal with mental illnesses.

Without insurance, families can be torn apart in their attempts to access the needed mental health services, particularly for children. On the consumer's part, this is very much a civil rights movement, and because there are treatments that work, we know that recovery is possible and further, that it is possible to have a full life in the community.

Bringing together the difficulties around insurance and discriminatory notions of the mentally ill is the issue of rehabilitation. A common and deeply damaging view held by some of the general public and insurance companies is that there is no scope for rehabilitation for those suffering from diseases such as schizophrenia. Associated with this is the idea that rehabilitation begins - if at all - when medication stops: in fact, rehabilitation is part and parcel of treatment per se, thus beginning the moment that treatment does.

Insurance companies which refuse to offer coverage for mental illness in the first place are unlikely to consider covering for rehabilitation. However, mental health professionals are keen to stress that what is sought for the mentally ill is not charity, but a more inclusive and responsive approach which may, for example, cover acute hospitalisation as well as the kind of rehabilitation that is an integral part of the process of the mentally ill putting their lives back together. Even something as basic as a six month package covering rehabilitation - perhaps capped - would provide some financial and emotional relief for the families of the mentally ill in addition to helping the persons get back on their feet.

Unfortunately, the discrimination against the mentally ill found in sections of society and in the policy and practices of insurers is not restricted to these areas. The marginalisation of the mentally ill goes right to the top in terms of governmental organisation. Importantly, this colours the way that the human rights of the mentally ill are handled. On the one hand, The Ministry of Health sees itself as responsible solely for the medical management of mental illness. On the other, the Ministry of Social Justice and Empowerment governs rehabilitation. There remains a startling disparity and notable lack of dialogue between these two ministries. In the interests of the mentally ill and their families, cooperation between these two ministries is imperative to produce real change in the area of human rights and mental health care provision.

The ideal treatment plan should include both medication as well as a properly structured rehabilitation programme. What results instead is a compounding of the exclusion of the mentally ill from the arena of health care and the further infringement of their civil liberties. Human Rights bodies, along with the mental healthcare professions, need to be the torch bearers in initiating change. In fact dialogue should happen amongst the ministries, insurance companies and mental health professionals, to address this significant issue to ensure that those afflicted with these unfortunate illnesses are not further burdened by the economic exclusion. This is not simply to lobby for healthcare provision covered by insurance but also to ensure that we do not forget the human rights of those suffering from mental illness.

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# Women and children: mental health dimensions

## Kanchan Kumari

## Introduction

In any discussion on the mental health needs of women and children, the focus needs to shift from an individual view towards recognizing the broader social, economic, environmental and legal factors that can influence their lives and thereby affect their mental health. The first part of this chapter deals with the larger framework in which the mental health needs of women in our country needs to be understood and addressed. The latter part focuses on the mental health needs of children, an important but neglected area that has only recently been receiving somewhat greater attention.

## Women's Health

'Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination' (1). Sordid tales of apathy, neglect and indifference to women's woes are frequently encountered in daily newspapers. Issues of female infanticide, rape, dowry harassment, discrimination, and denial of their basic rights continue to be grave issues in Indian society, and all of these carry immense implications for the mental health of women.

## Women and mental health

Mental health is recognized globally as being of enormous social and public health importance. World over, more women than men, suffer from common mental disorders (2). Several mental health issues arise from social, psychological and physiological differences on account of gender and need specific attention (3). Gender based violence has far-reaching mental implications (4). Mental ill-health and its profound stigmatization carry with it a burden of human suffering that at times is not only incalculable, but incomprehensible to the non afflicted onlookers. The situation can be much worst if the affected person is a woman.

The critical gap between availability and accessibility of health care services, various social, legal and ethical issues need to be looked at in the care of mentally ill women. Recent research has demonstrated the impact of social circumstances upon women's private experiences and actions. Whether it is denial of economic resources, education, legal and health services deprivation, lack of physical and mental nurturance and exhaustion from overwork or sexual and other forms of physical and mental abuse across the life span, research corroborates that it is women who are at greatest risk. These issues not only fall within the fabric of human rights, but also are those which understandably affect mental health.

Mental illness among women and specific treatment needs have hardly been paid any attention in India. There are gender specific issues like mental illness in pregnancy, motherhood and pre- and postnatal care, co-morbidity, care and custody of children whose mothers have mental illness, trauma, domestic violence, sexual abuse, vulnerability, stigma and victimization in the context of mental illness which need attention (4, 5). In the Indian context, these issues are not even adequately discussed, let alone addressed. Homelessness is a well-known consequence as well as cause of mental illness and disability. For many women, homelessness follows years of violence and abuse which undermines their self esteem, contributes to the pain of powerlessness, and reinforces the social invisibility of their lives.

In addition, the routine of women's lives render them at risk to experience more stress than men. This is reflected by the greater number of social roles women fulfill as wife, mother, daughter, care-giver and as an employee. Furthermore, women's reproductive and nurturing role with respect to children produces unique potential for stress related effects. Thus, the well-documented higher morbidity in women's health across the life span has clear underlying biosocial causes. There is accumulating evidence that links mental disorders with poverty, powerlessness and alienation, alcohol consumption and domestic violence inflicted by their spouses and dowry harassment (4).

The magnitude of the problem and the implications warrants the urgent attention of all the service providers and policy makers. In India a "consciousness raising" exercise is now mandatory.

# The relationship between female illiteracy and mental health

The work on the national literacy mission in northern India demonstrates the association between female illiteracy and poor mental health (6). Women belonging to a rural community in Himachal Pradesh had significantly more symptoms of somatic disorders and anxiety than men, and this was strongly associated with the lack of education, poverty and low caste. A community psychiatric survey by Carstairs and Kapur (7) showed that women had higher rates of psychiatric symptoms and that higher levels of education had a positive effect on the well-being of both genders.

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### DALYs for women

The burden of disease and DALYs (Disability Adjusted Life Years) which have now been extensively studied show the importance of mental health of women in terms of role performance, productivity and health economics.

- For women, neuro-psychiatric conditions were the second leading cause of disease burden, following infections and parasitic diseases worldwide.

- For women between the age of 15 and 44 years, unipolar depression was the leading cause of disease burden in both developed and developing countries.

- Schizophrenia, bipolar disorder and obsessive–compulsive disorders also ranked in the top ten leading causes of disease burden for women aged 15–44 years.

- Projections till the year 2020 still foresee that the major impact of six mental disorders will overwhelmingly affect women in this age group. The ageing effect of this population will not change the profile of the impact of these disorders.

Source: Thara and Patel (8)

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# Women and Common Mental Disorders (CMDs)

There are a number of potential factors which increase vulnerability of women to common mental disorders (CMDs). In a population based cohort study in Goa in 2006 (9) an association was demonstrated between psychological distress and poverty, being married, using tobacco

and having gyneacological problems. The reproductive roles of women, such as her expected role of bearing children, the consequences of infertility and the failure to produce a male child, have been linked to wife battering and female suicide.

Furthermore, the negative effects of globalisation and economic reform on public health are likely to hit women harder than men; for example, since the economic reforms and subsequent crisis in Southeast Asia, there has been a rise in reported domestic violence and alcohol abuse. Indeed, 'it is not surprising that the health of so many women is compromised from time to time, rather, what is more surprising is that stress-related health problems do not affect more women' (10).

## Rehabilitation of women with mental illness

This throws up a number of challenges which are different from those concerned with men. It is not unusual that women brought for rehabilitation are more often accompanied by their parents than their spouses, even if they are married. These parents are often quite elderly and burdened by ill-health, as well as the additional stress of having to care for a mentally ill daughter and sometimes her children as well. Concern about early return to their family, lack of social support, side-effects of prescribed medication, particularly weight gain, amennorhoea and disturbances in lactation are specific problems that must be addressed in their treatment and rehabilitation.

## Future directions and suggestions

Women's mental health is increasingly recognised as a major public health concern, with a critical impact on the well-being of individuals, families and society. It is also recognised that this field is in its infancy, calling for more research and the development of policies and programmes consistent with the broader definitions of health.

The last two decades have witnessed a growth of self-help movements in women's groups, and some local groups have been outstanding in their efforts. Example of this is the spearheading of the anti-alcohol movement by women in the South Indian state of Andhra Pradesh. There is an urgency to strongly reinforce such movements in the community.  It is important to introduce measures that will strengthen self-esteem, enhance problem-solving abilities, and reinforce autonomy and assertiveness skills among women. It is equally important that clinicians are trained to be sensitive to

the mental health impact that various disorders and their interventions can produce.

Stigma and misconceptions about mental illness can be tackled only by extensive and intense public education efforts. While NGOs can do this in their limited catchment areas, it warrants a national effort by the government to initiate a suitable programme.

Policy planners also play a critical role, since any comprehensive strategy to improve the mental health of women necessitates coordinated action. This involves the improvement of policies and legislation, better access and availability of healthcare facilities, better health education and determination of safety at the places where women live and work. Enhanced gender sensitivity in all walks of life will certainly augur a better future for the mental health of women. Sensitisation of the police and law makers, legal reform, community based facilities and support for homeless mentally ill women in the governmental and non-governmental sector, greater participation of the private sector in the care of women with mental problems, access to benefits under the PWD Act for women with mental illness, special attention to childcare, inclusion for pension and disability allowance are specific needs. Care providers must be sensitive to the needs of women, particularly women with severe mental illnesses. There needs to be effective co-ordination between the Ministries of Health and Family Welfare, Social Justice and Empowerment, Women and Child Welfare, Law, Labour and Education. Stringent action needs to be taken against any human rights violation of women, particularly those with mental illness.

The role of civil society in bringing about attitudinal change and the crucial role of the media in ethical reporting and giving due priority to the subject is also very critical in the efforts to address mental health care issues for women.

## Children's Mental Health

It is never too early to consider children's mental health. Genetic factors, maternal ill health, birth complications, a non-nurturing environment can all need to serious mental health problems among children. While nutritious food, adequate shelter and sleep, exercise, timely immunization and a health living environment are important basics for a child's good physical health, basics for a child's good mental health includes unconditional love from the family, development of self-confidence and self esteem, opportunities

to interact and play with other children, encouraging teachers and supportive care takers, safe and secure surroundings and appropriate guidance and discipline (11).

## The global panorama

The global panorama suggests that children's rights have had a real set-back with many instances of violence against children, including corporal punishment, sexual abuse, exploitation, including child labour and involving children in armed conflict, illegal adoption and so on. Poverty (12) and additional problems like family disruption, social unrest, involvement in drug use, trafficking and criminality, all lead to poor mental health. Adverse factors in childhood including direct exposure to violence or even witnessing violence can lead to poor mental health later in life (4).

## Children and mental health problems in India

In India, children constitute 46% of the population and the country is home to nearly 19% of the world's children. Children thus represent an important constituent for mental health care.

Studies from the Indian Council of Medical Research show that the prevalence of diagnosable mental disorders is 12-13% among children in the community (13, 14). School studies show that more than 17% of school going male adolescents had psychosocial problems (15).

## Policies and programmes to promote mental health

Way back in 1977, the World Health Organization made recommendations to protect the mental health of children and subsequently in 2005 recommended health policies and plans for child and adolescent mental health (16). The United Nations Convention on the Rights of the Child (17), often referred to as CRC or UNCRC, is an international convention setting out the civil, political, economic, social and cultural rights of children. Mental health rights are integral to these rights. A recent article, however, argues that rights also need to be accompanied by responsibilities, and that non-western cultures focus on duty, responsibility and a community orientation to promote psychiatric well being (18).

## Developments in India

With regard to socially disadvantaged and disabled children there have

been several initiatives in both the government and non-governmental sectors. Preventing child labour, addressing the needs of street children, children of parents with HIV/AIDS, children with physical and developmental disability are issues that have been receiving relatively more attention in recent times. Children's help lines have been set up in some parts of the country. The system of Integrated Child Development Services (ICDS) which is poised for universal coverage has played a pivotal role for mother and child development in rural, urban and tribal areas. Non-formal education component and early childhood stimulation through play way activities help to lay down firm physical, mental and psychological development foundation (19). In a way, the institution of anganwadis has been recognized as a sheet anchor in personality development of young children. Structured programmes for mental health in Indian schools and life skills programmes have been developed (20, 21). An Indian Association for Child and Adolescent Mental Health (IACAM) has been in existence since 1991 (22).

## Needs for the future

"Children are our future. Through well conceived policy and planning, governments can promote the mental health of children, for the benefit of the child, the family, the community and society" (16). Although children's mental health has received some attention in the last few decades, it is still far from being a reality. Changing life situations and lifestyles bring newer problems like addictions to the forefront. From the existing governmental policies and national programmes for children, the wide gap between children's mental health needs and existing resources is evident. There is neither an independent nor integrated child mental health policy in India. It is crucial to develop a comprehensive policy to cover all aspects of children's mental health (23, 24).

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# Human rights and disaster: psychosocial support and mental health services

K. Sekar

## Introduction

Disasters expose normal populations to severe threats to life and to a series of traumatic losses. The effects of any disaster will be long lasting and the resulting trauma can reverberate even among those not directly affected by it. India, which supports one-sixth of the world's population on just 2% of its landmass, suffers heavily from natural disasters of every description that hit the poorest of the poor. Twelve percent of the land area in our country is vulnerable to floods, 8% to cyclones, 59% to earthquakes and 28% to drought (1). Of the 35 States and Union Territories, as many as 27 are prone to disasters, which very well explains the disaster profile and the extent of impact of disasters in India. Thus India can be called a 'theatre of disasters' (2) as almost all types of disaster that include natural disasters like earthquake, cyclone, floods, landslides, tsunami, drought etc. and man made disasters like gas, fire tragedy, communal riots, bomb blasts, rail, road, air crashes and terrorist activities have hit India at different points of time.

The World Bank Report 2006 (3) estimates that during the last 40 years the number of global disasters has increased 15-fold. Over the last quarter century, the number of reported natural disasters and their impact on human and economic development worldwide has been increasing yearly. In the year 2005 alone, the earthquake and tsunami in the Indian Ocean killed an estimated 220,000 people and left 1.5 million people homeless. Today 85% of the people exposed to earthquakes, tropical cyclones, floods and droughts live in countries having either medium or low human development. There has been an increase in the number of natural disasters in recent years.. Urbanisation and population growth, with increasing population density mean that the impact of natural disasters is now felt to a larger extent, with greater human and economic losses. According to the World

Disaster Report 2005 by Red Cross and Red Crescent (4) between1995 and 2004, 5989 reported disasters killed 901,177 people and affected over 2.5 billion people, causing at least US $ 738 billion in damage. This compares to 643,418 reported killed and 1.74 billion reported affected by disasters from 1985 to 1994. Over the decade, 51 people died per natural disaster in countries of high human development, compared to 573 deaths per event in countries of low human development. In developing countries like India, Bangladesh and China disasters (mainly due to floods) affected 146 million people and inflicted estimated damage of US $ 100-145 billion.

## Impact of disaster

The impact of disasters on any community depends on its level of vulnerability (5). The impact of any disaster can be classified as physical, social, emotional, and economic (6).

| Physical impact | Social impact |
| --- | --- |
| Cough, cold, fever, headache, tiredness | Damage of living structure |
| Injuries due to stabbing, bullet, sharp objects | Displacement in camps |
| Broken limbs, severed body parts | Loss of privacy |
| Premature deliveries among women | Family structural changes |
| Problem in childbirth | Women widowed |
| Loss of weight among children | Children orphaned |
| Stomach-aches, diarrhea, body aches | Single parent children |
| Burns (heat, acid, gas bombs) | Eroded social support system |
| Physical impairments (limbs, sight, voice, hearing) | Disruption of normal routines |
| Epidemics in camps | Increased domestic violence |
| Skin allergies | Loss of family member |

| Bowel, bladder problems | Compensation |
|---|---|
| Increased alcohol use | Discontinuation of education |
| Increased tobacco consumption | Corruption |
| Increased health system use | Human rights violations |

| Emotional Impact | Economic Impact |
|---|---|
| Anxious feeling | Loss of property |
| Avoidance behaviours | Loss of work |
| Crying | Lack of basic raw material supplies |
| Frustration | Loss of primary livelihood |
| Fear of recurrence | Loss of secondary and allied livelihood |
| Grief | Inundated agricultural land – crop failure |
| Helplessness | Loss of equipment due to disaster |
| Hopelessness | Increased salinity of agricultural land |
| Hyper vigilance | Loss of capital seeds / fertilizers |
| Inability to regain confidence | Loss of livestock |
| Intrusion | Loss of personal belongings and savings |
| Sadness | Loss of household goods |
| Sleeplessness | Increased health care cost |
| Sexual desires decreased | Inadequate compensation |
| Suicidal feelings | More frequent occupational dysfunction |

An important social issue in disaster is Human Rights. Human Rights violations are pervasive in most emergencies. Many of the defining features of emergencies – displacement, breakdown in family and social structures, lack of humanitarian access, erosion of traditional value systems, a culture of violence, weak governance, absence of accountability and a lack of access to health services – entail violations of human rights. The disregard

of international human rights standards is often among the root causes and consequences of armed conflict. Also, human rights violations and poor governance can exacerbate the impact of natural and human made disasters. It is imperative to understand the need for human rights in disaster situations.

## Development of human rights

Before getting into the details of the human rights in disaster situation it is very useful to understand the evolution of laws and conventions with respect to human rights around the world.

The 1945 UN Charter (7) can be seen as the 'Constitution' of the United Nations, that is the wider legal framework that establishes its basic functions and principles. At the time, the Charter laid down the fundamental pillars upon which to build the post-war world order: international peace and security, international development and co-operation, protection and respect for human rights and the rule of law.

By proclaiming the promotion and protection of human rights as one of its central purposes [article 1(3)], the UN Charter paved the way for the development and consolidation of human rights as internationally recognised legal rights. The Charter imposes a number of legal duties on member states, including the promotion of human rights (articles 55 and 56). The specification of those rights and obligations was left to subsequent declarations and treaties (7).

Less than four years later, in December 1948, the first step towards such a specification was taken: a (UDHR) was adopted. Although lacking binding force, the 1948 Universal Declaration (8) represents a decisive landmark in the struggle for human dignity. The Universal Declaration has become "the basic international code of conduct by which performance in promoting and protecting human rights is to be measured".

The Declaration does not establish any difference in value or importance between economic, social and cultural rights, on the one hand, and civil and political liberties, on the other. They are granted the same degree of protection.

It is worth noting that UDHR, as Robertson (9) argues, was not formulated as a legal guarantee. It had no binding legal force. In addition, no enforcement mechanism was then instituted for the protection of

international human rights. Yet its enormous value is undeniable. Its influence in the later development of the human rights system has been extraordinary, inspiring numerous contemporary Constitutions, international treaties and court decisions, both international and national.

The Universal Declaration of Human Rights adopted by the General Assembly on 10th December, 1948, was followed by two Covenants – International Convention on Economic, Social and Cultural Rights (ICESCR) (10) and International Convention on Civil and Political Rights (ICCPR) in 1966 (11).

## International instruments addressing specific human rights concerns

The international 'human rights' system has continued to expand. The following is a brief description of some of the most relevant international legal instruments.

Convention on the Prevention and Punishment of the Crime of Genocide

This treaty (1948) envisaged the establishment of an international criminal court to punish genocide. The Convention imposes a basic duty on the states parties "to prevent and to punish genocide", and contemplates both individual criminal responsibility and State responsibility. According to the International Court of Justice, the principles that underlie the Genocide Convention have become part of customary international law (binding on all states) (12).

## International Convention on the Elimination of All Forms of Racial Discrimination (1959)

It came to define and condemn racial discrimination. Under this Convention, the State parties and their organs assume the following duties:

- to **condemn** racial discrimination and to **implement** policies aimed to eliminate racial discrimination, while encouraging integration among all races (article 2);

- to **declare punishable** by law certain offences concerning racism and racial discrimination, such as racist propaganda (article 4);

- to **adopt** immediate and effective policy measures, in the field of teaching, education, culture and information (article 7). (13)

In the course of the United Nations Decade for Women (1976-1985), the Convention on the Elimination of All Forms of Discrimination against Women (1979) (14) was adopted and entered into force (1981).

## Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

In 1987 the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (15) entered into force. Torture and other inhuman or degrading treatments had been already contemplated in a number of universal and regional human rights instruments (e.g. article 5 of the Universal Declaration; article 7 of the Covenant on Civil and Political Rights; European Convention and American Convention; and the African Charter.

**Convention on the Rights of the Child – CRC - (1990)** has been almost universally ratified. The Convention incorporates an exhaustive catalogue of human rights to which children are entitled (16). The legal system for the protection of children's rights rests upon the following fundamental principles:

**Non-discrimination:** Every child no matter what race, creed or religion may be, come under the protection of the Convention20 (article 2).

Based on the recognition of children's inherent human value, the **best interests of the child** will be a primary consideration in all legal, administrative or social policy actions concerning children (article 3).

**Participation:** Under article 12, the opinion and views of the child should be heard and taken into account in all those situations where it is possible.

## European system of human rights

One of the most remarkable achievements of the European system of human rights has been the establishment of an effective enforcement machinery. It comprises two institutions: the European Court of Human Rights (ECHR) and the European Commission of Human Rights (the Commission). Other regional instruments adopted under the European system of human rights are the European Convention for the Prevention

of Torture (1987) (17) and the Framework Convention for the Protection of National Minorities (1995) (18).

## American Convention on Human Rights

The ACHR entered into force in 1978 (19), within the framework of the Organization of American States (OAS). It is worth mentioning that, together with a detailed list of civil and political rights, the American Convention on Human Rights includes the right to participate in government (article 23). Unlike the European Convention, the ACHR incorporates a number of economic, social and cultural rights (articles 26 to 42). The Inter-American Commission on Human Rights' mandate includes the promotion and protection of human rights in all OAS member states. Besides its supervisory role, the Commission has three main functions: a) to process individual complaints, b) to prepare reports, and c) to propose measures to ensure respect for human rights in the region. The main function of the Inter-American Court of Human Rights is to apply and interpret the provisions of the American Convention of Human Rights.

## African Charter on Human and Peoples' Rights

**ACHPR** which entered into force in 1986 (20), was to place particular emphasis on African tradition and the peoples' rights to development. Except Ethiopia and Eritrea, the African Charter has been ratified by all the OAU member states. On paper, the African Charter is highly progressive. It includes a vast list of rights, both individual and collective. The Charter covers not only the traditional civil, political, economic, social and cultural rights, but also a number of rights considered as part of the so-called third generation of human rights (e.g. rights to development and to a satisfactory environment).

## National Human Rights Commission in India

The National Human Rights Commission was established on 12th October, 1993 (21) under the legislative mandate of the Protection of Human Rights Act, 1993 (22). Over the years the Commission has endeavored to give a positive meaning and a content to the objectives set out in the Protection of Human Rights Act, 1993. It has moved vigorously and effectively to use the opportunities provided to it by the Act to promote and protect human rights in the country. While undertaking the tasks set

out in the Protection of Human Rights Act, 1993, the Commission has noticed several lacunae in the Act over the years.

The Commission's purview covers the entire range of civil and political, as well as economic, social and cultural rights. Areas facing terrorism and insurgency, custodial death, rape and torture, reform of the police, prisons, and other institutions such as juvenile homes, mental hospitals and shelters for women have been given special attention. The Commission has urged the provision of primary health facilities to ensure maternal and child welfare essential to a life with dignity, basic needs such as drinking water, food and nutrition, and highlighted fundamental questions of equity and justice to the less privileged, namely the Scheduled Castes and Scheduled Tribes and the prevention of atrocities perpetrated against them. Rights of the disabled, access to public services by disabled, displacement of population and especially of tribals by mega projects, food scarcity and allegation of death by starvation, rights of the child, rights of women subjected to violence, sexual harassment and discrimination, and rights of minorities, have been the focus of the Commission's action on numerous occasions.

Despite the initiatives to improve human rights over decades, the actual practice of the human rights worldwide as well as in India is still under criticism. It is very important to understand that it took almost six decades to institutionalise conventions on Human Rights and bring all the Nations together to act upon the conventions. The effective practice of the Human Rights conventions would be definitely possible as the Human Rights Commissions are becoming more focused. In this context, it is the right time to discuss about the Human Rights and Disasters in the Indian context.

## NHRC directives on human rights and disasters

The National Human Rights Commission has been proactive in providing various directives to the State and other Departments with regard to the human rights violations for survivors of disaster (21).

## Orissa super cyclone

Subsequent to the Orissa Super Cyclone **(1999)**, the commission has been able to look into the human rights violations such as equal dispensation of compensation, identification of the special groups like widows, orphan children, senior citizens, welfare measures and long-term

rehabilitation issues. The commission was able express its concerns or directions (*suo moto* cognisance) as follows:

The Commission requested its special representative, stationed at Bhubaneswar, to keep a watch on the system of dispensation of relief measures to the affected people. The Commission also deputed its Secretary General and Special Rapporteur to visit the affected areas and interact with the concerned senior government officials.

It directed that:

- the State Government should complete the enumeration of the casualties and publish a list in each Gram Panchayat area so as to correctly identify the dead, provide the right compensation and assistance to the survivors, and secure the rights of those below the poverty line

- the Food for Work Programme should be organised to provide wages in terms of grains (rice) through a special dispensation system

- special feeding centres should be organised for those who are old or incapable of physical work

- district-wise census must be undertaken to get correct information on all widows and senior citizens rendered destitute on account of the death of earning members of their families and to provide welfare measures to this category.   enumeration of children who have become orphans

- publicise through the media the entitlement to various forms of relief and compensation decided by the Government.

Twelve ICDS schemes were sanctioned to cater to the needs of children.

The Commission directed that the rehabilitation work must be based on an action plan with clearly indicated financial implications and that a white paper on the same should be published in order to inform and educate the affected citizens of their rights to relief of different kinds.

NHRC proposed to closely monitor the long-term rehabilitation programme, specifically looking at relief in the categories of orphaned children, destitute women and senior citizens, Scheduled Castes, Scheduled Tribes and other marginalised sections. The Commission had

directed the State Government to associate its Special Rapporteur in a State level monitoring committee to monitor, on behalf of NHRC, the progress of the work being done.

## Gujarat earthquake

NHRC issued directions to the Government to protect the human rights of the weaker and deprived sections of the society. These included directions that the State Government should hasten the progress of rehabilitation work and ensure that, before the monsoon breaks, temporary shelters are provided to all quake-affected people. It should complete enumeration of orphan children, destitute women, elder citizens and draw up an action plan for providing relief and rehabilitation, taking special care of those belonging to the marginalised section of society. The Government was also directed to ensure that a mechanism was set up by which the case of each orphaned child was monitored on a long-term basis and officials were sensitised to prevent any kind of exploitation of the children. It suggested that any policy providing for adoption should take into consideration the revised Guidelines for Adoption of Indian Children, 1995 (23), as laid down by the Supreme Court, seek advice and assistance of the Central Adoption Resource Agency and be sensitive to the communities' views on adoption of children.

Directions were issued that there should be no discrimination against any section of the population while providing relief and rehabilitation assistance. The Commission suggested that Government should come forward with a plan of long-term relief and rehabilitation for those orthopaedically affected, with special reference to amputees and those suffering from partial/permanent incapacitation. Government was also asked to empower an officer stationed at Bhuj with sufficient powers to sort out the problems of the affected people at the district level itself, thus ensuring expeditious redressal of grievances and an increase in the credibility of performance.

The Government was also directed to review the building by-laws, update them and ensure their proper implementation. The Commission recommended to the State Government to issue family identity cards to ensure that assistance goes to the right people; associate NGOs, prominent citizens, philanthropic organizations in a formalized cooperation in each affected area and in each Taluk of the affected districts. A plan to set up HAM Radio Clubs in schools/colleges in the quake/ cyclone prone

areas of the State was to be formulated to have a better communication system in case of a major calamity.

In order to monitor closely the follow-up action being taken by the Gujarat Government to implement its directions and to act upon its recommendations, the Commission setup a monitoring group. The monitoring group reported periodically to the NHRC on the level of compliance of its directions; any case of discrimination based on caste, community and religion; grievances of the affected population and transparency or lack of it in action and free-flow of information to affected persons and agencies involved in rehabilitation work. The commission was given powers to necessary action and intervention, if necessary, in redressing the complaints of violation of human rights in accordance with the provisions of section

## Gujarat Communal Riots

The State functionaries of Gujarat were accused of abetting and facilitating atrocities on the minority in the wake of the Godhra violence in 2002. The Commission visited the affected area. It made many recommendations to the State Government and thereafter continuously monitored the progress of measures taken by the State for the relief and rehabilitation of the riot-affected persons

In 2003, the Commission filed a Special Leave Petition in the Supreme Court of India under Article 136 of the Constitution of India to enforce "the right of fair trial" for all and a petition for transfer of 9 serious cases for trial outside the State of Gujarat was also filed. All this was done to instill a sense of security in the people and to encourage faith in the constitutional machinery.

In 2007, NHRC requested the Government to conduct a CBI enquiry. It directed that the Gujarat government should communicate its consent for CBI investigation of the authenticity of the tapes and the allegations made therein to the Central government and the Commission within two weeks in November 2007.

## Torture of Tribals in the JSTF Karnataka and Tamil Nadu operations

In 1993 the Joint Special Task Force (JSTF) was set up by the states of Karnataka and Tamil Nadu as a part of a concerted law enforcement effort

aimed at eliminating the smuggling network headed by forest brigand Veerappan. Atrocities and human rights abuses began almost immediately as a part of the systematic JSTF strategy intended to terrorize and intimidate the villagers living on the periphery of the reserve forest along the border of the two states. The STF's functioning and behaviour with the forest dwellers while in pursuit of the smuggler has been dogged with controversy. Following allegations of human rights violations, the NHRC set up a commission of enquiry on June 28, 1999, to enquire into the alleged human rights violations. The panel had recorded the deposition of 192 victims as well as 28 JSTF officers. Apart from these, depositions of the representatives from organisations, doctors and jail authorities were taken into consideration. The Committee submitted its report in 2003. The Justice Sadashiva committee recommended compensation for the victims of JSTF. This was one of the important initiatives taken by NHRC in tackling human rights violations in human made disasters.

## South India Tsunami

Following the tsunami (2004), the NHRC issued notices to all State and Central government machineries involved in rehabilitation to:

- ensure all necessary steps for an equitable distribution of both relief as well as rehabilitation measures while maintaining transparency

- ensure that the poor, destitute women, destitute children and all persons, who would be in greater need of the relief and rehabilitation measures, are not deprived or made to suffer and are well taken care of

- prepare and publicise a computerised list of persons, dead or missing, because of the disaster as also list of the properties, which were totally/partially destroyed or damaged in the disaster. Such authentic list would help in smooth settlement of Insurance and other claims of the victims and expedite the rehabilitation process and also help the families to trace the missing persons.

- Children and widows should be protected against sexual exploitation, Government should prepare computerised list of such persons.

## Jammu & Kashmir

In November 1993, the Commission, suo moto, took cognizance of press reports about the death of about 60 persons in and around Bijbehara in Jammu & Kashmir, as a result of firing by security forces operating in the areas and called for reports from the Ministries of Defence and Home Affairs as also the Government of J&K. Payment was recommended of interim compensation on a graded scale.

It was recommended that a thorough review be undertaken by Government of the circumstances and conditions in which units of the Border Security Force are deployed and expected to operate in situations involving only civilian population. These were communicated to the Central Government and the Commission has since been informed that the recommendations made by it have been accepted.

## Psychosocial care and mental health services in disaster

The National Institute of Mental Health and Neuro Sciences (NIMHANS) is a pioneering centre for service, training and research in mental health. Over the last two and a half decades, there has been an extra emphasis in the area of disaster management and psychosocial care (24). NIMHANS has been at the forefront in systematically studying psychological consequences of disasters and interventions since 1981.

The first disaster that NIMHANS responded to was the Bangalore circus tragedy that occurred on 7th Feb, 1981 (25). A community-based approach of providing psychosocial care for the families by mental health professionals was initiated. During the major chemical disaster that occurred in December 1984 in the Union Carbide factory at Bhopal, mental health needs assessment of the population was carried out and followed by setting up a comprehensive community based mental health care through medical officers of health (26). This was needed, as there were no mental health professionals available at that time in Bhopal.

Apart from its interventions in these two man-made disasters, NIMHANS got involved in the Marathwada earthquake relief effort in 1993. The institute not only addressed the emotional impact, but also influenced the planners and professionals in providing mental health care as part of disaster relief, rehabilitation and reconstruction activities. A decade later, follow-up of the affected population pointed out that one out of four survivors still had

psychological distress and impact from the event (27). The Gujarat cyclone (1998) and the Orissa super cyclone (1999) saw the development and emergence of a formalised psychosocial care programme with the community level workers from the affected areas providing the essential services to the general population in the initial phases of relief and rehabilitation. This was followed by intensive provision of psychosocial care along with other rehabilitation and rebuilding activities especially for widowed women, orphaned children and the uncared-for elderly. NIMHANS was one of the major agencies that carried out the training of the community level workers (28-32) and provided them continuous support through follow-up. An evaluation of the psychosocial interventions was carried out at the end of thirty months which revealed that the populations in whom the interventions had been carried out had lesser distress and disability and a better quality of life (33).

A further expansion of psychosocial care activities through a large number of NGOs and varied populations occurred in the aftermath of the Gujarat earthquake in 2001 through the joint activities of the Government of Gujarat education sector, NIMHANS, UNICEF and Gujarat State Mental Health Authority to address the issues of school children (34), widowed women and paraplegics. Following the Gujarat riots a year later, NIMHANS scaled up the psychosocial care activities with a larger number of organisations. Psychosocial care was provided in a systematic manner right through the phases of relief, rehabilitation and rebuilding (35-37). Various studies conducted during these disasters revealed that the populations that had received psychosocial care fared better in the long term as compared to the populations without such interventions(38).

In the aftermath of the Tsunami (December 2004), NIMHANS responded instantly and nearly 50 professionals were deployed in provision of immediate emotional first aid and emergency mental health care in the affected states. Intensive training programmes (39) were held over the next few months with the community level workers (40-43) and various other NGO personnel and volunteers.

NIMHANS has identified support to survivors of disasters as a priority area. Over the last two and a half decades, the institute has systematically developed resource material for psychosocial care and sensitised various stakeholders about its importance. Currently psychosocial care for survivors of disasters is an accepted module in terms of healing of the minds both at micro level and macro level. Based on these experiences,

the Government of India has designated NIMHANS as the nodal centre for psychosocial care in disasters for the country. In terms of human rights in disasters NIMHANS emphasises the rights of the individual to a spectrum of care including housing, paralegal aid, compensation, health care, psychosocial care, education and dignity in living. The community level helpers are provided with capacities not only to deal with psychosocial issues, but also to be sensitive to human emotions and the feelings of human being when they are severely distressed due to the consequences of the disaster. Psychosocial intervention therefore is not only some thing which is good to do, rather it is something which is essential to do. From the human rights point of view, psychosocial care is one of the basic rights of the disaster survivors, to live with dignity and receive empathy from others. Therefore stress is laid on the ethical aspects of psychosocial care that are needed to maintain the sanctity of a psychosocial care programme. Care is taken to balance the demands on the rehabilitation workers and their own personal and professional stress. Considering the complex situation of disaster intervention work, ethical issues must be maintained to take care of the survivors and also look after oneself.

## National Policies and Human Rights

As part of psychosocial care in disaster management, it is also essential to look at the available policy documents addressing psychosocial issues at the national and international level. In the last two decades there has been major concentration on psychosocial care for disaster survivors. Simultaneously, various policy initiatives are visible at different levels. Policy documents have covered both man made and natural disaster situations. The National Health Policy (2002) (44) reiterates the need for an adequately robust disaster management plan in place to effectively cope with situations arising from natural and man made calamities. The National Disaster Management Act (2005) (45) under section 12 directs that the National Authority shall recommend guidelines for minimum standards of relief to be provide to persons affected by disaster, which shall include (i) the minimum requirements to be provided in relief camps in relation to shelter, food, drinking water, medical cover and sanitations; (ii) the special provisions to be made for widows and orphans; (iii) *ex gratia* assistance on account of loss of life as also assistance on account of damage to houses and for restoration of means of livelihood; (iv) such other relief as may be necessary. Section 38 k reiterates the provision of rehabilitation and reconstruction assistance to victims of any disaster situation or disaster. Section 61 outlines that while providing compensation and relief

to the victims of the disaster, there shall be no discrimination on the ground of sex, caste, community, decent or religion.

The Human Rights initiatives by National Disaster Management Authority include development of the National Disaster Management Guidelines on Medical Preparedness and Mass Casualty Management which was released in October 2007 (46). The guideline places emphasis on basic human rights in the provision of health care management prior to, during, and after disasters. The guideline also takes into consideration the psycho-social and economic impact and the need for psychosocial support and humane treatment to the survivors. The Authority has also finalised the draft version of the National Disaster Management Guidelines on Psychosocial Support and Mental Health Services (PSS MHS)(47). This draft guideline section 6 on implementation of the guideline for PSS MHS under the legal and institutional framework lays emphasis on an '*all-hazard focus and shall be considered as a matter of basic human rights*'.

The broad areas of actions for preparedness for disaster PSS MHS at the national and State levels shall include "developing, monitoring and evaluation procedures to ensure quality control and issues related to ethics and human rights during disaster management"

## Post-disaster period community practices

The guideline lays importance on certain community practices that are clearly harmful to the mental health and PSS of people (not giving medicines to a diagnosed mentally ill) or violate human rights (like chaining or restricting personnel freedom, gross gender discrimination). Such practices should be reported immediately to senior persons for appropriate intervention in a tactful non confrontational manner

Further under the interface of service delivery and research the guideline seeks to ensure quality services as per the needs of the affected groups in the community. There has to be a silent convergence of research and service deliveries, which have to be thoroughly mingled in such a way that it does not interfere with the human rights of the affected population.

Finally Section 5.11.1 primarily deals with the dimension of human rights needs to be taken care of during preparedness, mitigation, response, relief, recovery, rehabilitation and reconstruction phases of disaster management at a macro level, while some extra precautionary measures should be taken

during the planning of PSS MHS and its implementation. The human right issues of high risk groups are critical during the post-disaster phase.

## International initiatives on Human Rights and Disaster

The World Health Organisation document on Mental Health in Emergencies brought out in 2003 (48) outlines the general principles in responding to the emergencies:

**Preparation before the emergency:** This focuses on the preparedness aspects in terms of developing coordinated systems, training of the relevant personnel on psychological and social intervention for dealing with any emergency situation.

**Assessment:** The assessment has to be in the local cultural context and with adequate qualitative information on needs and local available resources.

