Addressing concerns of women admitted to psychiatric institutions in INDIA: An in-depth analysis

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कृष्णा राज
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सत्यमेव जयते

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शुभकामना संदेश

आज हमारा देश स्थायी विकास के मार्ग पर निरन्तर अग्रसर हो रहा है, समग्र विकास के लक्ष्य की पूर्ति के लिए लिंग समानता, नारी सशक्तीकरण एवं बच्चों का विकास आधारशिला बन गया है। इस मंत्रालय ने हाल के वर्षों में महिलाओं और बच्चों से संबंधित मुद्दों पर ध्यान देते हुए और उन्हें विकास एवं शासन की उच्च प्राथमिकता सूची में रख कर अनेक व्यावहारिक उपाय शुरू किए हैं।

राष्ट्रीय महिला आयोग ने अपने अधिदेश के तहत मानसिक अस्पतालों में महिलाओं की स्थिति पर वृहत और व्यापक अध्ययन किया है। यह रिपोर्ट उन महिलाओं की स्थिति पर प्रकाश डालती है जो मानसिक अस्वस्थता से जूझ रही हैं। इस अध्ययन के निष्कर्षों से एक बात उजागर होती है कि लंबे समय से रोगग्रस्त महिलाओं की संख्या बहुत अधिक है, जिसके कारण अन्य निवासनियों पर भी नकारात्मक प्रभाव पड़ता है। इसलिए यह महत्वपूर्ण है कि जिन महिलाओं का इलाज पूरा हो चुका है और जो संस्था के बाहर भी समाज में बेहतर जीवन का निर्वहन पाने में सक्षम है, उन्हें समाज की मुख्यधारा से वापस जोड़ा जाना चाहिए।

मुझे प्रसन्नता है कि इस अध्ययन के परिणामस्वरूप राष्ट्रीय महिला आयोग ने, अस्पतालों में इलाज करा रही महिलाओं की स्थिति में सुधार के लिए, ऐसे 11 मानसिक अस्पतालों को गोद लेने तथा उनकी पुनर्वास योजना को कार्यान्वित करने का निर्णय लिया है। निश्चित रूप से मानसिक अस्पतालों में महिलाओं की स्थिति में सुधार के लिए ऐसे कार्य दूरगामी कदम सिद्ध होंगे।

शुभकामनाओं सहित।

(कृष्णा राज)

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ललिता कुमारमंगलम
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भारत सरकार

CHAIRPERSON
NATIONAL COMMISSION FOR WOMEN
GOVERNMENT OF INDIA

Foreword

A significant population in India suffers from mental disorders of which women form a significant group. Mentally ill women, experience social and economic marginalization which is exacerbated not only due to gender inequity and inequality but also stigma and insensitivity surrounding mental illness in India. Mental illness is also a misconstrued phenomenon in India. There is a need for early detection and treatment of mental disorders among women so that they can regain their social skills and augment their psychological resources to cope up with the world outside. Good social support with timely rehabilitation is a necessity to lead a dignified and fruitful life. There is also a need for wide awareness to discredit/debunk the stigma and myths associated with mental illness in India.

Apart from being mentally ill, these women have a host of issues in their life amongst which their abandonment remains the most common issue. Some families, who are unwilling to bear the burden of care, label women as mentally ill and abandon them in institutions which lead to their isolation which further increase the problem of women. There is, hence lack of both familial support as well as lack of state facilities for mentally ill women in India.

Deeply concerned about the condition of women suffering from mental disorders, the National Commission for Women in collaboration with NIMHANS conducted a research study on addressing the concerns of women admitted to psychiatric institutions in India.

This research study attempted to explore the clinical, social, cultural, familial, economic and legal factors likely to affect the lives of women with mental illnesses admitted to mental hospitals and has proposed recommendations on various aspects concerning women psychiatric institutions including existing laws and policies or programmes, to ameliorate the condition of women admitted in government psychiatric hospitals across the country.

I do hope the recommendations emerging out of this study will help the government to take the positive steps for safeguarding the rights of women with mental disorders

(LALITHA KUMARAMANGALAM)

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Preface from the NIMHANS Team

We are a multi-disciplinary group of professionals from the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore and have been working with persons with a wide range of mental illnesses and their families.

The strength of our team is that we are multidisciplinary (faculty from psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing); the greater strength lies in the fact that members of our team have been involved, at various stages in the last two decades, on various issues relating to the mental health of women. This has included mental healthcare of women in custody in collaboration with the National Commission for Women; the conditions in mental hospitals in collaboration with the National Human Rights Commission; authoring of a publication for the World Psychiatric Association on Women and Mental Health; assessment of mental health concerns of women in prison; mental health care of the elderly; life skills for adolescents, (particularly adolescent girls), both in schools and marginalized communities, and rehabilitation of persons with mental illness. The common bond that binds the team together is that we are faculty members at NIMHANS, providing clinical care to persons with mental illness. In some ways, we have a finger on the pulse and are acutely aware of both institutional and community challenges in the effective care of the mentally ill.

The opportunity to carry out this work at the request of the National Commission for Women has given us further insights into areas that require focused attention within the scope of institutional care, as well as, and even more importantly, outside institutions. This report raises important challenges of finding ways of providing care, support and empowering women with mental illness. This includes supporting families to provide care for their wards, as well as making alternative community arrangements when family care is not available or possible.

We are grateful to the Chairperson, Ms. Lalitha Kumaramangalam, as well as all the members and officials of the National Commission for Women (Ms. Preeti Madan, Ms. Laldingliani Sailo, Ms. Rekha Sharma, Ms. Sushma Sahu) who accompanied the NIMHANS team on the hospital visits and provided insightful comments and recommendations. We specifically thank Ms. Preeti Madan, Member Secretary of the Commission and Ms. Richa Ojha, Senior Research Officer for their constant interaction and support to the team.

At NIMHANS, we are grateful to the past directors, Dr. P. Satish Chandra, Dr. Uma Maheshwar Rao, the present director, Dr. B. N. Gangadhar for their support and to Dr. Mathew Varghese, former Head of the Department of Psychiatry for his encouragement. The team is also grateful to the Heads of the Department of Clinical Psychology, Psychiatric Social Work and Psychiatric Nursing, for their support.

We hope that this report will serve as a bedrock to the National Commission for Women in order to plan a coherent and convergent plan of action that engages the different players – various agencies (government, private and voluntary) and individuals who need to get involved in the care and support of women with mental illness. While many of the issues that have been raised in this report are relevant to anyone with mental illness, gender-related issues have their unique complexities and need gender-nuanced approaches. The Ministry of Health and Family Welfare, Ministry of Social Justice and Empowerment and Ministry of Women and Child Welfare, as well as other agencies involved in the care and welfare of this vulnerable group will need to work in a concerted and co-ordinated manner.

Women with mental illness are close to our hearts and we are committed to working with the National Commission for Women and other agencies to support further tangible action in this area.