**Collaboration:** Adequate collaboration with government and other non-government agencies is very crucial for psychosocial care.

**Integration into primary health care:** Mental health interventions should be carried out within general primary health care and should maximise care by active use of resources within the families and the community.

**Access to service to all:** The service should be for the whole community and separate vertical mental health services for special population are discouraged. It also focuses on the awareness programme to ensure the treatment of vulnerable or minority groups within PHC.

**Training and supervision:** Training and supervision activities should be conducted by mental health specialists or under their guidance, with allocation of sufficient amount of time to ensure lasting effects of training and responsible care.

**Long-term perspective:** In the aftermath of a population's exposure to severe stressors, it is preferable to focus on medium- and long-term development of community-based and primary health care services and social interventions rather than to focus in immediate short-term relief of psychological distress during the acute phase of an emergency.

**Monitoring indicators:** Activities should be monitored based on the predetermined indicators.

Some of the International NGOs had taken the initiative to formulate guidelines on Human Rights in Disaster based on various conventions of Human rights. Though it is not legally required to be followed in disaster situations, they clearly point out the standards and indicators of various aspects of disaster management which impact on the human rights of survivors of the disaster. The following are some of the initiatives taken worldwide to strengthen human rights in disaster management.

## Humanitarian Charter and Minimum Standards in Disaster Response

The cornerstone of this handbook (Sphere 2004) is the Humanitarian Charter (49), which is based on the principles and provisions of international humanitarian law, international human rights law, refugee law and the Code of Conduct for the International Red Cross and Red Crescent Movement and Non- Governmental Organisations (NGOs) in Disaster Relief. The Charter describes the core principles that govern humanitarian action and reasserts the right of populations affected by disaster, whether natural or man-made (including armed conflict), to protection and assistance. It also reasserts the right of disaster-affected populations to life with dignity.

The Charter points out the legal responsibilities of states and warring parties to guarantee the right to protection and assistance. When the relevant authorities are unable and/or unwilling to fulfill their responsibilities, they are obliged to allow humanitarian organisations to provide humanitarian assistance and protection.

## International human rights standards on post-disaster resettlement and rehabilitation

This charter (2005) focuses specifically on long-term post-disaster resettlement and rehabilitation. While some organisations may have created internal modes of operation that incorporate broad human rights standards, this is probably the first time that a comprehensive guide has been compiled for external and widespread use. The goal is to help institutionalise these international standards for all relief and rehabilitation work to come. The use of these standards will be an empowering and farsighted problem-solving tool for those affected, as well as for all parties engaged in post-disaster reconstruction and rehabilitation. It is the first step towards bringing applicable human rights standards to all those

involved in reconstruction, most importantly, the survivors. The next steps focus on providing tools and training for the actual implementation of such standards through a collaborative process.

'A proposal for "The Integration of Human Rights Standards in Resettlement and Rehabilitation in the Tsunami-affected Countries in Asia"' (50) details the design for a checklist, planning manual, toolkit, training modules and evaluation processes of the programme. The checklist will help ensure relevant human rights standards are being incorporated into operational processes. The planning manual and toolkit will provide constructive guidance on integrating international standards into relief operations. The manual will provide steps to actualise rights and assess vulnerability. The training will focus on involving local groups in planning and implementation. The modules developed will train participants and officials in the assessment of project design, monitoring, review and evaluation. The guidance details mid-term review and other evaluation processes, in order to best document and evaluate the experience of initiatives taken. Lastly, the overall programme seeks to bring together community leaders, government officials, NGOs, donor organisations, government organisations, the UN and other multilateral organisations in this common, urgent and, ultimately, very human task.

## IASC Guidelines on MH & PSS in Emergencies

In emergency situations, an intimate relationship exists between the promotion of mental health and psychosocial well-being and the protection and promotion of human rights (51). Advocacy for the implementation of human rights standards such as the rights to health, education or freedom from discrimination, contributes to the creation of a protective environment and supports social protection. Promoting international human rights standards lays the ground for accountability and the introduction of measures to end discrimination, ill treatment or violence. Taking steps to promote and protect human rights will reduce the risks to those affected by the emergency.

At the same time, humanitarian assistance helps people to realise numerous rights and can reduce human rights violations. For example, enabling at-risk groups to access housing or water and sanitation increases their chances of being included in food distribution, improves their health and reduces their risks of discrimination and abuse. Also, providing psychosocial support, including life skills and livelihoods support to women

and girls, may reduce their risk of having to adopt survival strategies such as prostitution that expose them to additional risks of human rights violations. Care must be taken, however, to avoid stigmatising vulnerable groups by targeting aid only at them.

Because promoting human rights goes hand-in-hand with promoting mental health and psychosocial well-being, mental health and psychosocial workers have a dual responsibility. First, they should ensure that mental health and psychosocial programmes support human rights. Second, they should accept the responsibilities of all humanitarian workers, regardless of sector, to promote human rights and to protect at-risk people from abuse and exploitation. Protection requires both legal and social mechanisms. Legal protection entails applying international human rights instruments, and international and national laws.

The key actions suggested by the IASC Guidelines on Mental Health and Psychosocial Support in Emergency settings on psychosocial care and Human Rights (2007) are as follows:

1.  Advocate for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies.

2.  Implement mental health and psychosocial supports that promote and protect human rights.

3.  Include a focus on human rights and protection in the training of all relevant workers.

4.  Establish – within the context of humanitarian and pre-existing services – mechanisms for the monitoring and reporting of abuse and exploitation.

5.  Advocate and provide specific advice to states in bringing relevant national legislation, policies and programmes into line with international standards and on enhancing compliance with these standards by government bodies (institutions, police, army, etc).

## Conclusion

The human aspects and the human rights in disasters were not taken seriously by those responsible for relief and rehabilitation measures for a long time. However, through tremendous efforts of local, national and

international players, relief and rehabilitation processes are now effectively handled to a large extent, though with difficulties. Certain issues need to be handled much more intensively, e.g., people and communities living in makeshift, uninhabitable shelters; compensation being inadequate, and not reaching many of the affected; health and nutrition needs being compromised; livelihood restoration being slow; and safety and security, particularly of women and girls, being under threat. The failure of states to monitor relief and rehabilitation work at times, and to bring a halt to these negative developments calls into question their obligations to the international human rights instruments that they have willingly ratified, as well as their national, constitutional and other commitments to promote social justice for their people.

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# Resource convergence and mental health care

## Aruna Sharma

## Introduction

Individuals suffering from depression and other mental illneses have an equal right to a life of dignity, just as any other citizen of this country. Enshrined in the Constitution of India, the Universal Declaration on Human Rights and the Covenant on Economic, Social and Cultural Rights (ESCR) is the principle that every human being has the right to the highest attainable standard of physical and **mental health**, without discrimination of any kind.

## Mental health care as a rights issue

Mental health is an essential component of the right to health, which in turn is crucial to the realisation of many other human rights. The Directive Principles of State Policy explicitly mentioned that it is the duty of the State to raise the level of nutrition and the standard of living and to improve public health. The Supreme Court has also laid down the maintenance and improvement of public health as one of the obligations that flow from Article 21 of the Constitution. As a corollary, mentally ill person have the right to receive quality mental health care and to humane living conditions in the mental hospitals. The right to life in Article 21 of the Constitution refers to something more than mere survival or animal existence. On the contrary, the mental illness has not got adequate attention from the State in its health policy and programmes. The mentally ill persons are deprived of their right to treatment, their due place in the society and health services.

## The Persons with Disabilities [Equal Opportunities, Protection of Rights and Full Participation] Act, 1995

Article 66(1) of Persons with Disability Act (PWD Act) states, "The appropriate Governments and the local authorities shall within the limits of their economic capacity and development undertake or cause to be

undertaken rehabilitation of all persons with disabilities." Mental Illness is also recognized as disability according to the section 2 of the PWD Act, 1995. Thus, even though the provisions of the Constitution, their interpretation by the supreme court and specific legislations recognize the mental health care as a rights issue, there is need to converge the programmes, schemes and implementation of mental health care to ensure that the mentally ill are able to lead a life with dignity.

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### International Commitments on Mental Health Care as a Rights Issue

Enjoyment of the human right to health is vital to all aspects of a person's life and well being, and crucial to the realization of many other fundamental human rights and freedoms. It is explicitly mentioned in Article 25(1) of the Universal Declaration of Human Rights that 'Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing and medical care and necessary social services'. The inclusion of "health" and "medical care" in the UDHR has led to an Article in the International Covenant on Economic, Social and Cultural Rights Covenant (Article 12). Furthermore, the social rights of victims of crime and their need for mental health support are based on the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, 1985. (Resolution adopted by the UN General Assembly). Article 5 of UDHR states no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. This article is reinforced by article 7 of the ICCPR which explicitly says that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation. The mentally ill often receive inhuman and degrading treatment. Sometimes there are questions about their right to autonomy or self determination viz., when they are not informed or their consent not taken for treatment of ECT. "Intervention among mentally ill persons must include preventive aspects as well as crisis management".

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To ensure the rights of mentally ill, the need is, therefore, to address the following components to have a holistic impact:

## Identification and early detection

This will require trained manpower in the near future. Approach to health

care has traditionally focused on physical health, while neglecting mental health. Over the years, mental illnesses have increased manifold. Although there has been no authentic demographic study, psychiatrists estimate that about two per cent of Indians suffer from mental illnesses, thus putting the figure at a staggering 20 million out of a population of over 1000 million. Epidemiological surveys done in India indicate that 10 to 15 per cent suffer from so-called mental disorders. One to two per cent of Indians suffer from manic-depressive illness alone. Nine million people have schizophrenia in India (one out of 1000). Mental health needs may emanate from sociological pressures and breakdown of personal relationships leading to ailments like anxiety, depression, fear, obsession, somatic symptoms due to tension, alcohol and drug abuse, etc. Thus the need is to have trained manpower in terms of psychiatrists and other mental health professionals.

While mental health has been acknowledged as part of the public health agenda and has been considered a part of the primary health system, the real situation in the health sector is that it has been totally indifferent to this specific need. Primary health centres are not well equipped with medicines and staff. On the one hand, the Ministry of Health and Family Welfare is training existing MBBS doctors in the government sector for mental health care in their district programme, and on the other, MCI has laid down stringent conditions which limit intake of students for psychiatry courses. Thus the first need is to train existing personnel in mental health care so that at least one trained doctor is available in the district for mental health care.

## Mental health care in and outside mental health institutions

The National Mental Health Programme (1982) was a major development in providing mental health care through different methods while keeping the overall goals of general health care. The hospitals for mental health and some district hospitals are the main locations for treatment. But a study conducted by NHRC in the 37 mental hospitals during 1998 revealed that most of the hospitals had inadequate infrastructure, staff, clinical services, availability of medicines and treatment modalities, quality of food, availability of clothing and linen, recreational facilities, vocational rehabilitation facilities. The other location for mental illness related treatment are mental homes run by religious institutions where traditional healing is practiced for treatment purposes. The patients many a time are treated in

an inhuman manner. Sometimes they are chained and malnourished. There is no attention on treatment and beating is the only treatment. The Article 6 (1) of the Mental Health Act prohibits the running of a home without license and Article 11 1(b) says that "the licensing authority can revoke the license if the maintenance of the home is being carried on in a manner detrimental to the moral, mental or physical well being of other in-patients". Even though illegal mental homes are being run in the country, there is a lack of adequate and effective interventions by the State authority. These are the places where chances of human rights violations are high.

The National Human Rights Commission (NHRC), after an empirical study of mental hospitals in the country in 1999, expressed serious concern over the state of mental health institutions. "*The findings reveal that there are predominantly two types of hospitals,*" the report said. "*The first type does not deserve to be called 'hospitals' or mental health centres. They are 'dumping grounds' for families to abandon their mentally ill member, for either economic reasons or a lack of understanding and awareness of mental illness. The living conditions in many of these settings are deplorable and violate an individual's right to be treated humanely and live a life of dignity. Despite all advances in treatment, the mentally ill in these hospitals are forced to live a life of incarceration.*"

"*The second type of 'hospitals',*" the NHRC report continues, "*are those that provide basic living amenities. Their role is predominantly custodial and they provide adequate food and shelter. Medical treatment is used to keep patients manageable and very little effort is made to preserve or enhance their daily living skills. These hospitals are violating the rights of the mentally ill persons to appropriate treatment and rehabilitation and a right to community and family life*".

NHRC, during its inspections observed that the dignity of persons with mental illness is not respected in mental health institutions. Sometimes they are found in the worst imaginable conditions, i.e. naked, in dirty and old clothes and unhygienic conditions. Sometimes, women were found in dreadful conditions, not "*wearing any undergarments and intimate parts of their bodies could be seen through the ill fitting clothing.*"

## Policies

Health policies and programmes have a significant role in shaping health service system and care. It is evident from the report of all committees

that in the field of mental health, our achievements are not satisfactory. It is completely wrong to say that the persons admitted to mental hospitals are the prime clientele for mental health care. There are 42 mental hospitals in the country with the bed availability of 20,893 in the government sector. In the private sector, there are 5096 beds. These facilities have to converge with more and more outpatient treatment facilities and half-way homes to facilitate treatment and early rehabilitation of cured patients.

The World Health Organisation's World Health Report (2001) estimates that there are 1,02,70,165 people with severe mental illnesses and 5,12,51,625 people with common mental disorders needing immediate attention (Janardhan and Bitopi Deka). These huge numbers pose significant and practical difficulties for persons with mental illness and their families to access and afford health services. The setting up of in-patient and outpatient departments at general hospitals, independent psychiatric and mental health clinics, and institutions for the mentally ill have all therefore been recommended.

NHRC efforts in the past and present endeavour to converge medical education, and specialised education, and seeks to converge the efforts of treatment centres like NIMHANS etc., District Mental Health Programmes, MCI, Nursing Council, and mental hospitals. A beginning was made to work out basic minimum standards of services.

Thus, a comprehensive policy of mental health care is to converge on the issues of :

A.  Training existing doctors in the districts for mental health care.

B.  Incorporating the mental health care capsule in the MBBS course so that future doctors are trained enough to assist identification of patients.

C.  Equipping the mental hospitals and having a systematic policy to license private hospitals.

D.  Diluting the existing MCI norms to increase manpower on one time basis. Many mental hospitals do not have psychiatrists, as the country is not producing sufficient manpower in this field. NHRC has taken up this issue with MCI to sanction more post-graduate seats for psychiatry in medical colleges to fill this gap.

E.  Besides there is a need for psychiatric nurses, clinical psychologists and other trained staff. Institutes like NIMHANS, RINPAS and

others should be recognised to impart such academic training both on and off campus.

F.    Half-way homes to be approved for the mental hospitals and they need to converge with the pension schemes for destitute. Training to be imparted to them in various skills under poverty alleviation programmes.

G.    There is a strong need to recognise and assist NGOs who work in this sector. The convergence with the assistance programmes of Ministry of Social Justice and Empowerment is needed to ensure that genuine NGOs are involved to handle mental health care. The NGOs can be suggested by the respective mental health hospitals through their state governments.

## Programmes and Schemes

| The Background |
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| Active thinking in the area of mental health marked the decade of the seventies. The Srivastava Committee (1974) recommended that one hour (out of the total training of 200 hours of community health workers) be devoted to mental health. In addition, a manual for community health workers would deal with the recognition and management of mental health emergencies and problems. |
| In 1983, the National Health Policy suggested that a "special well-coordinated programme should be launched to provide mental health care as well as medical care, and also the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged" (GOI 1983). |
| The National Mental Health Programme (GOI 1982) is the outcome of various initiatives taken to provide mental health care through different methods. It aims at providing mental health care to the population utilising the available resources. |
| The Central Council of Health and Family Welfare has recommended that mental health should form an integral part of the total health programme, and should be included in all national policies and programmes on health, education and social welfare. |
| As decided in the meeting of the Central Council of Health in 1995 and as recommended by the Workshop of all the Health Administrators of |

the Country held in February 1996, the District Mental Health Programme was launched in 1996-97 in four districts, one each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu with a grant assistance of Rs 22.5 lakh each. A budgetary allocation of Rs 28.00 crore was made during the Ninth Five-Year Plan for the National Mental Health Programme.

## Manpower Training

The training of the trainers at the State level is being provided regularly by the National Institute of Mental Health and Neuro Sciences, Bangalore under the National Mental Health Programme. The District Mental Health programme was extended to seven districts in 1997-1998, five Districts in 1998 and 6 districts in 1999-2000. Now this programme is under implementation in 124 districts in all the States.

When we talk of convergence and mental health care, then it is not just the medical interventions we have to take into account but also converge the interventions for awareness building, legal redress, community acceptance, and relief in handling sociological pressures and personal relationships. Gender concerns also need to be addressed as women seem to be more prone to anxiety and depression while men to alcohol and drug abuse. Convergence between medical colleges and mental hospitals is the need of the day. The number of mental health professionals in the country is limited. The variations across States are significant. For example, Kerala (with a population of 30 million) has over 300 psychiatrists while Madhya Pradesh (with a population of 70 million) has only 31 psychiatrists and 300 psychiatric beds. In addition, the implementation of NMHP has had an initial spurt, with delays in expansion. The development of support materials and models at the district level facility for initiating and coordinating the large-scale expansion of the mental health programme is a serious problem.

At the two-day conference of State Health Secretaries and mental health authorities organised by National Human Rights Commission on May 8-9, 2008, it was pointed out that psychiatry has been removed from the under graduate medical curriculum. The conference made a recommendation that the matter be taken up further. Accordingly, the Commission took it up with the Ministry of Health and Family Welfare and Medical Council of India.

The Commission received response from the Medical Council of India allaying the apprehensions of many experts in this regard. MCI confirmed that "as a matter of fact, psychiatry is included within the course curriculum of "Medicine and its allied specialties" as prescribed in the regulation on Graduate Medical Education, 1997. The detailed curriculum for teaching and training in subject of psychiatry to under graduate medical students is incorporated within Section 11 – "Clinical subjects of phase-II and phase-III"; (1) Medicine and its allied specialties (C) Psychiatry (Page 36 to 38 of Regulations)."

## Trauma

There is need to converge the services of personnel trained in psychological issues in instances of trauma to the patient and next of kin. The trauma could be because of accidents, natural calamities, man-made calamities like conflict situations, displacements due to development projects, etc. These are instances where the individual has to restart life afresh, either in the same vicinity or entirely in a new area. Insufficient attention is paid to mental health care and rehabilitation needs are restricted to only economic needs in terms of food, shelter and occupation. This major neglect results in severe incapability of the recipient to restructure his/her life.

Thus there is need for psychiatric care in the rehabilitation package of trauma victims. Experiments were done in this regard on the Tsunami victims and the results were noteworthy. Besides trained experts, religious leaders were also requested to address the victims, who were exposed to meditation techniques to overcome their personal loss.

## Awareness Building

It is necessary on the part of public health personnel to conduct research in bringing out the epidemiological basis for such programmes. Responsibility also lies with the social scientists to influence the government and public health system in order to have a broader view and better understanding of the problems related to mental health. In the Indian context, no proper research has been done to examine the ways in which culture and religion influence mental illnesses and health. It is also clear that mental illness is a significant cause of disability in India, which has been largely ignored in health related development activities. The impact of economic structural adjustment in impoverishing people, the breakdown of traditional community and family relationships caused by urban migration,

and the myriad adverse effects of newer diseases like AIDS are likely to cause a greater impact on people's psychosocial health. In addition, these programmes do not incorporate proper preventive measures, even curative and rehabilitative services provided are inadequate in terms of the estimated needs. Thus there is need to converge all the health awareness programmes, education at school, women and child awareness programmes using IEC to make the society aware of the psychological issues and mental well-being.

## Discrimination

Any kind of discrimination, whether based on gender, caste or poverty, has a lasting impact on the mindset of an individual. The Constitution of India categorically emphasises right to equality and equal opportunity before law under the chapter on Fundamental Rights.

Many private initiatives where homeless victims and socially deprived are kept in homes and shelters, are run on the principles of 'humanity' and 'sewa'. Staff at these shelters may have no training whatsoever to attend to the special needs of victims or patients with psychological disorders. The need is to enforce effective programmes of social reintegration with adequately sensitised and trained staff.

## Children

Remarkable developments have taken place both internationally and nationally when it comes to prioritising child rights, but the links between child abuse, child labour and the care of a child's mental health are still absent. In India, there is no separate law with regard to sexual assault on children. The general law on rape contained in the Indian Penal Code covers child sexual abuse and assault. Similarly, the Juvenile Justice Act 1986 has an impressive preamble, but despite this, the Act scarcely touches upon the subject of child sexual abuse, and completely leaves aside therapy and mental health considerations. The role of mental health of rescued and victimised children is also absent in Indian case law. *M C Mehta vs State of Tamil Nadu* (AIR 1991 SC 417), is undoubtedly the most significant case on the need to improve conditions of children rescued from hazardous labour. Here it was argued that children below 14 years cannot be employed in any factory, mine or other hazardous work and they must be given education. The Supreme Court ruled that employers of children were liable to pay Rs 20,000 as compensation for every child

employed. The government was asked to provide job to an adult member of the family in lieu of the child or deposit Rs 5000 for each child. Thus there would be a corpus of Rs 25,000 for each child. The fund would be deposited in the "Child Labour Rehabilitation-cum-Welfare Fund". The payment made from the fund or the employment given would cease if the child was not sent to a school.

## Women

Civil society groups and NGOs have recognised the lack of insight and priority accorded by policy makers and legislators to mental health concerns. They have taken up the battle, generally though, in an unguided manner. Help-lines, friendly and non-professional counseling is given to patients in need of professional mental health support. This can lead to dreadful outcomes, when for instance a victim of domestic violence comes to seek what, in her view, is guidance within the framework of counseling, but instead receives a cultural orientation on how the role of the Indian woman is to compromise and how with time the violence against the victim may reduce. In Amritsar and Chandigarh, at help-lines run by women's rights organisations, I have learnt that individuals with no training in mental health counseling, give advice in a majority of cases. There is currently no set protocol or system in place. This only makes it very difficult to assess whether the counseling offered meets the victims' needs. Protocols and mandates have to be introduced on the basis of which a counsellor can be evaluated. Failing the standards should automatically lead to re-evaluation of the counsellor. Bhargavi V. Davar in her book, *Mental Health of Indian Women - A feminist Agenda*, says that the presence of distress is estimated to be present in about 15% of the entire population. This is only a part of the truth. Davar examines data from various studies to conclude that common mental illnesses are more common among women than in men. Even feminists have been largely silent on mental distress among women. While mental health professionals have sidestepped the issues of gender and social problems, Davar's analysis of disaggregated data proves that marriage in Indian society is probably the single most important cause of distress to middle class women, as she says, "*Marriage is a stressful occupation for women*". She feels that mental distress may be a good indicator of social stress and justice.

## Disability Acts and mental health care

Technically, the mentally ill are also covered under the rights of the disabled.

However they do get discriminated in this category. In the implementation of these Acts, persons with mental illness are unfortunately not treated as disabled persons and their inclusion in any social security benefits like concession, scholarship for education etc. is negligible compared to other categories of disabled people. A common assumption is that a person's civic rights are suspended upon admission in a mental hospital. The rights that can be suspended during hospitalisation are right to vote, right to enter into a contract, right to drive a car, right to practice any profession and right to marry, social life and privacy. Institutionalisation puts an end to social life.

## Conflict situations

Democratic societies have an obligation to alleviate the effects of crime, including the adverse consequences that victimisation has, on all aspects of life. The victims must be supported in a way which shows an understanding of the whole range of their problems. All victims of crime have the right to ask for their privacy, their physical safety and for their psychological well-being to be protected. Child victims in particular may experience difficulties obtaining support, either from their family or from professionals. Specialist services should be made directly accessible to them, and professionals made available to provide individual support for each child.

Pilot projects in community mental health services were started in India by 1975. They have subsequently been integrated into the primary health care system. A specialised programme, the National Mental Health Programme was initiated in 1982. Community based mental health rehabilitation services however, did not expand fast enough, because of many difficulties. Firstly, the stigma of mental illness prevented affected persons from coming forward to seek help. Because of the same reason, they did not organise themselves into self-help groups to demand services. At the policy level, mental illness was only recently classified along with other disabilities by the Government of India, making it difficult to access resources, and as a result the established CBR programmes did not include these people in their programmes. **Thus, at present, the only programmes that exist for mentally ill persons in the community are limited to identification of cases and medical treatment**. Yet, there are not enough places to train personnel, if they are needed by CBR programmes to rehabilitate mentally ill persons in their projects.

In the current situation, the primary need is to sensitise the multi-disability CBR programmes regarding the potential of community based mental health services. This process reduces the stigma for the decision makers in CBR, and gives mental health rehabilitation strategies equal priority with other disabilities. It results in initiation of programmes that are realistic and need based, and are likely to give rise to tangible benefits. Similarly, availability of information regarding the limits of such services, and the levels of success that they can achieve, will result in better operational plans that are more cost-effective.

## Half-way homes

Often, even if clinically cured, some persons have no place to go. If abandoned and left on their own, due to social neglect and societal prejudice, such persons may again end up in depression etc. Thus, in many situations, there is no other solution than a half-way home. An advantage is that they have the strengths of institutional care which takes care of daily ration, health care and dwelling. An added advantage is occupation. There is a need to link such facilities with the 'pension for destitute' scheme of the government as these individuals, irrespective of age, will be entitled to it. This will assure them a regular though small income of Rs 200 per month, but will add to their dignity. Many a time the affected persons are sought to be rehabilitated through traditional means of knitting, candle making etc., but they can be exposed to more vocationally relevant work like horticulture and nursery. Space around mental hospitals can be used for commercial floriculture and growing vegetables as it is time consuming and gives quick returns and has therapeutic value. Dairy is another activity where the products can be used for the hospital, residential colonies and medical college hospital as well.

## Community care

The best of rehabilitation is through near and dear ones, accompanied by training of families and with special care needs provided. The next step from half-way homes would be community acceptance. There is a need for harnessing lending schemes, insurance schemes for self-employment and rehabilitation education to the community. Reduction of stigma by not using demeaning words like *'pagal'* etc., must be strongly advocated. There is a strong need to provide platforms for social network groups to share experiences and success stories.

# Conclusion

Mental health care is not just a medical care issue but a social one. The stress, discrimination, trauma due to natural and man-made disasters, personal tragedies and social intolerance can only lead to or aggravate mental illness. The need is to adopt a holistic approach to ensure access to mental health care, provide well-equipped mental hospitals for specialised care (including manpower and infrastructure), train the family care givers, respect the dignity of patients, provide half-way homes, pensions for the residents of such facilities, skill improvement, NGO assistance and facilitate the rehabilitation process by recognising them under assistance programmes. Finally, these initiatives must converge with community awareness to ensure mental health as a rights based issue.

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# Future directions for mental health care in India

## D Nagaraja & Pratima Murthy

## Introduction

'Brain disorders', neurological, psychiatric, and developmental, now affect at least 250 million people in the developing world, and this number is expected to increase as more people live to old age. Yet public and private health systems in developing countries have paid relatively little attention to these disorders, concentrating instead on the major communicable diseases. The Institute of Medicine (1) recommends the following strategies for reducing the burden of 'brain disorders':

- Increase public and professional awareness and intervene to reduce stigma and ease the burden of discrimination;

- Extend and strengthen existing systems of primary care to deliver health services for these disorders;

- Make cost-effective interventions available to those who will benefit;

- Conduct operational research to demonstrate cost-effectiveness of specific treatments and health services in local settings;

- Create national centres for training and research;

- Create a programme to facilitate cost-effective funding for research and for the development of new and enhanced institutions devoted to brain disorders in developing countries.

Common themes that run through three recent global publications with reference to public health (1-3) are the following:

- Need to develop adequate human resources (at the primary care level, specialised staff as well as trained service providers in the non-formal sectors);

- Extend and improve care in the community;

- Inter-sectoral collaboration for effective mental health care delivery;

- Strengthen other mental health components that improve provision of care (policy, programmes, legislation, community participation, advocacy).

The Lancet series on Global Mental Health refers to several barriers to improvement of mental health services in low-income and middle income countries (4). Such barriers include the prevailing public-health priority agenda and its effect on funding, the complexity of and resistance to decentralisation of mental health services; challenges to the implementation of mental health care in primary-care settings; the low numbers and few types of workers trained and supervised in mental health care; and the frequent scarcity of public health perspectives in mental health leadership. Mental health investment in primary health care is important but is unlikely to be sustained unless preceded by the development of community mental health services to allow for training, supervision and continuous support for primary care workers. Community members need to partake in advocacy and service delivery (4).

In developing countries, there is a great mismatch in the areas of mental health research, practice, policy and services in comparison to developed countries. There have been few studies that have investigated major mental health problems prevailing in these countries, but such studies have tended to be more donor-driven and conducted in tertiary centres (5). The low priority accorded to mental health by the policy makers, scarcity of human resources, lack of culture-specific study instruments, lack of support from scientific journals have been some of the impediments to mental health research in these countries. In addition, lack of community participation and absence of sound mental health policies have deprived the vast majority of the benefit of modern psychiatric treatments (5).

## Developments in India

In the previous chapters, various developments in India in the area of mental health have been discussed. These can be summarised as follows (6):

- Indigenous post-graduate training which eliminated the need for training abroad, at least at the basic DPM and MD levels

- Development of general hospital psychiatry in the 1960s

- The emergence of community psychiatry initiatives in the 1970s

- Change in the laws pertaining to mental illness in the 1980s

- Powerful judicial interventions for the rights of the mentally ill in the 1990s

- Greater availability of a range of psychotropic medication for the effective treatment of mental illnesses in the last two decades

In more specific terms, there have been serious attempts to improve care and expand the scope of functioning of government run psychiatric facilities and to expand the National Mental Health Programme under the 11th Five-Year Plan (7), with a broad-based approach focused on mental health promotion, early diagnosis and treatment in primary and general care settings, extension of the district mental health programme to all districts in the country, and a significant budget allocation for mental health research (8). Policy reform has included the integration of mental health in the National Health Policy (2002), the drafting of a proposed National Mental Health Policy in 2001 with a clear roadmap for activities in the 10th (2002-2007), 11th (2007-2012) and 12th (2012-2019) five year plans (7).

A range of effective medical treatment options are available and the treatment cost is comparable with costs of other chronic medical illnesses (9). A large number of psychotropic medications have become available in district settings. The costing of treatment of mental disorders like depression, schizophrenia and alcohol and drug dependence have been included in the budgeting exercise undertaken by the government of India to improve financial allocation for such care at the solo physician, primary, secondary, and tertiary health care levels (10).

Simultaneous with these developments is the development of a range of community level approaches to mental health care. Community based models of care in both the government (11-14), and non-governmental sector (15-17) have been shown to be acceptable and effective models of health care delivery for the last three decades.

The problem is not in the demonstration of efficacy of these models, but their systematisation. The generation and demonstration of workable models involves a great degree of motivation, a desire to demonstrate change, and a willingness to put in the necessary effort to make such change possible. When attempts are made to systematise such models within the community, the lack of human resources, motivational barriers,

inadequate or dysfunctional mechanisms for service delivery, non-existent or ineffective monitoring mechanisms, inadequate measurement of deliverables in real world settings become practical difficulties.

## Challenges for effective mental health service delivery

In order to make specific recommendations for future action, we need to reconsider local barriers to effective mental health service delivery. Many of these have been raised in the preceding chapters.

*The need for services and efforts to reduce the treatment gap*

It is estimated that about 500 lakh for common mental disorders (7) and about 200 lakh individuals in the country need treatment for severe mental disorders. Thirty lakh people need long-term care, and between 30 and 35 lakh need hospitalisation at any given time. Only about 29,000 beds exist in both government and private sectors. There is a huge treatment gap with nearly 50-90% of persons not being able to access services.

*Human resource: scarcity of specialists*

Even after nearly six decades of indigenous post-graduate training there is an acute shortage of psychiatrists. To have a desirable ratio of 1 psychiatrist for every 1 lakh population, we need to train a further 7000 psychiatrists (7). At the present rate of training (about 250 annually through MD, Diploma and DNB training programmes), it would take a further 30 years to achieve this. Moreover, nearly half the physicians in high-end institutions, including psychiatrists, migrate (18).

Other mental health professionals like clinical psychologists, psychiatric social workers and psychiatric nurses are also very scarce. To have a desired ratio of 1 clinical psychologist per 1.5 lakh population, 2 psychiatric social workers per lakh population 12,000 and 17,000 professionals respectively need to be trained (7). Psychiatric nurses are limited to a few hospitals.

*Training of primary health care doctors and general physicians*

Training of primary health care doctors and general physicians in mental health care has occurred sporadically in the country and it is difficult to speculate how many of them have been adequately trained and can deliver basic mental health care. The proportion is likely to be negligible.

### Training of primary health care workers

Training of primary health care workers was initiated under the NMHP in the 1980s, but this was not expanded and does not represent a well-trained sector for integrating mental health into general health care.

### Human resources in the non-governmental sector

In the early 2000s, there were about 50 non-governmental organisations (NGOs) throughout the country working in the area of mental health (excluding those working in the area of mental handicap and commercially run long-stay rehabilitation centres), which again represents a motivated but small human resource pool (19).

### A poorly informed public

Very little information is available to the public on any of the issues relating to mental health, whether it is on mental well being, protecting against depression or identifying symptoms of serious mental illness. They are even less aware of treatment facilities and their rights. Without information, there is no advocacy. Without advocacy, there is not enough demand for services and system accountability to provide equitable and good quality mental health care. Stigma and misconceptions related to mental illness are present among sufferers, their families as well as among untrained service providers.

### Systems for effective service delivery

Mental health has always suffered from a lack of financial resources in the past. For the first time in history, under the NMHP, the mental health sector has received more generous funding. While this is exciting, it is also a sobering fact. Unless accountable systems for effective service delivery emerge, and bureaucratic hurdles and apathy of state administrations is overcome, quality mental health service delivery will remain an Utopian dream, despite all the available financial resources.

## Recommendations

The following recommendations are made particularly recognising that the philosophy of mental health care in India has now moved from a custodial to a therapeutic approach, from a social cause to a rights based approach, from a tertiary care approach to community care, primary and secondary care.

1.  **Mental health services should be accessible, equitable and affordable**

Community care is the best approach for providing broad-based mental health services in the country, especially given the shortage of trained human resources. All the districts of the country should be covered under DMHP.

The Government should ensure that cost of drugs used in the treatment of psychiatric disorders do not become prohibitive.

Psychosocial interventions should be available at all levels.

2.  **Government should downsize large psychiatric hospitals**

Efforts should be made to reduce hospital beds to manageable numbers. Duration of admission should be as short as possible. More open ward treatment facilities must be created.

3.  **Human resources for mental health must be systematically enhanced through both short-term and long-term strategies**

Each state must have at least one training institute that provides multidisciplinary training in psychiatry, psychology, social work and mental health nursing.

For a period of 10 years, the Medical Council of India should relax faculty student ratio for PG intake from 1:1 to 1:2. Teachers with DPM qualification and 8 years of teaching experience should be considered as post graduate teachers.

The Central and State governments should encourage short-term training programmes in psychiatry of 3 to 12 months duration for their medical officers in established training institutions so that every district can be provided with a trained person where there are no psychiatrists.

Every state should undertake short-term training programmes for all their medical officers in the identification and management of common psychiatric disorders.

The State and Central governments should encourage training of general practitioners through agencies like the Indian Medical Association.

The government should fix minimum CME credits in psychiatry to be obtained for renewal of license.

Undergraduate training in psychiatry must be strengthened and a clinical case examination in psychiatry must be introduced.

## Other mental health professionals

Since adequate MPhil trained candidates are not available, candidates with MA/MSc in psychology and social work should be trained for three months in PG centres, so that they can be recruited to provide psychosocial interventions at the district level.

Psychiatric institutions as well as general hospital departments must be encouraged to develop multidisciplinary teams and offer post-graduate courses for other mental health professionals.

## Training of lay counselors

In view of the acute shortage of trained manpower, lay counselors need to be trained to manage common psychological problems which require counseling. Every state should have a training centre, preferably in each district. Where available, local NGOs can be involved in providing such training.

Curriculum and training materials can be obtained from NIMHANS for the above activities.

All professionals must be provided adequate remuneration as well as conducive work conditions, including administrative support.

4.  There should be a national data base of services and human resources available for mental health care in the country and this should be periodically updated.

5.  The State and Central Governments should follow a stepped care approach to mental health services as follows:

   • Health education

   • Health promotion through school health programmes

   • Counseling centres

   • Early diagnosis and effective management/emergency services

   • Short periods of hospitalisation when required

### 6. After care rehabilitation and reintegration within the society

The approach to mental health care must shift from hospitals to families and efforts should be made to address issues of care givers. Care givers must be provided adequate support including facilities for short-term respite care for their chronically ill wards whenever required. For individuals for whom family care is not feasible, there should be operational co-ordination between the Ministry of Health and Ministry of Social Justice and Empowerment for establishment and effective management of after care homes and rehabilitation centres.

### 7. Mental health must be converged with the social, education, labour and legal sectors. Translational research must be encouraged in all areas

### 8. Law review and reform needs to occur periodically

Mental health acts/rules must be periodically reviewed. They must emphasise community care, rehabilitation and aftercare. Various rules and regulations with reference to mental illness reflected in different acts and rules of the Centre/State must be harmonized.

### 9. Limitations imposed on mentally ill in the area of insurance should be rectified. Mental illness treatment should be covered under simple schemes like the Yeshaswini scheme.

### 10. The mental health care of vulnerable groups like children, elderly, women subject to domestic violence should receive priority attention.

Translational research in all the above areas must be strongly encouraged and feed into further policy and programme development.