Members of the Team
April 2016

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ATM	Automated Teller Machine
BMH	Berhampore Mental Hospital, Murshidabad
CCTV	Closed Circuit Television
CIP	Central Institute of Psychiatry, Ranchi
CSA	Childhood Sexual Abuse
Dept	Department
DIMHANS	Dharwad Institute of Mental Health and Neurosciences
DGHS	Directorate General of Health Services
DNB	Diplomate of National Board
DPM	Diploma in Psychological Medicine
DPN	Diploma in Psychiatric Nursing
DHFW	Department of Health and Family Welfare
DWCH	District Women and Child wing
ECT	Electroconvulsive Therapy
FIR	First Information Report
Govt.	Government
GHMC	Government Hospital for Mental Care
GMA	Gwalior Manasik Arogyashala
GPDH	Government Psychiatric Diseases Hospital, Srinagar
HIV	Human Immunodeficiency Virus
HMH	Hospital for Mental Health
HHMHR	Himachal Hospital of Mental Health and Rehabilitation
IHBAS	Institute of Human Behaviour and Allied Sciences, Delhi
IMC	Institute of Mental Health Care, Purulia
IEC	Information, Education, Communication
IMH	Institute of Mental Health
IMHH	Institute of Mental Health and Hospital, Agra
IOP	Institute of Psychiatry, Kolkata
IP	Inpatient
IPHB	Institute of Psychiatry and Human Behaviour, Bambolim, Goa
LGBRIMH	Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam
LPMH	Lumbini Park Mental Hospital, Kolkata
MD	Doctor of Medicine
MIMHANS	Meghalaya Institute of Mental Health and Neurological Sciences, Shillong
MH	Mental Hospital
MHC	Mental Health Centre
MHA	Mental Health Act
MHI	Mental Health Institute, Cuttack
MO	Medical Officer
MOH	Ministry of Health
MoSJE	Ministry of Social Justice and Empowerment
MPH	Modern Psychiatric Hospital, Tripura
MPhil	Master of Philosophy
MR	Mental Retardation (Intellectual disability)
MS	Medical Superintendent
MoSJE	Ministry of Social Justice and Empowerment
MSc	Master of Science
MSCW	Maharashtra State Commission for Women
MWCW	Ministry of Women and Child Welfare
NCW	National Commission for Women
NHRC	National Human Rights Commission
NIMHANS	National Institute of Mental Health and Neurosciences
NGOs	Non Governmental Organisations
NMHP	National Mental Health Programme
OCD	Obsessive Compulsive Disorder
OP	Outpatient
OPD	Outpatient Department
OT	Occupational Therapy
PC	Psychiatric Centre, Jodhpur
PDH	Psychiatric Diseases Hospital, Jammu
PG	Post-graduation
PHC	Primary Health Centre
PIL	Public Interest Litigation

PMH	Pavlov Mental Hospital, Kolkata
PSWs	Psychiatric Social Workers
PWD	Persons with Disabilities
PWDA	Persons with Disability Act
RCI	Rehabilitation Council of India
RINPAS	Ranchi Institute of Mental Health and Neurosciences
RMH	Regional Mental Hospital
RMO	Resident Medical Officer
RPD	Rights of Persons with Disability
SAL	Social Action Litigation
SCW	State Commission for Women
SMHI	State Mental Health Institute, Dehradun
SMHI	State Mental Hospital Institute, Kohima
SMDs	Severe Mental Disorders
STI	Sexually Transmitted Infection
TISS	Tata Institute of Social Sciences, Mumbai
UNCRPD	United Nation Convention on the Rights of Persons with Disabilities
UNDP	United Nations Development Programme
UP	Uttar Pradesh
WHO	World Health Organization

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Executive Summary

Gender is a critical determinant of mental health. Mental illness among women needs to be understood in the context of a myriad of realities in India - gender inequity, stigma, gender-insensitive and fragmented services for mental health in general and women's mental health in particular.

Women are vulnerable to mental disorders across their life-span. Severe mental illnesses like schizophrenia and bipolar mood disorder affect young adults, and often strike as the young woman stands on the threshold of a promising and exciting future. In a sudden twist of circumstances, the road ahead becomes hazy and daunting. Severe mental disorders are not devastating because of their symptoms alone. Poor understanding of these disorders, delay in treatment seeking, poor accessibility of services, poverty and stigma often hide these illnesses from the public gaze, until very late. It is now well-recognised that in addition to biological predisposition, the precipitation of mental disorders, their aggravation, outcome and ensuing disability are socially determined. Early detection, prompt treatment, rehabilitation and social support can help people recover from acute episodes and effective prophylaxis can prevent relapses. With good social support and timely rehabilitation, women with mental illness can lead complete and productive lives, realizing their rights both as women and as equal citizens.

Reality, however, is quite different. Women with severe mental illnesses often have to cope, with more than just their inner turmoil of confused thinking, turbulent moods, hallucinations and delusions. They also have to deal with the harsh world outside. A harsh reality of sometimes helpless and poverty-stricken families, some families simply unwilling to 'bear the burden' of care and worse still, families which connive to put the woman in an institution and label her as mentally ill, all with an ulterior motive. Abandonment in institutions, thus, may be helpless abandonment, careless abandonment or wilful abandonment.

Institutions where such women, as well as men, are left and often forsaken, have generally been demonised and not without reason. They have been traditionally viewed as hell-holes, where rampant abuse and human rights violations occur. The word 'asylum' – a place of refuge, has given way to the ugly notion of 'institutionalisation'- where people are locked up....and forgotten.

In India, the story of asylums and mental hospitals, as they were subsequently called, follows a similar thread. For more than a couple of centuries, asylums in India became known as breeding grounds of gross abuse and deplorable living conditions. As incisively stated by the psychiatrist Edwin Mapother in his report on the mental hospitals in 1938, 'The Indians have been unable to exercise the authority to enforce change...the only thing they know is to lock up the worst patient'[1]. Post-independence, starting in the 1960's concerned superintendents of the mental hospitals sincerely tried to change that perception. They met at successive workshops and came up with several issues and recommendations, none of which resulted in substantive changes.

[1]National Human Rights Commission. Quality Assurance in Mental Health, 1999, NHRC New Delhi.

Things did change with public interest litigations and judicial activism. The Hon'ble Supreme Court of India began monitoring some of the mental hospitals in the country where the situation was 'deplorable'. The National Human Rights Commission (NHRC) was assigned the responsibility of overseeing some of the mental hospitals in the country. The NHRC expanded its mandate and with the help of the National Institute of Mental Health and Neuro Sciences, Bangalore, carried out a quality assurance in mental health, which included a thorough evaluation of the mental hospitals in the country. Several recommendations were made and they were viewed with the seriousness they deserved only after the Erwadi tragedy in 2001.[2] A review undertaken in 2008 by the NHRC[3] showed several positive changes in the mental hospitals in the previous decade. The most dramatic improvements were noted in hospitals that were being regularly monitored.

Meanwhile, the need to develop mental health care closer to the community and the expansion of the National Mental Health Programme (initiated in 1980, expanded in 1996, re-strategised in 2011-2012), underscored the importance of developing mental health care services at the district level. A recent review of mental health services in India by a technical committee constituted by the NHRC reveals that the pace of development of decentralised mental health care is very slow.

Background to the present study

Meanwhile, the focus shifts back to the mental hospitals. On this occasion, it is a report by the Human Rights Watch in 2014, which selectively focuses on human rights abuses on women with mental disabilities both in mental hospitals and women's homes. With interviews of 52 women and visits to mental hospitals and state residential care facilities in six cities in the country, the report makes scathing generalisations of the gross human rights violations in institutions, deceit on the part of families to dump women into institutions, forced treatment and denial of adequate and appropriate health care and gross inadequacies in institutional care, physical, verbal and sexual abuse at the hands of institutional authorities.

The attention thus shifts back to the mental hospitals to both ascertain what aspects of the Human Rights Watch are arbitrary inferences, selective abstractions or overgeneralisations that such problems are widespread in these institutions. It also seeks to provide a counter narrative about the mental hospital, which, with all its undesirability, has remained, over centuries, the bastion of care, to tens of thousands of women with mental illnesses. Of course, women should not remain there, they should be treated and return to their families; they should be in least restrictive settings like community living, half-way homes, etc. Where are these in India? The only alternative presently is the street, which has begun to increasingly see more and more homeless mentally ill; the jails, where women get taken to when vagrant, wandering and behaviourally disturbed, women's homes, beggars' homes etc. where conditions are dismal and rights violations are rife.

[2] S M Channabasavanna, Murthy P (2004) The National Human Rights Commission Report 1999: A Defining Moment. In Mental Health An Indian Perspective. Agarwal SP (ed) Reed Elsevier Private Limited, New Delhi.

[3]National Human Rights Commission. Mental Health and Human Rights. Nagaraja D, Murthy P (eds), NHRC 2008. ISBN-978-81-9044117-5

The present study

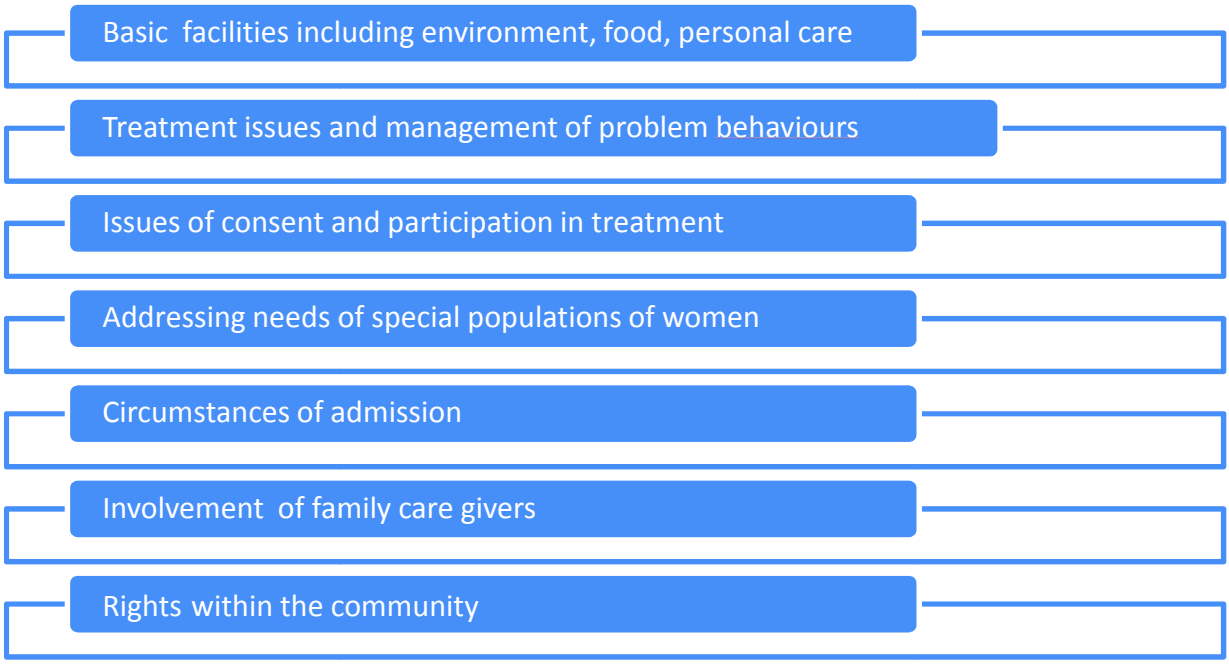
This investigation, commissioned by the National Commission for Women under its mandate 'to inspect or call to be inspected a jail, remand home, women's institution or other place of custody were women are kept as prisoners or otherwise and take up with the concerned authorities for remedial action if found necessary'. NIMHANS was approached by the National Commission for Women in July 2015, with a request to study the issue of 'women patients getting incarcerated inside mental institutions of India for prolonged periods of time' and formulate a report along with recommendations to improve the scenario.

Objectives

The objectives of the study *Addressing concerns of women admitted to psychiatric institutions in INDIA: An in-depth analysis*, were to explore the clinical , social, cultural, familial, economic and legal factors likely to affect the lives of women with mental illnesses admitted to mental hospitals in India. The specific objectives were to:

1. Assess the level of care of women admitted to government psychiatric institutions in terms of living spaces, basic care including health care, access to contemporary treatment, access to recreation and rehabilitation, legal, and economic assistance, through hospital based reports and physical visits to select facilities.

   Specific areas of enquiry included:



2. Prepare a set of recommendations regarding the care, admission and discharge of women to psychiatric institutions, as well as recommendations to existing laws and policies or programmes related to the mental health of women in order to reduce stigma, facilitate their recovery and re-integration as well as protect their rights in an

equitable manner, both within the institution and in the community, including free legal aid, access to disability benefits, travel, safe living spaces, work opportunities, etc.

METHODOLOGY

This study involved 3 activities.

Activity 1 consisted of joint on-site visits were carried out between December 2015 and January 2016 by the NIMHANS team and members of the NCW. The visit included personal interviews with patients, family care givers, service providers and administrators, as well as direct observations of the teams. The selection of the 10 hospitals for on-site visits was based on the number of long-stay women patients as per the Inspection Committee Reports of the Ministry of Health and Family Welfare, Govt. of India.

Activity 2consisted of analysis of the consolidated information of the interviews with women patients, family care givers, service providers and administrators across the visited hospitals to highlight the general issues across institutions.

Activity 3 consisted of analysis of a questionnaire that was sent out to all the mental health institutions in the country seeking gender-specific information, including the background characteristics of women with mental disorders seen in these institutions, their diagnoses, infrastructure and facilities that existed for their care, staffing, with a specific focus on long-stay patients and difficulties faced with their rehabilitation and discharge.

SUMMARY OF FINDINGS

The major findings from the three activities are presented in 3 sections.
Section 1. On-site visits
Section 2. Summary of consolidated responses of women patients, family carers, service providers and administrators
Section 3.Questionnaire-based self-reports from psychiatric institutions

SECTION 1. ON-SITE VISITS

This included on-site visits to RMH, Yerwada, RMH Thane in Maharashtra, IPHB Goa, GMH Kozhikode, Kerala, Calcutta Pavlov Hospital and Berhampore Mental Hospital in West Bengal, RINPAS in Jharkhand, IMHH Agra and MH Bareilly in Uttar Pradesh and IMH Amritsar in Punjab, all chosen based on high numbers of long-stay patients.