## Towards integrated mental health service delivery and inter-sectoral convergance
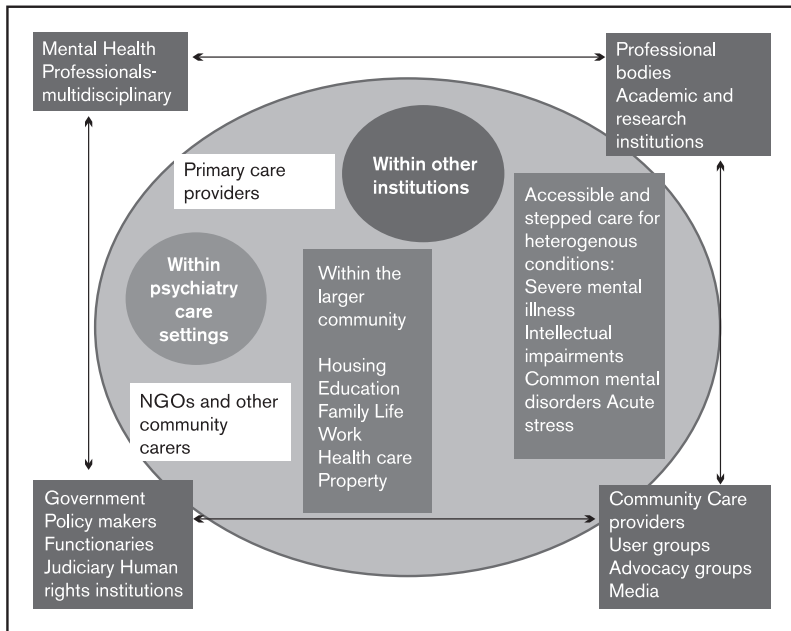


## Conclusion

Mental well-being and the care of mental illness cannot be the concern and responsibility of mental health professionals alone. There are now several well recognised players involved in the mental health field. However, mental health is everyone's concern. Every government should provide mental health services. Every citizen should assert his/her right to such services in the community. Working together, we can hopefully address the mental health care of our country in a more meaningful manner.

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# NHRC/NIMHANS 2008 update on government psychiatric hospitals

K. Sekar & Pratima Murthy

## Introduction

The National Human Rights Commission Project Report on Quality Assurance in Mental Health published in 1999 (1) details reports on each of the mental hospitals in the country. This chapter outlines the changes that have taken over the decade in each of the hospitals and their functioning in 2008. Reports of each State detail the name of the psychiatric hospital, year of establishment, bed strength, specific recommendations in the NHRC/ NIMHANS 1999 report in terms of infrastructure, amenities and facilities, financial, diet, kitchen, bed facilities, investigation and treatment facilities, staff and training, supportive services and recreation/occupational therapy/rehabilitation services. Against each of the recommendations, the available information based on the reports sent by the individual hospitals on proforma 1 and 2 (appendix), the DGHS report 2004 (2), presentations of the representatives of the States in the NHRC NIMHANS deliberations of the Health Secretaries and Mental Health Authorities of all the States / Union Territories organised at NIMHANS, Bangalore on 8th and 9th May 2008(3), the Chaman Lal report (NHRC, 2007) (4-7), Lakshmidhar Mishra report (NHRC 2007) (8), Shivraj Patil report (NHRC, 2006) (9), NHRC reports on the inspection of the activities of Mental Hospital, Varanasi (NHRC, 2007) (10,11) and NIMHANS review reports of selected mental hospitals have been sourced to provide a comprehensive picture of the changes in the decade following the Quality Assurance report.

## Andhra Pradesh

### Institute of Mental Health, Hyderabad

(Established 1907, 600 beds)

**NHRC/NIMHANS 1999 report**: *Unlike many mental hospitals, the architecture of the hospital is not that of a jail. The floor space is not sufficient to accommodate all the patients. Currently 48 posts of nurses, 91 posts of ward attenders, one post of occupational therapist and one post of x-ray technician are vacant. All the vacant posts should be filled up at the earliest. The Indian Lunacy Act 1912 or Mental Health Act 1987 govern all admissions. This is because the judicial officers themselves are not aware of the new act.*

Earlier rating: Average

NHRC/SHRC visits during the last decade: 1

Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | A new building for starting a short-stay ward, open wards and family wards to be built | Many open wards and family wards constructed<br><br>A 10 bedded casualty-cum-emergency service started. Separate Acute Admission Ward<br><br>Shelter for attendants of OP patients built with the help of the District Collector, Hyderabad |
| Amenities and facilities | An overhead tank should be constructed for uninter-rupted water supply to the entire hospital campus | Land given to the Hyderabad Metro Water Supply and Sewerage Board for construction of reservoir and supply station in the hospital premises, with condition to supply water 24 hours for the overhead tank |

| | | |
|---|---|---|
| | Hot water facilities for bathing should be available in the wards. Number of toilets to be increased and maintained properly | All the wards have been provided with geysers and solar heaters. Does not address the suggestion of increase in number of toilets |
| | | Female patients of the open ward and family wards permitted to wear the clothing of their wish. |
| | Dress for female patients must be modified (locally appropriate clothing sari or skirt blouse) | However providing saris could not be implemented in the closed wards due to the increasing chances of committing suicide by the patients |
| | | Family and open wards, Separate drug and alcohol de-addiction and marital counseling services provided |
| Financial | Medical Superintendent be given more financial and administrative powers. Medical Superintendent must have the power to accept donations in cash and kind to improve the hospital. | MS has financial powers for giving administrative sanction up to Rs. 10000. |
| | Total budget approximately Rs 200 lakh (plan 1.74 Lakh) | Total budget Rs 317 lakh (2004-05) |
| Diet/Kitchen | Kitchen in an old building. Food reasonably good | Modern kitchen has been constructed |
| | | Government has increased diet to Rs 28 per day |

| | | |
|---|---|---|
| Linen | Each patient should have a cot mattress, pillow and bed sheet | This is currently being provided |
| Investigations/ Treatment | Only modified ECTs should be given to both outpatients and inpatients | The report states that the hospital is administering modified ECTs since 1991<br><br>All recent psychiatric drugs included in the rate contract list |
| Staff and training | All the vacant positions should be filled up at the earliest<br><br>As many of the nurses should be sent for specialised training in psychiatric nursing such as the diploma or Masters level course | All nursing posts have been filled, most of the vacant Class IV and ministerial posts were filled by the District Collector<br><br>Proposed<br><br>Department actively involved in research |
| Supportive Services | Ambulance services should be made available<br><br>Medical records section needs improvement modification. Trained medical records officer should be in charge of this section<br><br>Rehabilitation services | The hospital currently has three ambulances<br><br>Computers were installed in the Medical Records section to feed data along with photo. On the request of MS some software engineers from GE have volunteered to develop a software for better maintenance of records of the patient |

| Recreation/ Occupational Therapy/ Rehabilitation | should be improved | As part of rehab services this hospital has started male and female quarter way homes. As proposed by the MS the AP State Mental Health Authority has decided to start rehab services for the mentally ill with NGO collaboration

Disability certificates being issued for persons with mental illness and mental retardation |
| --- | --- | --- |

## Hospital report update

The hospital is presently constructing a separate outpatient and registration block, emergency block, record section, radiology wing, outpatient pharmacy, acute admission ward, consultation rooms, toilets, ECT administration room, a 10 bedded short stay ward, a modern kitchen, a mechanized laundry and visitors room. A separate 150 bed criminal and court ward is also under construction. New water lines and drainage lines have been laid, biomedical waste management occurs through contractual services. The hospital has a liaison with jails and correction homes. It has private security and is working with HUDA for a green environment. It has a Board of Visitors that meets monthly. According to the hospital, several problems continue. Several land cases are pending before the courts laying claim to the hospital land. The hospital seeks the active involvement of the advocate general in this matter. While the hospital perceives adequate general nursing staff, it reports understaffing of psychiatric faculty (no Associate Professors, inadequate Assistant Professors) to meet MCI requirements for UG and PG Teaching. A lack of psychiatric social workers and psychiatric nurses, as well as other paramedical professionals are highlighted but mechanisms to address this are are not stated. The hospital is planning to start MPhil courses in clinical psychology, psychiatric social work and psychiatric nursing. It is in the process of getting recognition from MCI for the MD and DPM Psychiatry courses. It is planning proposals for developing the Institute of Mental Health on par with NIMHANS with the funds of the government.

The hospital received a 2.71 crore grant from the Government of India for upgradation of the hospital. It has constructed on an eight feet stone compound wall with barbed fencing around the hospital premises. It may be noted that the NHRC/NIMHANS report 1996 had recommended that high walls and custodial appearances must actually be done away with. To recall a comment of Dr MV Govindaswamy in 1950, "No modern mental hospital is enclosed by a high compound wall". In the future, it plans for the construction of a seminar hall for academic purposes, and an amenities complex for families of patients admitted to the hospital. It is trying to secure a police outpost in the hospital for the escort of under trials undergoing treatment at the hospital requiring emergency medical treatment.

## Government Hospital For Mental Care, Vishakapatnam

(Established 1863, current hospital built 1871, bed capacity 300)

**NHRC/NIMHANS 1999 report**: The overall condition of the wards is grossly inadequate. The wards are not cleaned regularly, have a dirty smell and are full of cobwebs. The few bed sheets that are in use are not clean and most patients do not have any sheets and blankets either to cover the bed or themselves. Due to overcrowding many patients sleep on the floor. The wards are full of mosquitoes….About one third of patients are locked up in cells and each cell has at least 3-4 patients. Food is of very poor quality. The kitchen is in bad shape and needs renovation. There are no recreational facilities. Patients are not allowed to go out either to exercise or to play games because the administration is afraid of patients escaping. There is no occupational therapy section and no efforts made to rehabilitate the patients.

*Earlier rating: Poor*

**Interim Observations**: The DGHS report (Agarwal 2004) reported that little information was received from the state in several aspects. It however commends the state for taking the lead in rationalising the infrastructure at the mental hospital in Vishakapatnam. *"In an innovative and bold step, the Government, vide G.O. Ms No 336, dated 29.8.2001, has drawn up a well thought out plan to dispose off the surplus land available to the mental hospital as well as the Chest and I.D. Hospital and utilise the sale proceeds thereof to build a modern multi-specialty institute along with a new Hospital for Mental Care. This momentous initiative could become a model for other states which have large, unmaintainable mental hospitals which can be similarly streamlined, downsized and rationalized".*

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/NIMHANS Report 1999 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | Abolition of cell wards, demolition of dilapidated wards, construction of new wards with not more than 20 in-patients per ward | New hospital constructed with incorporation of all suggested changes including decreased number of beds per ward |
| | Repair of roads and provision of adequate street lights. Improve communication facilities between wards, OPD, administrative building, lab, duty doctor room, nursing staff | New hospital constructed with incorporation of all suggested changes |
| Amenities and facilities | Better amenities are needed in the outpatient- larger hall, adequate setting, fans and lights, toilets. Improve availability of drinking water, lighting, laundry and toilet facilities for inpatients.<br><br>Communication facilities between the wards and different parts of the hospital | Seating capacity in OPD increased, PVC molded chairs and steel benches in OPD along with ceiling fans, wall fans, toilets, cool drinking water facility, consul-tation rooms increased from 3 to 12 |
| Financial | Insufficient funds | Budget sufficiently enhanced with expenditure for 2007-08 plan (Rs 81,16,862 and non-plan Rs 2,34,19,257) |

| | | |
|---|---|---|
| Diet/Kitchen | 3000 calories per patient as diet with specifications for cutlery and dining area. | Diet cost per patient enhanced from Rs.20 to Rs.28 |
| Ward facilities | Grossly inadequate. | Many new wards and improved amenities<br><br>Budget allocated for Deaddiction, occupational therapy and OPD block |
| Investigations/ Treatment | Only direct ECTs being administered. | Full time anaesthetist available. 98% of ECTs modified. Upgradation of diagnostic, therapeutic and testing facilities in process improved<br><br>Supply position of drugs by the APHMHIDC has improved |
| Staff and training | Fill up all vacancies with special emphasis on appointment of 5 psychiatric social workers, 5 clinical psychologists and 5 psychiatric nurses for psychosocial care | Proposals submitted to State Government for appointment of psychiatric social workers, clinical psychologists<br><br>Psychiatric nursing training required<br><br>Six MD Psychiatry seats sanctioned vide GO Ms No 14, HM&FW 21.1.2002. Presently waiting MCI clearance |
| Supportive Services | Separate MRD, radiological services | Case sheets have been computerised |

| | Recreational facilities, Occupational therapy, day care, | TVs in all the wards with Dish TV. Mini library for patients. New training and rehabilitation centre for the mentally ill has been set up. |
|---|---|---|
| | | Occupational therapy facilities available |
| | | Manovikas, a training and rehabilitation centre started in August 2007 |
| Others | Separate facility for children | No information provided |

**Hospital Report update:** As per the report of the report furnished by the hospital, there are major infrastructural changes. There is presently no overcrowding and bed occupancy as on 1 April 2008 was 266. All cells have been abolished. There are 189 toilets (1:1.6). The open wards have been increased from 2 to 4. There are however 220 closed ward beds compared to 80 open ward beds. Thus of a total of 3198 admissions in the previous year, only about 40% of admissions occurred in the open wards. There are 10 patients with a stay over one year. Many of the long-stay patients have been sent to their homes or to State managed NGO homes. As observed in the earlier report, about 5% of admissions occur through the courts. The hospital was sanctioned Rs 3 crore by the Government of India in addition to funds sanctioned by the Government of Andhra Pradesh for strengthening of the hospital. The following proposals have been sent to the State Government: for construction of staff quarters in the hospital premises, special recruitment of vacant posts, starting of psychiatric nursing courses in Government nursing colleges through the NTR University of Health Sciences. The hospital is keen that a government order be made to retain the vacant land in the premises of the hospital (which originally belonged to the hospital) for further development of the hospital.

Different parts of the hospital are well connected through telephone. There is a postgraduate library with a computer and internet connection. The hospital has community outreach activities, with visits to Prema Samajam,

Mother Teresa Home and the Central Prison. The DMHP is being carried out in Vizianagaram district.

A complaint was made by Mr Umamaheshwara Rao, Vijayawada to the NHRC New Delhi against the conditions of the mental hospital. The Director of Medical Education, AP visited the hospital on 8-6-2008 as per the directive of the Principal Secretary to Government. The hospital has a board for disability certification. The hospital has constituted a Hospital Development Society with the District Collector as chairman and medical professionals, self help groups, people's representatives, principal of the medical college, executive engineer, APHMIDC, RMO, MP, social workers and ex-students of the hospital as members. It does not have a functioning Board of Visitors.

## Assam

### Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur

(Established 1876, rebuilt 1926. Bed strength 500 earlier, presently 336)

### NHRC/NIMHANS 1999 report:

*"This is the larger of the two mental hospitals serving the entire north-east region. It ranks among the better government hospitals in India. It is a good example of how hospitals can be improved if there is a will and cohesion among staff members. There is an urgent need to increase the hospital beds in the whole state, as the current position is too meagre for the population. It is better to have smaller hospitals in many areas as it is difficult to travel from place to place. The North Eastern Council and the Government of Assam have suggested that the hospital be converted into an autonomous regional institution of mental health along the lines of NIMHANS. This has been implemented at the time of writing this report".*

### Earlier rating: Good

**Interim observations:** *"The dramatic improvement in the standards of mental health care at the LGBRIMH Tezpur is something which the State can take pride in and which can be a role model for the other mental hospitals to follow… The Institute has been taken over by the North East Council and is being renovated gradually"* (DGHS 2004).

*NHRC/SHRC visits during the last decade:* 5 (3 NHRC, 2 SHRC)

## Specific Recommendations and Action taken

| Domains | Suggestions of NHRC/ NIMHANS Report 1999 | Interim observations (GOI/MOH report 2004) | Reported status as in 2008 |
|---------|------------------------------------------|--------------------------------------------|----------------------------|
| Infrastructure | Emergency services and open wards needed | | Already the Institute has been handed over to the Ministry if Health and Family Welfare, GOI and the government is planning its expansion and development in a phased manner |
| Amenities and facilities | Emergency services and open wards with provisions for family members to stay will raise the standard of this hospital.<br><br>There should be separate wards for medical emergencies, children. Open and special wards should also be built.<br><br>Support services like kitchen, laundry, | Inadequate | The report states that the facilities are started in the hospital and is taken up in the new proposal for its implementation. The hospital reports that this is included in the new plan and that presently there is no facility for children and special wards in this hospital.<br><br>The hospital reports that this is |

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| | pharmacy, stores and maintenance should be improved. | | included in the new plan. |
| Financial | Rs 110 lakh (plan Rs 10 L, non-plan 100l) | | Rs 2902.94 lakh (plan 823 L non plan 2079.94 L) |
| Diet/Kitchen | No specific comment | Kitchen needs to be improved | 2800-3200 k calorie diet |
| Investigations/ Treatment | Quality psychiatric care in terms of modern drugs modified ECTs and psychosocial treatments in wards and OPD must be followed.<br><br>Better lab facilities for essential investigations are needed in the outpatient services. | Drugs available.<br><br>No anaesthetist available.<br><br>Still only direct ECTs being given. | The hospital reports that these are already implemented.<br><br>The hospital reports that this has already been started and that the institute has modern diagnostic facilities<br><br>Mainly modified ECTs<br><br>7 pg students |
| Training | The hospitals should be made into a teaching hospital with postgraduate students posted in the wards | Inadequate clinical staff | currently doing DNB psychiatry, 4 MSc psychiatric nursing. Starting MPhil psy-social work and in psychology. Inspection by Gauhati university for starting MD psychiatry done in May 2008 |

| Recreation/ Occupational Therapy/ Rehabilitation | There is ample space for the starting of rehabilitation facilities such as horticulture for the ward patie- nts There should be recreational facilities availa- ble in each ward | Lack of recreational facilities | The hospital reports that a comprehensive centre is being newly built with funds form the Ministry of GOI and the facility is on the way of completion. It is to be commissio- ned shortly. |
| --- | --- | --- | --- |
| | | | Trade instructors, occupational therapist, physiotherapist are appointed and looking after the rehab facility of the Institute |
| | | | No functioning board of visitors |
| | | | No disability certification |

**Hospital report update:** After 1996, the outpatient services have been modified to ensure 150 seating capacity, the consultation rooms have been upgraded, a canteen set up and computerisation of OPD completed. The wards have been reorganised and the capacity deliberately reduced to 336 beds. Bed occupancy as on 1 April 2008 was 83%. Of the 336 beds, 315 (94%) are open ward beds.

In between 1st March 2007 and 31 March 2008, only 19(1.3%) admissions were through court orders. Twenty-two cells have been renovated and are currently used as interview rooms. Toilet facilities, water supply and drainage have been improved. Patient toilet ratio is 1:6. Modified ECTs were administered with an anesthetist till February 2008. Of a total of 738 patients receiving ECTs in the previous year, 73 (9.9%) received direct ECTs.

Day-care centres are functioning. A new rehabilitation building is being constructed with a fund of Rs 300 lakh received from the Ministry of Health and Family Welfare. A library with internet connection and good communication between all sections of the hospital through telephones has been established.

According to the institution's report it is still lacking in indoor facilities for child psychiatry, geriatric psychiatry and family wards, etc., which are essential for total mental health care. The present setup is merely a transition from an asylum setup. It is necessary to convert the custodial care set-up to open wards, like that of a general hospital. For this, however, the numbers of care givers, i.e. nursing professionals and attenders have to be increased. The Institute can be upgraded to a full-fledged teaching institute for development of manpower in mental health and allied sciences.

# Delhi

### Institute of Human Behaviour and Allied Sciences (IHBAS)

A mental hospital set up in 1966 that was converted into an autonomous institute in 1993. Earlier bed strength 400, current bed strength is 180 for psychiatry.

**NHRC/NIMHANS Report (1999):** '*The hospital has 100 acres of land and has a modern look with a new outpatient and administrative block with a beautiful garden in front of it. The wards and toilets are getting renovated. Round-the-clock casualty and emergency services are available with ambulance facility. Patients are allowed to wear their own clothes and uniforms are provided to those who don't have their own clothes. Though a separate occupational therapy building is present it is underutilised. Involvement of NGOs or volunteers on a regular basis does not occur. Kitchen and dietary services are very good. Quality and quantity of food given to the patients is good*.'

Earlier rating: Good

Specific Recommendations and Action taken

| Domains | Suggestions made by NHRC | Reported status as in 2008 |
|---|---|---|
| Infrastructure | The institute has prepared a master plan and has taken up implementation of the same in a passed manner. This should be completed within the time frame | The hospitals report of 2008 states that IBHAS has been equipped with many state-of-the art infrastructures that include a separate centrally airconditioned academic block and a diagnostic block<br><br>Two new buildings of Neurology Block and Psychiatry Block with centralised ICUs and private wards have also been constructed. One separate Neurosurgery block with two operation theatres have been provided<br><br>Separate waiting hall general toilet facilities for ladies, gents and physically handi-capped persons as well as a provision of dharamshala for outpatients has been made |
| Amenities/ Facilities | Child psychiatry, family wards, mental retardation clinic and other special services should be started. Inpatient facilities should be further improved | Specialised OPD services in the form of movement disorder clinic, drug addiction treatment and rehabilitation clinic, tobacco cessation clinic, mental retardation clinic, child guidance clinic, marital and psychosexual clinic and epilepsy clinic are also functional currently |

| Diet/Kitchen | | A herbal garden has been developed. There is rainwater harvesting, solar heating system in the kitchen; an effluent treatment plant and biomedical waste collecting chamber have also been provided. The budget allocation for food is Rs 50/ per day per patient. |
|---|---|---|
| Recreation/ Rehabilitation /Occupational Therapy | Psychosocial rehabilitation should be taken up in a systematic manner and greater empha-sis needs to be given to this important area. Community-based programmes like satellite/extension clinics and school and college mental health programme should be started. The involvement of NGOs in organising services should be encouraged. | The report states that in-patient rehabilitation care has been systematised with Day Care Activity scheduling, Recreational activities and Group Sessions. There is also pre-vocational and vocational skills training, discharge planning and home management. Trades such as Tailo-ring/Stitching/Embroidery, Envelope making, candle making, arts and crafts are available in occupational therapy. There are also indoor and outdoor games, and TV, radio and computer as well as a library available as recreation for patients |

**Current status of the hospital:** IHBAS currently has a separate OPD block with dedicated 24 hour Emergency services. OPD lab services are also available with free medicines for patients. Separate medical records section and educational material for patients is also available. Current patient-toilet ratio is inadequate (1:7) as NHRC recommendations state the ratio as 1:5. There is 24 hour running water with fans and coolers in the wards. Uniforms continue to be compulsory for patients. Modified ECTs are given. The institute is currently running MD (Psychiatry), DNB (Neuro) and M. Phil (Clinical Psychology) courses. The Board of Visitors is functioning in the hospital.

# Goa

## Institute of Psychiatry & Human Behavior, Bambolim

(Established 2001. Earlier bed strength 300, current bed strength 190)

## NHRC/NIMHANS 1999 report:

"The new facility at Bambolim on the Panaji Vasco highway is close to the Goa Medical College. The site is huge and spacious. The mental health professionals have been involved in planning of the construction. The new building promises to realize many more of the recommendations earlier made by Dr Govindaswamy. The IPHB, Goa is an example of one of the better psychiatric hospitals in the country and has incorporated many modifications".

## Earlier Rating: Good

**Interim observations**: "*Given the right kind of dynamic and imaginative leadership the IPHB can become a major centre for training mental health personnel including clinical psychologists, PSWs and psychiatric nurses*" (DGHS 2004). "*The involvement of the NHRC through Dr Channabasavanna Committee has helped in reviving the report of the WHO consultant Dr MV Govindaswamy submitted way back in 1950 which has remained forgotten all these years. Implementation of the recommendations of the Dr Channabasavanna Committee (NHRC/NIMHANS 1999) is thus found to be generally good with promising signs of early completion of pending tasks....The institute has been performing commendably in the field of education and training in mental health and research activities*" (Shri Chaman Lal Report 2006)

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations NHRC - Chamanlal report 2006 | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Was still at Altinho. | Shifted to Bambolim | New facility<br><br>In the second phase of construction 100 beds including 20 private proposed |
| Amenities and facilities | Special facilities for substance use and for children with psychiatric problem should be introduced<br><br>Services for the criminal mentally ill are unsatisfactory and should be improved | Children's clinic set up but no Deaddiction facility<br><br>Living conditions have improved, satisfactory sanitary facilities<br><br>A proposal for creating additional capacity of 100 beds to raise it to earlier level of 300 is under consideration of the Government of India | Child guidance and adolescent Clinic No special wards available for the children or for patients with substance abuse problems.<br><br>Proposal to start a Deaddiction centre being worked out<br><br>Separate wards are provided for mentally ill prisoners.<br><br>The locked up cell has been discarded |
| Financial | Rs 280.12 lakh (plan 78.06 L, non plan 202.06 L) | Rs 450 lakh (plan 50 L, non plan 400 L) | Rs 666.9 lakh (plan 164 L, non plan 502.9 L) |

| Diet/Kitchen | Rs 15 per person/day | Diet requirement to be worked out in calories | Rs 22/person/ day, providing 2500 calories is being worked out |
|---|---|---|---|
| Investigations/ Treatment | | Modified ECTs being given. Anaesthetist present | All modified ECTs |
| Staff and training | Sensitisation regarding the rights of the mentally ill should be arranged for all categories of staff<br><br>Regular meetings of different groups of mental health professionals with adminis-tration to discuss patient issues, improvements of facilities, as well as staff grievances | Staff patterns show little improvement<br><br>Ancillary staff vacancies(nurses and ward attendants) present | 90 staff appointed after 1996.<br><br>22 resident doctors on hospital premises.<br><br>MD and DPM courses running.<br><br>Nurses are deputed for training, including psychiatric nursing courses<br><br>Sensitization regarding rights of mentally ill is organized regularly with help of organizing lectures to the staff and carers by District Legal Services Authority<br><br>Regular meetings are held with admin staff and faculty members |

| Supportive Services | Better liaison with voluntary agencies/NGOs | | IPHB liaises with Goa Psychiatric Society, Indian Medical Association, Kripa Foundation, AA groups, Lions Club, Rotary Club, and several NGOs which help with rehabilitation of patients |
|---|---|---|---|
| | | | MRD facility |
| | | | Record computerisation underway |
| | | | Has a Board of visitors which meets regularly |
| Recreation/ Occupational Therapy/ Rehabilitation | More extensive rehabilitation services catering to more of the recovered patients should be evolved. The vast area in the new premises will certainly facilitate this | Occurring on a small scale | The State government has approved the proposal to start the day care centre in IPH Complex for rehabilitation of admitted patients and also OPD patients |

## Hospital report update

The Institute of Psychiatry and Human Behaviour, Bambolim, Goa was constructed in 2001 at a cost of Rs 3.5 crore, borne by the Government of Goa. Diet: Increased to Rs 22. Proposal sent to increase to Rs 40. Canteen is available close to the OPD. All medications are available. Recreation therapist supervises various recreation activities. There is a spacious library. Good network of telephone communications throughout the hospital and wards. As on 1 April 2008, 129 beds were occupied

(85%). Open wards are still few (only 2 with 32 beds) when compared to closed facilities (9 with 152 beds). However, there were 1053 admissions to the open wards between 1st March 2007-31st March 2008, compared to 661 admissions to the closed facility. Less than 10% of admissions are through court orders. In the previous year, 891 ECTs were administered, all modified. There are 7 long stay patients, still in the hospital after 5 years.

The institute has an active post-graduate training programme, a well-equipped library and all the staff is encouraged to undertake research activities. Medical students of Goa Medical College receive regular lectures in psychiatry and psychology from IPHB staff. The IPHB renders community services through fortnightly extension clinics at the Rural Health Centre, Mandur, Chimbel, Asha Mahal and at the Central Jail. The Chaman Lal report notes that the voluntary admissions constitute 69.5% of the total admissions between 2001 and 2005. Admissions under Section 19 of the Mental Health Act (admission under special circumstances) constitute 17.2%. The report points out a flaw in the application of the spirit of this section with respect to a few patients who require staying for beyond 90 days. "*However, in some cases (very few in number) the person is shown as discharged and readmitted for a fresh period of 90 days. Obviously this is being done to avoid the cumbersome procedure and difficulties involved in obtaining the reception order from the competent authority*". The report takes objection to this and recommends strict adherence to the obligations under this section.

The report commends the display of patient's rights within the hospital:

"*It is heartening to note that a Citizen's charter containing general information about the Institute, guidelines for availing of various facilities and mechanism for redressal of complaints and grievances has also been issued (Chaman Lal report 2006)*". The report also observed that this was probably the only institution in Goa having the key post of medical superintendent in the lower grade of Assistant Medical Officer.

# Gujarat

## Hospital for Mental Health, Ahmedabad

(Established 1863. Bed strength 317)

### NHRC/NIMHANS 1999 report:

*"The main hospital is built on the lines of a prison with single cells. Many parts of the hospital are no longer habitable and have been closed down".* The report recommended a new building, open and family wards, abolition of uniforms, improvements in staff position, greater emphasis on psychosocial intervention and rehabilitation.

### Earlier rating: Poor

### DGHS 2004 review:

*"One of the oldest mental hospitals; well managed. The new building will provide better infrastructure. The hospital has good potential not just for services, but also as a training centre".*

**NHRC Rapporteur remarks (15-17 October 2007):** *"It is matter of great satisfaction that almost all recommendations of Dr. Channabasavanna Committee have been implemented. Upgrading OPD services and enhancing the extent of psychological intervention have improved therapeutic and diagnostic facilities".*

*"Conditions in closed wards have been bettered resulting in an overall relaxed atmosphere with no sign of gloom or morbidity generally associated with a mental hospital".*

*"HMH, Ahmedabad presents an excellent example of effective functioning of **Boards of visitors** and active involvement of the **NGO sector** in patient care, capacity-building and rehabilitation, and has the potential to become a good centre of education and research in the mental health field".*

No. of NHRC/SHRC visits: 1

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations (DGHS 2004/ NHRC 2007) | Reported status as in 2008 |
|---------|---------|---------|---------|
| Infrastructure | Construction of the new hospital building must be started without further delay. In the interim period some basic toilet facilities must be provi-ded for the male patients | Huge area. Current building unsatisfactory. New one being built.<br><br>No casualty and emergency services | Old building cons-truction totally demolished in a phased manner from 1998-2002. In 1998 the foundation stone of the new building was laid. In 2001 a new male wards and kitchen blocks were inaugurated<br><br>A short-stay ward started from June 2008 |
| Amenities and facilities | In the new building there should be open wards where a relative can stay with the patient, family wards wherein families as a whole can be given specia-lised inputs<br><br>There should be special wards on a payment basis and an ICU for | Clinical services adequate, can be improved<br><br>Proportion of voluntary admission gone up appreciably an open ward equipped with facilities for the stay of a family member with pt. has been added and is producing | An open ward equipped with facilities for the stay of a family member has been added<br><br>Emergency and short-stay wards still not available<br><br>Segregation of criminal patients has been done |

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| | physically ill patients and emergencies<br><br>Criminal patients should be kept separately or treated in jail itself by the visiting psychiatrist<br><br>Patients to be provided with individual lockers and encouraged to wear personal clothing | expected results.<br><br>Standby generator essential | Generator budgeted this year |
| Financial | Rs 194 lakh (plan 67 L non-plan 127 L) | | Rs 243.4 lakh (plan 7 L, Non-plan Rs 220 L others 16.4 L) |
| Diet/Kitchen | Adequate | Adequate | 2500-3000 calories per day (Rs 33.8/day) |
| Investigations/ Treatment | Greater attention needs to be paid to psychosocial intervention so as to reduce the duration of hospital stay and the disability of the patient | Drugs adequate | The hospital reports commendable work by PSWs in tracing families of unknown patients and restoring cured patients to their families<br><br>All ECTs are modified |
| Staff and training | Staff patterns have to be improved considerably. Posts of | Inadequate number of psychiatrists and other mental health | There are two psychiatrists, one CP, two PSWs and no trained |

|  | psychiatrists, CP, PSWs and psychiatric nurses have to be created | professionals | psychiatric nurses |
|  |  | Sanctioned nurses to be increased to 50 | Reorientation training provided to the staff every two years |
|  |  | Earlier practice of posting MD psychiatry students to HMH on 3 month rotation to be revived | Proposal sent |
|  |  |  | Proposal sent to the DME for arrangements |
| Supportive Services | Mental health education needs to be taken up on a war footing and families need to be involved as partners in care |  | A self-help group for the caregivers of the mentally ill has been formed. The hospital conducts meetings with caregivers twice a month |
|  |  |  | MRD staff trained. Computerisation of records under process |
| Recreation/ Occupational Therapy/ Rehabilitation | Rehabilitation facilities has to be improved<br><br>The response of the community and NGOs has to be positive and this needs to be channelized so as to facilitate early rehab of the patients | The most notable prog-ress is seen in development of occupational therapy facili-ties, starting Day Care cen-tre and numbers of measures taken up for rehabilitation of cured pts.<br><br>The performa- | Currently the hospital provides occupational therapy facilities, day-care centre, day-care centre, skills develop-ment, behaviour modification training, social skills training, vocational training, job placement |

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|---|---|---|---|
| | | nce of social work team has been extraordi- narily with visi- ble results of their efforts in restoring wand- ering mentally ill to their families | where possible. The hospital follows a comm- unity-based rehabilitation model and closely works with several NGOs in the community |
| | | Remuneration to rehabilitation service and day- care centre attendees to be increased | Revised |
| Other | | Death reporting system and audit | Inquiry committee formed |
| | | | Boards of visitors active |
| | | | Disability certifi- cation is done. |

## Hospital report update

The old building was totally demolished between 1998 and 2002 and the government sanctioned Rs 9.9 crore for a new construction. This has separate blocks for OPD, occupational therapy, sheltered workshop, quarter way home, kitchen and administrative block. The new construction has small units of wards accommodating 10-25 patients. Semi-special and special wards are provided. No new cells have been constructed. Cells exist for mentally ill prisoners, but their utilisation is low, and is mainly use for storage of linen. The campus has common gardens. There is a separate well-equipped seminar hall in the training block. There are special OPDs for child guidance and mental retardation, geriatry, epilepsy and neurobehavioral problems, schizophrenia and an adolescent clinic runs in the evening hours. Adequate laboratory facilities, psychosocial counseling services are provided.

Of a total of 987 admissions in 2007, 784 (79.4%) were voluntary (in contrast to 26% in 2002), 148 (14.9%) under special circumstances and 54 (5.4%) admitted through the courts. Only one criminal patient received inpatient care.

The ratio of psychiatrists, nurses, medical officers, mental health professionals and attendant staffs recommended as per the central government notification have been met. However, the hospital perceives a need for more staff for better quality of work. Several of the staff have attended training within the hospital as well as been to several training programmes and conferences in the country and abroad. Students from nursing colleges, medical social work students, psychology students have educational placements at the HMH.

The HMH has introduced a range of occupational activities as well as vocational training in collaboration with the HRD Department of the Gujarat University and Ahmedabad Sarvar Mandal. An innovative research project undertaken by the HMH is the rehabilitation of the wandering mentally ill, using the provision under Section 23 of the MHA 1987. This project attempts to rehabilitate and reintegrate the wandering mentally ill with the help of the police inspectors within each jurisdiction. The HMH has initiated a self help group of family caregivers of mentally ill (SATHI). It has an active community-based rehabilitation approach and has conducted outreach activities with AWAG, Blind Peoples' Association, Avirat and Sathi, produced IEC materials, held camps, conducted training for NGOs and has had collaboration for rehabilitation with the Gujarat Sarvar Mandal, Om voluntary organisation, Banyan, Chennai, Sahyog, Kasturba Trust, Sadkary Seva trust and the Jain Youth Trust. The HMH has also instituted a help line under the control of the State Mental Health Authority. It has been actively involved in multiple research activities.

## Hospital for Mental Health, Vadodara

(Established 1898. Bed Strength 300)

### NHRC/NIMHANS Report 1999

*"High walls surround the complex… The basic structure is still in good condition…But tiles and walls are in damaged condition…Toilets are not in good condition…There is a problem of running water…lighting is insufficient…Current staffing position is inadequate…Voluntary admissions form only 15% of total admissions…and majority (63%)*

*are still through court order…No casualty or emergency services…living arrangements barely adequate….Ten single cells present….Food adequate…No laboratory facility….Inadequate pharmacotherapy…patients' physical health good…. Regular patient monitoring…No clinical psychologist… Recreational facilities present….Minimal occupational therapy present. Liaising with NGOs to provide community service….Board of visitors exists".*

"*A progressive step is the conversion of six single rooms into an open ward where the relative can stay with the patient".*

### Earlier rating: Poor

### Interim Observations

DGHS (2004): This team observed that the state of the buildings was unsatisfactory, that there were multiple unfilled vacancies, that the staff required training. The team concluded that "*The hospital is one of the oldest mental hospitals. It is reasonably well-managed at clinical as well as administrative levels. The engineering maintenance leaves a lot to be desired. No instance of physical abuse or chaining has been reported. The inadequate group C and D and paramedical staff adversely affects the patient care services".*

### Chaman Lal report (NHRC Visit 15-17 October 2007):

"*The NHRC recommendations of Channabasavanna Committee (NHRC/NIMHANS report 1999) found to be just satisfactory".*

"State Govt. has taken some steps recently to provide better living condition to the patients…Institution is doing very well in the field of community outreach services and academic activities. The MS is dynamic with innovative ideas and leadership qualities. He is aware of the newer developments in the field and sensitive to the professional inputs provided by other members in a multidisciplinary team".

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations (DGHS 2004/ NHRC 2007) | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Infrastructure to be upgraded especially for improving outpatient services, wards, toilets and providing an intensive care unit facility and rooms for the staff and duty doctors | Unsatisfactory maintenance | The report states that the new OPD building with a short-stay ward in currently under construction and will be completed by Dec 2008. Male and female ward renovation is under progress and will be comp- lete by December 2008 from the one time central government grant. Collapsed community hall reconstructed. |
| Amenities and facilities | A positive step has been the starting of open wards and this needs to be substantially strengthened | Adequate but can be improved<br><br>Good treatment and care | The report stated that the OPD facilities have been upgraded and new building offers reasonably good facilities for a family |
| Financial | Rs 104 lakh (plan 19 L non plan 85 L) | | Rs 211.18 lakh (plan 66.1 L, non plan 145.1 L) |

| Diet/Kitchen | Adequate | Adequate in quality and variety | Provided as per government norms |
|---|---|---|---|
| Investigations/ Treatment | Arrangements to administer ECT in the hospital and the services of an anesthetist either part time or as a visiting consultant | | The report states that modified ECT is in use but also states that ECT use has been suspended recently

Medication adequate |
| Staff and training | Staff patterns has to be improved and psychiatrists, CPs, PSWs and psychiatric nurses are to be appointed | | There are still no CPs, PSWs, trained psychiatric nurses

Library, internet facilities available |
| Supportive Services | Greater support needs to be provided for this centre in terms of computer and library facilities so that research initiatives can be under taken | | The report states that 'books are available; all newspapers are given to each department'. Details of computerisation not stated

Separate MRD set up |
| Recreation/ Occupational Therapy/ Rehabilitation | Rehabilitation services to be improved and daycare/ sheltered workshops can be started within | | There is currently a half-way home, a day care centre, one occupational therapist, 3 tailors and 2 carpenters. The hospital is also a nodal |

| | the hospital premises | | institution for the implementation of the DMHP and shows good beginning. They also run a self help group |
|---|---|---|---|

## Hospital report update

Between 1997 and 2008, the hospital has received a total grant of Rs 47, 84711 towards works. A new outpatient building with short stay ward, an administrative block and lecture hall are under construction from an additional central government one time grant of Rs 2.99 crore. The renovation of the male and female wards is also under progress. The collapsed community hall has been reconstructed at a cost of Rs 21 lakh. Emergency services are to be started after completion of the construction. The hospital reports adequate staff. Any vacancies are filled up on a contract system. There are regular training programmes for the staff.