Onsite visits showed many deficiencies in infrastructure and facilities, though many of the hospitals also showed up positive aspects. Despite the deficiencies, patients seemed generally satisfied. However, across all the hospitals, the common refrain was that the women wanted to go back home to their families.

Observations by the NCW/NIMHANS teams to individual institutions:

1. **RMH Yerwada, Pune**

The visiting team noted glaring deficiencies in infrastructure, facilities and care, although patients themselves expressed dissatisfaction only in a few areas. The major observations of the visiting team was that the roads were poorly maintained, wards were all closed wards, lighting was inadequate; wards were overcrowded, beds and mattresses were inadequate, some fans were not working, hot water was not provided, water for bathing and washing clothes was inadequate. The team noted that there were some outside toilets; that the bathrooms were inadequate; that there were mosquitoes in the ward; the dining facilities were inadequate and the eating area was full of flies; patients had to wear compulsory uniforms and these were sometimes torn and dirty; there was a lack of privacy during bathing; though sanitary napkins were provided, some patients did not know how to dispose them and would wash them; adequate toiletries were provided; patients were provided some space for their spiritual and religious activities; patients told the team that medical rounds were infrequent; they were poorly informed about the side-effects of medicines and emergency medical attention was inadequate; patients were engaged in some occupational therapy, but only a few destitute patients had been rehabilitated.

Most of the patients that the team spoke to expressed concerns not about the care in the hospital, but whether their families would take them home or visit them. A majority wanted to go home to their families. Wrong addresses, cases of abandonment were not uncommon. For the women who had been in the hospital long-term and had not seen the world outside, they perceived that they were getting the best facilities.

2. **MHC, Kozhikode, Kerala**

From the on-site visit, the major aspects that need immediate attention are mechanisms to provide regular non-psychiatric medical care, streamlining discharge procedures for out of state patients, more community rehabilitation units and providing rehabilitation facilities for in-patients. The work of the staff to ensure quality service even in these conditions needs to be positively highlighted.

3. **RMH, Thane, Maharashtra**

The team visiting RMH Thane felt that there are genuine problems in an urban mental hospital such as Thane, where patients are kept for long periods and families cannot take them home. Poor infrastructure, old dilapidated buildings and lack of basic hygiene facilities, make the experience dehumanising. Women do not have recreational facilities or occupational therapy which leads to lack of skills and institutionalisation. However, some aspects of care were good- adequate medical care, humane staff, no incidents of violence towards patients, adequate food, regular dental and dermatology camps for patient.

4. **Institute of Psychiatry and Human Behaviour, Bambolim, Goa**

The visiting team observed that, the hospital has a large number of long-stay women patients, majority who are destitute and many belonging to other states. The team found the toilets and bathrooms clean but inadequate. Water supply was erratic. The hospital did not have its own laundry facilities. Uniforms were being provided and patients did not have a choice of what to wear. The construction quality and design of the buildings is unsatisfactory. However, they felt the need for better planning of outpatient and inpatient services, need for increase in open ward facilities, need for increase in specialised services (children, addiction, forensic), setting up of community rehabilitation and long-stay facilities for women patients. The team also observed the lack of provision for providing undergarments, slippers to the patients.

5. **Calcutta Pavlov Hospital**

The visiting team observed that there are a proportion of out-of-state patients. There are infrastructural deficiencies with respect to access to the top floors, poor drainage system, mosquitoes and other pests, lack of heaters and hot water, lack of lockers. Care appears to have improved following the involvement of the National Medical Hospital. Food has improved, but there are no designated dining spaces. Hair is cut short, often against the patient's wishes, though informed consent 'is taken'. Undergarments are shared. Sanitary napkins are inadequate. Sleeping arrangements seem satisfactory. Medicines are available. There are clinical psychologists involved in care. But there are no psychiatric social workers. Documentation in the case files is adequate. Reduction in overcrowding has reduced incidents of violence. Staff shortage is still a problem. Although there are some recreational avenues, under-stimulation is a great problem. Rehabilitation is unsatisfactory although two NGO's, Anjali and Paripurnita have had a positive impact on engaging the women in productive work. Most of the preoccupation of the women is about returning home. Only a very small percentage of patients here seem to get discharged to their homes.

6. **Berhampore Mental Hospital, Murshidabad**

The visiting team observed that admissions are largely involuntary. Some of the basic facilities like hot water, drying areas, toilets, sleeping arrangements are inadequate. Lack of cleanliness is appalling. Patients are not provided with any personal effects. Lack of privacy is glaring, with community bathing. Food is adequate in quantity, but eating spaces are inadequate. The quality of food has improved although some patients complain of a lack of variety. Sanitary napkins are inadequate and thrown randomly. Very few patients have their own clothes. Hair is cut short. Sleeping arrangements are inadequate. There is no heating provided. There is little face-to-face interaction with the treating team and little positive engagement. However, the record keeping is good. Most mental health faculty are engaged in private practice outside the hospital. There is a shortage of nurses and psychiatric social workers. Medical management of physically ill patients is inadequate. There are instances of patient abuse by the staff. Recreation and rehabilitation activities are very minimal. An exception is the involvement of an NGO, Anjali, which engages a few patients with a range of social and recreational activities. Women in this ward appear cleaner and socially more

responsive. For most patients, their constant preoccupation is discharge and the hope of being reunited with their families. There are many barriers to discharge.

7. **Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Jharkhand**

The visiting team observed that many of the long-stay patients are from out of station. Although the ambience is prison like, the wards within are open. The buildings are very old. Ward maintenance is adequate. Patients are bathed in groups. Toilets are situated outside the wards and patients complain of difficulties in going out at night. Water supply is adequate. Fans and lights are inadequate. Drinking water is adequate. However, the water coolers are not well maintained. The food is hygienically served and adequate. But the dining hall seating facility is not comfortable for elderly and those with orthopaedic problems. The hospital uses its large campus to generate a lot of produce for hospital use. Though personal hygiene appears generally adequate, patients say bathing is irregular because of lack of hot water. Patients are not allowed to wear their own clothes but provided with a range of uniforms. They are also given sufficient toiletries, footwear as well as adequate sanitary napkins. But the team observed that these are not disposed properly. While patients are provided with warm clothing, inner garments are not provided.

The sleeping facilities are adequate, although pests are an issue. Patients appear to be treated well and the team did not come across any cases of abuse during their visit. On the contrary, there were many stories of patients being abused by a family member or someone in the community, coming into hospital with an HIV infection, or a pregnancy discovered after admission.

The team observed that involvement of the family is minimal. Although pre-admission and pre-discharge counseling is done with the families, absence of a family ward prevents effective family engagement.

The team was generally appreciative of the hospital staff for their dedicated work in providing quality care to the patients despite having limited human resource.

8. **Institute of Mental Health and Hospital (IMHH), Agra**

The visiting team observed that overall basic facilities are good. Wards are clean, hot water is available and bathrooms and toilets are adequate and well maintained. There are facilities for washing clothes, but inadequate place to dry them. Lighting is adequate. There are fans but no heaters. There is running water but no geysers for hot water. There are lockers. Food is adequate. Dining halls are present but overcrowded.

Patients have to bathe together. Patients are not aware of sanitary pad disposal and proper use. Toiletries are provided. Hospital uniforms are compulsory. Winter wear and footwear are regularly provided. Cosmetics are provided to some.

Sleeping and resting arrangements are satisfactory. Medication and other treatment modalities are up to date. There is a library. However, psychosocial interventions need further improvement and the biggest barrier for this is the lack of human resources and their training. Records are well maintained. Although the staff feels there is little time to interact with patients, patients feel the staff is empathetic and responsive. Minor incidents of physical violence are occasionally reported. Social and religious needs are reasonably met. There is a small rehabilitation unit, but human resource for rehabilitation is a big constraint.

However, almost unanimously, the uppermost desire expressed by patients is a desire to return home.

9. **Mental Hospital, Bareilly**

The study team observed many areas of deficiency in the basic facilities, although a majority of the respondents rate them as being good. The wards are not well maintained and damp, making it difficult in the chilly weather, particularly in the absence of heaters. Patients complain about safety of drinking water and the lack of hot water. Toilets are inadequately maintained. Patients sometimes have to take bath in the open. There is overcrowding. Basic cosmetics are not provided to the patients. The dining space is inadequate. Some of the patients complain of staff rudeness, particularly in the dining area. Staffs justify rudeness because patients are sometimes violent and uncontrollable. Sleeping facilities are adequate. The lack of human resources, particularly psychologists, psychiatric social workers and psychiatric nurses is glaring. Some patients complain that doctors do not see them regularly. The hospital has a small recreation section but the activities are non-existent. The team observes that the staffs are not keen on rehabilitating patients. There are no separate facilities for prayer. Some patients feel humiliated by the staffs, who punish them if they do not work in the ward.

10. **Institute of Mental Health (Govt. Mental Hospital), Amritsar, Punjab**

The NCW project team observed that a majority are involuntary patients, including out-of-state patients. The team observed that the premises are clean. Patients seem to be happy. The laundry and kitchen are well-maintained. There seems to be a lot of support from *Pindalwaras*. The team observed that there are prolonged power cuts with no back up leading to distress due to heat/freezing cold. Floor and ceilings need renovation. Water tank needs cleaning.

The food is adequate, but there is no dietician. It is wholesome and hygienic. Resting facilities are adequate. Attention to personal care and medical care is adequate. But there are no rehabilitation programmes.

There are 3 PSWs whose services are not made use of appropriately. There is no provision for vehicle to make home visits and they are not allowed to do detailed work ups in the OPD either. The predominant issue seems to be high stigma levels, family detachment from the patients' needs, and lack of sufficient number of qualified mental health professionals, NGOs

and contract posts. Considering the number of beds, this could become a teaching hospital. The biggest concern for patients and staff is the discharge of patients who need not stay in the hospital.

SECTION 2: SUMMARY OF INTERVIEWS WITH WOMEN PATIENTS, FAMILY CARE-GIVERS, SERVICE PROVIDERS AND ADMINISTRATORS ACROSS ALL THE INSTITUTIONS VISITED

Interviews with women patients

Personal interviews carried out with 245 respondents, the following feedback was provided.

Satisfaction with overall facility (rated as good or very good)	
Area	**Percentage satisfied**
Basic facilities	90.6
Food and dining facilities	86.5
Facilities for personal hygiene and basic comfort	82.8
Sleeping and resting facilities	
Facilities for medication and treatment	86.9
Meeting of emotional needs	95.9
	86.5

Areas of dissatisfaction (dissatisfaction expressed by 10% or more respondents at each site)

Areas of relative dissatisfaction with facilities (10% or more responses as poor/very poor)	
Area	**Dissatisfied (%)**
Basic facilities	RMH Pune 12%, CPH Kolkata 24%, BMH Murshidabad 40%
Food and dining facilities	RMH Pune 28%, MHC Kozhikode 20%, RMH Thane 24%, BMH Murshidabad 46%, IMHH Agra 28%
Facilities for personal hygiene and basic comfort	RMH Pune 16%, MHC Kozhikode 20%, RMH Thane 28%, BMH Murshidabad 80%, RINPAS 12%, MH Bareilly 20%
Sleeping and resting facilities	RMH Pune 20%, MHC Kozhikode 24%, RMH Thane 24%, CPH Kolkata 28%, BMH Murshidabad 32%, IMHH Agra 28%
Facilities for medication and treatment	RMH Pune 16%, MHC Kozhilode 12%, RINPAS 16%
Meeting of emotional needs	RMH Pune 20%, MHC Kozhikode 24%. CPH Kolkata 16%, BMH Murshidabad 20%, RINPAS 28%, MH Bareilly 20%

Relatively higher rates of dissatisfaction on many of the facilities were expressed by patients in BMH Murshidabad, RMH Pune and RMH Thane.

Areas of relative dissatisfaction regarding rights- based issues

While a majority of respondents was satisfied with the facilities provided, what was striking were the responses related to recognising the personhood and rights of the woman undergoing treatment. Although most hospitals said they provided information about patient rights, practically all the women unanimously said they were not informed about their rights. Most denied that they were coerced (except in MHC Kozhikode and RMH Thane where 24%, and BMH Murshidabad, where 15% said they were treated against their wish). Many provided a feedback that informed consent for treatment was not sought, health decisions were not made by the patient and confidentiality was not maintained in many places. Compulsory hair cutting was another infringement.

Areas of relative dissatisfaction regarding rights based issues	
Area	**Institution and % responded**
Hair cut without consent	RMH Pune (40%), MHC Kozhikode (36%), RMH Thane (16%), IPHB Goa (40%), CPH Kolkata (48%), RINPAS (24%), IMHH Agra (32%), MH Bareilly (20%), IMH Amritsar (20%)
Not educated about illness	MHC Kozhikode (48%), RMH Thane (60%), IPHB Goa (44%), BMH Murshidabad (95%), RINPAS (24%), IMHH Agra (40%), MH Bareilly (32%) and IMH Amritsar (24%)
Not allowed to make health care decisions	RMH Pune (68%), MHC Kozhikode (88%), IPHB Goa (84%), CPH Kolkata (92%), BMH Murshidabad (100%), RINPAS (96%), IMHH Agra (96%), IMH Amritsar (88%)
Not informed of rights in hospital	RMH Pune (100%), MHC Kozhikode (100%), RMH Thane (100%), IPHB Goa (100%), CPH Kolkata (100%), BMH Murshidabad (55%), RINPAS (96%), IMHH Agra (96%), MH Bareilly (100%), IMH Amritsar (100%)
Informed consent for treatment not obtained	RMH Pune (64%), MHC Kozhikode (72%), IPHB Goa (64%), CPH Kolkata (44%), BMH Murshidabad (100%), IMHH Agra (32%), MH Bareilly (56%), IMH Amritsar (40%)
Confidentiality not maintained by treating staff	RMH Pune (72%), MHC Kozhikode (52%), RMH Thane (64%), IPHB Goa (64%), CPH Kolkata (60%), BMH Murshidabad (50%), RINPAS (56%), IMHH Agra (72%), MH Bareilly (24%), IMH Amritsar (88%)