## Hospital for Mental Health, Jamnagar

(Established 1959, new construction 1984, earlier bed strength 50, presently 70)

NHRC/NIMHANS Report (1999):

"The hospital has been built as a mental health facility. Although the basic structure is still in good condition, maintenance had been inadequate. All wards are closed. Staff position is grossly inadequate. All admissions are through the judiciary by court order. In patient services are inadequate. There is no liaison with any other organisations. Board of visitors is constituted but does not meet regularly. Overall awareness of the rights of the mentally ill among the staff and patients needs to improve".

**Earlier rating: Poor**

**Interim observations:**

The Chaman Lal review report (2007) recommended the amalgamation of the HMH Jamnagar, with the GG hospital.

**Visits by the NHRC/SHRC during the last decade: 2**

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations (NHRC 2007) | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Inadequate maintenance | | Occupation therapy building in 2004<br><br>Rehabilitation complex in 2008<br><br>Kitchen renovation and new auditorium underway |
| Amenities and facilities | Involuntary admissions need to be kept at a minimum<br><br>Open wards to be started and family members to be educated and involved as partners in care<br><br>Running water in toilets and improvement in clothing and linen | | Involuntary admission kept to a minimum also is being followed. Open ward has been started 12 months back and the processes for keeping<br><br>A grant of Rs 9 lakh has been transferred to the PWD for necessary work and the report states that work will start shortly. The hospital |

| | | | |
|---|---|---|---|
| | | | currently has 6 water coolers and 6 water purifiers |
| Financial | Rs 19 lakh total | | Rs 43.79 lakh total (plan 8.99 L, non plan 34.8 L) |
| Diet/Kitchen | Adequate | | 2500 calories/day (pre-existing) Rs 28/day |
| Investiga- tions/ Treatment | No lab facilities available | See below | Adequate drug supply |
| Staff and training | A psychiatrist should be immediately appointed as the Medical Superin- tendent. He should prefera- bly have some experience in administration or sent to the hospitals at Ahmedabad or Vadodara for a short training Staff positions should be improved immediately to change the type of care from custodial to therapeutic | Medical officers to be present at night No lab technician | There have been psychiatrists in the position of MS from 1999 Seven positions of nurses were created in 2002 and were filled gradually. Clinical Psycho- logist, Social Worker and Occupational Therapist were trained at Hospital for Mental Health, Ahmedabad. Staff are routinely informed and trai- ned about human rights issues dur- ing staff meeting and ward rounds RMO has made |

| | | | |
|---|---|---|---|
| | Staff needs to be sensitised about the rights of the mentally ill | | arrangements |
| | | | Patient welfare committee permitted filling on contract basis |
| | | | Separate MRD |
| Supportive Services | | Deficiency of community services | An OPD has been started at Porbander, training programmes initiated for medical officers, ANMs and other staff. |
| | | | NGOs currently working with the Institute |
| Recreation/ Occupational Therapy/ Rehabilitation | Involvement of voluntary organisations especially for stating rehabilitation services | | Recreational facilities present |
| | | | Rehabilitation activities present |
| | | | Committee formed |
| Others | | Regular Death Audit | Board of visitors active |
| | | | No disability certification |

## Hospital report update

Posts of clinical psychologist (1), psychiatric social worker (1), additional nurses (7), occupational therapist (1), and RMO were created following the NHRC/NIMHANS recommendations. The NHRC review (2007) still perceives the staffing as inadequate. The hospital received Rs 82.28 lakh grant from the central government in 2005-2006. It presently has 70 beds available. The bed occupancy rate is 80%. Eight cells still exist, 6 for males and 2 for females. Of 127 admissions during the prior year 105 (82.7%)

still occurred into closed wards. A majority (73%) were admissions through the courts. There are 20 patients staying in the hospital for more than one year. The hospital has adequate running water and the patient toilet ratio is 1:2. There are no compulsory uniforms for any patients. While ECT services are available, no patients received ECTs during the last year. The hospital has no outpatient or inpatient specialized services for children, elderly, criminally mentally ill or deaddiction. Repairs include installation of a new drainage system at a cost of Rs 9 lakh (funds transferred to the PWD, work to commence shortly). The hospital has provided six water coolers and purifiers.

It conducts two community outreach services each month. It does not conduct any post-graduate courses, but medical social work students are posted. The hospital is conducting IEC activities in collaboration with Blind People's Association, Ahmedabad.

The Chaman Lal Review (2007) recommended amalgamation of the HMH, Jamnagar with the GG Hospital. In this regard a proposal was put up the superintendent and is awaiting clearance.

## Hospital for Mental Health, Bhuj

(Established 1957. Completely destroyed following 2001 earthquake and rebuilt. Bed strength 16.)

### NHRC/NIMHANS 1999 report:

*"The condition of the building is fairly good…Majority of the admissions are voluntary. Occupancy rate is more than 100% because the hospital is popular and well accepted…overall, inpatient facilities are adequate. Local charitable organisations like the Lions and Rotary are associated with the hospital, but there is no formal community based activity. The medical superintendent is young and enterprising and managed to mobilize community support".*

### Earlier rating: not rated

### Interim observations:

The Chaman Lal (NHRC 2007) report observes that the NHRC recommendations found to be just satisfactory. Staff position and budget allotment is strengthen and enhanced, well designed new hospital has been constructed

## NHRC/SHRC visits during the last decade: 2

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations (NHRC 2007) | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Adequate for a 16 bedded facility | | New facility |
| Amenities and facilities | Bed strength can be increa-sed to about 30 as greater dema-nd for services in this region<br><br>New wards should be open wards with facility for family members to stay with the patients<br><br>Special wards for patients willing to pay<br><br>Routine head shaving to be stopped and adequate delou-sing measures to be adopted<br><br>Patients to be encouraged to wear own clothes and more variety in hospital clothing | Just satisfactory | The hospital currently is 16 bedded, but present occupancy is 34. Proposal submitted for a 30 bedded facility<br><br>New building<br><br>No private wards<br><br>No uniforms |

| Financial | Total Rs 10.5 lakh | Budget has been enhanced | Rs 41.41 lakh (plan 17.2 L, non plan 24.2 L) |
|---|---|---|---|
| Diet/Kitchen | Adequate | Food budget reduced | Currently Rs 25.21/day |
| Investigations/Treatment | Anesthetist on part time basis or as a visiting consultant for proper administration of ECTs | ECTs should be made available at the nearby district hospital | ECTs provided at the general hospital |
| Staff and training | Staff positions need to be strengthened with adequate number of mental health professionals | Vacant positions | There is currently only one qualified psychiatrist, one PSW. There is no clinical psychologist, no psychiatric nurses and no occupational therapist<br><br>Vacancy recruitment planned through contract appointment |
| Recreation/Occupational Therapy/Rehabilitation | Existing ground space to be utilised to put up a separate building for rehabilitation | Occupational therapy not started for want of an occupational therapist<br><br>Large number | There is one carpenter who trains patients. There is also provision for computer training, machine embroidery training and machine sewing training.<br><br>The report does not talk of a separate building for rehabilitation work |

| Others | | of admissions u/s 19 MHA. Potential for misuse | |
|---|---|---|---|

**Hospital report update**: The new building was constructed from a MPLAD fund of Rs 70 lakh, in the vicinity of the collapsed hospital. Initially, the building was built on the lines of a halfway home and was to be handed over to the department of social defence, but now houses the hospital. A medical college has come up where the district hospital was situated. Other sources of recent funding include Rs 9 lakh from NIrmal Gujarat, Rs 4 lakh and Rs 6.25 lakh from the Rogi Kalyan Samiti. The HMH Bhuj has 27 rooms, a large kitchen and a large dining facility around a central compound. There is a separate OPD block. A sheltered workshop has also been set up. The hospital has 32 sanctioned staff and perceives that this is inadequate. None of the staff stays on campus. Recreational and rehabilitation facilities are provided to the patients. Facilities are reportedly adequate. There is a library for patients. Telephone facilities are available. Patient toilet ratio is 1:2. There is adequate running water and electricity. Patients do no have compulsory uniforms. Separate dining facilities are available. Drug supply is adequate. Anesthetist is available and all the 52 ECTs administered in the previous year were modified (however not in the hospital). There are no specialised outpatient or inpatient services for children, elderly, criminally mentally ill or Deaddiction. Although the bed allocation is 16, the number of beds occupied as on 1 April 2008 was 34. There are no cells or closed wards. Of 195 admissions that occurred in the previous year, 28 (14.4%) were through the courts. The Chaman Lal report (NHRC 2007) however takes exception to the fact that 123 of 164 patients in 2006 were admitted under section 19 of the MHA citing that such a practice can give 'ample scope for abuse'. There are no paid wards. Three patients have been staying in the hospital for more than one year.

The hospital conducts 3 camps each month, one at Kutch and two under the DMHP in Diyodar in Banaskantha district. The hospital does not offer any postgraduate training. It has a functioning board of visitors.

# Jammu & Kashmir

## Government Disease Hospital, Jammu

(Established 1964. Bed strength 75 (currently allocated bed strength mentioned as 70)

### NHRC/NIMHANS report 1999:

"*Though the hospital was started as a mental hospital, it is now working as a psychiatric institute attached to a medical college. It has an open ward set up where family members can stay with the patient. This open ward system is an example of how a typical closed mental hospital can be transformed when it becomes an open system. This change has been facilitated by the attachment of a teaching hospital with postgraduate students. The effect of adequate staffing is evident from the better care that is available at this hospital*".

Earlier rating: Good

Interim observations: none available

NHRC/SHRC visits during the last decade: 3

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/NIMHANS Report 1999 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | Adequate | New OPD complex, deaddiction facility, seminar hall, casualty, administrative complex built<br><br>Male and female wards renovated |
| Amenities and facilities | Adequate | No canteen services exist<br><br>Telephone connection present |
| Financial | | Total Rs 127.4 lakh (plan 26.07 L, non-plan 101.37 L): figures for 2004-2005 |

| Diet/Kitchen | Rs 14/day | Not mentioned |
|---|---|---|
| Investigations/ Treatment | Modified ECTs should be administered. Services of an anesthetist can be procured on a consultancy basis | There are two anesthetists coming in as visiting consultants. Modified ECTs are being provided<br><br>16 channel EEG machine, X-ray plant |
| Staff and training | Post of clinical psychologist and occupational therapist should be created so that the interdiscipli-nary team is complete<br><br>Post-graduate courses should be started so that adequate number of mental health profe-ssionals can be trained | There is one clinical psychologist and one psychiatric social worker<br><br>DNB course is being provided. No MD course |
| Supportive Services | Rest home for the relatives should be built<br><br>Rehabilitation services | A separate block for family members is currently under construction<br><br>MRD services expanded |
| Recreation/ Occupational Therapy/ Rehabilitation | for the mentally disabled should be started immediately | Recreation room constructed<br><br>There are still no rehabilitation facilities available for patients |
| Other | | Functioning board of visitors<br><br>No community outreach<br><br>Disability certification provided |

**Hospital Report update**: The hospital has not received any special funds for improvement. It offers psychosocial interventions. A deaddiction facility with 4 beds has been started at the GMC since 2004. The hospital has a

separate forensic ward (6 beds). The clinical laboratory has been strengthened. There is adequate running water and ventilation. Patient-toilet ratio is 1:5.

Of the 1167 admissions during the previous year, 775 (66%) have been to open wards. There are no paid wards. There were 15 admissions (1.3%) through the courts. The hospital does not have any long stay patients. Closed ward patients still have compulsory uniforms.

The allocated staff (4 psychiatrists, 5 GDMOs, 1 clinical psychologist, 1 psychiatric social worker, 2 psychiatric trained nurses, 15 general nurses, 1 occupational therapist and 39 supportive staff) is perceived as inadequate. There is a visiting anaesthetist. There is a perceived need for training of the nurses and paramedical staff. Adequate medications are available. 40 patients received ECTs during the last year, all modified, under supervision of an anaesthetist. Human rights of patients are displayed in the hospital.

The hospital's request for new land area is presently with the administrative department, Jammu & Kashmir.

## Government Psychiatric Hospital, Srinagar, Jammu & Kashmir

**NHRC/NIMHANS report 1999**: This hospital was not visited by the NHRC team in 1999

**Interim observations: none available**

**Specific Recommendations and Action taken**

| Domains | Reported status as in 2008 |
|---|---|
| Infrastructure | An OPD Block has been constructed with 3 rooms for consultation, EEG lab, haematology and biochemistry lab, drug counter, 5 emergency beds, a Medical Records section and 6 OPD cubicles. There has also been construction of two open wards with 10 and 20 beds each, an ECT theatre, a faculty block, a recreational hall and seminar room, a counselling centre, and residential quarters for doctors and other employees. Medical records are being maintained manually |

| Amenities and facilities | There is broadband internet connection in the library. There are facilities for toilets and drinking water and a waiting hall in OPD. Wards are well lit with atta-ched bathrooms and dining hall. There is also a generator facility in case of power break-down. There are 24 hours casualty and emergency servi-ces as well as telephone and ambulance facilities |
|---|---|
| Diet/Kitchen | Diet is free which includes two meals, dinner, breakfast and evening snack |
| Investigations/ Treatment | There is a separate dispensary for drugs. Essential drugs are available for OPD patients. |
| Staff and training | There are 8 qualified psychiatrists, two GMOs, two clinical psychologists, 10 general nurses, 1 lab technician, 5 administrative staff and 15 ward atten-ders. There are no psychiatric social workers, trained nurses or occupational therapists. As this centre is associated with a larger government medical college, consultants of all disciplines are supposed to be on call whenever needed. The Nurse Warden and Medical Superintendent stay on campus. |
| Recreation/ Occupational Therapy/ Rehabilitation | A new recreation block has been constructed. There is no rehabilitation facility |

**Hospital Report update**:

The hospitals report of 2008 states that there are 8 qualified psychiatrists, 2 clinical psychologists and no psychiatric social worker. A new recreation block has been constructed. There are currently 30 open ward beds as compared to none in 1999. There are telephone and ambulance facilities as well as canteen toilets and drinking water. Duty doctors are available round the clock.

# Jharkhand

## Central Institute of Psychiatry, Ranchi

(Established 1918. Bed strength 643)

### NHRC/NIMHANS report 1999

*"The hospital is enclosed by huge walls with large entrance and exit gates resembling that of a jail…The entire grounds of the hospital are full of lush green trees, some of rare variety. The family wards function in four cottages (outside the hospital boundary walls). There is one ward for children by the side of the family unit. An alcohol and drug unit is under construction. Seclusion and single wards are present but not used…Casualty and emergency services are present and are easily accessible…Daily outpatient services are available…The basic facilities in the wards for the patients are inadequate. The hospital has a well-equipped pantry and dietary section. The laboratories are very well equipped…Direct electroconvulsive therapy is given in the institution…Direct ECT needs to be replaced by modified ECT. Non-biological methods of treatment like psychotherapy, group therapy, behaviour therapy, guidance and counseling are inadequate for lack of faculty in clinical psychology and psychiatric social work departments. There is a need for a medical record officer….Not all the staff are aware of the rights of the mentally ill. Water, electricity and drainage facilities are inadequate…Mental Health Act is not complied due to the non-implementation of the statutory requirement by the Bihar government…There is a separate rehabilitation ward…Once a month a team of doctors provides psychiatric services to the West Bokkaro Colliery".*

### Earlier rating: Good

**Interim observations: DGHS (2004)**: *"The buildings are old barracks type, unsatisfactory and dilapidated: all wards were constructed in 1918 except two. Hostel facility for students and residents is inadequate. All the posts in clinical psychology and psychiatric social work are vacant and lapsed. Vocational rehabilitation facilities are available".*

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations DGHS 2004 | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Needs to be improved | Renovation of the old buildings and construction of new, modern hospital buildings is required | Recommendations reported as met |
| Amenities and facilities | Improvement of OP services with adequate staff  Rs 522.9 lakh | | All recommendations reported as met |
| Financial/ Administrative | The Mental Health Act should be complied with immediately  Rs 31 (veg) -Rs | | Total Rs 1515 lakh (plan revenue and capital 1200 L, non-plan revenue 1315L)  Recommendation reported as met |
| Diet/Kitchen | 36 (non-veg) | Satisfactory | Food adequate. No ceiling on cost/ patient/day. 2500 calories |
| Investigations/Treatment | Routine investigation facilities and biochemical investigations should be made available at | Satisfactory | All recommendations reported as met  However, no anesthetist is available and direct |

| | | | |
|---|---|---|---|
| | casualty and OP departments ECTs should be modified | | ECTs continue to be given |
| Staff and training | Director or medical superin-tendent should be a psychiatrist Recommendations of the work study committee in terms of creation and abolition of posts should be implemented The staff should be sensitised about the rights of the mentally ill through workshops and seminars | Many posts lying vacant | All recommendations reported as met |
| Supportive Services | There is need for a medical records officer, increase in the number of MRD technicians, MRD attendants. Computerisation of MRD could reduce missing and duplication of files | | All recommendations reported as met |
| Recreation/ Occupational | The Occupational Therapy unit | | All recommendations |

| Therapy/ Rehabilitation | should be strengthened with greater emphasis on placement of improved patients in the community | | reported as met. |
|---|---|---|---|
| | There is a need to extend mental health care services to the community. | | |
| | A vehicle for mobility for community service is necessary | | |
| Others | | | |
| | | | Board of visitors functioning |
| | | | Board for disability certification present |

**Hospital report update**: The hospital reports that all the requirements to meet the NHRC recommendations have been met. The medical superintendent is presently a psychiatrist. Facilities like waiting hall, drinking water, toilets are adequate, as are OPD laboratory and rehabilitation services. There are specialised services for child, geriatric, forensic and de-addiction services. There are no cells. Patient toilet ratio is 1:4. Bed occupancy as on 1 April 2008 was 392 (61%). During the previous year, 3930 ECTs were given. Direct ECTs continue to be given. A majority of patients (98%) continue to be admitted to closed facilities (9383/9547). Patients do not need to wear uniforms. Human rights are displayed in the hospital

The institute has an active post graduate programme (6 MD, 12 DPM, 4 PhD and 12 MPhil Psychology, 8 MPhil Psychiatric Social Work and 12 Diploma in Psychiatric Nursing.

## Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS)

(Established: 1925, earlier bed strength 600, current bed strength 500)

### NHRC/NIMHANS Report 1999:

"The architecture of the hospital is more of a jail…. The hospital is spread over a very vast area…The buildings are very old…The toilets, bathrooms, duty rooms are not properly maintained and have poor electricity and insufficient water supply…There has been a sharp decline in voluntary admissions. Admissions through the court have increased…Subsequent to the Supreme Court directives and monitoring by the NHRC, a major change has taken place in the quality assurance of mentally ill in this hospital".

### Earlier rating: Good

**Interim observations:** Chaman Lal report (NHRC 2004), DGHS Report (2004). The Chaman Lal report remarked that RINPAS had been making steady progress in achieving the objectives set by the Supreme Court while granting it autonomous status. It observed improvement in diagnostic and therapeutic services, living conditions and patient care. "*Promising steps have been taken for developing training facilities for medical and para-medical personnel. The scope and reach of the community outreach programme has been expanded. The credibility of RINPAS in government and private circles is seen to have gone up. The institution is capable of making a still greater progress and realize its potential of becoming an outstanding hospital and a centre of excellence in the field of training and research provided the management committee boldly exercises its autonomy and strengthens the hands of the who has been working with great zeal and providing an inspiring leadership to a team of competent an dedicated workers*".

**The DGHS review (2004)** mentions satisfactory clinical services and investigation facilities, adequate drugs, satisfactory quality of kitchen and food, linen and clothing, recreational facilities and vocational rehabilitation. However it points out inadequacies in terms of water supply, inadequate staff accommodation, old buildings in need of renovation and vacancies in staff positions. It points out that ECTs are still given directly because of a lack of anaesthetist facility.

**NHRC Report (2005)** The Chairperson of the NHRC, Justice Anand and the special rapporteur visited RINPAS. The observation was that "*RINPAS*

*is making steady strides towards realization of the objectives set by the Supreme Court by improving the diagnostic and therapeutic facilities, developing the social and occupational rehabilitation facilities and expanding the community services and research activities".*

**Lakshmidhar Mishra report (NHRC 2007).** The Mishra Report (NHRC 1997) states that a number of visits by the NHRC have been undertaken *"not with a view of finding fault with the management for the gaps, omissions and deficiencies, but to extend a helping hand to take up various proposals pending with the Government of India and the Stage government for modernization, expansion and total quality improvement in the management of the Institute. As a result of these interventions, there has been a perceptible change and improvement in the overall management and functioning of various departments of the Institute. There has been a spurt in teaching and research activities, too".*

## NHRC/SHRC visits during the last decade: 10

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations NHRC 2007 | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Old prison-like architecture. Needs to be modified<br><br>Problems with estate management | Many improvements and all the blocks are wearing a new look<br><br>NHRC has undertaken discussions with the Deputy Commissioner Ranchi regarding encroachments | Several renovations of wards under-taken, new administrative and academic block, community hall, OPD hall<br><br>Drug deaddiction centre functioning since 2005<br><br>Convention centre proposed |

| Amenities and facilities | Electricity, water supply, construction, repair and maintenance should be under the direct control of the institutional head and the management committee.

Basic amenities for the patient in the wards like better water supply, electricity, drinking water and furniture should be provided or improved

Improved long stay persons in the hospital should be discharged back to their homes with the help of the police and judiciary

The hospital should have open ward facility wherein family members can stay along with the patient. Further family members should | Canteen facility available for families

OPD services satisfactory

Case file data being computerised

Mineral plant is installed and fully functional

Overhead tanks in place

Every ward has attached toilets, with flushing facilities and are immaculately clean and tidy

Old cells have been converted to sanitary latrines

Mechanical laundry present

Lighting and ventilation adequate

Adequate | Active involvement of the Board of Management which oversees infrastructure and functioning

Currently only prison ward is a closed ward

Toilets drinking water and canteen are available. Electrical lighting for reading at night and generators for the male side are available. Patients provided with sweaters and adequate number of blankets. Delousing and debugging are done. Each ward has a separate treatment room. Activities of each ward are structured. |
|---|---|---|---|

| | | | |
|---|---|---|---|
| | be encouraged and allowed to visit the patients in the wards rather than outside the hospital | telephone and intercom connectivity present<br><br>Waste management through contract | |
| Financial | Rs 439 lakh | | Rs 645 lakh (plan 100 L, non-plan 545 L) |
| Diet/Kitchen | Diet Rs 30 per day | Operations in the kitchen are not mecha-nised<br><br>Diet is varied and provides 2800 to 3000 calories per day | Proposal for mechanised kitchen.<br><br>Rs 35 per head, 3200 calories |
| Investiga-tions/Treat-ment | | Modern diag-nostic facili-ties available | CT scan being installed |
| Staff and training | Gross inade-quacy in the staff pattern in terms of vacancies in the mental health team including psychiatrist, clini-cal psycholog-ists, psychiatric social workers and psychiatric nurses should be filled up | Adequate library<br><br>Computerisation of library in progress<br><br>Paramedics request risk allowance | Clinical psycholo-gists and PSWs are Class 1 officers<br><br>M Phil (6 seats) in CP and Ph D (2 seats) are being run from 2000<br><br>MD and DPM courses started in 2007<br><br>Several research projects ongoing |

| | | | |
|---|---|---|---|
| | Workshop for the staff of the mental hospital relating to the mental health and rights of the mentally ill are necessary | | Proposal for M Phil Psychosocial rehabilitation and enhancement of M Phil and PhD seats<br><br>Approval of additional posts of professor of psychiatry awaited |
| Recreation/ Occupational Therapy/ Rehabilitation | There is an urgent need to set up half way-homes in the neighbourhood and strengthen the rehabilitation and vocational training unit. | Institute has a full fledged occupational and rehabilita-tion unit | Yoga is done centrally in the morning indoor/ outdoor games are available. TV and newspapers in regional language are available in each ward.<br><br>Active involvement of an NGO, Sanjeevani |
| Others | | The institute runs 4 satellite clinics as community outreach<br><br>Works with NGOs | Proposals for training progra-mmes for medical officers, social leaders, NGO workers awaiting approval<br><br>Regular sensiti-sation of judicial officers<br><br>Website under development<br><br>Functioning board of visitors |

## Hospital report update

(Based on hospital report and action taken report of the visit of Dr L Mishra, Special Rapporteur NHRC -25-27 February 2007)

The Board of management of RINPAS comprises the Divisional Commissioner, South Chotanagpur who is the Chairman, the institute Director who is the member secretary, the Secretaries, Department of Health and Family Welfare, Governments of Jharkand and Bihar, Deputy Commissioner, Ranchi, Senior Superintendent of Police, Ranchi, Director, Rajendra Institute of Medical Sciences, Ranchi, Vice-Chancellor, Ranchi University, Vice Chancellor, Agriculture University, Ranchi, Ex Director, NIMHANS, Bangalore and a neurophysician as members (latter two honorary). There are eleven sub-committees looking after different areas like accounts, purchase, rehabilitation, welfare, appointments, works, hospital, academic, ethics and medical education.

Several changes have occurred at RINPAS in response to the recommendations of the Chaman Lal (NHRC 2004) and Mishra (NHRC 2007) reports. The institution received Rs 2.45 crore from the Central Government for infrastructure and Rs 2 crore from the State Government for a CT scan centre.

Salient changes include OPD services (better seating, investigation facilities, concessions for BPL card holders, free medications for one month), casualty services and short-stay ward, improved inpatient facilities (open wards, no floor beds, individual lockers to patients, water cooler in all wards, patient toilet ratio 2.5:1, recreational facilities), kitchen modernisation, very active rehabilitation and modern lab facilities. Bed occupancy as on 1 April 2008 was 474 (94.8%). There are 106 long stay patients. ECTs are still given directly as no anaesthetist facility is available. Only 6 ECTs were administered in the previous year. There are specialised geriatric and de-addiction services. There is no board for disability certification. Rights of patients are displayed in the hospital. A national workshop on human rights of the mentally ill was conducted in 2005.

The institution has a vibrant academic post-graduate programme. It also provides training to MBBS students, nursing students, counsellors for NACO centres, judicial officers, family courts and conducts workshops in mental health for teachers and lay persons. It is involved with the DMHP which is functioning at Dumka since 2006. Two additional DMHPs have been sanctioned at Gumla and Daltonganj.

# Karnataka

## Karnataka Institute of Mental Health, Dharwad

(Established 1845, bed strength 375)

### NHRC/NIMHANS report 1999

*"The wards are distributed over a large area. They are predominantly closed wards… Individual cells are present but infrequently used… There is lack of running water for the toilet and bath…The approach to the hospital has been altered to give it a general hospital type of ambience… The hospital has successfully brought down the long stay patients… It has been working with the magistracy to prevent frequent readmission and encourage voluntary admissions… Shaving of head is routine…there are only 2 psychiatrists and of the 4 medical officers, one is a radiologist, one a paediatrician and one an obstetrician… There is a great need to sensitize the ward staff to these (human rights) issues…The Board of Visitors has been constituted but does not meet… The KIMH has come under the attention of the courts recently…An NGO is functioning in the campus of the KIMH but meets rehabilitation needs of only 10-12 patients…There are hardly any community programmes undertaken, mainly because of a lack of psychiatrists".*

### Earlier rating: Average

### Interim observations:none available

### NHRC/SHRC visits during the last decade: 3

### Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Many of the wards are in a state of disrep-air. Appointing a PWD official full time to oversee | | Reported status as in 2008 New building constructed in 2005 including an |

| | | | |
|---|---|---|---|
| | such problems may be a solution | | outpatient block, drug store, record section, laboratory, open and special wards, duty rooms ECT facility and auditorium |
| | | | Canteen built. |
| | | | Tender for modern kitchen and forensic ward given |
| | | | Generator installed for power supply |
| Amenities and facilities | Toilets need urgent attention. Running water must be immediately provided | | New facility built |
| | | | Running water provided, 3 bore wells dug |
| | Automated washing facilities should be provided | | Tender for mechanised laundry given |
| | | | Cells completely abolished |
| | | | Library facilities available |
| | | | Intercom facility since 2006 |
| Financial/ Administrative | Total Rs 184.2 lakh (plan 2 L, Non-plan 182.2L) | | Total Rs 222.75 lakh KIMH attached to the KIMS Hubli |
| Diet/Kitchen | Diet Rs 16/day Better facilities for transport of food to the wards should be introduced | | Rs 36 per day providing a 3000 calorie diet |
| | | | Facilities being upgraded |

| | | | |
|---|---|---|---|
| Investiga-tions/Treat-ment | Only basic investigations available<br><br>Practice of direct ECTs must be discontinued. Separate place for ECT adminis-tration must be identified an ECT given under supervision of an anesthetist | | Free medications to all patients<br><br>All modified ECTs under supervision of anaesthetist |
| Staff and training | 167 staff currently<br><br>There is an urgent need for trained manpower<br><br>There is a need for trained psy-chiatric nurses<br><br>Ward attenders should be sensi-tized about the rights of rights of the mentally ill | | Sanctioned 230, many posts re-cruited, but existing 77 vacancies.<br><br>No trained psychiatsric nurses, but current staff adequately trained.<br><br>Clinical psychologists received 4 months training at NIMHANS, Bangalore |
| Supportive Services | | | Records after 2000 computerised |
| Recreation/ Occupational Therapy/ Rehabilita-tion | There should be greater empha-sis placed on rehabilitation<br><br>Need for better community liaison including | | Rehabilitation centre started |

| Others | awareness and education about mental illness | | |
|---|---|---|---|
| | Board of visitors present, but does not meet regularly | | Functioning Board of Visitors

Board for disability certification present

Awareness programmes done in consultation with Karnataka State Legal Service Authority. |

## Hospital report update

In 2007, the KIMH received a one time grant of Rs 3 crore for strengthening the hospital.

It has undertaken several infrastructural changes. The hospital runs a separate OPD block and has dedicated emergency services. It has a facility for relatives to stay, a waiting hall, adequate toilet, drinking water and canteen facilities. OPD lab services and essential psychiatric drugs are available. It does not have specialised services for children, elderly or deaddiction.

Bed occupancy as on 1 April 2008 was 263 (70%). All cells have been abolished. 3063 of the total of 3159 admissions during the last year (97%) occurred to the open facilities. The hospital has 12 paying ward beds. Only 50 admissions (1.6%) occurred through the courts. The hospital has 36 patients staying in the hospital for more than one year. Patient: toilet ratio is 1:8. Fans and running water is available. There are separate dining facilities. Wearing of compulsory uniforms has been abolished except in the closed wards. Drug supply is adequate. Of the 4644 ECTs administered during the last year, all were modified and under supervision of an anaesthetist. A separate forensic ward housing criminal patients with mental illness and court admissions exists.

In addition to the rehabilitation facility which the hospital itself has started, the hospital reports 13 community outreach activities each month.

It does not provide any post-graduate training presently, but the Indian Medical Council has approved the starting of the MD course.

## National Institue of Mental Health and Neuro-Sciences, Bangalore

(Established 1954, Earlier bed strength 650, current bed strength 686)

### NHRC NIMHANS Report 1999

The hospital offers in-patient services in psychiatry, neurology and neuro-surgery. Psychiatric facilities include 2 closed pavilions, 7 open wards and two paying ward blocks accounting for 650 beds. Separate facilities are provided for children (20 bedded ward), family therapy (14 rooms), alcohol and de-addiction (60 beds). There are separate chronic wards where stabilized patients unable to return home or be placed outside lead a semi-independent living. Some of the buildings are old and need repair. The psychiatric services are administered through a unit system, with a multidisciplinary team comprising a psychiatrist, psychiatric social worker, clinical psychologist and psychiatric nurses. Casualty and emergency services are present and easily available... OPD functions in a separate block…there is a waiting hall for patients. A dharamshala has been constructed to provide accommodation to families. Modified ECTs are available…Free drugs available…Facilities for lab investigations available in the OPD. A separate department with 15 different fully operational sections provides rehabilitation to both in-patients and outpatients, mentally ill and mentally retarded. NIMHANS has a full-fledged community mental health unit.

**Earlier rating:** Good

**Interim observations**: DGHS (2004): '*Infrastructural facilities are Good. Except for two pavilion type buildings, all others are open wards. Staff is adequate and of very high calibre, with a high degree of motivation…All modern investigation facilities are available… All modern drugs and psycho-social therapeutic treatment modalities are available. Colour TVs are available in all wards.*

*There are active departments of rehabilitation and occupational therapy…This institution has attained national/international fame due to its professional and research activities. It has become a model for other institutions in the country.*'

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Reported status as in 2008 |
| --- | --- | --- |
| Infrastructure | Structural chan-ges and regular ward repairs must be made<br><br>Open wards must be re-built with better amenities for family members | In the year 2001, 15 special wards were constructed and 15 more special wards were added in the year 2008. A new building for open general wards has been constructed. It accommodates 112 patients. There is also a new children's ward with 40 beds. |
| Amenities and facilities | Better toilet, water cooler facilities in all wards, especially open wards must be provided | The patient - toilet ration of 1:5 is maintained. Fans/coolers are adequate in the wards and there is 24 hour running water facility. |
| Diet/Kitchen | Dining facilities for in-patient must be provided | The food is budgeted at Rs 50 per head |
| Investiga-tions/Treat-ment | More intensive family education about mental illness and their treatment must be provided. | Patients are admitted into the wards with the care givers. Psychi-atrist, psychiatric social workers and clinical psychologists provide comprehensive psychosocial interventions to the patient as well as caregivers. Behavioural therapy as well as family therapy services is also provided. Special material for use in educating family members of the mentally ill has been prepared and is in use. |

| | | Tele-medicine facility has been started |
|---|---|---|
| Staff and training | All levels of staff must be sensitized | Periodic training programmes are given to the staff members |

## Hospital Report Update

NIMHANS is a secondary and tertiary care hospital in the fields of psychiatry, neurology and neurosurgery, with inpatient and outpatient care and comprehensive neuro-psychiatric rehabilitation. The institute renders services to patients from all over the country as well as neighboring countries in the South Asian region. The hospital has a separate OPD and emergency service. There is a rest house (Lakshmi Mittal Rest House) for visiting relatives to stay. Specialised outpatient clinics ar conducted for schizophrenia, obsessive compulsive disorder, postpartum psychiatric disorder and tobacco dependence in addition to separate services for children, the elderly and de-addiction. Comprehensive lab services are available. There is a well-organized medical record section. Medical records have been computerised. Only modified ECTs are given and transcranial magnetic stimulation (TMS) services are also presently available. The hospital has a separate children ward, family ward, forensic and de-addiction ward. A new three-tier rehabilitation building, new casualty building, psychiatry ward and basic sciences research facility have come up in the current year. An advanced centre for yoga in mental health promotion and treatment has been initiated. NIMHANS has community outreach programmes and runs extension clinics at 7 places namely Anekal, Sakalwara, Gowribidnur, Gunjur, Maddur, Madhugiri and Kanakpura. NIMHANS is a Deemed University and contributes to the important requirement of manpower development in the field of mental health and neurosciences through several advanced and basic courses related to mental health. Life skills education in schools, training college teacher counselors, training medical officers in substance use management and active liaison with both governmental and non governmental agencies in providing mental health care are important activities undertaken by NIMHANS. NIMHANS is the nodal centre for psychosocial care for survivors of disaster in India. It also trains personnel for the District Mental Health Programme (DMHP). NIMHANS also makes significant contribution in diverse areas like training, research, policy formulation at

the national and international level. Its research in the area of mental health is world renowned and spans community mental health care to neuroimaging and molecular genetics studies of mental illness.

# Kerala

### Government Mental Health Centre, Kozhikode

(Established 1872, bed strength 474)

### NHRC/NIMHANS Report 1999

"This mental health centre ranks among the worst hospitals in the country. The conditions of the ward are characterised by overcrowding, dilapidated facilities, bad hygiene and care. The patients do not get standard psychiatric care, which is their right. Even after recovery, they are confined in the hospital against the law. There is interference in the process of admission by politicians and government officials. There is evidence of staff burnout as observed by a lack of motivation and inertia among the staff. This is due to overcrowding, poor work conditions and absence of trained staff. There is an urgent need for intervention here to assure rights for this large population of mentally ill deprived of their rights".

### Earlier rating: Very poor

**Interim observations**: DGHS (2004): "*The hospital requires replacement/renovation of old buildings. Deficiencies in staff affect patient care. Rehabilitation component requires augmentation*".

The hospital also came under a monitoring committee set up by the High Court of Kerala.