Summary of areas of dissatisfaction

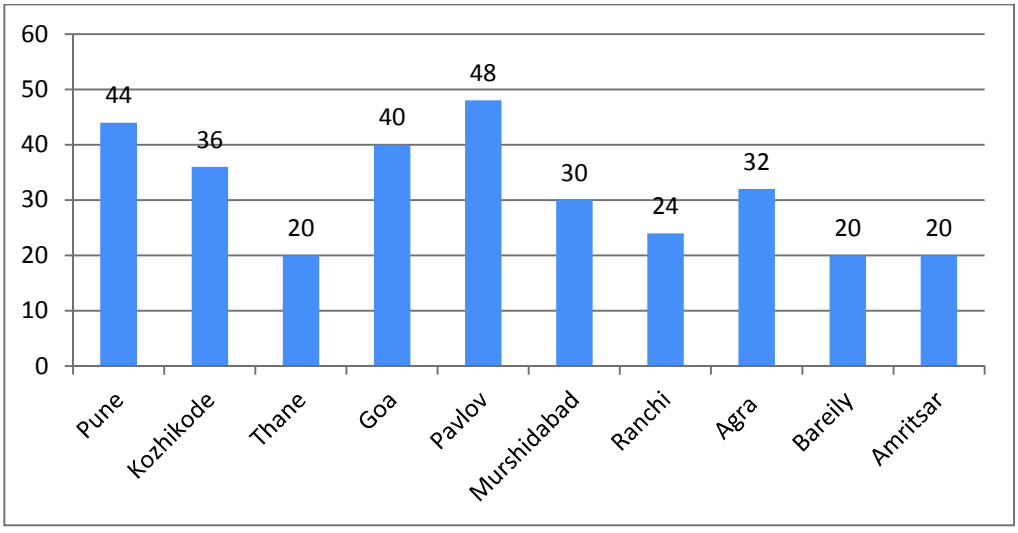
1. Living conditions and basic facilities

Area of Dissatisfaction (Living conditions and Basic facilities)	Percentage
Overcrowding	**54**
No inner garments provided	**51**
Not permitted to wear own clothes	**47**
Inadequate participation in games/cultural activities	**45**
No toiletries provided	**39**
Not allowed to go out of the ward	**54**

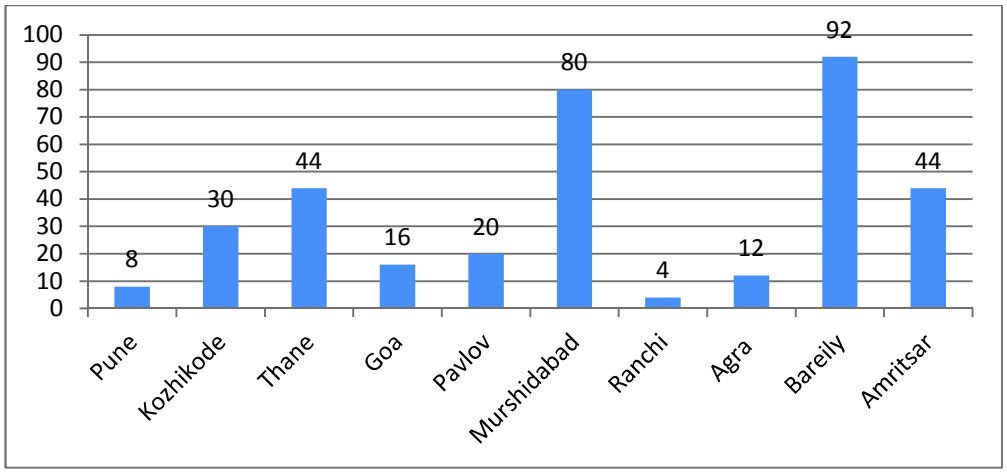
2. Areas of Dissatisfaction related to rights

Area of Dissatisfaction (Rights)	Percentage dissatisfied
No information about rights	96
No access to records	82
Not explained regarding treatment	65
No access to phones	61
No knowledge about whom to complain to	56
No access to newspapers & magazines	40
Kept in restraints for more than a day	29

3. Forceful hair cutting and tonsuring



4. **Lack of group activities for women inpatients**



CARE GIVER PERCEPTIONS

A total of 31 family care givers of both patients admitted to the closed wards as well as open ward across the 10 institutions were interviewed. Concerns of family care givers of patients in the closed wards were financial difficulties, inadequate family and neighbourhood support, social stigma, lack of adequate living space, old age and illness, safety concerns and livelihood issues. Families that stayed in the open ward with their wards were generally likely to be more aware of the illness and treatment and better engaged with service providers and expressed relatively more confidence with the treatment being provided.

INTERVIEWS WITH SERVICE PROVIDERS/ADMINISTRATORS

About 100 service providers including directors, medical superintendents, nursing superintendents, psychiatrists, clinical psychologists, psychiatric social workers, social workers, nurses, attendants and NGO representatives (when available) were interviewed. The major themes of these interviews were the following:

Reasons for long-stay:

- Rejection by family, mentally ill women seen as a liability
- Legal issues including property, custody of children), remarriage of spouse
- Pressure from families for admission/readmission including legal and political pressure)
- Rampant stigma
- Difficulty in establishing bona-fides of persons who come to discharge the patient
- Policy, legal and judicial issues which do not pressurise able families to take responsibility

According to the respondents, the situation here is different from other countries where women are better educated, more independent, employed or have social security; lack of places for rehabilitation; need for greater engagement of the welfare sector, law and

police; greater priority for mental health by the state; acute staff shortages and lack of training; need for a greater autonomy to the hospitals, need for a legal cell in every hospital and need for better supportive medical services for women with mental disorders. Another important concern was that the prime land in mental hospitals, which could be used for rehabilitation of the mentally ill, was being handed out by state governments for many other facilities.

SECTION 3: QUESTIONNAIRE-BASED SELF-REPORTS FROM PSYCHIATRIC INSTITUTIONS

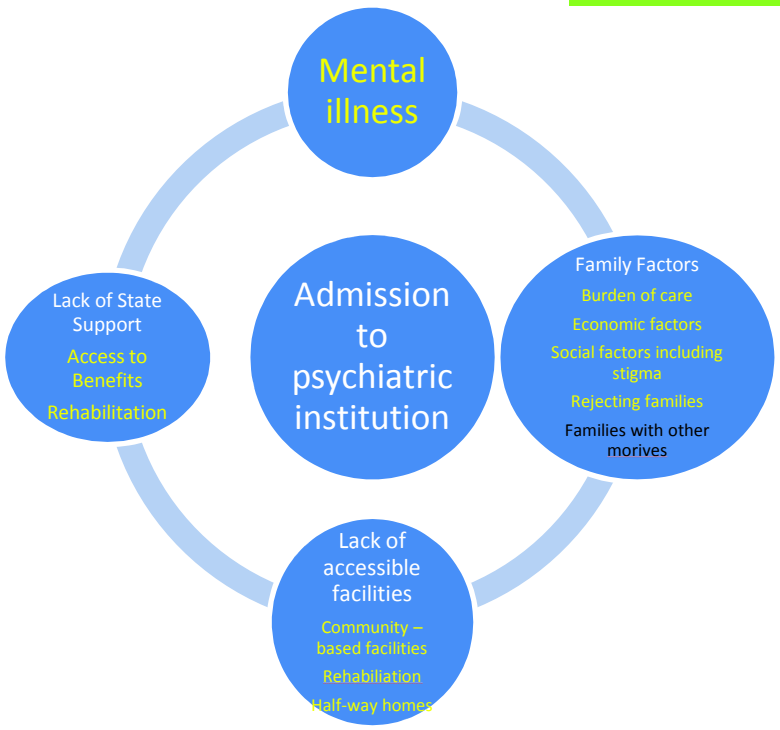
Information received from 43 psychiatric institutions reveals the following positive and negative aspects with regard to inpatient care for women with mental disorders, a majority of whom have severe mental disorders such as psychosis (mainly schizophrenia), bipolar mood disorder or intellectual disability (mental retardation) with behavioural problems.

Feedback provided by the Institutions (Self-Report)

Reported positive aspects/practices	Areas of concern from self-reports
• High number of voluntary admissions which far exceed the involuntary • Spaces for cooking, dining, washing/drying, entertainment present in two-thirds of the hospitals • Most hospitals allow women to wear their own clothes or provide clothes to those who do not have their own • Footwear is provided in most hospitals • Toiletries are provided in most hospitals • Sanitary napkins are provided in most hospitals • About two-thirds of the hospitals provide lockers for patients • Most say informed consent for treatment is taken • Most provide free medications for below poverty line patients • Most report satisfactory record maintenance • Two thirds carry out disability certification • More than two-thirds report that they offer free legal aid • Most women are actively discharged, most often to their families	• 16 institutions still have largely involuntary admissions • More closed wards rather than open wards • Library facilities, cultural and outdoor activities, spiritual activities are relatively lacking • In more than half, clothes are still uniform-like • Inner wear is not provided in most hospitals • Hair tonsuring is still carried out in six hospitals • Inadequate staff, including female staff • Group interventions are carried out in less than a third • Less than half have day care • Only a fifth to a third have specialised facilities (pregnant women, women with babies, women with substance use disorders) • Occasional critical incidents, including death occur; more in hospitals with long-stay patients • Legal issues pertaining to property, finance, custody and divorce are reported in a few institutions • Placement of long-stay patients is very low • Some long-stay destitute patients are from out-of-state and the procedures to send them back to those states are tedious and largely unsuccessful

Summary of factors leading to admission and long-stay in psychiatric institutions

Many of the problems women with mental disorders face are compounded gender inequities they face in society



RECOMMENDATIONS EMERGING FROM THE NCW/NIMHANS STUDY

The recommendations emerging from the different phases of the NCW project include the following:

I. Institutional

1. It is necessary to specifically focus on gender related issues while planning/improving mental health services in both residential and community settings.
2. The rights of women with mental illness must be protected in institutional, community as well as family settings.
3. Within psychiatric institutions, gender-sensitive aspects in need of urgent attention include facilities to improve personal hygiene (provision of toiletries and personal effects, provision of undergarments, regular supply of sanitary napkins and instruction on their proper disposal), reduction of overcrowding, focus on dignity (ensuring privacy during bathing, changing, using the toilet; banning compulsory tonsuring and uniforms), improving comfort (better arrangements for resting, warm clothing and heaters in winter, fans and coolers in summer)

4. Focus is specifically required on the rights and personhood of women- making them aware of their rights on an individual basis, involving them in decisions about their health, educating them about the illness and planned treatment, informed consent prior to treatment, informed consent for any other interventions or arrangements made in their interest.
5. Adequate facilities for recreation, leisure time activities and spiritual needs must be available.
6. There is a need to address human resource deficiencies; ensure adequate gender ratio of staff at all levels.
7. A regular audit of satisfaction with the facilities and treatment must be carried out (once a year).
8. Long-stay must be discouraged by increasing family and open wards and voluntary admissions, improving the awareness of families regarding mental illness and sensitising the judiciary.
9. Even for patients admitted involuntarily, the hospitals must establish contact with families and document their identities at the time of admission.
10. There is a need to examine and develop standard procedures for homeless out-of-state women so that they may be transferred to facilities closer to their own places of origin if they so desire.
11. The issues of long-stay need consistent attention (Homeless & abandoned-minimising stay, establishing identity, skilling/re-skilling, graded placement).
12. Mid way homes for women now have recovered but need a place to stay and get training to start their life on their own.

II. Support and Monitoring

1. The NCW/SCW need to be part of the monitoring committees of hospitals to specifically address women's issues
2. A routine legal aid need assessment must be carried out for each women who is admitted involuntarily or is not discharged within 3 months of hospitalisation. Such a facility may be set up by the State Legal Services Authority and emergent issues discussed with the hospital committee as well as other monitoring committees.
3. The SCW can set/oversee a Women's Support Service in each of the hospitals to holistically address women's issues both in treatment settings and in the community and ensure access to benefits, support for child care, etc. This should involve scrutiny of the annual audit of women's satisfaction and suggestions for improvement in facilities and would involve engagement with the hospital staff, social service agencies and NGOs on a regular basis.

III. Help and empower families

Families caring for persons with chronic mental illness must be empowered and supported through measures such as:

1. Accessible and free/subsidized treatment.

2. Access to incentives like disability benefit, travel benefit etc.
3. Awareness about these benefits and how to access them
4. Women-centric information regarding importance of early help-seeking for psychological distress and support
5. Women's mental health Help lines [Organizational aspects could be led by the NCW and engage Mo SJE, Women and Child Welfare etc.]
6. In cases where the family is the source of neglect and abuse, a proactive role of NCW/SCW for rescue and rehabilitation
7. To create a Mental Health Cell to monitor human rights violation in women with mental illness. To have a corpus fund to fulfil these objectives

IV. Community –level responses

With the challenges posed by shrinking families, as well as families that have lost the capacity to care, the need to set up community level facilities is a social reality. Towards this there is an urgent need to set up:

1. Women's respite/half-way home facilities/rehabilitation including treatment for addiction related problems
2. Shelters for women with mental health needs
3. Day care facilities
4. Linking with vocational centres to ensure equal opportunities for women with mental health issues
5. Linking with self-help groups, employment schemes, other social benefit schemes

V. Evaluation of care and monitoring in other settings

Violation is known to occur in many settings where women with mental health issues are located. Thus, steps to evaluate the extent of mental health disorders, the capacity of staff to detect and assist women with such problems, to develop networks for remediation and rehabilitation must occur in the following settings:

1. Social Service Facilities
2. Beggars' homes
3. Juvenile homes for adolescent girls
4. Prisons
5. Homes for children with mental retardation
6. Elderly homes for women
7. NGO and private residential facilities
8. Any other location of institutional care for women.