**Visits by NHRC/SHRC during the last decade**: 1 visit by SHRC

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | All old wards in a terrible state of disrepair | Reported status as in 2008<br><br>New constructions in1999 (2 wards), canteen<br><br>2001 (nurses' hostel)<br><br>2004 (flour mill)<br><br>2005 (3 wards including a medical ward, ICU, main gate<br><br>Repair and renovation of several buildings<br><br>Generators available for power |
| Amenities and facilities | Daily out-patients and emergency services proper out patient amenities<br><br>Regular water and electricity supply drainage and communications network (telephone and intercom) must be ensured<br><br>Cell admissions in all hospitals must be abolished<br><br>Discharge after recovery must be hastened<br><br>Overcrowding must be prevented | The hospital has constructed a new ward as well as repaired existing wards, dormitory, and waiting 'shed' in the OPD<br><br>Telephone and intercom available<br><br>The report does not address the other recommendations |

| | | |
|---|---|---|
| | Admissions to open wards with a family member must be encouraged | |
| | Smaller wards with recommended number of staff nurses and ward attenders | |
| | Patients must be seen regularly by a multi-disciplinary team of doctors and other professionals | |
| | Separate wards for medico-legal patients, medical emergencies, alcohol and drug dependence and children should be set up | |
| Financial/ Administrative | Total Rs 148 lakh | Total Rs 165.84 lakh (plan 15.2 L, non-plan 150.84 L) figure for 2006-2007 |
| Diet/Kitchen | Rs 22 per day | Not specified |
| Investigations/Treatment | Standard psychiatric care in terms of recommended drugs, modified ECT and psychosocial treatments in wards and OPD must be followed | Available

OPD/IP lab services are available only to a limited extent |
| | Better lab facilities for essential investigations in the OPD and IP services should be provided | The report does not address the other recommendations |
| | Adequate support services like kitchen, laundry, pharmacy, stores and maintenance should be ensured | |

| Staff and training | Staff pattern with reco-mmended psychiatrists, psychiatric nurses, psy-chiatric social workers, CP's, occupational therapists, instructors and ward attenders must be improved<br><br>Regular in-service trai-ning for all staff members must be provided<br><br>These hospitals must be made into teaching hospitals with postgra-duate students posted in the wards | The staff pattern in all categories of staff have not been raised as per NHRC recommendations<br><br>The institute provides training to MD (Psychiatry) students of Kozhikode Medical College and M. Sc (Nursing) Students of Government College of Nursing, Kozhikode |
|---|---|---|
| Supportive Services | | A new MRD has been constructed with adequate manpower. |
| Recreation/ Occupational Therapy/ Rehabilitation<br><br>Other | Proper rehab facilities including day care centre must be provided | There is a rehabilitation centre functioning within the campus, which has printing, notebook making, medicine cover making tailoring etc. |
| | Needs to have Board of Visitors | Not existing. Hospital has sent a request to the government to constitute the same<br><br>Disability certification done |

## Hospital report update

The hospital has a separate OPD and emergency service. There are no facilities for visiting relatives to stay. Amenities in the OPD are provided and include canteen service. OPD lab services are limited. There are no separate services for children, elderly or for de-addiction. There is a

separate medical record section. Bed occupancy as on 1 April 2008 was 540 against a sanctioned strength of 474 (114%) occupancy. The report states that "cells have been converted into single rooms with provision for the bystanders to stay in front of the rooms". Of a total of 2166 admissions in the previous year, 1869 (86.3%) were to the open facilities and the rest were court admissions. About 155 patients have been in the hospital for more than one year.

Patient toilet ratio is 1:4. Running water is adequate. There are separate dining facilities. Current dietary budget is not mentioned. Patients do not have to wear compulsory uniforms. Disposable syringes are used throughout the hospital. Lab investigations are basic, and adequate drugs are available. No ECTs have been given during the last year due to absence of a regular anaesthetist. The hospital has a children's ward with 10 beds, and a separate forensic ward. There is a rehabilitation facility, and 42 inpatients were referred to this facility in the previous year. It offers no community outreach. The institution provides training to MD Psychiatry students of Kozhikode Medical College and to MSc nursing students of the Govt College of Nursing. The hospital is a nodal centre for the DMHP.

## Mental Health Centre, Thiruvananthapuram

(Established: 1817, bed strength 507)

### NIMHANS Report 1999

"This mental hospital in the capital is better than the one in Kozhikode in terms of facilities and better staffing though not adequate. However the problems that plague the earlier hospital in terms of overcrowding, inadequate standards of psychiatric care and poor maintenance of the infrastructure are the same. So also are the infringement of patient's rights in terms of proper treatment, respect and dignity of the individual. The more serious problem is the illegal confinement of persons who are well and non-compliance with the Mental Health Act. The interference by government officials and politicians in the functioning of the hospital is deplorable and the judiciary has been unable to improve matters significantly despite commissions and monitoring committees".

Even prior to the NHRC/NIMHANS report of 1999, several commissions had visited this hospital in the past.

**Earlier rating: Average**

**Interim Observations**: DGHS (2004): "*The hospital is deficient in all facilities. Some equipment has been added to the labs but basic infrastructural facilities remain grossly inadequate. The staffing in all areas is even less than the sanctioned strength. However, the OPD and records are computerised. The hospital has been able to bring down the proportion of long-stay patients significantly during the last two years*".

**Visits by NHRC/SHRC during the last decade: no details provided.**

**NHRC/ Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations DGHS 2004 | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Large number of very old buildings that require immediate renovation | Inadequate. Major improvements are required. | Behavioural intensive care unit started in 2006 (6 beds) New child and adolescent block, forensic block female ward ready and awaiting inauguration De-addiction ward being constructed Generator for power supply |
| Amenities and facilities | Overcrowding Inadequate standards of care | | Psychosocial interventions routinely done Telephone and intercom functioning |
| Financial | Total Rs 54 lakh | | Total Rs 371.94 lakh (plan 30 L, non plan 341.94 L)- figures for 2004-05 |

| | | | |
|---|---|---|---|
| Diet/Kitchen | Diet Rs 20 per day<br><br>Frequent complaints from patients about the quality and quantity | Quality of food barely satisfactory. Kitchen facilities have been improved but still below prescribed minimum standard | Diet 3000 calories |
| Investigations/Treatment | Hospital uses direct ECTs | Inadequate technical staff.<br><br>Psychosocial interventions practically non-existent | Only modified ECTs<br><br>Psychosocial interventions routinely offered |
| Staff and training | Staff position not adequate for number of patients | Total staff is much short of sanctioned strength | In accordance with staff pattern of other health institutions<br><br>New positions created in 2006<br><br>Regular in-service training occurs |
| Recreation/ Occupational Therapy/ Rehabilitation | In the wards none of the patients have a proper activity for the whole day.<br><br>No separate rehabilitation ward | Vocational/ rehabilitation facilities nil | Several rehabilitation units functioning<br><br>Recreational facilities present |
| Other | Confinement of recovered patients is illegal<br><br>Board of Visitors present but does not visit regularly | | Computerised medical records |

## Hospital report update

The hospital received Rs 110 lakh as central assistance in 2002-2003 and Rs 250 lakh as central assistance from the NMHP in 2005-2006. There has been an increase in the Hospital Development Society Funds from Rs 1 lakh in 2000 to Rs 45 lakh in 2008.

The average bed occupancy is presently 600 as against a sanctioned strength of 507 (118%).

New staff positions (2 medical officers, 4 staff nurses, 4 nursing assistants and 2 security staff) were created in 2006 for the behaviour intensive care unit and have been filled. Three staff nurses and 2 medical officers have been posted on a temporary basis under the National Rural Health Mission in 2008. An anaesthesiologist from the government hospital visits the hospital twice weekly to give modified ECT. Only a few of the staff stay on campus. Given the strength of the hospital the current posts(15 doctors, 71 nurses, 2 psychiatric social workers, 2 psychologists, 1 occupational therapist, 57 attenders, 122 nursing assistants and 4 security) is inadequate. The hospital is a nodal centre for the DMHP.

The hospital has not provided details in the supplementary proforma.

# Government Mental Health Centre, Thrissur

(Established 1889, bed strength 361)

### NHRC/NIMHANS report 1999:

"This is the only hospital in Kerala where the quality of care is average… They have managed to avoid overcrowding…The wards and facilities are fairly clean and the amenities and supportive services are adequate... The only dark area is the use of cells that are overcrowded without facilities... To add insult to this indignity, in the cells patients are stripped down to their underclothes on account of fear of potential suicide... The role of the government officials together with the mistaken attitude of the mental health professionals is responsible for these anomalies".

Earlier rating: Average

**Visits by the NHRC/SHRC in the last decade: 2**

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations DGHS 2004 | Reported status as in 2008 |
|---------|----------------------------------------------|--------------------------------|----------------------------|
| Infrastructure | Changes in infrastructure in terms of wards and adjoining facilities must be made | The state of the buildings is satisfactory but sanitary annexes require improvement | Reported as being under progress<br><br>Sick ward, ICU completed, chronic male ward modified in 2007. Female rehabilitation centre in female ward-civil works in May 2008<br><br>Generator installed for power supply |
| Amenities and facilities | Regular water and electricity supply drainage and communica-tions network (telephone and intercom) must be ensured Adequate sup-port services like kitchen, laundry pharmacy stores and maintenance should be en-sured<br><br>Daily out- | | The hospital reports that these are currently available<br><br>The hospital reports that these are ensured<br><br>The hospital reports that this is currently being followed<br><br>The cell rooms are still being used though it is reported that this practice is |

| | | | |
|---|---|---|---|
| | patients and emergency services with interview rooms, waiting hall, medical records, short-stay wards and adequate staff must be ensured | | discouraged |
| | | | The report does not address the other recommendations |
| | Cell admissions in all hospitals must be abolished | | The hospital reports that this is not currently occurring The hospital reports that these are currently available |
| | Discharge after recovery must be hastened and duration of hospitalisation minimised | | The hospital reports that these are under construction |
| | Overcrowding must be restricted and patient strength reduced to the sanctioned number Admissions to open wards with a family member must be encouraged and closed ward admissions must be avoided | | |
| | Smaller wards with recommen-ded number of | | |

|  | staff nurses and ward attenders dedicated to each ward must be created | | |
|  | Patients must be seen regularly by a multi-disciplinary team of doctors and other professionals | | |
|  | Amenities like adequate food medicines clothing drinking water costs, linen and other necessities must be provided | | |
|  | Separate wards for medico legal patients, medical emergencies, alcohol and drug dependence and children should be set up | | Total Rs 246.05 |
| Financial/ Administrative | Total Rs 85 lakh | | lakh, plan 4.93 L, non plan 241.12 |
|  |  |  | Diet Rs 28.75 |
| Diet/Kitchen | Diet Rs 25 per patient.<br><br>Patients complained about poor quality of food. | Quality of food is barely satis-factory. Kit-chen facilities have been im-proved during | |

| | | the last two years but are still below the prescribed minimum standards | |
|---|---|---|---|
| Investigations/ Treatment | Standard psychiatric care in terms of recommended drugs, modified ECT and psychosocial treatments for IP and OPD to be followed

Better lab facilities for essential investigations in the OPD and IP services should be provided | Clinical services including investigations grossly inadequate

Drugs available fairly satisfactory but newer drugs need to be added | Upgradation of lab in progress

Has adequate list of drugs |
| Staff and training | Staff pattern with recommended staff must be improved

Regular in-service training for all staff members must be provided

These hospitals must be made into teaching hospitals with post-graduate students posted in the wards | Total staff is much short of the sanctioned strength | The hospital reports that these proposals have been put forward to the DHS, Trivandrum in 2007, but there is no report of any changes made in staffing

The hospital reports that all such programmes are being provided

Regular training being provided

Training |

| | | | |
|---|---|---|---|
| | | | programmes for MSW students, students of nursing |
| | | | Medical library established |
| Recreation/ Occupational Therapy/ Rehabilitation | Proper rehab facilities including day care centre must be provided | | The hospital has constructed these facilities |
| Others | Board of Visitors to act as inspection monitoring authority for each hospital must be constituted | | Board of visitors proposal given, but still not set up |

## Hospital Report Update

The MHC does not report having received any special funds. But the HDC fund improved markedly due to training programme of nursing students, etc. The hospital has dedicated outpatient and emergency services. It does not have any facility for visiting relatives to stay. It reports that the outpatient facilities are adequate and that there are canteen services. Basic outpatient lab services are available. Adequate drugs are provided. It offers de-addiction services, but no specialized services for the children and elderly. There is a separate medical records section. As on 1 April 2008, against the sanctioned strength of 361, there were 390 patients (108% occupancy). Twenty-five cells still exist in the hospital. Steps are being taken to restrict and gradually avoid admissions to cell wards. Presently highly excited patients and suicidal patients are lodged in cell rooms Of a total of 1889 admissions during the last year, 1592 admissions (84.3%) were to the open wards. 223 (14% of admissions were through the courts. The hospital has 14 paid ward beds. There are 196 patients in the hospital with a stay more than one year. Patient toilet ratio is 1:3. There is adequate running water. Fans and coolers are available. There are separate dining facilities. Uniform is not compulsory. Disposable

syringes are used throughout the hospital. Though ECT services are available, the hospital has not administered any ECT during the last year. There are no separate in-patient services for children or elderly. There is a separate forensic ward with 30 beds and a de-addiction ward has been constructed and will be functioning very soon. Rehabilitation facilities are available for in-patients and 50 patients have been referred to this service during the last year. The hospital is associated with the District Mental Health Programme and conducts 27 outreach clinics every month, reaching 10,200 patients through outreach. It provides post-graduate training for medical social work and clinical psychology. There is presently no Board of Visitors and no disability certification

## Maharashtra

## Regional Mental Hospital, Thane

(Established in 1901, earlier bed strength 1880, current bed strength 1850)

### NHRC NIMHANS Report 1999

"The hospital is surrounded by a high jail-like wall with barbed wire on the top. Many of the old structures are unfit for use. Some of the buildings still in use are in poor condition with problems aggravated in the monsoon season. All wards are closed. There are no open and special wards. Many of the wards are over crowded. Many patients sleep on the floor and the fact that there is not enough space raises the possibility of physical and / or sexual abuse. Wards have adequate ventilation and electrical supply. Each ward has 2 toilets, which is insufficient. Other amenities like running water, bucket or mug are absent. There are no emergency services. The ambulance is not in roadworthy condition. The staff burnout is quite high especially at the group D level as most of them are transferred to the mental hospital as a punishment.

New building with all facilities for better outpatient and in-patients services is urgently needed. The number of involuntary admissions has to be brought to a minimum. Psychosocial intervention including psycho education and individual and family counseling must be provided as routine services. Posts of clinical psychologists must be filled up".

Earlier rating: Poor

Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Reported status as in 2008 |
| --- | --- | --- |
| Infrastructure | New building with all facilities for better outpatient and inpatients services is urgently needed | The hospital report states that fund are available and building structure administrative approval for plan by the government of Maharashtra. But construction NOC permission is to be given by TMC.<br><br>Laundry upgradation for better washing of clothes has been done.<br><br>Repair of roads is done. New utensils for kitchen and food carriers are purchased |
| Amenities and facilities | The number of involuntary admissions has to be brought down to minimum. Short stay wards and open wards to be started. Contact between the patient and the family to be encouraged and strengthened.<br><br>Beds to be divided into func- tional units with a psychiatrist in charge and individual and family counselling to be provided as a routine service | The hospital has started a separate geriatric service. Emergency or any other special services are yet to be stared.<br><br>No report provided |

| Staff and training | Posts of clinical psychologists to be filled up. Services of a clinical psychologist to be used not just for testing purposes but in developing modules of intervention using cognitive, behavioural and psychological principles. Till the vacancies are filled services of a clinical psychologist can be obtained on contract or visiting consultancy basis.<br><br>Staff needs to be sensitised about the rights of the mentally ill. | The post of clinical psychologist has still not been filled up. No comment on has been made in the report on whether the services of a CP are being contracted externally<br><br>No report provided |
|---|---|---|
| Recreation/ Occupational Therapy/ Rehabilitation | Recovered persons to stay sepa-rately from the chronic patients<br><br>Active efforts to be made by social workers to contact family members educate them about the illness and help recovered patients to return home<br><br>Psychosocial intervention inclu-ding psycho-education and indi-vidual and family counseling to be provided as routine services<br><br>Psychosocial rehab need to be planned in a more structured manner from ward based activities that emphasise daily living skills to prevocational and vocational activities that enable the patient to develop a work habit. Occupational therapists can be deputed for training so as to be able to deal effectively with the psychiatrically ill | Indoor game and television is provi-ded. Planning to develop a day care centre.<br><br>No report provided<br><br>No report provided |

**Hospital report update:** There are no interim reports available for this hospital. The hospital has brought a few changes in the infrastructure mainly in terms of improving the drainage, painting the walls, and flooring the kitchen. There is considerable increase in the number of patients treated on IP as well as OP basis. There are no open wards yet. The new developments also reflect in the development of geriatric services, establishment of a medical records section and improved rehabilitation facilities. However the staff strength is still inadequate. Rs.35 per day (2400 k calories) is allotted for diet. Investigations are adequate as per the new report.

## Regional Mental Hospital, Yervada, Pune

(Established in 1907, Bed strength 2540)

### NHRC / NIMHANS report 1999

"The hospital comprises largely single storey barrack-like structures. All wards are closed. The number of cots is inadequate. Electricity and water supply are erratic. The existing toilets, fans and lighting arrangements are not adequate. There are no emergency services or casualty. The large and unwieldy size of the hospital, the lack of adequate trained staff and the poor infrastructure makes the inpatient facilities far from desirable".

### Earlier rating: Poor

### NHRC/SHRC visits during the last decade: 1

### Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | A master plan for downsizing of the hospital needs to be drawn up. Although the number of professional staff has to be increased it would not be advisable to create posts | Four new dormitories have been constructed for the indoor patients. One ward has been renovated to house family ward. New internal roads have been laid from central |

| | | |
|---|---|---|
| | for a 2500 bed hospital. Instead the reorganization should lead to more functional and manageable units. This has to be done in a phased manner and cater to the needs of different categories of patients | assistance. Bathrooms & toilets renovated. Kitchen renovated<br><br>No plans for downsizing have been provided |
| Amenities and facilities | Admission procedures need to be simplified and the majority of admissions should be under the voluntary category<br><br>Open and family wards should be started and psychosocial interventions should form a part of the routine care<br><br>Keeping children in the mental hospital with adult patients is in violation of the mental Health Act 1987. The children should be immediately transferred to a more conducive environment or provided a separate facility with special inputs in child and adolescent psychiatry | Admissions, discharge procedures within the purview of Mental Health Act 1987.<br><br>Medical information system is updated every month with diagnosis of newly admitted, discharged and re-admitted pts. and submitted to the head office on its website.<br><br>Total number of children admitted in last 3 years is displayed here.<br><br>No children under juvenile act 2000 are admitted in this hospital. There is currently a separate children's ward |
| Staff and training | One or two clinical psychologists to be appointed immediately. Contract basis or visiting consultancy can be considered in the interim period | Psychologist on contract basis has left 3 months before and we are awaiting a new recruit |

| Recreation/ Occupational Therapy/ Rehabilitation | Occupational therapy and psychosocial rehab inputs to be made more structured and strengthened so as to benefit a larger number of patients. Motivated occupational therapists can be deputed for training in psychiatric aspects to NIMHANS<br><br>Day-care centres and sheltered workshops to be started, preferably with support and participation of local NGOs or voluntary bodies | There are separate male and female units. Various wards and sections involve around 170-200 patients. Indoor activities include tailoring, minor craft, screen printing, knitting, crochet. Around 150-170 patients attend. Occupational therapist is the main person to place the patients for various activities. For every trade there is a trained person like carpenter, tailor, weaver, etc.<br><br>There is a rehabilitation unit in the male section. Around 10-15 patients attend the unit<br><br>No financial incentives are given in the form of cash. However they are given biscuits and other eatables. |
|---|---|---|

## Hospital Report Update

The 2008 hospital report states that there are visiting non-psychiatry consultants including gynaecologists, anaesthetists and pathologists. Medical records are maintained manually. The diet is given as per the norms prescribed in Maharashtra Civil Medical Code. Non-vegetarian diet is given in the form of eggs. Special diet is available for weak and convalescing patients. The daily allotment is approximately 2800 calories at a daily cost of Rs 32.62. There is no canteen available. The patient toilet ratio is not up to NHRC recommendations at 1 toilet per 10 male patients and 1 toilet per 7 female patients. There is non-availability of 24 hour running water. The hospital has community outreach activities in 9 rural hospitals in the Pune district.

# Regional Mental Hospital, Nagpur, Maharashtra

(Established in 1904, Bed strength, 910)

## NHRC/NIMHANS report 1999

*"The hospital has been experiencing administrative difficulties as has been functioning under a series of in-charge superintendents. The hospital has several individual buildings and a jail-like appearance as high walls surround it. There are no open wards. The old cells have been converted into special rooms for individual occupation on the basis of payment. Unfortunately the wards that have been built recently have not incorporated modern facilities. The inpatient services are inadequate. The number of psychiatrists, psychologist and psychiatric social workers need to be increased. In order to provide quality care the post of other mental health professionals, especially psychiatric social workers and psychologists should be filled and new posts created if necessary. The hospital needs to have out patient facilities and short stay ward. Psychosocial rehabilitation facilities have to be strengthened in order to help patients return to the community".*

Earlier rating: Poor

NHRC/SHRC visits during the last decade: 1

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | New wards constructed should be on modern principles... More wards should be open and provide for a relative to stay with the patient.<br><br>The hospital should be downsized in a phased manner. To facilitate this | The state of buildings and sanitary annexes is generally satisfactory but the boundary wall is broken. Non-existent in many places. Many State | No comment made on this in report<br><br>No comment made on this in report |

| | | | |
|---|---|---|---|
| | outpatient facilities need to be improved a short stay ward will help in early discharge of patients who do not need to be hospitalised for long periods.<br><br>New wards constructed should be on modern principles... More wards should be open and provide for a relative to stay with the patient. | agencies have encroached upon the hospital campus and PIL has been filed. | |
| Staff and training | Psychiatrists must be immediately appointed to the posts of Medical Superintendent and Deputy MS. In order to provide quality care the post of other mental health professionals especially clinical psychologists and psychiatric social workers should be filled and new posts created if necessary<br><br>Greater emphasis needs to be paid to staff issues such as in-service training deputation for short-term training or workshops etc so as to reduce amotivation on the part of the staff | MS is not psychiatrist. Over 100 posts are vacant | The MS is a psychiatrist. There is still no clinical psychologist but there are 4 psychiatric social workers, 12 trained psychiatric nurses, 54 general nurses, 4 occupational therapists<br><br>No comment made on this in report<br><br>No comment made on this in report |

|  | The hospital should be downsized in a phased manner. To facilitate this outpatient facilities need to be improved a short-stay ward will help in early discharge of patients who do not need to be hospitalized for long periods |  |  |
|---|---|---|---|
| Supportive Services | The first to start OP services. Direct ECT was administered. No psychosocial interventions as staff are inadequate. | Psychosocial interventions are not up to the mark. Library facilities are not available. | OP services are available.

Modified ECT is given.

Community mental health programmes are available every month.

However there are no emergency services nor any specialized services. |
| Recreation/ Occupational Therapy/ Rehabilitation | Psychosocial rehab facilities have to be strengthened in order to help patients return to the community by starting a full-fledged rehabilitation facility

Development of day-care centre for chronic patients is necessary | Kitchen and gardening are conducted as occupational therapy. No other facilities | No comment made on this in report |

## Hospital report update

The hospital has new constructions in terms of day-care centre; female ward and existing building were renovated. There have been changes in the diet and recreation. However there are not many additional changes from 1996 in the areas of medical records, rehabilitation, and canteen facility. The hospital received a special fund from the Central Government for improvements, a sum of Rs 289 lakh. Proposals and correspondence have been made to the government for taking action on the recommendations made. Rs 45 is allotted per person at 2700 k calories. The hospital received Rs 981 lakh as budget in the year 2008. Investigations have improved.

# Regional Mental Hospital Ratnagiri, Maharashtra

(Established in 1886, Bed strength 365)

**NHRC / NIMHANS report 1999**: *"All the wards in the hospital are closed. Although the number of toilets is adequate, they need to be improved. Running water is not always present and amenities like buckets and mugs need to be provided. The post of clinical psychologists and social worker are currently vacant. The hospital does not have casuality or emergency services. Psychosocial interventions, behaviour therapy and psychological testingare reported as being provided, but it is not clear as to how these are carried out in the absence of personnel. Recreational facilities, occupational therapy and routine investigations are available".*

**Earlier rating: Average**

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | Most of the present wards can be converted into open wards with facilities for the relatives to stay | There is one open ward with five beds where patients can stay with family |
| | Toilet and bathing facilities to be improved | Not addressed in the report |

| Amenities and facilities | Most of the present wards can be converted into open wards with facilities for the relatives to stay | There is one open ward with five beds where patients can stay with family |
|---|---|---|
| | Toilet and bathing facilities to be improved | Not addressed in the report |
| | Special wards and single rooms with attached toilet to be provided on payment basis | Not addressed in the report |
| Investigations/ Treatment | Available but inadequate | Available and adequate |
| Staff and training | The MS is a dynamic young psychiatrist and should be immediately supported with more mental health professionals, especially psychiatrists, CPs and PSWs. | Staffing shows the presence of only one qualified psychiatrist, no CP and 4 psychiatric nurses |
| Recreation/ Occupational Therapy/ Rehabilitation | Occupational therapy to be further strengthened to include more patients and also ward-based activities | Not addressed in the report |
| | With adequate staff emphasis on psychosocial intervention should be increased | Psychiatric social worker posts have been filled, hence all possible efforts are taken to reintegrate the patient to the community at the earliest Hence there is a decrease in the average patient stay |
| | Day care centre and sheltered workshop can be started with the involvement of local voluntary organizations | Not addressed in the report |

## Earlier report update

Though there are no interim reports available, the 2008 report states that the hospital extends its service through community programmes thrice a month. There have been renovations of the old in-patient building, though no new constructions have been made. The OP block is separate

with facilities like lab services, waiting hall, toilets and drinking water. Staffing consists of only one qualified psychiatrist, no CP and 4 psychiatric nurses. There is sufficient supply of medicines. Canteen facility for the patients has not started. The hospital is yet to start specialised services for children, geriatric population and persons with addiction. There is only one single open ward available in the hospital, rest of the wards are closed. The toilet facilities for the in-patients remain inadequate. Emergency services have started. Rehabilitation services are yet to be started. There has been an increase in the allotment of funds to Rs 675.9 lakh. The budget for food allotted has increased from Rs 15 per person per day to Rs 25 and the caloric allocation has minimally increased from 2500 to 2600 k calories.

## Maharashtra Institute of Mental Health, Pune

This facility is included here as it is intended to address human resource training needs of the region. It was not individually reviewed in 1999.

The Maharashtra Institute of Mental Health is located in a general hospital and jointly functioning with the Department of Psychiatry, B.J. Medical College and Sassoon General Hospital, Pune. According to the 2008 report submitted by the Institute, MIMH has been instrumental in conducting several training activities for developing multidisciplinary mental health manpower for the State of Maharashtra. Having received an initial impetus and appreciation for the work done, the Institute now needs to be developed not only by the State government but also through the funding from the Government of India, Ministry of Health and Family Welfare, New Delhi. This will help to create a Regional Care Centre for Mental Health that can cater to the needs of the states around Maharashtra including Gujarat, Goa, Madhya Pradesh and Orissa. The creation of Regional Institutes of excellence will serve the best interest of mental healthcare delivery to the needy.

## Madhya Pradesh

### Gwalior Mansik Arogyashala, Gwalior

(Established 1935. Bed strength 212)

### NHRC/NIMHANS Report 1999:

"The two mental hospitals at Gwalior and Indore have received a lot of

negative media attention. Although the public interest litigation and ensuing court orders have brought about some changes especially in Gwalior, the conditions in these two settings is far from satisfactory. The human rights of the mentally ill continue to be violated in Gwalior…This reflects a lack of sensitivity on the part of the health administration. The nature of care has to change from custodial to therapeutic. In addition to biological methods of treatment it is imperative than an equal emphasis be placed on psychological and social therapies. Only when the biopsychosocial model of care is implemented will treatment for the mentally ill person be complete. There is an urgent need to take steps to train all categories of staff. Currently, four medical officers are undergoing training in psychiatry at NIMHANS. All the vacant posts should be filled up (vacancies include 10 clinical psychologist and additional clinical psychologist posts, 8 medical social worker post, 1 occupational therapist post and 26 nurses post). As a matter of fact even the post of director is currently vacant".

**Earlier rating: Average** (several structural changes had occurred after the Supreme Court interventions in 1993 and 1994 following the PIL filed by Sheila Barse vs. the State of Madhya Pradesh), but there were great deficiencies in patient care and amenities.

**NHRC observations**: Three reports of the NHRC rapporteurs were available for review (Chaman Lal Reports (NHRC 2000, 2001), Sen and Chaman Lal Report (NHRC 2002), Chaman Lal Report (NHRC 2004) :

**The Chaman Lal Report** (NHRC 2001) reviews the reports of the Union Health Secretary (1995 and 1997), the Central Action Group constituted by the NHRC (1999), the NHRC/NIMHANS report(1999). It concludes: "*Intervention of the Supreme Court does not seem to have made any significant change in the efficiency and quality of the services at the GMA. The directions of the Apex Court in regard to improvement of infrastructure, upgradation of diagnostic and therapeutic techniques, development of training and research facilities, computerisation of hospital records have remained unimplemented for various reasons. Though living conditions of patients have improved appreciably, the absence of occupational therapy and lack of entertainment facilities do not speak well of the hospital management. The Management Committee has not been able to ensure that the Institution functions as an autonomous body headed by a properly selected Director with sufficient administrative and financial powers…The Commission may have to remind the UP Government about its obligations to comply with the directions of the Supreme Court".*

Chaman Lal Reports (NHRC 2004, 2005, 2006) reflect the same findings as above. The 2006 report concludes: *"In my opinion the intervention of the Supreme Court does not seem to have made any significant change in the efficiency and quality of services at the GMA. I do not think the Commission's continued involvement is likely to make any difference. I reiterate what I had recommended last year that we should bring all these matters to the notice of the Supreme Court and request the apex court to deal with this institution directly."*

The report of 2006 further states: *"The staff position remains unsatisfactory as before. The only significant development of the period of review has been that Dr. Ram Ghulam Razdan, Supdt. of the hospital at Indore assumed additional charges of the Director GMA in 2005. However, as he is drawing his salary from Indore, the post of GMA Director, remains vacant. He has been visiting Indore frequently and has not yet been able to devote much time to the affairs of GMA. Four posts of psychiatrists are also lying vacant. All the sanctioned posts in the discipline of clinical psychology and psychiatric social work are lying vacant… In the dept of nursing the post of nursing superintendent, 3 sanctioned posts of matron and 34 posts of staff nurse are lying vacant. The nurse to patient ratio is found to be 1:30 in the closed ward …In the female section the nurse to patient ratio is as high as 1:60.'*

The Chaman Lal Report (NHRC 2007) is more positive than the earlier report. This report documents improvements in infrastructure (efforts to improve the greenery, improved building maintenance), improved outpatient turnout, adequate OP facilities, shorter duration of stay in the open wards, significant reduction in closed ward admissions (less than 10% of total), improved diet for inpatients, improvement in electricity supply, ventilation, water supply and toilet facilities, improved lab facilities and supply of drugs. It reports better telephone connectivity. It recognises that half way wards homes have been functioning under the supervision of NGOs of established repute.

Continuing problems highlighted in this report: Need to follow up on staff vacancies, more adequate space for inpatient beds, a time bound campaign to reduce long stay patients, manual laundry facilities, lack of firm policy of the State government for rehabilitation

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Many infrastructural changes have already occurred The drainage system needs to be improved. | | Many new constructions |
| Amenities and facilities | To improve the basic amenities in the wards. Adequate toilet facility should be available in all wards and in the outpatient<br><br>Proper washing facilities to be provided by starting a modern laundry unit | No arrangement for collection of waste disposal<br><br>Laundry services currently manual. Urgent need to install a mechanical laundry service at an estimated cost of 4 to 5 lakhs. | Toilets renovated or reconstructed<br><br>Under process |
| Financial | Diet Rs 15/day | Diet being provided as per ICMR scales | Rs 26/day, 2806 calories |
| Investigations/ Treatment | Hardly any psychosocial interventions | | Modern lab facilities<br><br>Psychological tests and psychosocial interventions are available |

| Staff and training | Filling up of all vacant positions especially of mental health professionals. Post of psychiatric nurses to be created | Many nursing vacancies (29/59)<br><br>Lack of nursing quarters | New professionals have been appointed.<br><br>Attempt to fill up vacancies |
| --- | --- | --- | --- |
| Supportive Services | No medical record section | | Medical records section present |
| Recreation/ Occupational Therapy/ Rehabilitation | Involvement of NGOs and voluntary bodies in rehab and placement | Responsibility of halfway home entrusted to NGOs | There is an Occupational Therapy Unit available but there is only one instructor. There are over five sections in occupational therapy. There is also a half-way home. The hospital reports that rehabilitation is being actively pursued by the staff. A meeting of all NGOs was called for in the month of January 2008 |
| Other | No board of visitors | | There is no Board of Visitors<br><br>Disability board present |

## Hospital status report

Rs 2.13 crore was sanctioned during 2006-07 by the Government of India. Recent additional sanctions include Rs 4.2 lakh for installation of solar plant by the State Energy Development Corporation and Rs 4.18 lakh by MP State Small Scale Industries Development Corporation for computerisation.

New constructions in the hospital include a new two-storey outpatient building, canteen, a new female ward, dining hall facilities. There are no specialised services in the OPD for children, elderly, de-addiction or forensic services. Several toilets have been constructed or renovated, with a current patient toilet ratio of 1:4.

Beds occupied as on 1 April 2008 was 200/212 (94.3%). Seventy six percent of admissions in the last year occurred to the open wards (2398/ 3169). There are 125 patients in the hospital with a stay longer than one year. The hospital still has compulsory uniforms for the closed ward patients. Only modified ECTs have been given during the last year (2067 in total). There are no specialised inpatient services. There is an active rehabilitation service. The hospital conducts 8 community outreach programmes per month.

There is no post-graduate training, but teaching is provided for nursing and MA Psychology students. Four medical officers have obtained their DPM. Many of the vacancies have been filled, but there are still staff nurse vacancies (26/59).

The medical superintendent is not a psychiatrist. Disability certification is done at the Civil Hospital at Morar.

The hospital is in the process of constructing a new female ward, and proposes to construct a long stay home, day care centre, child guidance clinic and de-addiction centre. It plans to train psychiatric nurses in co-ordination with VIMHANS, Delhi and NIMHANS, Bangalore. Preparations to start post-graduate courses at GMA are under way. The faculty vacancies (Professor, Associate and Assistant Professor) are being filled up and the no objection certificate from the University has been obtained.

# Mental Hospital, Indore

(Established 1930, Bed strength 155)

## NHRC/NIMHANS Report 1999

"The building is very much dilapidated…The front land is encroached by small shops and hence it is difficult to identify the entrance…All the wards are closed wards…There are no facilities for criminal patients. Most of the toilets in the female wards have no doors, hence there is no privacy…The male wards have no toilets…An open drain is used as toilet…Lighting and ventilation is not sufficient…There are only two qualified psychiatrists…There are no posts of clinical psychologists…There is only one social worker functioning…Admissions are made through court orders and till date no voluntary patients have been admitted…Most of the male patients are in cells and many of them are chained…The patients are given hospital uniform…Food is prepared in a small, dirty and dilapidated room…There is a small basic laboratory…Treatment is mainly medical with drugs and direct ECT is administered…Hospital has very poor recreational activities and no rehabilitation activities at all…Medical record section is poorly maintained…The human rights of the mentally ill have been totally ignored in Indore".

## Earlier rating: Very poor

## Interim Observations

DGHS (2004): "*The hospital is in a highly deplorable state in almost all aspects of patient care as well as the working conditions of the staff members. The overall scenario and atmosphere are highly regrettable. Evidence of chaining of patients, clinical abuse and active neglect is seen. Needs CRISIS RESPONSE*"

*Chaman Lal Report (NHRC 2004):* "*A lot of improvement has been affected as a result of the enforcement of the Commission's directions through its report (*NHRC/NIMHANS 1999*) and the active interest of the Madhya Pradesh Human Rights Commission. The state of buildings has improved with repairs of wards and construction of a new male ward. All cell structures have been closed and closed wards have been converted to open wards. Round-the-clock water supply has been ensured and additional toilets and bathrooms constructed. The percentage of voluntary admissions which was nil when the NIMHANS*

*study was made is nearly 50% now. The average duration of stay of voluntary patients is less than 60 days….however not much could be done about the long-stay patients who are still languishing in large numbers, most of them abandoned by their families…Although the level of compliance with the recommendations of the NIMHANS report can be broadly considered satisfactory with visible improvement seen in hospital management and patient care, the Institution still lacks in infrastructure and modern diagnostic and therapeutic facilities. Occupational therapy is yet to be provided in the hospital in real sense".*

**Visits by NHRC/SHRC during the last decade: 4**

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1999 | Interim obser- vations Chaman Lal Report (NHRC 2004) | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | The main building should be demolished and a new building with open family wards built<br><br>Separate ward for criminal admissions<br><br>Female ward to be renovated<br><br>Water supply, electricity, toilet, and other facilities should be improved<br><br>A compound wall with a gate has to be built | State of hospital building is poor and funds for maintenance inadequate<br><br>Repair/reconstruction of:<br><br>Female ward (No 2)<br><br>Occupational therapy unit (male)<br><br>Separated ward for mentally ill prisoners referred to hospital | Reported status as in 2008<br><br>New male ward (2003)<br><br>Repair and renovation of hospital building, drainage system, connecting roads, electrification etc. (March 2008)<br><br>No generator |

| | | | |
|---|---|---|---|
| Amenities and facilities | | Inadequate linen and clothing for patients<br><br>Should have a mechanised laundry | New mechanised laundry |
| Financial | Total Rs 65.5 lakh | | Total Rs 144.82 lakh |
| Diet/Kitchen | Diet Rs 14/day<br>A separate kitchen with gas facility to be constructed. Food should be prepared hygieni-cally under the guidance of a dietician | Unsatisfactory and inadequate<br>Patients to be supervised for activities of daily living | Diet Rs 25-30/day<br>2223-2442 k calories<br>Kitchen has been shifted into a new place and upgraded to maintain proper hygiene and other facilities<br>Being super-vised by social workers and ward staff |
| Investigations/ Treatment | Majority of the admissions have to be made voluntary<br>Lab facilities to be upgraded to provide routine investigations | Inadequate clinical services<br>Up gradation of laboratory facilities<br>No facilities for psychological tests and psychological and social therapies<br>Unused ECTs | Voluntary admissions started in 2001<br>Open wards functional from May 2008<br>At present specific investi-gations done at MGM Medical College |

| Staff and training | All vacant posts should be filled up. Posts of clinical psychologists and psychiatric social workers and psychiatric nurses need to be created

The number of posts of nurses should be increased and some of the motivated and committed ones should be identified and deputed for in-service training in psychiatric nursing. The number of staff quarters to be increased. | Staff inadequate in number

Need to be sensitised and trained

Currently no staff in disciplines of clinical psychology, psychiatric social work, nursing and occupational therapy (from both reports)

No drivers available | Due to shortage of staff nurses are being trained within the Institute.

At this time the services of the Clinical Psychologist of DMHP is being used

Proposal for new posts submitted to State Government (biochemist, psychologist, social worker, conversion of one Asst Surgeon post to Asst Professor Anaesthesia

Proposal given |
|---|---|---|---|
| Supportive Services | Ambulance facilities to be provided

Medical records section to be improved | | Ambulance available. Driver provided by Dean, MGM College Indore

The centre reports that medical recording has been made more systematised |

| Recreation/ Occupational Therapy/ Rehabilitation | Psychosocial intervention has to be provided as routine care and rehabilitation work taken up seriously | Inadequate recreational facilities for patients | The hospital reports that a social worker is training the patients and there is great improvement in activities of daily living. |
|---|---|---|---|
| | | Some effort being made but inadequate in terms of infra-structure facility and staff | Occupational Therapy Unit Doctor in-charge with ward officials and social workers are ensuring that patients are actually using the items and facilities pro-vided to them |
| | | Male inpatients not receiving any worthwhile attention through occupational therapy | |
| | | Concept of half-way home yet to be tried in the institution | Proposal for half-way home sent to government |
| | | Death records, if any, to be properly maintained | Doctors of hos-pital offering of-fices at Central Jail, Indore |
| | | | No functioning board of visitors |
| | | | Disability certifi-cation is done |
| | | | Being properly maintained as per WHO |

The Mental Hospital, Indore which was earlier functioning under the Public Health and Family Welfare Department is now under the Medical Education Department since 1998.

Additional funds received include a grant from MP Government (Rs 72 lakh) for renovation of the hospital building. This year an additional fund of Rs 6, 20,000 has been received from the Rogi Kalyan Samiti.

The hospital has a separate OPD block and dedicated emergency services. There is a waiting hall for patients and adequate amenities in the outpatient. OPD lab services offer only basic tests. All categories of psycho tropics are available for free dispensing. There are no separate facilities for children, elderly, de-addiction, forensic services in the out-patients. The OPD attendance has increased since 2004.

Bed occupancy as on 1 April 2008 was 97(62.6%). Patient to toilet ratio is 1:7. Running water is available, fans/coolers are available. There are no separate dining facilities.

Uniform is compulsory for closed ward admissions. Disposable syringes are used throughout the hospital. Investigations available are very basic. Medications are adequate. ECT services are available but have not been operationalised because of lack of anaesthetist. No ECTs have been administered. There are no specialized inpatient services.

No cells exist. All admissions have been to closed wards (197 in the last year). Open wards have been started in May 2008. There are no private wards. There are 33 long stay patients with duration of stay greater than 5 years. Rights of patient are displayed in the hospital.

In response to the Chaman Lal report (NHRC 2004) the hospital has reported that it has centralized the process of medication supply, has renovated the OPD block with repair of toilets from Rotary funds. A letter has been written to the Indore Development Authority for construction of Sulabh complex in hospital compound. Attempts to discharge some of the longstay patients in compliance with this report were taken by the hospital. One such patient was sent to Swadhyay Mancy in Mandsaur, but could not be managed there, another's address was untraceable, the third has still not responded to treatment. The hospital is currently discharging fit patients under section 40 of the Mental Health Act on the recommendation of the psychiatrist. Long-stay patients remaining in the hospital for more than one year include 164 women patients and 24 men. The report had also recommended better security

measures, which have been undertaken. It had commented that housing facilities for the staff are utterly inadequate. A proposal of Rs 3.2 crore for construction of residential quarters in the hospital campus has been sent to the State Government.

The hospital has sanctioned posts of 9 psychiatrists, 3 junior doctors, 1 psychiatric social worker, 68 general nurses, 5 supervisors, 1 occupational therapist, and 108 supportive staff. There are several vacancies, including 4 vacancies of psychiatrists and 40 nurses. There are no residential staff on the premises. The staff has been provided training under the DMHP.

The hospital provides outreach through one monthly community outreach programme under the DMHP. The hospital has given a proposal for a modern hospital building. It proposes to start a day care centre, psychotherapy and counselling unit, specialized clinics. It has initiated DMHP in Shivpuri, Dewas, Sehore, Mandla and Satana districts. A body with a Public Information Officer and Assistant Public Information Officer, functions as the appellate authority to answer queries under the Right to Information Act.

# Nagaland

# Mental Hospital, Kohima

**Bed strength: 25**

**NHRC/SHRC visits**

**Infrastructural facilities:** A new OPD Complex as well as one Medical Officer quarters is under construction through grant in aid from the Government of India. There are 25 beds in the in-patient unit with 12 female beds and 13 male beds. There is no medical records section, library or canteen. There are also no telephones.

**Staff:** There are two qualified psychiatrists, one General Medical Officer. There are however no clinical psychologists, psychiatric/medical social workers or trained nurses, occupational therapists or lab/radiology technicians or medical records officer. There are 8 general nurses. The State government has currently imposed a ban on new appointments. The institute in its report requests a lifting of the ban and creation of new posts like clinical psychologists, occupational therapist, grade 4 staff or appointment on contract basis by the central government.

**Clinical services (Including investigation facilities):** Unmodified ECTs are given as no anaesthetist is available. Forty-eight patients have received such unmodified ECTs between March 2007 and March 2008. No OPD lab services are available and there is no lab technician available.

**Availability of drugs and other treatment modalities:** The report states that there are free medicines available for OP dispensing. There are no psychosocial interventions available to patients.

**Quality of food/kitchen facilities:** The budget allocation of food per patient per day is Rs 46. The food has not been calculated as per calorie requirement. There is a separate dining room for in-patients.

**Recreational facilities:** There are no recreational facilities.

**Vocational rehabilitation facilities:** There are no rehabilitation facilities.

**Remarks:** The report states that the State budgetary allocation for Mental Hospital Kohima barely meets the salary of the staff. It requests for remedial measures that would increase the budget in all the different heads as well as an improvement in infrastructure, adequate staff quarters, trained manpower and more exposure training for the hospital staff.

# Orissa

## Mental Health Institute, SCB Medical College Institute, Cuttack, Orissa

(Established 1996, Bed strength 60)

**Infrastructural facilities:** The institute is currently a 60-bedded facility with no new construction in IPD or OPD since 1996. The Works department has renovated the male and female wards of the IPD with Rs 20 lakh sanctioned under the 12th Finance Commission in the year 2008. Rs127, 34,211 was placed with the CPWD in August 2007 for construction work under National Mental Health Programme. The CPWD has started renovation work from April 2008. No canteen facility is available within the institute, there is also no separate library available but the central library of SCB Medical College Hospital, Cuttack has some books on psychiatry and journals. There is no separate MRD. The registration-cum-reception counter also serves as the MRD here the records are stored and retrieved manually.

**Staff:** There are no staff quarters in the campus of the institution. There is only one staff nurse and one attendant staying within the campus of the SCB Medical College Hospital. There are 6 qualified psychiatrists, 2 clinical psychologists, 5 general nurses, 3 administrative staff, 25 ward attenders and peons and 3 pharmacists. There are no psychiatric social workers, trained psychiatric nurses, lab technicians, or occupational therapists. As the Institute is inside the premises of the SCB Medical College Hospital the consultants from all the departments of the hospital are available when required.

**Clinical services (Including investigation facilities):** Unmodified ECTs are in use here as neither an anaesthetist nor required equipment is available. The report does not address the availability of other investigations.

**Availability of drugs and other treatment modalities:** There is a budget of Rs 15 lakh for medicines during 2007-08.

**Quality of food/kitchen facilities:** The dietary budget for 2007-2008 is Rs 2, 19,000. The expenditure towards diet has been increased from Rs.10 to Rs.20 per patient and it remains at Rs.40 for Ranchi patients.

**Recreational facilities:** The report states that there is no recreational facility available.

**Vocational rehabilitation facilities:** The report states that there is no rehabilitation facility available.

**Remarks:** The institute requests for the necessary infrastructure for use of modified ECTs, creation of posts of PSWs, OTs, CPs and psychiatric trained nurses. It also requests to increase the budget allotment towards medicines so that free medicines can be provided. It also requires material for psychological assessments.

# Punjab

# Dr. Vidyasagar Government Mental Hospital, Amritsar

(Established in 1950, earlier bed strength 850, current bed strength 400)

## NHRC / NIMHANS report (1999):

'*There are 4 psychiatrists, 1 clinical psychologist, and 2 psychiatric nurses. There are no psychiatric social workers or occupational therapists. The staff are poorly trained and amotivated. There is a new outpatient block with adequate facilities. Approximately 50% of patients receive free drugs. Records are maintained poorly. Family members are allowed to stay with patients. There are no cots mattresses or adequate toilet facilities. Patients bathe and defecate in the open. The wards housing old patients, epileptics and mentally retarded are in worst shape. Staff members are not aware of the rights of the mentally ill. A Board of Visitors is present. They are practically ineffective.*'

**Earlier rating: Very poor**

**NHRC/SHRC visits during the last decade: 6**

**Specific Recommendations and Action taken**

## Hospital report update

| Domains | Suggestions made by NHRC 1996 | Interim Report | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | This is an old mental asylum set up and needs immediate attention and improvement. This hospital requires immediate structural changes. Safety of female patients is a great cause for concern. Legal | The DGHS (2004) records the construction of the new building and the demolition of the old one | The Punjab Government transferred the administrative control of the hospital to Punjab Health Systems Corporation in the year 2000. A new building has come up with all the |

| | | | |
|---|---|---|---|
| | problems in sending them back without going through the court is a major hurdle in discharging the improved patients. | | amenities and become operational since 2003.<br><br>The old Mental hospital has been demolished and the surplus handed over to the government and the loan repaid to the government |
| Amenities/ Facilities | | Chamanlal (2005) reports that the newly constructed building has a sewage treatment plant, modern kitchen and mechanised laundry. The toilets and bathrooms are provided in sufficient numbers in each ward. Sanitation and drinking water facilities were found to be adequate. The report however points out that the supply of hot water for bath- | The hospital reports that the geysers meant to heat up the water were installed by the Construction Agency in a defective condition. However all the geysers were serviced and repaired. Patients now have hot water facility in the winter months |

| | | | |
|---|---|---|---|
| | | ing purposes, which is a necessity in Amritsar's cold climate is yet to be commissioned | |
| Diet/Kitchen | Food quality and quantity requires urgent attention | The new kitchen complex uses gas as fuel and meets all standards of hygiene. The patients are provided bed-tea, breakfast, lunch, evening tea and dinner with food meeting nutritional standards. Kheer is served twice a week with daily lunch including a seasonal fruit. | |
| Staff and training | | Barring a few individuals the entire staff needs to be trained and sensitised in the matter of human rights of the inmates. The absence of PSW is adversely affecting the improvements that were registered in the | |

| | | patients care and handling after the reorga-nization of the Institute. | |
|---|---|---|---|
| Recreation/ Rehabilitation on Occupational Therapy | Many patients, who were sent through reception order and improved, continue to stay for several years without any efforts to rehabilitate or discharge. More psychosocial interventions need to be developed to overcome this problem. | According to the Chamanlal Report of 2005 the matter is referred to the Magistrate whenever the patient admitted needs to be hospitalised beyond 90 days. | Improved |

and the staffs appear quite committed. A lot of vacant posts of psychologists and social workers exist. The report states that the main limitation of this hospital is shortage of qualified psychiatrists, psychologists, psychiatric social workers, trained nurses and paramedical staff. The report states that this institute has the potential of becoming a model psychiatric hospital. The Chamanlal Report (2005) states that the new building that came into function in 2001 is constructed to accommodate 450 indoor patients. There is a separate ward for forensic patients. There is also a separate family care ward, which can hold up to 50 patients. All patients have been provided with iron cots and mattresses and all wards are attached with toilets and bathrooms with adequate water supply. Patients are not tied up any more. Modified ECT was introduced from 2002 and unmodified ECTs have been completely stopped. The Chamanlal report of 2005 also notes that '*the extent of psychosocial inputs to diagnosis is still inadequate and needs to be increased. The techniques of psychosocial therapies are yet to be introduced*". According to the Chamanlal Report, the NHRC reco-mmendations to sensitise the

judiciary remains valid to date reporting of observations of reception orders where the word 'lunatic' was used by the magistrate oblivious to the provisions of the Mental Health Act. The DGHS report (2004) states that clinical services are adequate. Basic investigations are being done in the hospital. However special investigations like clinical psychological testing are not available. According to the Chamanlal Report of 2005 all the observations of the Channabasavanna Committee Report were satisfactorily addressed.

# Rajasthan

# Mental Hospital, Jaipur

(Established in 1952. Earlier bed strength 312, current bed strength 280)

### NHRC NIMHANS Report (1999)

'*The hospital has a general hospital type of architecture…four pavilions for chronic patients, two each for males and females…does not have a separate outpatient building, criminal ward or a rehabilitation centre… there is no modern laundry and modern kitchen. Majority of admissions are voluntary...there is no planned budget for developmental activities…there is no facility for casualty and emergency services. Toilets are not clean and maintenance is very poor…Chronic wards for males and females are overcrowded and in need of immediate attention…routine investigations are available…food is prepared in an old building without proper ventilation…The hospital is actively engaged in community based activities…a school mental health programme is also being carried out…the hospital is in need of a vehicle and driver for continuing the community services.'*

### Earlier rating: Average

There were no interim reports available for this hospital

### NHRC/SHRC visits during the last decade: 5

### Specific Recommendations and Action taken

# Hospital report update

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Reported status as in 2008 |
| --- | --- | --- |
| Infrastructure | Since the outpatient services have been steadily increasing there is a need to have a separate building with adequate staff built on modern lines with a waiting hall, adequate seating, interview rooms that provide privacy, rooms to carry out psychological testing and intervention etc.<br><br>It should be well lit and ventilated with toilets, drinking water telephone and canteen facilities. Separate facilities to cater to the needs of children and adolescents must be provided. Family wards to be started with specialised inputs for working with families.<br><br>Departmental library of the hospital needs to be upgraded with more periodicals and journals and more computer facility to be provided | A separate OPD block has been constructed with dedicated emergency services working 24 hours, facilities for visiting relatives to stay, a waiting hall for patients, toilets for patients and relatives, drinking water, canteen services, OPD lab services.<br><br>There is a separate children's ward with specialised children's services. The report mentions that Rs 2.65 crore has been received from the National Mental Health Programme for upgradation of the hospital for construction of Family Psychiatry Ward, dining halls, hostels for trainees and repairs. There are new library rooms with full time staff. |
| Amenities/ Facilities | Basic infrastructure in the wards needs to be improved. There should be better toilets in adequate numbers. Hot water facility | The report places the current patient to toilet ratio at 1:8. There is 24 hour running water with fans and coolers.  Separate dining |

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| | to be provided in winter. Improved mode of communication between the wards through telephone and intercom. Phone facility that can be utilised by patients and relatives. The kitchen of the hospital needs to be upgraded. A modern system of laundry so as to provide clean linen. Criminal patients must be kept in a separate unit | facility is under construction. The report does not address the suggestion for better laundry facilities and hot water facility for winter. Intercom facility is available in all rooms wards, OPD and administrative block. There is a separate unit for forensic services with 14 beds |
| Investigations/Treatment | Laboratory investigations in the hospital need to be upgraded.<br><br>A separate clinical psychology unit with adequate professional staff and testing and other equipment to carry out psychological testing and psychosocial and behavioural methods of treatment | Details of laboratory investigation services provided in the hospital are not mentioned in the report.<br><br>Not addressed in the report |
| Staff and training | The lack of professional staff is a major handicap. Although training of psychiatrists has started there are no centres to train other members of a multidisciplinary team such as clinical psychologists, psychiatric social workers. It would be prudent to start such training centres, which would cater to the needs of the state and the region | There are currently 12 psychiatrists, 6 GMOs, 1 PSW, and no trained psychiatric nurses or CPs. However there is one CP working on contract basis There is 1 occupational therapist, 1 lab technician, 61 general nurses and 62 ward attenders and peons. |

| Recreation/ Rehabilitation on Occupational Therapy | A separate rehabilitation unit with new building, staff and equipment should be provided | The report states that IP rehabilitation services are available |
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badminton and ring tennis. There are specialised children's services, geriatric services, forensic services, de-addiction services and a separate medical records section available.

## Tamil Nadu

## The Institute of Mental Health, Chennai

(Commissioned in 1794. Total bed strength 1800)

### NHRC / NIMHANS Report 1999

*The prison-like gate enclosures must be removed. Although the institution's name has been changed and words like asylum are not used, terms such as enclosures and overseers reflect the enmeshment of the institute in the last century. It is important to be freed of such shackles of custodial care. Cells must be abolished".* The report states that the Institute of Mental Health, Chennai still continues to be a prototype mental hospital. Despite the presence of highly skilled and competent psychiatric staff, and the free use of the most recently introduced psychotropic medicines, basic living conditions of the patients remains much the same. While the psychiatrists are continually exposed to research and training there is little training for the other mental health professionals. There are few psychiatric nurses. There is no sensitisation for the ward attendants. There are no in-service training programmes. Basic lab, X-ray, EEG facilities are available in casualty... Referrals for CT scan are sent to the general hospital. Specialists visiting the hospital include an ophthalmologist and TB specialist. There are daily OPD services.

### Earlier rating: Poor

### Visits by NHRC/SHRC during the last decade: 1

## Specific Recommendations and Action taken

### Hospital report update

The DGHS (2004) report states that the hospital has undergone significant

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations (DGHS 2004) | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Rather than waste so much money on repairs, many of the outdated buildings needs to be demolished. New wards in keeping with the modern facility need to be built

Walls to be lowered prison like gate enclosures must be removed... It is important to be freed of such shackles of custodial care. Cells must be abolished. Greater privacy during OPD evaluation by social worker | Infrastructure change is inadequate. It is understood that a plan for demolition of obsolete structures in phases and building a modern structure is under formulation. | New wards have been constructed and changes made including in in-patient wards, criminal wards and female wards

Cells continue to be present |
| Amenities and facilities | Living conditions, toilets, privacy, linen, personnel appearance need | Availability of linen and patients clothing is inadequate. | The report states that these are inadequate in |

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| | to be paid imme-diate attention<br><br>The overcrowding within the wards submerges any possible attempts at improving quality of life of patients. This has to be addressed by decentralising psychiatric facilities within the state and rehabilitating many of the mentally ill presently in hospital who do not need institutional care.<br><br>More open wards with admission along with family, needs to be encouraged.<br><br>Improvement of campus facilities, lighting, maintenance | Steps are under-way to improve the quality of linen as well as patients clothing | the chronic wards but adequate in the new wards. It also states that only in selected wards 'inmates' have personal belongings like separate cupboards. In many wards, they have only common cupboards. In many wards 20 to 30 'inmates' are staying in one block, whereas in the chronic wards 40 to 50 ' inmates' stay in one ward.<br><br>The report does not address this suggestion |
| Diet/Kitchen | Dietary provisions to be increased | Quality of food is satisfactory and the kitchen has modern equip-ment | The report states that hygienic nutri-tious diet to all patients is being provided three times a day. The pro- |

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| | | | cess of cooking and serving food is supervised by a dietician, medical officer, staff nurses and social worker |
| Investigations/Treatment | | Just adequate. Further augmentation of lab and X-ray facilities is required | |
| Staff and training | The attendants need to be trained sensitised and brought under the nursing administration to ensure better monitoring less evaluation of patient rights<br><br>In-service training for mental health professionals. Deputation of more nurses for psychiatric nursing training. More doctors to be available after 2pm. A multidisciplinary team approach and regular administrative meetings may help in smoothening out staff | While the number of psychiatrists is adequate the strength of other mental health professionals is below the sanctioned level | The report states that the Director of Medical Education, Chennai appoints D group employees. They come under the control of the Director<br><br>The report does not address the other recommendations |

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| | functioning and other issues More liaisons with other specialists. Sensitisation of judiciary to pre-vent further admissions under the Indian Lunacy Act. Filling up of vacancies | | |
| Recreation/ Occupational Therapy/ Rehabilitation | | Color TVs are available in most of the wards There are no other recre-ational facilities Vocational and rehab services are inadequate but efforts are being made to improve this area through an officially spon-sored NGO | |

changes over the past two years though the vestiges of the old custodial legacy remain. The proportion of long-stay patients is still high. Plans have been submitted to the government for construction of a modern hospital and a half-way home. The hospital report of 2008 states that cells still exist. The PWD, Civil and Electrical Department functions within the campus to take care of the repair and maintenance work. The hospitals report of 2008 states that 50% of the long stay patients in the hospital have no social support or are not recovered patients hence rehabilitating them has not been possible. The hospital also has NGOs involved in rehabilitating the patients by working with them in recreation therapy centre, occupational therapy centre and industrial therapy centre. Occupational Therapy is available for both male and female patients with an approximate

capacity of 200. Tailoring, painting, basket making, doll making and paper cover making is available for women. Gardening, carpentry, blacksmith, binding, weaving, bakery and canteen work is available for men. The report states that there is a centralised biochemical lab, clinical lab, and radiology department. Two psychological treatment centres, one each for OP and IP are available. Casualty and emergency services are available. The hospital runs community mental health services at Poonamallee. One medical officer attends the centre every Tuesday and the Beggars Home at Melpakkam.

# Uttar Pradesh

## Agra Manasik Arogyashala (Presently Institute of Mental Health and Hospital (IMHH), Agra

(Established in 1859. Bed strength 718)

### NHRC / NIMHANS Report 1999

'The family wards were started in 1997. The hospital has a land area of 175 acres. The Hospital buildings are nearly 75 years old and require extensive renovation. Only 5% of admissions are voluntary…Nearly 50% of patients have been staying for more than 2 years. Seven psychiatrists are available for the entire hospital. There is one clinical psychologist and social worker…there is amotivation among the staff…The nursing staff work in three shifts and the nurse to patient ratio is 1:225…Casualty and emergency services are present and easily available…OPD functions in a separate block…there is a waiting hall for patients which accommodates only 50% of patients…Modified ECTs are available…No free drugs available…No facilities for lab investigations in the OPD…The lighting within the wards and in the compound is poor…The female patients wards are in a separate compound and the main door is always kept locked with a female chowkidar…When family members wish to meet a patient, a meeting is arranged at the entrance of the gate…The attenders use a long lathi to control the patients.'

**Earlier rating: Average**

Visits by the NHRC/SHRC during the last decade: 10

Specific Recommendations and Action taken: The hospital has not submitted its current status report

| Domains | Suggestions made by NHRC 1996 | Interim Reports |
|---|---|---|
| Infrastructure | The buildings need to be repaired and the basic facilities need to be improved | The Dr. Mishra report of February 2007 states that the present building is too old with construction of most of the blocks dating back to 1859.The existing arrangements of the State PWD carrying out the repairs are not very satisfactory. The waiting space in the OPD for relatives is inadequate The drug dispensary is not an integral part of the OPD so relatives have to walk about 1/3 kilometer to the dispensing room to collect medicines leaving the patient alone in the OPD. However essential services like drinking water, toilet, lighting, ventilation, etc. are available. Of the total land that belongs to the Institute, 33 acres is farmland. A part of the farmland is within the boundary wall housing the patients' wards while the rest is outside and is under encroachment. The Institute has a number of pro- |

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| | | posals in the pipeline for future expansion and growth, which may not be possible unless the encroachment is removed and the vacant space is made available to the Institute. |
| Amenities/ Facilities | It is better to increase the open ward and family ward facilities so that relatives may stay with the patients<br><br>Improvement in the living conditions such as sanitation and regular water supply is needed | The Dr Mishra report of February 2007 states that there is a half-way home in the Institute as an integral part of the Family Ward. At the time of the report there were only 6 'inmates' in this Home. A separate dining hall, recreation and reading facilities have been provided to them. Two barbers are engaged for haircuts and shaving. There are no female barbers for female patients. Anti-lice, anti-bug measures, fogging with malathion is done, toilets are clean and tidy, and there is sufficient warm protective clothing. The Mishra Report comments that the water supply system is quite old and has outlived its utility. The supporting beams in the overhead tanks have developed cracks and according to the engineers repairs are not possible. A total replacement would be required<br><br>The Chamanlal Report of |

| Investigations/Treatment | Free drugs to be provided for deserving patients attending the outpatient facility | March 2004 states that poor patients attending the Institute get medicines free of cost |
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| Staff and training | There is an urgent need to improve the staff strength of psychiatrists and other support staff | According to Dr Lakshmidhar Mishra's report of February 2007, several essential and paraprofessional posts are currently lying vacant. |

The DGHS report (2004) states that the institute has a total area of 172 acres with ample space for patients to move about…emergency/routine OPD services are available. Clinical psychology services are available but in inception stage and psychiatric social work services are poor. Drugs as well as ECTs are available only for in-patients. The kitchen facility is satisfactory and there are patients working in the kitchen. However, there is no facility for transport of food from kitchen to dining area. Clothing and linen are provided but of poor quality. TV is available in most wards and dining area. There is one full-sized auditorium and one recreation room each for male and female patients. There are large-scale vacancies causing problems in the smooth management of the hospital. Each ward has sufficient number of cots/beds, fans and water coolers. Every bed has a mattress, bed sheet, pillow and blankets. Bed sheets are changed once a week. Dress and linen are changed regularly twice a week. Patients take bath regularly. However, no hot water is provided to them for bath in the winter months. The Mishra report 2007 comments that this is inhuman. Patients are engaged in various occupational activities in the institute and are remunerated for the same. The Mishra report states that the half-way home has a very systematically drawn up healthy schedule for the members. There is also an acute shortage of qualified personnel as the Institute runs the home. There are two occupational therapy units, one each for male and female patients with separate instructors in envelope making, candle making, laundry, 'Dona' making, chalk making and weaving, dhurri making, tailoring, carpentry, spiral binding, cane binding, lamination, painting, knitting and embroidery and idol making. The NHRC Report (2005) mentions that IMHH, Agra has significantly improved its patient care and facilities. The staffing pattern has improved with creation of additional posts in all

disciplines. A number of long-stay patients have been restored to their families through special efforts of the staff and volunteers of Action Aid India. However, inadequacy of occupational therapy facilities remains a pronounced weakness of this Institute. The reach of community health programme needs more attention. Pace of training facilities is also found to be slow.

## Mental Hospital, Bareilly

(Established in 1862. Bed strength 408)

**NHRC / NIMHANS Report 1999:** *'It has a jail type of architecture… Of the total patients 156 are staying for more than 2 years…there are no separate beds for children…there are 34 cells, which are still in use. No family members are allowed to stay or visit the patients freely. Most of the admissions are involuntary…There are no casualty and emergency services provided. …Surprisingly there is not a single nurse posted in the hospital or nurses' posts. There are 56 male and 23 female attenders…Toilets are inadequate in the ratio of 1:30… Most of the time the inpatients are locked up and they cannot move freely…Medical records are poorly maintained and files are not retrievable… This hospital is one of the poorest in terms of patient care and needs improvement in all areas…The judiciary not being aware of the Mental Health act 1987 continue to admit children and persons with mental sub normality to the mental hospital…'*

**Earlier rating: Very poor**

**Visits by the NHRC/SHRC during the last decade: 2**

**Specific Recommendations and Action taken.**

| Domains | NHRC/NIMHANS Report 1996 | Reported status as in 2008 |
|---|---|---|
| Infrastructure | | |
| Amenities and Facilities | Supportive services like kitchen, laundry, medical records need to be developed | Separate washing places have been provided for washer men and washer-women. Solar water heaters have been provided in |

| | Living conditions of the patients inside the hospital should be improved immediately | the wards for regular hot water supply. Food is being prepared on LPG gas stoves and is being served in dining sheds on tables since May 2008. Exhaust fans have been fitted in the kitchen for better ventilation. |
|---|---|---|
| | Single cells should be abolished. Hospitals should be opened up with family members being allowed to stay with the patient | Single cell system has been abandoned and cells have been closed |
| Financial/ administrative | There is an urgent need to improve the overall budgetary provisions | Total budget allocation of the hospital was Rs. 321.3 lakh in 2006-2007 and has been increased to Rs. 336 lakh in year 2007-2008. |
| | The MS should be a psychiatrist | This power lies with the State government |
| Diet/Kitchen | | Diet provided at 3000 kcals per person |
| Investigations/Treatment | Modified ECTs should be given to patients | Modified ECTs are being given with the help of anesthetist |
| | Establishment of clinical lab with infrastructure, equipment and staff. There is a need to establish a separate x-ray and EEG department with staff and infrastructure | The hospital has acquired an EEG machine and CT scanner. Building for X-ray and EEG lab is available but machines and technical staff is not available |
| Staff and training | Creation of posts of psychologists, social worker, nurses is an urgent requirement | Four general staff nurses have been posted and are working from April 2008. No CP and PSW posts currently exist |

| Recreation/ Occupational Therapy/ Rehabilitation | Establishment of rehabilitation and recreational services with infrastructure, staff and equipment is a must for the patients in the hospital | TV music system, indoor/ outdoor games, magazines and two recreation halls with male and female instructors are available. |
|---|---|---|

## Hospital report update

According to the hospital report in 2008, the family ward has started functioning from May 2008. However, funding and manpower needs to be sanctioned by the State government. A building for MRD is available but no staff. Relatives are allowed to visit the patients on all working days. The hospital reports that active efforts are being made to discharge long-stay patients and that a number of such patients have already been discharged. A building for family ward for 60 patients including 10 private ward beds has been constructed and 30-bed family ward has been started. Proposal to sanction funds and manpower is pending with the State government. The number of toilets has been increased to meet the ratio of 1:5. Running water has been made available round-the-clock. Modified ECTs are being given. There are no posts for clinical psychologists, psychiatric social workers or nurses. An auditorium with 450 seating capacity, a photocopier, a tractor, and computers for library, store, dispensary and OPD have been acquired. The report also states that the building for the laboratory is ready, proposal for equipment has been sent to the State government and creation of a post for manpower is also pending with the State government.

## Mental Hospital, Varanasi

Established in 1809. Total bed strength 331)

 **NHRC / NIMHANS Report 1999:** '*The hospital resembles a jail. There are two closed wards and the rest are barracks and cells. There are two psychiatrists and 56 attenders. There is no nurse, clinical psychologist, psychiatric social worker; occupational therapist available…there are daily out patient services…There is no interview room in the OPD …separate 'jungy' wards are built to house 'criminal' patients. There are single cells with no basic facilities…Every patient is looked at as a potential candidate for escape…When a patient is brought in he is kept in a single cell without medicine and locked up*

for 2 weeks these cells are small enclosures without beds, water, light, linen and toilet. Food plates are pushed into the cell or kept near the door…Patients are treated like caged animals…there is no water facilities…the wards are very badly maintained. Patients live in inhuman conditions...the kitchen is in bad shape. There is only one cook. Firewood is used. Rs.12 per day per patient is the expense on food. Patients bathe under taps in the open…Family members are allowed to see the patients once a week in a safe enclosure…There is no communication between patients and their families…there is no community services or rehabilitation services in the hospital'*

**Earlier rating: Very poor**

**NHRC/SHRC Visits during the last decade: 4**

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations (DGHS 2004) | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | The hospital continues to function on custo-dial care rather than therapeutic care lines<br><br>Buildings are in dire need of repair and maintenance | The buildings are approx. 200 years old and several buildings have been condemned. Patients are kept in closed wards | |
| Amenities and facilities | No ceiling fans<br><br>Lighting and venti-lation inadequate.<br><br>Regular OPD services need to be available. | Conditions of the wards are very poor, lighting is inadequate, no fans, patients sleep on floor beds. Cells are present but no longer in use. | Insufficient seating no drinking water or toilet facilities for out patients and their families. There is no proper facility for |

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| | Security to be provided by the jail authorities for the criminal mentally ill at the hospital. All the patients are confined because of fear of escape of the group | | registration and recording of out patients. No separate MRD.<br><br>The report does not address this suggestion |
| Financial/administrative | | | No managing committee to oversee day to day management of the hospital and to take decisions. |
| Diet/Kitchen | | There is only one cook and the kitchen is dilapidated, quality of food could be improved | |
| Investigations/Treatment | | There is no facility for X-ray, lab or ambulance | |
| Staff and training | Immediate recruitment of nurses. Creation of posts of Clinical Psychologists, Nurses and Social Workers.<br><br>Proper monitoring of patients by medical personnel | The essential psychiatric medical and paramedical staff as well as group C and D staff is inadequate. Direct ECTs are given because of no anesthetists. There is no psychiatric | No PSWs, Clinical Psychologists. Psychiatric Nurses<br><br>The report does not address this suggestion |

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| | and better records mainte-nance Sensitiza-tion and training of all levels of hospital staff | nurse, social worker or clinical psychologist | |
| Supportive Services | Liaison with other hospitals to provide physical care<br><br>Facilities such as ambulance and telephone to improve communi-cation with out-side agencies | | The report does not address this suggestion<br><br>One ambulance was supplied by the State government in 2001. There is one telephone for the office of director and no PCO |
| Recreation/ Occupational Therapy/ Rehabilita-tion | | Very poor, only some patients are involved in horticulture. Two black and white TVs. No recre-ational room | No rehabilita-tion facilities available |

## Hospital report update

The DGHS report (2004) states that this hospital needs major improvements in building and maintenance, basic facilities for patients such as clothing, proper sleeping and living conditions. The food also needs improvement in quality and variety. Specific facilities like medical and paramedical care, investigation facilities, communication facilities between working units are needed. In rehabilitation and recreation, a lot is needed to bring the services closer to adequate.

# West Bengal

## Institute of Psychiatry, Calcutta

(Established: 1817, Bed strength: 36)

**NHRC/NIMHANS 1999 report:**

*"Majority of the buildings are old. There are only closed wards. Facilities like electricity, telephone, and library are adequate. Water supply is inadequate and drainage has to be improved. Staff structure is highly inadequate and there are no qualified psychiatrists and PSWs in the hospital. No budget is allocated for the hospital. Casualty and emergency services are absent. Inpatient wards are cleaned once in a fortnight. Patients are given bath daily. The ratio of toilets to patients is 1:2. All the other facilities are adequate. Routine investigations are present. There is no board of management".*

**Earlier Rating: Below Average**

**Visits by NHRC/SHRC in the last decade: nil**

**Interim observations**: The buildings are in a poor state and the facilities are inadequate. Facilities for investigations are unavailable, direct ECT is given. The kitchen is satisfactory. The linen and patients clothing is inadequate. Recreational and vocational/rehabilitation facilities are absent. Clinical, para-clinical and recreational staff position requires strengthening. (DGHS 2004).

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---------|-----------------------------|---------------------|----------------------------|
| Infrastructure | Construction of the total hospital building as per the proposed master plan | The building is in a poor state | The Institute of Psychiatry was abolished and made into a Department of Psychiatry of Bangur Institute |

| | | | of Neuro-Science and Psychiatry, which in turn is under the administrative control of Neurology |
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| Amenities and facilities | Necessary action to be taken to revive the inpatient services | Inadequate facilities. | The report does not address this suggestion |
| Financial/ Administrative | A Board of Visitors has to be constituted<br><br>The Institute may be declared as an autonomous teaching hospital with a Director.<br><br>A proper academic wing should be formed for post-grad education (MD/ DPM), Diploma in Psychiatric Nursing, teaching to other post-grad students, physiotherapy students, B. Sc nursing students, etc. This institute has the potential to develop as a regional psychiatric training centre for the whole region | | The report does not address this suggestion<br><br>All financial power has been shifted to the Secretary, BINP as such HOD of Psychiatry does not hold any financial power whatsoever |

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|---|---|---|---|
| Diet/Kitchen | | Satisfactory. Kitchen requires improvement. | |
| Investiga-tions/ Treatment | | No facilities for investigations are available. However, help is taken from the neighbouring hospitals. | |
| Staff and training | Optimum man-power provision-both teaching and non-teaching categories | The clinical, para-clinical and recreational staff position requires strengthening. | There are no trained psychi-atric nurses, no psychiatric social workers and no lab/ radiology technicians. However there are 9 psychia-trists and 1 clinical psy-chologist. |
| Supportive Services | Additional sup-port staff espe-cially ward staff should be pro-vided. They should be trained to handle the mentally ill | Anesthetist is not available in the hospital. In female wards ayahs are unavailable. | No training is provided to the staff for dealing with the mentally ill. |
| Recreation/ Occupa-tional Therapy/ Rehabilita-tion | Do | Lack of recreational facilities. | |

## Hospital Report update

Independent existence of Institute of Psychiatry has been abolished. The hospital is currently known as the Bangur Institute of Neuroscience and Psychiatry. The Institute reports that budget allocation is adequate for its 36 psychiatry beds but has not given figures about the budget. It has not received any special funds for improvement. The hospital has specialised de-addiction (6 beds), children and forensic services at the OPD level. All the wards are closed type and cells still exist. There are 32 paid wards in the hospital. There were no admission through the court during 1st March 2007 – 31st March. Patient-toilet ratio in the wards both in male and female side is 1:2 and 1:1 respectively. Running water is adequate. Dining room is available for the patients while fans/coolers are absent. It is not compulsory to wear uniforms in the ward.

The medical superintendent is not a psychiatrist. There are nine qualified psychiatrists and a clinical psychologist in the hospital. However, there is no psychiatric social worker or psychiatric nurse. There is a felt need for more staff in the hospital. The institute provides PG training programmes in psychiatry and psychology. Direct ECT is still used. Board of visitors is not functioning.

## Lumbini Park Mental Hospital, Calcutta

(Established: 1940, Bed strength: 200)

### NHRC/NIMHANS report 1999:

*"This hospital is like a general hospital with open and closed wards in one single storied building. There are two pavilion type wards meant for males and females. Buildings are old but reasonably maintained. Water supply and electricity are adequate. 5 psychiatrists are available in the hospital. A clinical psychologist and 2 trained psychiatric nurses are present but there are no psychiatric social workers. There is no casualty or emergency facility. Facilities in OPD are inadequate. Dormitory type wards are available for inpatients. There is no seclusion ward. Toilets and fans are inadequate. There is little recreational facility available for patients. Routine investigation facilities are unavailable. Rehabilitation and community services are unavailable. A Board of Management has been constituted".*

**Earlier Rating: Poor**

**Interim observations:** The building is in a poor state with inadequate facilities. It requires lot of improvement. Facilities for investigations are unavailable; ECT is given without modification, as no anaesthetist is available. The kitchen is satisfactory. The linen and patients clothing are inadequate. Recreational and vocational/rehabilitation facilities are absent. Clinical, para-clinical and recreational staff position requires strengthening. (DGHS 2004).

**Visits by the NHRC/SHRC during the last decade: nil**

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | The visit to this hospital revealed that the office staff occupies a large area of space. There are posters of various trade unions inside the hospital and the walls look very shabby. Because of the excessive union activity the relationship among the staff members is not very cordial. This hospital needs a larger space, minimum basic facilities, rehabilitation programmes, and provision of additional mental health professionals | Inadequate facilities. The building is in a poor state. | The report by the hospital states that infrastructure is unplanned and inadequate and that the building is a very old damaged house not built for the purpose of running a hospital

There are pres- |

| Amenities and facilities | Hospitals should have more space in terms of building and campus<br><br>There should be adequately maintained gardens<br><br>A visitors annexe should be constructed for patients' relatives. | | ently no facilities for visiting relatives to stay<br><br><br><br><br>The quantity/ |
| Diet/Kitchen | There is a need to improve the variety and taste of food | Satisfactory. Kitchen requires improvement. | quality of diet is reported as unsatisfactory.<br>Not addressed in |
| Staff and training | Doctors and nurses should interact with patients more frequently<br><br>Patients should be encouraged to voice their grievances<br><br>A confidence building atmosphere should be constructed by all staff | | the report<br><br><br><br><br><br><br><br><br>There are no lab |
| Supportive Services | There should be adequate number of trained paraprofessionals. | | technicians available. Three pharmacists are available.<br>There is no |
| Recreation/ Occupational Therapy/ Rehabilitation | Rehabilitation facilities has to be started | Lack of recreational and vocational/ | occupational therapist, psychiatric social worker. There is |

| | | rehabilitation facilities. | one clinical psychologist. There are inpatient rehab services (details not provided) run by an NGO |
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## Hospital Report update

The hospital does not report of having received any special funds. It reports that budgetary allocation is inadequate. This hospital does not have any specialised services at the OPD level. It has two closed wards with 200 beds in total. Cells are absent. It has not mentioned the number of admissions through courts. The hospital has not reported about the adequacy of running water, patient-toilet ratio and budget allocation for food/patient. A dining room is available for the patients. Ward uniforms are not compulsory.

There are five qualified psychiatrists and a clinical psychologist in the hospital. However, there is no psychiatric social worker or psychiatric nurse. The staff is highly inadequate. The institute does not provide any PG training programme. Whatever little rehabilitation is done, it is undertaken by the NGOs. Recreation facilities are inadequate. Diet has not improved with time. Power gets interrupted frequently. Canteen service is unavailable and the hospital is planning to close the library as there is no post of librarian. This hospital does not have a telephone facility. ECT is not given to patients. The hospital does not mention if the Board of Visitors is present and functioning.

# Pavlov Hospital, Calcutta

(Established: 1966, Bed strength: 250)

## NHRC/NIMHANS report 1999

"The two-storied building is 105 years old. There are only closed wards. Buildings are reasonably maintained. The staff consisting of 7 qualified psychiatrists, 3 clinical psychologists and 2 medical social workers is inadequate. There are no trained psychiatric nurses or trained attenders.

There are only closed wards. Admissions are court directed cases as well as voluntary admissions. There is difficulty in discharging patients sent by the judiciary. Casuality and emergency services are absent. Facilities for outpatient are reportedly inadequate. Inpatient wards are cleaned once in 2-3 days. Patients bathe daily. Seclusion wards are present. Toilets and fans are inadequate. There is little recreational facility available for patients. Investigation facilities are unavailable. Rehabilitation and community services are not provided".

Earlier Rating: Poor

Interim observations: "*The building is satisfactory with adequate facilities. The hospital requires lot of improvement. Facilities for investigations are unavailable; ECT is given without modification as no anaesthetist is available. The linen and patients clothing are inadequate. Recreational and vocational/rehabilitation facilities are absent though an NGO is working to provide some vocational training. The female ward requires a lot of improvement. The kitchen and dining hall requires repairs. A lot of improvement is required for recreational and vocational training*" (DGHS 2004).

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Amenities and facilities | To separate the hospital campus from the residential quarters of the staff | | The hospital report does not address this recommendation |
| Financial/ Administrative | To develop this into a training institute | | The hospital report does not address this recommendation |
| Diet/Kitchen | | The kitchen and dining hall requires repairs | |

| Investiga-tions/ Treatment | Investigation facilities should be improved. | No facilities for investigations are available | The hospital reports that it does not have lab services at IP or OP level |
|---|---|---|---|
| Staff and training | There is a need for staff training | Clinical and para-clinical staff are deficient | The hospital report does not address this recommendation |
| Recreation/ Occupational Therapy/ Rehabilita-tion | A rehabilitation facility is started and | Lacks facilities in this field | The report submitted by the hospital states that there is an inpatient rehab facility<br><br>There are no psychiatric social workers, clinical psy-chologists or trained psychi-atric nurses. There are three social welfare officers |

## Hospital Report Update

The hospital currently has a separate OP block and dedicated 24 hours emergency services with waiting hall, toilets, drinking water and canteen services for the patients and caregivers. However, the facilities for the relatives to stay as well as lab services (OPD) are absent. The hospital does not offer any specialized services at the OPD. Free medicines are provided. There is no separate medical records section. No educational materials are provided for the patients. Out of the total 250 beds in IP, 288 were occupied as on 1st April, 2008. There are no open wards or paid wards. Patient-toilet ratio is not adequate in the wards. Dining facility, fan/cooler and running water are adequate. Uniform is compulsory but

laundry is not available. Disposable syringes are used and shaving blades are reused in the hospital (by the barber). Investigations are not available and ECT is not used. Food budget allocation per patient is Rs 28.50. Though the hospital reports the availability of rehabilitation services, details are not available. Recreational facilities are inadequate.

The Medical Superintendent is not a psychiatrist. There has been no litigation against the hospital. Board of Visitors made one visit between 1st March 2007 - 31st March 08. Staff position is highly inadequate; there are no psychiatric social workers, clinical psychologists or trained psychiatric nurses in the hospital. Plan budget is Rs 290 lakh while funding from other sources is reported as Rs 94.40 lakh.

# Berhampore Mental Hospital, Murshidabad

(Established: 1980, Bed strength: 230)

## NHRC/NIMHANS report 1999

"*An old jail was converted into a hospital in 1980 without making many changes in the basic structure. There are only closed wards. Single cells are poorly lit, ventilated and overcrowded with inadequate/ absent toilet facilities. Compound walls are high watchtowers that can collapse at any time. There are open drains with stagnant waters. The buildings are poorly maintained and not properly cleaned. Electricity, drainage, water facility, canteen, telephones and library are highly inadequate or absent. Staff is reportedly adequate with 5 psychiatrists. Clinical psychologists and PSWs are absent, though 4 medical social workers are available. Inadequate budget is allocated for maintenance. Though casualty and emergency services are present, there are no short stay wards or ambulance. Medicines and telephone facility is available. Seating conditions in OPD are poor. Overall hygiene in the wards is very poor. Cells are in use. There are complaints about the quantity and quality of food. Routine blood investigations and X-ray facilities are present. The hospital provides direct ECT. There is no medical records section. Rights of the mentally ill are flagrantly violated*".

Earlier Rating: Poor

**Interim observations**: "*The hospital lacks most of the facilities; building is in a poor state. Facilities for investigations are unavailable; ECT is given without modification, as no anaesthetist is available. The linen*

*and patients clothing are inadequate. Recreational and vocational/ rehabilitation facilities are absent. Clinical and para clinical staff is deficient. The hospital still gives an impression of prison rather than a mental hospital".* (DGHS 2004).

## Specific Recommendations and Action taken

| Domains | Suggestions of the NHRC/NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | Medical superindent, all the staff and the public feels that there is a need to provide ward infra-structure<br><br>It is very important for this hospital to improve the structure and functioning in total. | Lacks most of the facilities; the building is in poor state. | Has a new building<br><br>There are OP canteen facilities but the report merely states that inpatients have adequate care in terms of food and stay. The hospital does not have arrangements for visiting relatives. |
| Amenities and facilities | It is necessary to develop a closed drainage system. | | Not addressed |
| Financial/ Administra-tive | The most difficult pro-cess is to develop a good work culture among the staff. | | Not addressed |
| Diet/Kitchen | The patients felt im-provement of diet in terms of quality and quantity is essential. | Satisfactory, kitchen requires improvement. | Not addressed |

| Investiga-tions/ Treatment | | No facility for investigations are available | Not addressed |
|---|---|---|---|
| Staff and training | Need to increase the number of nurses. There is an urgent need for the training of staff from the MS to the attenders.<br><br>It is necessary to provide opportunities for updating the knowledge of medi-cal officers and psychiatrists<br><br>It is suggested that the government depute the different levels of staff for training to other centres | Clinical and para clinical staff is deficient. | The report does not address this |
| Supportive Services | The large number of attenders and peons need to be reduced, as most of them are not functional<br><br>The same people can be put in charge of regular activity programme under supervision of medi-cal officers<br><br>It is necessary to delegate responsibili-ties to the staff by the MS | | The report is silent on this recommenda-tion. |

| Recreation/ Occupational Therapy/ Rehabilita- tion | There is a need for recreational activities.<br><br>The large open space available can be used for outdoor activities and rehabili- tation work. | Lack recreational/<br><br>Rehabilitation facilities | IP and OP rehabilitation services done by NGO.<br><br>Colour TV, Carom, Radio, Ludo, etc available. |
|---|---|---|---|

## Hospital report update

A three-storied building has been constructed with a capacity of 260 persons. An OPD complex is under construction. Emergency services are available. The construction of a two-storied rehabilitation building is just completed. Psychiatrists, clinical psychologists and trained psychiatric nurses are present but there are no PSWs and other supportive staff are inadequate. Drinking water and canteen services are available at OP level. There are no specialised services available. Total inpatient beds are 350, only closed wards are present and cells are used. 73% of the admissions are through courts. Running water, fan/cooler and separate dining facility is available. Uniform is compulsory. Disposable syringes are used and shaving blades are reused in the hospital. The Report is silent on lab investigations, patient-toilet ratio, budget allocation of food/patient and free medicine supply. ECT is not available. Medical superindent is not a psychiatrist. It is reported that board of visitors is functioning, but they have not made any visit between 1 March 2007 - 31st March, 2008.

# Institute of Mental Care, Purulia

(Established: 1994, Earlier bed strength 80, current bed strength190)

### NHRC/NIMHANS report 1999

*"This hospital was established by the Government of West Bengal in 1994 to take over the state's patients from Ranchi (both CIP and RINPAS). It is very close to the jail. There are only closed wards. The buildings were apparently that of an old jail. There is only one psychiatrist in the entire hospital. Posts of PSW, clinical psychologists and psychiatric nurses are not there. No admission or discharge is done from the hospital. Casualty and emergency services are available. Routine medical investigations are available. There is a regular OP*

department. All the in-patients are provided with food, cots, bed and medical treatment. Specific uniform is present for males and females. There is no recreational facility. Drinking water is available. Drug therapy is the only treatment given. There is no canteen, telephone or library available. There are separate case files for in-patients. There is no liaison with voluntary agencies. No board of visitors is present".

**Earlier Rating: Average**

**Interim observations:** *"The state of the buildings is unsatisfactory, with widespread water seepage during rain; inadequate for the number of patients. The staff strength is inadequate. The clinical and laboratory facilities are inadequate. X-ray facilities, EEG, biofeedback and anesthesia facilities are lacking. Availability of drugs and other treatment modalities is inadequate. Kitchen facilities are inadequate and there are no dining hall. The linen and patients clothing is inadequate. Recreational and vocational/rehabilitation facilities are absent. The report concluded that building, equipment, staff and other facilities are insufficient (DGHS 2004)".*

**Specific Recommendations and Action taken**

| Domains | Suggestions of the NHRC/ NIMHANS Report 1996 | Interim observations | Reported status as in 2008 |
|---|---|---|---|
| Infrastructure | The NHRC team did not visit this hospital in 1996 as it was discovered only on the visit to West Bengal. | State of the buildings is unsatisfactory. Inadequate for the number of the patients. | Changes were made in the OPD building, Indoor wards, ECT room in 2007 |
| Amenities and facilities | | The linen and patients clothing are inadequate. | |
| Financial/ Administrative | | | |

| Diet/Kitchen | | Kitchen facilities are inadequate and there are no dining halls. | |
| --- | --- | --- | --- |
| Investigations/Treatment | | | |
| Staff and training | | | Staff is inadequate. |
| Supportive Services | | | |
| Recreation/Occupational Therapy/Rehabilitation | | Recreational and vocational/rehabilitation facilities are absent. | Rehabilitation is nil. Installed colour TV, carrom board, Radio, playing card, story books, etc |

## Hospital report update

The hospital has received a special fund of Rs 1 crore from the GOI for improvement. The superintendent reports that budgetary allocation for the Institute is still inadequate. A separate outpatient block has been constructed. There is a waiting hall and drinking water is available. However, lab services, facilities for relatives to stay, toilets and canteen services are absent or inadequate. Specialised services for children, geriatric, forensic and de-addiction problems are not present in the OPD. There is no separate medical records section. No education materials are provided for patients. Nine cells are present in the inpatient. There are only closed wards. There are 76 in-patients staying for more than 5 years. Patient-toilet ratio is inadequate. Running water is provided and fans are available. Rs 28.50 is the daily dietary budget allocation. Separate dining facility is provided for males. Uniforms are compulsory. Disposable syringes are used. Shaving blades are not reused. In-patient lab services are inadequate. ECT services are not being provided. There is no community out reach programme done by the hospital.

The Medical Superindent is a non-psychiatrist. NHRC and SHRC has visited the hospital. The hospital reports functioning of a Board of Visitors.

# Reports of the new psychiatric hospitals for 2008 not covered by the NHRC/NIMHANS Review(1999)

## State Institute of Mental Health and Allied Sciences, Bhojpur, Bihar

No reports were received from Bihar. The following details have been collated from secondary sources.

### The DGHS Report 2004

The State of Bihar appears to be an area of darkness with regard to mental health services. Till the Supreme Court order passed in October 2001, the State had neither implemented the Mental Health Act, 1987 nor constituted the State Mental Health Authority nor the Licensing Authority. At the time of the nation-wide survey of mental health facilities carried out by this Directorate during December 2001–January 2002, the situation in Bihar was the most dismal among all States/Union Territories. Since then there appears to have been marginal improvement in this area and SMHA/LA have been constituted. The State has a long way to go before it can reach even the basic minimum standards of mental health care. It is learnt that the MD (Psychiatry) awarded by the State Universities is not recognized by the Medical Council of India. In this context, it is unfortunate that the State Government has chosen to divert scarce resources towards creation of a 250 bed mental hospital at Bhojpur. This goes against expert opinion worldwide which favours community-based mental healthcare rather than prolonged incarceration in mental hospitals which eventually de-socialize and de-humanise mental patients. The Government of Bihar may be well advised to utilise whatever resources they have for implementing the DMHP in as many districts as fiscally feasible. This would be a much more cost-effective and scientifically desirable proposition.

### Excerpts from the DVD Recordings of the Meeting of Health Secretaries and Mental Health Authorities of States and Union Territories (NHRC and NIMHANS 2008)

Bihar has established a State Institute of Mental Health and Allied Sciences, Bhojpur. This was a TB hospital which was then converted to a psychiatric hospital. It has been functional since the beginning of 2008. There are 500 beds with both inpatient and outpatient facilities. The centre

has one medical superintendent, three psychiatrists and approximately 130 paramedical staff. There are no permanent staff and all staff are deputed. There are no psychiatric social workers or clinical psychologists. The Institute is apparently trying to establish itself as a postgraduate teaching and training centre.

## State Institute of Mental Health (Rajya Mansik Swasthya Sansthan), Pt. Bd Sharma, Pgims, Rohtak, Haryana

**Infrastructural facilities:** The institute has sent a report that outlines the proposal for a new building covering an area of 8 acres within the PGIM campus. The Chief Minister of Haryana laid the foundation stone on 26th November 2007 and the expected date of completion is 25th May 2009. The male open ward will have 30 beds. The male closed ward will have 20 beds. The female open ward will have 20 beds and the female closed ward will have 10 beds. There are provisions for day care, a rehabilitation unit, an administrative block and an OPD block. The OPD will have spacious well-ventilated waiting halls with adequate sitting arrangements, drinking water and separate toilet facilities for men and women. There will be an ECT room, a recovery room, and a separate records room. Open wards are on the ground floor. Access to first floor is by lift, ramp and staircase. There are 4 activity rooms located alongside each ward for multidisciplinary meetings, seminars, group discussions, counseling, academic activities and recreational facilities.

**Staff:** Since the hospital is still under construction the report proposes the following staffing patterns. One senior professor-cum-director, one senior professor-cum-medical superintendent, 6 medical teachers, 4 psychiatric social workers and 4 clinical psychologists, 5 medical officers, 3 occupational therapists, 30 nurses, one lab technician, an ECT technician and an ECG technician as well as several other administrative staff. The institute also plans for visiting non-psychiatry consultants in the disciplines of Medicine, Orthopaedics and Obstetrics and Gynaecology. The hospital will be supported by an already existing well-developed psychiatry department which has regular postgraduate programmes (MD and DPM) and a 64 bedded general health psychiatric unit and OPD. All the staff will have common teaching/training programmes.

**Clinical services (including investigation facilities):** The report talks

about appointment of ECT, ECG and lab technicians and the setting up of an ECT room with A/C facilities for anaesthesia and emergency management, but does not give details of the other investigation facilities that will b made available to patients.

**Availability of drugs and other treatment modalities:** The report states that there will be a pharmacy in the OPD block. The report states that there will be two isolation chambers in each ward which will be well equipped and secure.

**Quality of food/kitchen facilities:** The report states that there will be two separate dining rooms for men and women and a modern kitchen as well as canteen. The institute has also kept the post of a dietician.

**Recreational facilities:** The report does not mention the kind of recreational facilities that will be available.

**Vocational rehabilitation facilities:** The report mentions a day-care centre, which will have occupational therapy units with facilities for yoga, pranayama and recreational facilities.

**Remarks:** The report states that the institute being in the PGIMS campus, back up will be provided for diagnosis and management. It will also provide greater liaison for research and training.

# Himachal Hospital of Mental Health and Rehabilitation, Shimla, Himachal Pradesh

**Infrastructural facilities:** A newly constructed four-storied building with proper planning was started in 2004. The ground floor consists of a central heating plant with a control room, a kitchen and a store room. The first floor is the OPD complex with toilets, a recreation room and an occupational therapy room. There are a total of 50 inpatient beds.

**Staff:** There are three GMOs, 4 general nurses, 6 ward attenders, one cook and one pharmacist. There are no psychiatrists, clinical psychologists, psychiatric social workers or trained nurses. There are no visiting non-psychiatry consultants. The medical superintendent of the Centre is not a psychiatrist

**Clinical services (Including investigation facilities):** No ECT services are available. No community outreach activities are conducted. There is no board for disability certification. The hospital does not have any facilities

for investigation according to its report.

**Availability of drugs and other treatment modalities:** Free medicines are available

**Quality of food/kitchen facilities:** Not been calculated as per calorie requirement. The budget allocation for food per patient per day is Rs 27.40. Separate dining facilities are available.

**Recreational facilities:** The report states that recreational facilities are available but details are not provided.

**Vocational rehabilitation facilities:** There are no in-patient rehabilitation services

**Remarks:** The report state that there is a need to post a psychiatrist along with essential post of paramedical and other staff.

## Modern Pyschiatric Hospital, Narasingarh, Agartala, Tripura

**Infrastructural facilities:** The report states that this is an 89-bedded hospital, which will come into force in a phased manner. The first phase of civil construction has already been completed. It has started functioning with 20 beds since 20th July, 2007. The report states that there is a separate OPD with waiting hall and a separate IP facility. There are also casualty and emergency services with separate staff. There are no closed wards and no short stay ward. Currently, library and canteen are not available but are under construction.

**Staff:** The report states that there are 3 qualified psychiatrists, 1 trained psychiatric nurse, 7 general nurses, 12 ward attenders 2 cooks, 6 security guards and 6 sweeping assistants. There are no general medical officers, clinical psychologists, psychiatric social workers or occupational therapists. There are no administrative staff. Four staff nurses stay in the campus.

**Clinical services (Including investigation facilities):** The report states that as the hospital is new the proposal for lab and other facilities is under progress. At present all investigations are done at the Agartala Government College Hospital.

**Availability of drugs and other treatment modalities:** The report states that most of the drugs are provided free of cost.

**Quality of food/kitchen facilities:** No information recorded

**Recreational facilities:** The report states that recreational services are available but no details are provided.

**Vocational rehabilitation facilities:** No rehabilitation services are available

# References

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2.  Agarwal SP. Mental Health: An Indian Perspective 1946 – 2003. New Delhi: Directorate of Health Services, Ministry of Health and Family Welfare; 2004

3.  NHRC and NIMHANS. Meeting of Health Secretaries and Mental Health Authorities of States and UTs. (DVD). Bangalore: National Human Rights Commission and NIMHANS; 2008.

4.  NHRC. Report on the visit of Shri Chaman Lal, Special Rapporteur, NHRC to Gwalior Manasik Arogyashala (G.M.A) on March 31, 2004.

5.  NHRC. Report of Shri Chaman Lal, Special Rapporteur on his visit to the Institute of Mental Health, Amritsar on 8 February, 2005

6.  NHRC. Report of Shri Chaman Lal, Special Rapporteur on his visit to the LGB Regional Institute of Mental Health, Tezpur, Assam on 31st March – 1st April, 2005

7.  NHRC. Report on the visit of Shri Chaman Lal, Special Rapporteur NHRC to the Institute of Psychiatry and Human Behaviour, Goa on 3rd – 4th July, 2006.

8.  NHRC. Report of review of the activities of RINPAS conducted by Dr. Lakshmidhar Mishra, Special Rapporteur, NHRC from 25th to 27th February, 2007.

9.  NHRC. Report of review of activities of the Institute of Mental Health and Hospital, Agra by Dr. Lakshmidhar Mishra, IAS (Retd.) Special Rapporteur, NHRC on 14th - 16th February, 2007.

10. NHRC. Report on the visit of Dr. Justice Shivaraj V. Patil, Member NHRC to Hospital for Mental Health, Vadodara (Gujarat) on 27.4.2006

11. NHRC. A report on the inspection of the activities of Mental Hospital, Varanasi (13th – 16th July, 2007)

**Background information:**

Name of the Hospital: _____

Address: _____

State: _____

Telephone: _____

Fax: _____

Email: _____

**Hospital infrastructure**

Have there been any new changes in the out patient and inpatient department after 1996? (Mention in detail)

**Staffing patternd**

| Designation | Existing | Vacancy | Total ( for all staff) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Availability of non-psychiatry consultants. (mention in detail if yes) _____

Staff who stay in the hospital campus _____

Adequacy of staff strength _____

Suggest remedial measures in staffing pattern _____

**Any changes in the following areas after 1996**

Medical records _____

Rehabilitation _____

Medication available _____

Diet _____

Power supply _____

Canteen _____

Library _____

Telephone _____

**Finance**

Total budget-2007-2008 (if not the most recent budget) _____

Plan _____

Non Plan _____

Special funds if available _____

Quality of care for the mentally ill (details please) _____

**Action taken on recommendation of NHRC**

Signature of the
Mental Health Authority

Signature of the
Medical Superintendent

| Supplementary Proforma – Information pertaining to current structure and functioning of psychiatric facilities | | | |
|---|---|---|---|
| **Name of the Hospital:** | | | |
| **Funding** | | | |
| Please provide details separately | Plan (amt in rupees) | | |
| | Non-plan (amt in rupees) | | |
| | Other sources of funding (Approximate value in rupees) | | |
| | | YES | NO |
| Infrastructure Out Patient | Separate Outpatient block constructed | | |
| | Dedicated emergency services (working 24 hours) | | |
| | Facilities for visiting relatives to stay (hostel/guest house etc) | | |
| | Waiting hall for patients | | |
| | Toilets for patients/relatives | | |
| | Drinking water | | |
| | Canteen services | | |
| | OPD lab services (detail services available) | | |
| | List of free medicines available for OP dispensing | | |
| | OPD rehabilitation facilities available | | |
| | Specialised children's services | | |
| | Specialised geriatric services | | |
| | Specialised forensic services | | |

| | | Male | Female | Total |
|---|---|---|---|---|
| | Specialised de-addiction services | | | |
| | Separate medical records section | | | |
| | Educational materials for patients | | | |
| | Total number of OP new registrations between 1 March 2007-31 March 2008 | | | |
| | Total number of OP followups between 1 March 2007-31 March 2008 | | | |
| | | Male | Female | Total |
| **In-patient services** | Overall no of allotted beds | | | |
| | No. of beds occupied as on 1 April 2008 | | | |
| | Any cells still existing (mention number) | | | |
| | No. of closed wards (patients staying in a restricted environment) | | | |
| | No. of closed ward beds | | | |
| | No of admissions to closed wards between 1 March 2007 and 31 March 2008 | | | |
| | No. of admissions through the courts between 1 March 2007 and 31 March 2008 | | | |
| | No. of open wards (patients staying with family member) in an unrestricted setting | | | |
| | Total No. of open ward beds | | | |
| | No. of admissions to open wards between 1 March 2007 and 31 March 2008 | | | |
| | No. of paid ward beds (special wards) | | | |

| | | | | |
|---|---|---|---|---|
| | Total no. of discharges between 1 March 2007 and 31 March 2008 | | | |
| | Total no. of inpatients with stay duration more than one year | | | |
| | Total no. of in-patients with stay duration more than five years | | | |
| | No. of recovered patients who are destitute (no families who will accept them) | | | |
| | No of deaths between 1 March 2007 and 31 March 2008 | | | |
| | No. of suicides between 1 March 2007 and 31 March 2008 | | | |
| | Patient-toilet ratio | | | |
| | | YES | | NO |
| | 24 hour running water | | | |
| | Fans/coolers available | | | |
| | Budget allocation for food /per patient/day in rupees | | | |
| | If calculated as per caloric requirement, please mention calories provided per patient/ day | | | |
| | | YES | | NO |
| Pl provide if available | Separated dining facilities available | | | |
| | Compulsory uniform for closed ward patients | | | |
| | Disposable syringes used throughout the hospital | | | |
| | Shaving blades reused in any part of the hospital | | | |
| | During last year any outbreak of infectious disease (more than 30 inpatients affected in a week period) Provide details | | | |

| | | |
|---|---|---|
| | Budget allocation for food /per patient/day in rupees | |
| | List of investigations available within the hospital | |
| | List of free medications available | |
| Treatment Services | ECT services available | Yes/no |
| | No. of patients receiving ECTs between 1 March 2007 and 31 March 2008 | |
| | Anaesthetist availability for all ECTs | All the time/some of the time/ none of the time |
| | Any patients received unmodified (direct) ECTs during the last year | Yes/no |
| | Separate children's ward | Yes/no |
| | If yes, no. of beds | |
| | Separate geriatric ward | Yes/no |
| | If yes, no. of beds | |
| | Separate forensic services | Yes/no |
| | If yes, no. of beds | |
| | Separate de-addiction services | Yes/no |
| | If yes, no. of beds | |
| | In-patient rehabilitation services available | Yes/no |
| | No. of inpatients referred to rehabilitation between 1 March 2007 and 31 March 2008) | |
| Community outreach | Whether outreach services present | Yes/no |
| | Number of community outreach activities per month | |
| | No. of patients covered through outreach | |
| Post Graduate training | Any post-graduate training provided | Yes/no |

| | | | | |
|---|---|---|---|---|
| | If yes<br><br>No. of MD/DPM/DNB per year<br><br>No. of Ph D/M Phil Psychology<br><br>No. of  Ph D/M Phil in Psych. Social work<br><br>No. of  Ph D/M Phil in Psych. Nursing<br><br>No. of post-graduates posted for 15 days or more<br><br>No. of undergraduates/interns posted for 15 days or more | | | |
| Administrative issues | Whether the medical superinten-dent of hospital is a psychiatrist | Yes/no | | |
| | No. of visits by NHRC and SHRC during the last 10 years | | | |
| | Any litigation against hospital with regard to human rights infringement (please provide details) | Yes/no | | |
| | Display of human rights in the hospital | Yes/no | | |
| | Functioning Board of Visitors | Yes/no | | |
| | No. of visits made between 1 March 2007 and 31 March 2008 | | | |
| | Board for disability certification | Yes/no | | |
| | No. of certificates issued between 1 March 2007 and 31 March 2008 | | | |
| Action taken on NHRC recom-mendations | Suggestions made | Action taken | | |

Certified that the particulars provided in proformas 1 and 2 are true to the best of my knowledge and belief.

Date:                                               Signature of competent authority and seal

# Report of the NHRC's national conference on mental health and human rights

Organized by the National Institute of Human Rights (NLSIU, Bangalore), at the Training Centre, NLSIU on April 29 & 30, 2008

## Introductory Note

As a part of the larger mandate of caring for the Human Rights of every member of the Indian Society, the National Human Rights Commission has constantly striven to reach-out those sections of population that have hitherto remained naturally or socially excluded. Realizing that persons with mental disabilities constitute the most disabled, yet forgotten and ignored sections of the Indian society, the Commission had taken early steps by way of sponsoring the preparation and publication, in collaboration with the National Institute of Mental Health and Neuro Sciences, Bangalore of a monograph titled: **Quality Assurance in Mental Health,** way back in 1999, itself. The rich appreciation and great demand for the publication has inspired the Commission to put in place efforts to bring out an updated and enlarged version of the earlier publication shortly. With the growing consciousness about the mental health right (MHR) in our society and the World Communitys' better recognition for the rights of persons with disabilities, evidenced in the passage of the U.N. Convention on Rights of Persons With Disabilities 2007 (that came into effect in May, 2008), the Commission has renewed its efforts in the direction of creating a better understanding and awareness in the society about the MHR. With this end in view the Commission desired that a National Conference on Mental Health and Human Rights be organized by the National Institute of Human Rights (NLSIU) in collaboration with the NIMHANS (Bangalore) sometime in 2007-2008.

## (1) Preparatory Initiatives

It took couple of months for the NIHR to coordinate with the collaborators,

mental health experts, mental health NGO's, the resource persons and planning the Conference sessions. The **National Conference on Mental Health and Human Rights** was finally scheduled to be held on April 29 & 30, 2008. The Conference was to focus primarily on two issues, namely (a) Ensuring standards in the mental health field and (b) Charting out the implications of recognizing a 'right' to mental health. The inaugural and the four technical sessions of the Conference were aimed at providing a rich blend of MHR theory and practice so as to acquaint the Conference participants with the rhetoric and realities of MHR. The participants to the Conference were to comprise of the mental health experts, mental health law academics, mental health lawyers, mental health NGOs, Judges, media persons and the students pursuing LL.B. and LL.M. Courses at the National Law School. The discussion in each of the three technical sessions was to be initiated through two key-note presentations and expert comments on each from the discussants. The key- note presentations and comments by the discussants were to be followed by discussion from the floor, in each session. The fourth session was slated to be a Panel Discussion on four core issues. Every session was to be presided over by a Chairperson, who would sum-up the Session in his pre or post-session presentation. Efforts were made to identify and invite the leading experts in respective mental health right field. It was hoped that the Conference would not only be helpful in augmenting the expertise and understanding of all those involved in the delivery of mental health as well as adjudicating their rights issues, but also create a broader sensitivity towards the mentally disabled persons generally, particularly amongst the students and the youth who would be in the forefront in the days to come. The Conference preparations, like any other, had its dull, buoyant and tense, moments. When the firmed-up key-note speaker would inform you about his inability at the last moment or when a Chairperson would absent even without informing, hoping for a smooth run for the two day Conference appeared to be the only wish of the organizers for the moment.

## (ii) Reporting Session-wise Presentations and Deliberations

## Day 1: April 29, 2008

## Inaugural Session (9.30 to 10.30 A.M.)

The inaugural session began with welcome speech by Professor A. Jayagovind, Vice-Chancellor, NLSIU. Professor Jayagovind welcomed the

Chairperson NHRC, the Director, NIMHANS and all other mental health experts who made it possible for NLSIU to organize such a unique Conference. Dr. D. Nagaraja, Director, NIMHANS appreciated the initiative of the NIHR (NLSIU) in coming up with the idea of a National Conference on Mental Health Right and the unstinted support extended by the NHRC under the leadership of the present Chairperson for the Conference. He felt the MHR was being increasingly appreciated at the ideational and institutional level, but still lot more needs to be done to transform the reality at the ground level. The Chairman, Justice Reajendra Babu, in his inaugural address was appreciative of the fact that at long last the NIHR (NLSIU) has been able to put together the two day National Conference on Mental Health and Human Rights. To him mental health right was an important indicator in the overall national human rights journey. He emphasized growing shift towards mental health right paradigm, both nationally and internationally. He underscored the various legislative and judicial initiatives taken in India in the recent times concerning mental health right. Professor B.B. Pande, Human Rights Chair-Professor gave a brief resume of the forthcoming four technical session. He emphasized that the proposed Conference aims at enhancing the understanding concerning MHR appreciate operational difficulties, re-evaluate judicial issues relating to mental health right in the Indian Society context. The Chairman, Justice Rajendra Babu graciously released a Study Report conducted by the **Action for Mental Illness (ACMI),** Bangalore titled "The U.N. Convention on the Right of Persons With Disabilities 2007 vis-à-vis the Indian Mental Health Act, 1987". The session ended with a vote of thanks from Ms. Parvathi Menon, the Teacher Coordinator of the Conference.

## Session I : Mental Health Right : International and National Perspective of Emerging Aspect of Human Wellbeing

## (1030 to 1300)

The session was chaired by Justice Gopala Gowda, Karnata High Court. Key note paper I on "**Mental Health and Human Rights : International and National Dimensions** was presented by Mrs. Laila Ollapally, Advocate, Karnataka High Court.

Mr. Justice Gopala Gowda introduced Mrs. Laila Ollapally, whose keynote speech ran as follows:

Persons with mental illness are a very vulnerable group. Society progresses when people begin to discuss this and when the discussions crystallize into rights backed by legislation. This is the first step. Implementation is needed for complete progress, as the necessary follow up step.

Mrs. Laila Ollapally described her meeting with Nirmala Srinavasin, a **Caregiver**, who introduced her to the dimensions of mental illness. She understood that persons with mental illness are the victims of torture, stigma, etc., and are socially and legally vulnerable. There are no international or national laws which deal in depth with the rights of person with mental illness. International Laws which either touch upon the rights of people with mental illness or from which the rights of these people can be derived include the UN Declaration of Human Rights, the ICCPR, the ICESCR and the Vienna Convention. In India, the Mental Health Act and the People with Disabilities Act, together with Article 14 and 21 of the Constitution are often used to protect the rights of people with mental illness.

She pointed out that often, the weaker the user, the weaker the legislation, even though the need is the opposite. There are a number of lacunae in the law at present and numerous issues which have to be addressed:

## 1) Provisions to maintain minimum standards of providing supervised healthcare

Matters such as minimum food, accommodation, space between beds, clothing and hygiene in mental illness health centres should be prescribed.

She described the **Irrawady** incident which occurred around 1997, where around 25 persons with mental illness were locked in a hut which caught fire and burnt them all to death. The minimum standards should have been provided for, such as a security person outside the health facility. However, our standards do not provide the minimum but the maximum and logistically impossible standards, which even institutes like NIMHANS cannot comply with. The present Rules do not reflect reality and, as a result, are violated and ignored. According to the Malimath Report, mental health Institutions are the worst violators of human rights. And most often, people with mental illnesses cannot complain.

With respect to providing supervised healthcare, the Mental Health Act has prescribed a Board of visitors for the Mental Health Institutions. However, in reality, it has been noticed that none of the psychological

hospitals had it. When the court was approached, it directed the hospitals to produce a list. When this was done, it was found that the Board mostly consisted of family members, which was not according to the Rules. It has also been found that there is no political will to implement the law.

## 2) Treatment in the Community

This refers to the right of people with mental illness to live in the community. It is the basic right of everyone. Pre-1950, there were no medicines, and so it was needed to protect society from people with mental illnesses, because the illnesses could not be controlled. Now, it can be. Hence, the most important need or right is accessibility to medicines.

1% - 2% of people have mental illnesses, but only about 10% of them can reach treatment, and this small percentage is mostly in the urban areas. Because of this, our mental health policy at present lays down that every district hospital should have a mental health personnel for good access without the stigma of visiting a mental health hospital. Yet, in 1987, the Mental Health Act, in its definition of psychiatric hospitals did not include the district health hospital, i.e., the general hospitals.

Mrs Ollapally stated that the mental health hospital here is in Dharwad, which is 3 km away. She told us the story of a girl, Geeta, who could not get treatment at the district hospital because proper training had not been given to the doctors, and no medicines were available. However, even the hospital at Dharwad, was a closed institute all this time, and has become open only now (closed hospital meaning that family members are not allowed to stay at the hospital, or be involved in the treatment process, etc.) Partly because of this, most families reject patients, so 50% of the beds in the Dharwad hospital have long term occupants, because of patients whose families have rejected them. If the district hospitals were also suitably equipped, then this problem would not always arise as the families could stay at these hospitals. As of now, only 12 districts out of 27 have full time psychiatrists. The rest now have part-time psychiatrists.

## 3) Involuntary Admission

The foundation of medical treatment of patients is informed consent. But for people with mental illnesses, it is difficult, because sometimes detention may be required when the mental ill is not in a position to consent. But when informed consent can be got easily, provision needs to be made. Such as a legislative provision for advance directive (before becoming

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afflicted with the illness) or a legal representative, because otherwise, the right of self determination is violated. An advance directive may provide that in times of crisis or emergency or in case of a traumatic experience, that such a person be taken to the hospital. Generally, what occurs is that inexperienced neighbours take a person, and sometimes even violence is used to take them.

According to the present status, the Magistrate should provide for a reception order. However, there is an ambiguity in the legislation as to when this order should be passed. This leads to confusion and less people follow the rule. Discharge, at present, is also difficult. Only the person who applied for detention can do this. There should be a provision for empowering the doctor as well.

Legislation at present does not provide for the varying capacities of different people with mental illnesses. There is a need to take the differential abilities of mentally ill in according rights to them.

Mrs. Ollapally gave an example of how society provides only for the average person. In **Price v. UK** (2001), a person in a wheelchair was held for contempt of court and imprisoned for 7 days. There was no place in the cell for the wheelchair, nor were there facilities for it. The European Court for Human Rights said that this was a violation of Human rights, even if there was no intention.

Mrs. Ollapally ended her presentation with a series of suggestions, such as there being no unlimited discretion, the realistic targets be set, that implementation be monitored, that there be open access to hospitals for the NGOs, that Mental Health Legislations be periodically updated, and so on. She also stated that PILs have not been initiated at the Supreme Court in all the High Courts to protect the Human Rights of People with mental illnesses, excepting the State of Karnataka. The should be activated in all the other states as well.

## Comments from the Discussant - Prof. H.K. Nagaraja, NLSIU

The Professor pointed out that there are several factors which have been taken into consideration. The Legislature should identify the problems and rules to deal with these, and ensure amendments accordingly. Therefore, vulnerable groups have to be identified. Implementation is the most important aspect, because legislation is useless otherwise.

1) There is a Convention coming into effect on the first week of May. India is a party to that Convention, but not to the Optional Protocol, which means that it will not have to submit the report on the state of Human Rights here. Reports will have to reflect reality, and if it were compulsory to submit it, then the Committee under the Convention would have been able to see any lacuna in the Report, and so on. Therefore, NGOs should pressurise the State to sign the Optional Protocol.

2. Minimum standards should be imposed.

3) The community should be involved. People with mental illnesses are not objects of legislation, but subjects of legislations. Isolation or exclusion only perpetuates their condition. Community involvement is required, especially to make the stigma disappear gradually.

4) Hospitals should be required to follow standards.

5) Involuntary Admission is an important aspect. WHO has made a detailed study on this. Involuntary admission is a bad thing, but is needed in some circumstances. Therefore, certain identifiable criteria should be laid down with provisions for going into and even the option of appeal.

6) Dignity of the individual is very important and should be the centre point of all efforts.

7) Non-discrimination and equality are also emphasized by WHO. Non-discrimination and special protection is needed for the weaker sections of people with mental illnesses to secure equality.

8) The purpose of legislation should be that ultimately people with mental illnesses live independently in the community.

9) Training is important, especially for those who come in contact with persons with mental illness.

10) Limitation on rights in the ICCPR etc. – Circumstances should be stipulated as to when the rights of these persons can be limited.

The Professor concluded that unless the law satisfies these elements, it will not meet the needs of the mentally ill.

# Discussion from the Floor

- There should be a resolution passed to impress upon the government the need for responsible governance.

- Most legislations are very broad. There are many types of mental health patients of which some can take care of themselves. Therefore, there is a need to specify groups.

- Most often, discussions focus on people with mental illnesses in the context of hospitals, when 99% of them are in the community. Focus should be on this group, and thus a shift in focus is needed.

- With respect to mental health rules – these are often cut-copy-paste from other countries. There is a need to look at the real circumstances in India.

- Health is a State Subject. Policy making is by the Centre. There is presently a communication gap. Therefore, the result is less implementation of policy.

- With respect to training, the first contact is a team, who are expected to train all the doctors and other staff in primary health centres and district hospitals in the districts. As the result, the first contact will become the primary health centres in districts. If human rights movements back the district health programmes, it will improve the quality of training.

- Mental health should be treated like a physical illness.

- There are voluntary admission provisions in the Act, but this is not really so because generally, a family member signs. This is similar to physical illness because it makes it easier to discharge. However, the problem arises when collusion exists.

- Instead of going to a Magistrate for a reception order, a certificate from two independent doctors should be allowed, and this will make both commitment and discharge easier. At present, the magistrate, if he is unsure about whether or not a person is suffering from a mental disorder, issues an Observation Order. Such an Order can only be up to 90 days, 30 days at a time. Even an involuntary patient can request examination and then subsequent discharge. Most people are not aware of the nuances of the Act, and hence some mental illness patients are made to stay in mental-hospitals for the rest of their lives.

- In Dharwad, a Reception Order is not necessary. A person can be committed to any hospital.

- There was a question as to whether mental illnesses should be treated as a special kind of disability, similar to the manner in which the juvenile justice system constantly ran up against the question as to whether it should be treated as a separate system, or clubbed with the usual system?

- There was another question raised as to whether there should be a concept similar to guardian ad litem for persons suffering from mental illnesses?

- Another question was whether mental health rights should be in legal or in mental health terms?

- It was stated that the failure in implementation is due to the non-working of the Constitution. Section 256 and the Union Government giving directives to the State to implement any particular law. A suggestion for a National Health Service, on the same lines of the IAS was made.

- There was some debate as to whether the judiciary was doing enough to help the cause of the mentally ill. But no definite conclusion was reached.

- The rules which can be framed under Section 77 of the Mental Health Act have not been framed yet.

- The broad group of people with mental illnesses is a heterogeneous one, and it is a mistake for legal authorities to refer to them as one uniform group. Capacity should be the basis of differentiation.

- Even though HIV and mental illnesses have many parallels, the reason why people with HIV are almost guaranteed treatment while those with mental illnesses are not. This is due to absence of voice of the people with mental illness.

## Summing-up by the Chairperson

- Implementation of the Mental Health Act is only 2%.

- Article 256 of the Constitution may exist, but how many people know the Constitution? Unless the Constitution is questioned by the masses, it will fail to function.

- Lack of questioning means less implementation and less accountability. Budget allocation is also needed.

- The Karnataka Legal Services Authority should take- up the cause of mentally ill, in collaboration with the activists, judges.

- Awareness of these issues should be created by the media-print and visual.

## Keynote Paper II : "Current Statue of Mental Health Services in India, Including Updated in the National Mental Health Policy"-Professor B.N. Gangadhar, Professor of Psychiatry, NIMHANS

- Psychiatric problems are more than any other. Around 65 out of every 1000 people require treatment for a mental disorder, and about 3 in every 1000 are schizophrenic.

- The fight against mental disorders is helped by early recognition and medical treatment, social action, after care, and the role of family members and input of the family members.

- Out of all the specializations available, psychiatrists are the least in number – there are less than 3500 psychiatrists in the country.

- Most psychiatrists work in cities, and there is a disproportionate distribution of psychiatrists among the states – eg. Maharashtra has more than 450 and Arunachal Pradesh has only 1.

- The number of psychiatrists in India is less than in other countries.

- There are only about 37 mental hospitals in India, with about only 19,000 beds.

- Modest estimates is one psychiatrist for each hundred thousand.

- Migration has led to a brain drain of psychiatrists.

- The National Mental Health Programme (NMHP) was launched in 1982. It wanted to stimulate community participation, integrate mental health services into general health care, reach all the mentally ill, strengthen secondary and tertiary care institutions and train manpower.

- Under this programme, the Bellary District model was applied to

other districts. By 2006, 94 other districts have it, and it is hoped that it will soon cover the entire country.

- Recent research has shown that in Shimoga district, despite this district having the highest literacy rate in Karnataka, and there being awareness of mental illnesses and 6 psychiatrists available, 25% of psychotics here are never treated. The situation is probably worse in other districts.

- Treatment need not require admission, and makes a big difference for health.

- Evaluation barriers include admission, lack of clarity in guidelines, lack of manpower, lack of motivation, etc.

- The eleventh five year plan, under the NMHP has suggestions for a revitalized strategy, including equity in urban-rural health care, focus on the mental health of adolescents and in college goers, emphasis on public-private partnership, operational guidelines, developing manpower – which includes the development of regional institutes with clear targets of care for severe mental diseases and common mental diseases – ensuring a willingness to continue after five years.

- Preparation for this would include, mapping of resources in the District, public health systems, administrative departments set up, nodal offices at the State level, programme offices at the district level, where the programme officers should be non-psychiatrists, preferably in state service, who have been trained for 6 months. - Monitoring cells should also be present.

- A revised methodology is needed, such as the recruitment and training of psychologists and social workers locally, setting down guidelines for this, revising salaries, capacity building, including a nurse as part of the mental health care team, and networking with NGOs.

- The Different Elements in the proposed Mental Health Programme include Adolescent/School Mental Health Programmes which has already begun to be implemented, College Counselling Programme for PU and Degree students, Stress Management for Executive Officers, and Suicide Prevention Programmes.

- The projected targets of the programme include training in the first

year, continuation of training, integration and special programmes in the second year, and continuation of all the above in the third year.

- Long term and short term plans are both being made for improving manpower.

- The Budget for this was assessed and allocated in the eleventh five year plan.

- Evaluation of the implementation and mid-course evaluation are also suggested in the five year plan.

- This is what the government hopes to offer the Mental Health community.

## Comments from the Discussant – Dr. S.B.N. Prakash, NLSIU

- There is not much information on Government run hospitals and the problems encountered.

- We have not taken the Indian scenario into account.

- The Indian Medical Council only governs allopathic doctors and not homeopathic doctors. The latter do not have licenses and cannot operate under the definition of psychiatrists in the Mental Health Act.

- There has been some attempt made to provide mental healthcare as psychiatry is included in the MBBS syllabus.

- A re-look at psychiatric hospitals is needed.

- Section 14 of the Mental Health Act deals with treatment of the outpatient but very few steps have been taken.

## Discussion from the Floor

- There was some discussion on Centre State relations and the accountability of the government in the proposed system, to ensure that the allocated funds are used appropriately. There was also a question as to whether any allocation had been made to Half- way Homes and for private providers.

- More questions were raised as to non-state services, and primitive

or rural health services. It was pointed out that the picture was not complete if non-state services were not taken into account.

- It was affirmed that some programme was needed at the district level before taking it to the rural areas and getting the panchayats and local bodies involved.

- The point was raised that National Mental Health Programmes or policies are not under the purview of the Mental Health Act, but answers needs and looks at pilot projects all over the country. It is not possible to limit them only to psychiatrists. Training of other health professional, awareness in the community and education are also needed to reach the unreached.

- There was some more discussion about the role of the centre-state relations. State implementation of national programmes was not viable because Constitutional history shows that if this occurs, the sates are likely to loose freedom in accepting grants in aid.

- There was a trend of fewer people now opting for medicine as a career. A suggestion was made to nationalise healthcare and remove private players, bringing health professionals only under State employment.

- Even if accessibility is increased, it did not guarantee affordability, and therefore, a suggestion was made with respect to the government subsidizing treatment in private hospitals.

- However, this suggestion was met with the reply that the present mental health programme provides free treatment, and moreover, very few people require institutional treatment. It is mostly preventive action which is needed, and the cost of this is very small.

- A question was asked as to how a layman can recognize symptoms of mental health. The answer was any unusual behaviour, or any change in behaviour.

- The issue of house visits by doctors and their role in lessening mental health problems was raised, and it was felt that this was not really a practical possibility because of logistics and because mental problems are not easily identifiable. Moreover, from a legal perspective, house visits could involve a right to privacy violation, and a balance will be hard to maintain. However, at some level, such house visits are already being done, mostly in the urban areas.

# Summing-up by the Chairperson

- The poor need to be helped.

- NGOs need to be involved in the process.

- Legal awareness needs to be created, and a change in mental attitude of the community is needed.

- Strong political will is needed.

People should raise questions wherever needed, so that changes can be made and the Constitutional machinery runs smoothly and constitutionalism is implemented.

## Session II : Delivery of Mental Health Rights : Taking Stock of the Functional Realities

## (1400 to 1645 hrs)

The session was chaired by Dr. D. Nagaraja, Director/Vice-Chancellor NIMHANS. Dr. D. Nagaraja briefly introduced the Session relating to Standards and Procedures for treatment in mental hospitals and invited the first keynote paper presentor Dr. Pratima Murthy, NIMHANS to present her paper on "Defining Moments in Mental Health Care in India".

In her powerpoint presentation Professor Murthy gave a detailed account of Mental Illness and Psychiatric Services. According to her estimate the psychiatric service needs a exceed the total number of existing services i.e. for a total population of 20-30 million who need mental health care we have only 3000 psychiatrists, 800 psychologists and psychiatric social workers, 1000 trained psychiatric nurses and little over 20,000 beds in mental hospitals and psychiatric units. She traced the history of gradual improvement in mental health care, till a literal paradigm shift through the initiatives of WHO, progressive legislations, Supreme Court Directives and NHRC Guidelines. She backed-up her thesis of gross mis-match between mental health care needs and the existing range of services in the light of a empirical study of a small sample (32 mental hospitals – large, medium and small) mostly in the Karnataka State. She has collected data relating to treatment setting, services available structure and function, patient care issues, environment, staff issues etc. The over-all data conveyed a very negative picture of mental health care reality. Not only in infrastructure, environment, maintenance the mental hospitals are

developed on the lines of prisons and other repressive custodial institutions, but they follow outdated patient care, treatment and basic conditions within the mental care institutions. According to her one big reason for the existing state of things is that these institutions have a very poor record of liaison with the community agencies/NGOs that espouse for the rights of the mental patients.

In the end Professor Murthy displayed robust optimism, despite all the negative indicators in reality, that things can change for the better. She conclude that the road ahead would require taking, at least, these five steps:

(a)  Laying down minimum standards of care for mental hospitals

(b)  Divising strict monitoring mechanisms

(c)  Need for developing sensitivity for the mentally ill amongst the lower staff

(d)  Need for rehabilitation and re-integration of patients and combating chronicity

(e)  Community involvement in care – By developing liaison between families of mentally ill and community services.

## Keynote Paper II – "Admission and Basic Minimum Conditions of Custodial Care" by Dr. Mathew Verghese, NIMHANS (Bangalore)

In a large percentage of cases 'treatment' is given to mental patients in closed ward settings (as high as 75% mental hospitals in the Karnataka State). That is the reason why in almost 44% mental hospitals cells continue to exist, where patients are detained in single beds, without light, bed lenin or toilets. Food is pushed through the bars. Mental patients receive poor personal care (59% of hospitals). There are no toilets in 3 hospital, grossly inadequate number of toilets in almost 75% hospitals, where number of toilets ranges between 1:25 to 1:40. Head shaving is still practiced in 50% hospitals and in 56% hospitals uniform is mandatory for the patients. In one hospital suicidal patients were kept nacked because of fear of self harm. Food supplied to the patients was of poor quality in large percentage of hospitals (as the amount sanctioned varied between Rs. 8 per day to Rs. 20/- per day). Bed lenin/mattress were inadequate in 53% hospitals. In most of the hospitals there was significant over-crowding

– ranging between 860 patients for a bed capacity of 400 to 830 for a bed capacity of 500. Generally the building maintenance was poor, inadequacy of water (70%), problem in electricity and lighting (60), only rudimentary kind of recreation in 75%. Only 1/3 patients were visited by their families. There were report of assault, rapes and molestations within the mental hospital premises.

The aforesaid depressing picture of patient care, dignity and human rights conditions are responsible for high percentage of involuntary admissions (69% in mental hospitals). The conditions in a few distinguished urban mental health centres like NIMHANS, Ranchi have shown remarkable change in all most all respects, but for a vast range of rural, sub-urban mental health institutions things have remained more or less unchanged. How can over all mental health care be improved? Would it require only state initiative or would community chip in as well?

## Comments from the Discussant : Professor Parthasarathy, NIMHANS (Bangalore)

Though there are deficits in many sectors of mental health care, but at this juncture it has become essential to go to the root causes of growing gap between the policies and laws and their implementation. I identify the root cause of this situation in the following problems:

(a) The problem of over crowding

(b) The problem of lack of trained manpower and

(c) The problem of lack of funds.

Therefore, the focus should shift to solving these problems individually.

## Comments from the Discussant to Keynote Paper II : Dr. T. Murali, NIMHANS(Bangalore)

Drawing attention to yet another area of mental health care, the speaker emphasized that there is still very little attention paid to rehabilitation of mental health patients. Particularly, in the post independence period the vestiges of rehabilitation services crumbled because of the scramble for space. With the result of 64% mental hospitals follow activity therapy. However, in NIMHANS and Ranchi rehabilitation services are provided by mental health NGOs. Through rehabilitation approach is catching on in India, but it is not possible to adopt Western models, because of lack

of trained manpower here. There are some examples of mental patients rehabilitation back into the society after treatment. As in the case of a private person run initiative in Ahmedabad and Tejpur. The best therapy for rehabilitation is to create conditions that the patient can return back to work. The issue is the kind of role Government can play in the matter of rehabilitation of mental patient.

## Discussion from the Floor

### Dr. S. Patel

We hear so much about shortfall in mental health care services and rehabilitation of treated patients, but the clan of Indian Psychiatrists have themselves done precious little in changing the situation. I would go to the extent of saying that the out dated mindsets of the Indian Psychiatrists is the single biggest factor in blocking the progressive changes. They need to undergo a change of the mindset.

### Prof. Devidas

The Central and State agencies should exercise the Constitutional power to ensure that the mental health laws are implemented in letter and spirit.

### Prof. Pande

We should be careful that mental patient remains at the centre of all our thinking and deliberations. Law can only serve as a external factor, but the change of mindset requires a change from within.

### Dr. Nagaraja

The main problem is lack of monitoring and supervision of MH agencies.

### Dr. Murali

Despite problems, how have State of Maharashtra and Gujarat done so well in the field of mental health care?

### Dr. Murthy

Since the State Government keeps mental health on a low priority, the individual efforts of a few psychiatrists is unable to make an impact. The possible solution is to create an alliance of psychiatrists and encourage joint actions.

**Dr. Nagaraja**

The problem is not on intentional sidelining, but a lack of right knowledge and weak allocation.

**Dr. Verghese**

Though funds is a problem, but with the same funds one of the Superintendent of a Mental Hospital in Maharashtra managed to transform the level of mental health services.

## Chairpersons Comments

We have to ensure that the attitudes change. Once mental treatment becomes non-custodial there might be some change. Therefore, we require greater awareness, attitudinal change and at the end hope that things will change.

## Day 2 : April 30, 2008

## Session III : Trends in Policy, Law and Practice Level Reforms

## (1000 hrs to 1300 hrs)

## The Session was chaired by Justice Shiv Shankar Bhat, Retired Judge, Karnataka High Court

## Keynote Paper I : Community Involvement in Mental Health" by Professor Vikram Patel, Professor of International Mental Health, London School of Hygine and Tropical Medicine, SANGATH CENTER, Porvorim, Goa

He divided the speech into why we empower communities for improved mental health and how we do it?

Majority of the people are those who don't see the door of a mental hospital. There is therefore a distinction between mental health of those inside and those outside a mental hospital. Of the 37 mental hospitals surveyed in India, each one failed to meet even basic human rights standards. The treatment is often diabolical. Arthus Kleinman of Harvard

University and Benedetto Saraceno WHO have done some work in this area and photographic evidence was presented to describe the inhuman treatment of mentally ill people in mental hospitals.

The Time cover story covered this in pictures and the story was about Asian mental health crisis and the treatment meted out by the society to these inmates. The question to be asked is whether chaining drugging etc is just an extreme, almost an aberration from the norm, rather than the rule?

Total loss of dignity described by a picture of a naked man sleeping in a 10 by 10 feet room on a bed in the mental hospital was said to be the atypical scenario in mental hospitals. The second picture was that of a chained 16 year old in a hospital in Malawi. The third picture was that of children boxed in a cage.

The other question to be asked is whether this is only symptomatic of developing countries. But this is not true because similar pictures are seen in Eastern and Southern Europe. Romania has a strange system of a cage room where men sleep in nets. Images depict washing of men by pipes, urinating in a public room with other inmates etc.

Now the objective is to look for a solution.

The **Lancet** journal published a major issue on this aspect of mental health. The sixth article in this series had a call for action. Health is not just a medical issue it is a policy/ legal issue. Based on 2 principles:

1.  Everything that we do must be based on science. Evidence must back decisions.

2.  In the use of science, human rights must be protected of those mentally ill as well as their family. Human rights concerns of families and societies are often ignored by human rights activists and should be paid attention to.

Nobody cares whether in India is there a state funded comprehensive program for mental health care. Even in Tamil Nadu with the best mental health system, it required a direction from the Supreme Court for the removal of chains in 2001,but when journalists investigated the chains were still there. A picture of a mentally ill man tied to a tree in Goa shows the failure of the state in protecting the society at large and the ill person from ill-treatment and stigma. Increasingly mentally ill people are largely landing up in prisons.

The alternative side of these grim pictures is path breaking trials from around the world.

5 major barriers were identified in the Review 5 of Lancet series and 3 clear strategies were identified to

- Community based interventions to support people with mental disorders and their families allowing them to retain their environment and help the families

- Build capacities of stakeholders for community oriented mental health care

- Create a coalition for a new movement for mental health, something similar to a new social movement like HIV/AIDs awareness programs were able to build.

One of the programs identified as effective was lay health workers delivering interpersonal health care in Uganda. The other was an experiment in Chile where women were trained to intervene through lifestyle and psychological exercises and was largely successful. The other was an example of lady health visitors using CBT to treat post natal depression in rural Pakistan effecting positively the health of babies and mothers. Community health workers helping dementia and schizophrenia have been successful and the results have been positive.

Capacity building is a serious concern. On World Mental Health day on October 10th the theme is call for action and building of a broader coalition along with a sub-theme of empowering communities. There is a tremendous new opportunity for us to take scientific, legal and moral responsibility to ensure that evidence moulds our actions to tackle this problem and not a mere relief. Human rights evidence has to be combined with medical evidence to come up with an effective solution. The chains came away in France 200 years ago. We wait for this reform till today in India.

## Comments from the Discussant: Mr. Tigadi, Secretary, Karnataka State Legal Services Authority

Creating awareness about mentally unhealthy people and their identification is an important function of civil society in general. The Karnataka Legal Service Authority started with the objective of reaching out to the entire population of Karnataka and empowering them. Legal awareness was a challenge among the target group of non litigants and common citizens.

There was a problem of isolation and resistance among the government departments to cooperate in this regard. They wished to confine the movement building momentum to the law and health departments. However the key was to tie up with other departments for example the Women and Children department to reach out to a larger target group. This is a trend that can be replicated with mental health awareness as well. Coordination will probably engage the society at large and combine agendas of social as well as legal awareness.

Awareness is not confined to mere law but should also include factual data to sensitize a broad spectrum of people. The smallest unit of society is the family and the sensitization process has to include how the enabling process can go hand in hand with legal and medical intervention.

One of the major problems was that of mental health of prisoners. All prisoners have a right to life. Human treatment for this is therefore a corollary. A project with KLCS and NIMHAANS has been launched to address this. Identification of vulnerable groups within prisoners is perhaps the first important step towards this. For instance juvenile offenders, repeat offenders etc.

Capacity building is another key in this movement. Trained mental health workers may not be able to reach the entire target population but imparting basic training to make an environment conducive to help is a concrete step as well.

## Participation from the Floor

We can speak of the "other" treatment of mentally ill people in the law and the consciousness of the legal community. It is important to start asking questions about forced interventions. The punitive idea of law taking away civil rights of a person living with mental illness has to be addressed. A parallel story is the voice of the mentally ill person which is ignored in decision making by society, community and families about their life course. A whole new paradigm has to opened in terms of asking questions. The next step is to talk about the personhood of the person diagnosed with mental illness. The individuality and agency of the person in the healing process has to be restored. Law, medical treatment and policy has to take the mentally ill with them and not leave them behind. The Convention on the Rights of Disabled has come from the user community and not the treating community, which is an interesting departure from the norm. There

is a concrete legal agenda herein is to address the civil rights of mentally ill people on par with fully able individuals in current jurisprudence.

## Keynote II : Mental Health and Human Rights: At the Cross roads by Professor Amita Dhanda, NALSAR

There is a large scale ignorance of law at the highest level and no consonance between the courts, statutes and the Constitution. We are constantly fire fighting and addressing issues case by case rather than setting a policy precedent to address the issue on the largest scale possible.

The first issue addressed was how we organize and determine legal capacity. Law has taken a line of disengagement with respect to mentally ill persons. The construction of the narrative is therefore not coming from the people they are about or even with their involvement. Procedures of exclusion are on the basis of a presumption of incapacity of the mental patients on the part of law makers. Awareness building thus has to start from combating negative images of the person of unsound mind. It is a category of exclusion which doesn't let these people assert themselves in a lot of situations. Legal attribution of incapacity is of three kinds:

1. Status Test:     Determination of insanity/ lunacy / unsoundness by declaration.

2. Functional Test: Not just diagnosis and designation of status of unsoundness but also determination of how the unsoundess affects actions and therefore impairs capacity.

3. Outcome Test:  Based on kind of decision making which is not in conformity with social ethos in general.

This comes across in a range of jurisdictions and is not confined to any particular area.

It is in this context that we see the impact of the Convention on Disability. This Convention recognizes all persons with disabilities are persons in law. They are bearers of right and have agency to act. For exercising this ability you can take support. This support does not in any way negate legal capacity. This support also has to come into play after conclusive determination of incapacity. The support also has to vary according to improvement or deterioration in disability levels. This is a major recognition

of human interdependence. This marks the inclusion of the disabled person in decision making and is therefore a landmark in a changing paradigm of the mental health and human rights discourse.

The Convention provides for a comprehensive package of a right to life in context of granting of the full legal capacity including the freedom from cruel and degrading treatment, from exploitation, violence and abuse, protecting integrity of person and living independently within the community. The inducted capabilities include an enriched right to life bringing with it the right to education, freedom of expression etc which changes the landscape with respect to this narrative.

The Mental Health Act has a lacuna which also strikes discordant in terms of this new Convention that we have signed. This legislation came in for limited reasons and against the backdrop of inconvenient involuntary hospitalization procedures existing earlier. This Act later on incorporated language which was progressive but the underlying philosophy was primarily retrogressive and had a bureaucratic institutionalization agenda. It was a means of establishing due process of law to enable its consonance with the Constitution. Surrogate arrangements and deprivation of life and liberty are addressed in a procedural form in the Act. Law renders mentally ill a non-entity, once they are declared incapable and therefore, the entire management of their being by third persons becomes the focus of the law.

Our international obligations requires us to now reform the law. The Convention is largely silent on guardianship and it was for most part deliberate. This is because the idea of it all is not quite in keeping with the agenda of recognizing disabled people as complete persons in law and fact. It is of course possible to interpret that the option of guardianship is still open. But the question is whether at this crossroad we grab the opportunity offered by the Convention to have the framework of guardians as a support systems or do we continue with the status quo of their being a subject to substitution system. Either we can homogenize all persons with mental illness or recognize diversity within this category and afford them the dignity of being recognized as such. It is, therefore, this dilemma that we have to address in either adopting and recognizing the spirit of the Convention or reading it literally. Within an aspirational framework a pragmatic approach can be taken and not the other way round. Developing potential and deconstructing existing discourses is the opportunity offered by this Convention.

# Comments from the Discussant: Dr. Nirmala Srinivasan

## "Mental Health Right For Whom and Why?"

Of the total mental health needy only 5% get Institutional Care, 15% get Street Care or care through NGOs (like Banyan) and 80% have to depend only on Family Care. The existing reality of lack of easy accessibility for Family care, continuance of cells and closed wards in most of the mental hospitals and laws made to suite social reality requires to be critiqued. Most of the jurisdictions proceedings relating to MHR not per law.

There is a need to re-iterate that the citizen has a human right not only to mere life, health or political participation but a minimum quality of life too. Therefore, this new Human Right to Quality of Life would be possible when our society :

    (a)  Is more representative and democratic – How can it be more democratic when most have the consumers of mental health right have no awareness about it?

    (b)  Provides for non-institutional caring of family care and need at a realistic level.

    (c)  Provides for NMHP for all Districts, merely covering 100 districts may lead to violation of right to equality.

## Comments from the Floor

Mental Health Act was at one time hailed as a great advance in the field of MHR. But Convention 2007 has exploded this myth.

The impact of Convention 2007 is yet to be fully appreciated, much less made the basis for reforms in the MH Act.

The Session was concluded with a brief summing up by the Chairperson.

## Session IV: Human Right to Mental Health: The Way Forward

## (1400 hrs to 1630 hrs)

## Panel Discussion on Core Issues:

    (a)  Ensuring Universal Access to Mental Health Care

(b) Devicing Pro-active Mental Health Delivery Mechanisms

(c) Turning the Focus to specially Disadvantaged Sections such as women, children and rural population

(d) Rehabilitation of the mentally-ill.

The session was chaired by Professor B.B.Pande. NIHR Chair Professor. The session began with introductory comments from the Chair. All surveys' and researches on mental health field indicate a far from ideal situation- that needs to be improved by intelligent improvisions as follows:

- There is a pertinent need to identify factors/issues that inhibit access/availability to mental health services

- The possibility of a proactive delivery mechanism should be explored. eg. programmes for early identification right from the School, Community stage and exploring the possibilities of new kind of justice interventions for the mentally ill.

- Organization of mobile teams to expand the outreach mentally ill treatment programmes, especially in the remote corners of the city/state/country.

- Enhancing access to justice for the mentally-ill generally.

- Rehabilitation options for the cured patients need to be strengthened.

## Presentation from the Panelists

## 1. Prof Sarasu Thomas, Faculty, NLSIU

Prof Thomas began her presentation by emphasizing that women and health care as an area of study/discourse is a category that necessitates special and specific attention. She highlighted the fact that women face not only cultural biases but are victims of social and legal prejudices as well. She mentioned that the health care system in India for women is in shambles. eg. A large number of Indian women suffer from anemia, but iron supplements are given only in pediatric and not adult doses. This one small illustration exemplifies the ineffective existing health care system.

She opined that reproductive rights of women seldom receive the attention that they should get. What is done is to protect women who are pregnant until they deliver the child. There are a number of state run maternal and

child health centres but post childbirth the child remains the focus while the woman fades into insignificance. Instead the woman is targeted to implement the family planning programme which still exists despite renaming it to 'family planning'. She also asserted that physical health is the consideration always and not mental health. Abortion is encouraged if there is a suspicion that a child would be born with disabilities, but mental illness is rarely taken into account.

It was emphasized that there is scant acceptance of the fact that women as a social group have been traditionally subjugated to many patriarchal institutions. To add to this there is a strong denial to accept women with disabilities to be doubly affected. In addition, Prof Thomas explained that with regard to access to justice, though the Bangalore Police has a Legal Help Cell the majority of visitors are women with physical disabilities, and not women afflicted with mental disabilities. She gave the example of family law in India highlighted that in many divorce cases the husband simply asserts that 'something is wrong with the wife' and mental health/illness is considered a fault on basis of which a divorce is, often, claimed. This is further compounded when women who is disabled are either estranged from her family or gets thrown out of her house due to disability. Often families disinherit women of their rightful legal share in the property (as per the 2005 amendment to the HAMA) by falsely claiming them to be mentally unsound. She claimed that the distinction between medical and legal insanity is not clearly demarcated. The Centre for Women and the Law in several cases of domestic violence has come across divorce being granted to husband without questioning why wives behave in a particular way-it is easy to typecast a woman.

It was pointed out in the existing varied disparity between men and women afflicted with mental health. eg. There is a constant infantilization of women with mental disabilities. They are always depicted as a child like made to wear skirts. This outward forms of discrimination and infantilization reinforces the stereotype of the person not being a full fledged member of society.

It was further added that women with disabilities are in a way subject to a double edged sword. First, on account of being a woman and the other on account of being disabled. Families with girl children are seen as being disabled and if the child/women is disabled it has entirely different connotations than men being afflicted with disabilities. She opined that rural women occupy a special area of concern under CEDAW as public

health care system not equipped to handle women with mental health afflictions in rural areas.

Prof Thomas also perceived the existing justice mechanism to be gender insensitive. And also that not all women with mental disabilities have similar problems. Some may need family counseling, some with employment, some with legal advice etc. She suggested the following to improve services/facilities for women suffering with mental health issues-

- Greater sensitization amongst families, care givers, support agencies, general public
- Infantilization of mentally ill women should be stopped
- Greater access for women to primary and reproductive health care
- Better awareness about new forms of access to mental health care

## 2. Ms Arlene Manoharan, Centre for Child and Law, NLSIU

Ms. Manoharan began her presentation with live example of the case of Manoj, who had been willfully abandoned by his parents who were unable to cope with the effects of his mental health problems. The child had spent his short life of seventeen years in a custodial institution. Children like Manoj, psychologically challenged. Children are considered as doubly disabled (first, by virtue of being a child and then because of this disability).

She saw a lacuna in service delivery to the mentally ill, which require greater stress on interdisciplinary services such as socio-legal aid to the clients and their families. Her emphasis was on developing a sounder conception of childhood, crime, poverty and capacity of children. She pointed out that the enactment of JJ (C&P) Act, 2000 and ratification of the CRC have not been able to change the reality. To her the State in India has been able only to strengthen its parens-patriae role that appears to be interested in protection of the person of the child but not the rights of the child. To her the system operates in a custodial manner. According to her institutionalization of children has detrimental effect on their mental health.

She gave examples as to how some researches conducted by the CCL (NLSIU) could be helpful for children with mental health problems. Some of the pertinent questions raised in the course of aforesaid studies and projects are:

1. Do the rights of challenged children better served under the JJA or other laws specially dealing with the mentally challenged (Mental Health Act, Disability Act, Persons with Austism, RCI Act)?

2. Is the current practice of girls being housed in statutory institutions along with women a response that is in keeping with the best interest principle?

3. Should children who are mildly challenged be housed in Children's Homes and Observation Homes along with other children based on a policy of integration or should they be segregated the state sanctioned dump for such children?

A few recommendations that were made in her presentation are:

1. To frame Protocols and checklist indicators to help CWC and JJB members identify existence or risk of mental health problems so that appropriate orders may be passed.

2. To undertake Research into the law relating to ensuring mental health services for persons who genuinely need it because they are a risk to themselves and others, but are unable to understand and give their consent, while at the same time ensuring that these provisions are not abused by unscrupulous persons desirous of institutionalizing and abandoning them.

3. To ensure provision of more Short Stay or Residential Facilities for Girls and Women, as there are no state run services of this kind.

4. To conduct a study on the mental health issues of staff and children in the JJ system.

5. To create law and system that will enable all children to voice their concerns in decisions concerning them as this is not only empowering but also therapeutic.

6. To provide support to revise and complete a CCL Study of the JJ home for challenged children in the light of the recent UN Disability Convention.

7. To provide insights on these issues for inclusion in State Rules under the Juvenile Justice Amendment and to review the Karnataka Draft JJ rules through the lens of the UN Convention on Disability.

## 3. Ms. Shruti Pandey, Advocte, HRLN, New Delhi

Ms Pandey opined that under the Mental Health Act, the human rights provision could be found under Section 81. She pointed out that there exists a limited framework of rights. eg. in reservations the mentally disabled are excluded. Ms Pandey also emphasized that laws take away the rights and abilities of women with mental health issues. Ms Pandey highlighted the paradigm shift made under the UN Convention in Disabilities, where there exists no distinction between mental and physical disabilities. The Convention recognizes and gives agency to people with disabilities. Thus the onus remains on promotion of services. She also pointed out that the full capacity is a huge change in perception which is lacking in the existing Indian Mental Health Act.

## 4. Dr.Kalyana Sundram, Principal, RF PG College

Dr Sundaram described that 3 kinds of mental illness exists- chronic, relapsing and progressive. Out of this the chronic mental illness impairs ability/capacity to work and earn and can lead to worsening of illness. And 1/3rd recover normally, 1/3rd with certain disabilities and 1/3rd remain chronically ill. He pointed out that ensuing suffering is not confined to the individual alone but affects whole family. Dr Sundaram highlighted the importance of psychological rehabilitation by stating that care given to persons with disorders as knowledge and skills to help achieve optimum level of social and psychological rehabilitation This form of rehabilitation assists in developing social and occupational and living skills in order to assist them to live independently.

Dr Sundaram offered the benefits of psychological rehabilitation, which according to him:

- Can go hand in hand with medicines and thus optimizes pharma-cological treatment
- Improves adherence to treatment based on psychological intervention
- Helps in recovery and prevents relapses
- It is customized for individual patients
- Reduces stigmatization and improves access

Dr Sundaram however pointed out that rehabilitation settings/services are very few in India and are by and large offered by NGOs. He mentioned certain crucial issues in rehabilitation- the first contact is vital as it is important to feel comfortable. It is always a team work, planning must involve patient and family, there should be realistic expectations from families an professionals and lastly the apathy of professionals towards rehabilitation should be done away with.

Dr Sundaram also emphasized on the short term benefits/goals –controls and assess the symptoms, sets in a structured lifestyle, manages disruptive behaviour and cements interpersonal relationships. The long terms goals according him were- increases job prospects thus brining in finances, community reintegration, opportunities to work with families etc. Dr Sundaram nevertheless brought out certain flaws in rehabilitation- services are inadequate, services are not uniform, staff patient ratio is pathetic, cost of care enormous, insufficient manpower/personnel, financial crunch, licensing issues of institutions. Dr Sundaram also emphasized on concerted family involvement in all aspects rights from the beginning and the need to transfer skills to family to facilitate transition. With regard to the rural picture, Dr Sundaram also mentioned distance and poverty to be the two major hurdles as it disrupts services and continuous services remain the essence of this field. He laid emphasis on 7 Rs- realistic, reassess, reduce expectations, reset goals, resilience, reassure family/client, takes time

## 5. Prof Amita Dhanda

Prof Dhanda mentioned how often treatment and medicines are disempowering and the need is to make a connection between social justice and mental health. She emphasized on 'talking with each other' and not 'to each other'. She emphasized the need to make social justice and mental health connections. The challenges is how to create these connections? To her the stereotype way in which incapacities or abilities are attributed to a set of people disturbing. To her "rehabilitation" itself requires understanding and re-definition.

The session ended with a brief comment from the Chair.

The Conference concluded with a vote of thanks to the keynote presentors, panel speakers and the participants whose constant presence made the Conference a success. Special vote of thanks went to the student rapporteurs and volunteers whose names are mentioned below:

B.A.,LL.B.(Hons.) III yr

1. Ms. Ruth Anna Paul

2. Ms. Shruti Swaminathan

3. Ms. Vrinda Maheshwari

4. Ms. Kushal Bhimjiani

LL.M. – I yr

1. Ms. Sraddha Bararwal

2. Ms. Saurabh Samal

3. Mr. Irfan Rasool

4. Ms. Archana Mishra

A very warm vote of thanks was extended to the teacher coordinators, namely, Ms. Anuradha Saibaba and Ms. Parvathi Menon and also for the excellent secretarial support received from the Vice-Chancellor and Registrar's office staff and Training Centre staff, in particular Ms. Savithri Bhat, Ms. Usha A, Ms. Pushpa Kadam, Mr. Chandrashekar (Technical Assistant), Mr. Manikandan and others.

## (iii) Re-iterating significant Conference outcomes

(a) It was helpful in developing sensitivity towards the mentally ill and their families amongst a mixed constituency comprising of hard-core mental health experts, legal academics, and member of the judiciary, media and the National Law School students.

(b) Human Rights and Legal rights violations in the course of mental health delivery were brought to a sharper focuss.

(c) It was revealing to learn from the presentations of the prestigious mental health delivery institutions that there exist grave short –falls in the mental health delivery mechanisms.

(d) The major reasons and factors that contributes to crisis in mental health field were identified and some of the corrective measures such as better coordination between State and NGOs/CSOs, strengthening the non-institutional modes of treatment etc. were explored.

(e) Law should play greater role in regulating the mental health field, particularly the Human Rights, Constitutional rights and Statutory Law provisions should come into play right from the earliest stages of mental health interventions.

(f) The Bench and Bar should make a positive contribution by taking a pro-mentally ill and pro-active stance in the mental health field.

(g) The significant shift underlying the U.N. Convention 2007 that presumes every mentally ill as a full legal person, with marginal impairment of capacities needs to be fully comprehended and reflected in all the existing and future mental health laws and interpretations.