VI. Liaison and networking

1. There needs to be effective inter-sectoral liaison between the various sectors involved in the care and rehabilitation of women with mental health needs –health, social

justice and empowerment, women and child welfare, rehabilitation, housing, judiciary, law, police, home affairs, education, labour, law and others

2. Similarly, the NCW needs to liaise with other commissions (like NHRC, Disability Commission, Child Commission), other Governmental agencies and NGO's to proactively set standards of care to address women's mental health needs.
3. National Commission for Women should have a representative in all the committees and policy making bodies related to health and mental health
4. Sexual Harassment Committee needs to be formed in all mental hospital and custodial care settings.

VII. Legal recommendations

Legal provisions to ensure adequate standards of care and prevent any form of abuse are extremely important. They may include the following:

1. All psychiatric institutions in the country including privately managed institutions must be registered under State Mental Health Authority.
2. Annual social/gender audit of each psychiatric institution in the country may be undertaken by an independent agency duly recognized and empanelled by Ministry of Health & Family Welfare, GOI.
3. Any women leaving the mental health institution after being declared fit may be provided financial support to facilitate her re-integration into society in a manner as may be prescribed.
4. Provision for child care, day care facilities must be available for women with mental illness with living children upto the age of 18 years. The provision for child upto the age of 6 years to stay in the institution along with a relative, or guardian may be permitted to ensure that the child and mother are not separated. Adequate financial provisions need to be made for ensuring the same
5. Provision for after care visits by psychiatric social workers should be ensured for fit patients discharged by psychiatric institution.
6. Every application made for intake of allegedly mentally ill person must be accompanied by medical certificates from two medical practitioners ratified by government psychiatrist within 15 days of issuance of the order. Any contravention of the Act will impose the penalty clause of the proposed Bill (Mental Health Care Bill).
7. No child born to a woman with mental illness should be declared free for adoption without the consent of the mother and a proper assessment of her mental state and ability to provide care. Such an assessment should be properly documented.
8. Abused/violated women with mental illness and their rights in the absence of legal capacity, with relation to hysterectomy, termination or birth of child from rape encounters etc. should be ensured.
9. The provision for visiting system for external supervision of the psychiatric institutions especially for women patients may be incorporated.

ACTION PLAN

The following tangible steps are therefore suggested as an outcome of the NCW-NIMHANS study:

1. Adoption of 10 psychiatric institutions by the NCW to handhold, monitor and assist in improving facilities for the women. This will include regular visits to the hospitals, plan of action on the needed changes with timelines, dialoguing with the relevant state and central machinery and having time-bound and measurable targets. In addition to the areas outlined earlier, the possibility of making available adequate sanitary pads and their easy disposal needs to be explored. Of the 10 institutions visited, as IMHH Agra and RINPAS are already under NHRC monitoring, IMH Chennai and MH Varanasi may be added to the other 8 institutions for collaboration (RMH, Yerwada, RMH Thane, IPHB Goa, IMH Kozhikode, BMH Murshidabad, Pavlov Hospital, MH Bareilly and IMH Amritsar).
2. Many of the hospitals have large areas of land which are now being used by State Governments for several other purposes, including setting up of multi-specialty hospitals. This issue needs to be pursued with the Centre and State Governments to prevent any misuse of such land and use it instead to develop rehabilitation facilities for persons with mental health needs.
3. Improving awareness regarding mental illness and its treatment, direct the setting up of help-lines to address the mental health needs of women, given that suicide, depression and anxiety are all growing problems among women.
4. Hospitals must be encouraged and supported to develop facilities for women with special needs- pregnant women with mental illness, those with infants and young children, elderly, women with mental and physical disabilities, substance use etc.
5. A plan for rehabilitation is critical. There is as yet, no critical assessment of existing rehabilitation models in order to recommend one or more models. The NCW in consultation with NIMHANS can invite agencies which have implemented such rehabilitation models, to provide an evaluation of how well the models worked, what challenges they posed and how such challenges can be overcome. The output of such an initiative would be a white paper recommending effective models of rehabilitation which could then be replicated in other settings.
6. Long-stay women in the various hospitals should be helped to establish their identity (Aadhar card) many of which are necessary to avail any benefits.
7. In the existing hospitals where the NCW will collaborate, specific plans for rehabilitation need to be addressed. One potential area for rehabilitation is the complex at Varanasi. On a pilot basis, and in a careful planned, collaborative engagement with patients, a pilot may be carried out at the MH Varanasi to examine the feasibility of rehabilitation in that setting.
8. The NCW can explore whether the 'NIRBHAYA' and 'SWAADHAR' funds can be used for improving the living conditions of women with mental illness in institutional settings.

9. The incentives for families including free or subsidised treatments, travel concessions, disability assessment and pension, access to insurance schemes must first be ensured as being in place and then widely publicised.
10. The NCW can have a national consultation to disseminate the findings of the report and engage a variety of stakeholders.
11. The various recommendations of the Technical Committee on Mental Health of the NHRC submitted to the Hon'ble Supreme Court encompasses not just care in institutional settings, but also community care and care in medical colleges and general hospitals. All these are of relevance to women with mental illness. The mechanism to realize these recommendations for women needs the proactive engagement of the NCW.
12. A cabinet portfolio for mental health in general and women's mental health in particular can mainstream women's mental health issues in a big way, and this move has already occurred in some countries. The NCW can strongly suggest this to the government.

Mental health care institutions -the counter-narrative

While institutionalisation is perceived as a downward spiral, where long duration of illness, lengthy stays, de-humanising environments, desertion by families and de-skilling, the counter-narrative is that when these institutions are humanely run, stimulating, and supportive, they can be important places of decent care, in the absence of community facilities. While we are in the process of strengthening families and developing alternative systems of community care and rehabilitation, focusing on improving care and relevance of the existing institutions/hospitals will help to make them not just safe refuges, but vibrant centres of training to guide the development of community facilities and the direction of community care.

1. INTRODUCTION

Women are vulnerable to mental disorders across their life-span. Although women constitute 48% of the population[4], the discourse on women's mental health issues in India is extremely limited. Gender inequities, a lack of understanding of the influence of gender on mental health and illness, gender-insensitive planning of mental health services are primary contributors for the lacunae in the area of women's mental health.

Health in general and mental health in particular, 'cannot be fragmented or reduced to a single causal factor and women's mental health is no exception'[5].

Gender and Mental Health

Gender is a critical determinant of mental health[6].Both biological influences and psychosocial factors determine gender differences in prevalence, presentation and the aftermath of mental illness. With respect to psychosis, gender differences have been reported in the age of onset of symptoms, clinical features and frequency of psychotic symptoms, course, social adjustment, and long-term outcome of severe mental disorders.[7]Women with severe mental illnesses like psychosis and bipolar mood disorders face problems not only on account of their illness. A host of psychosocial determinants influence the outcome and ability to cope with mental disorders. Women with severe mental disorders are particularly prone for sexual and other forms of violence,[8]neglect and unaddressed medical co-morbidity. Thus, the approach to mental health issues among women needs to be broad-based and holistic.[9]

Social determinants are even more evident in causing and maintaining common mental disorders like depression and anxiety among women. Depression is at least twice as common in women when compared to men[10]. Poverty and deprivation are independently associated with the risk for common mental disorder in women and add to the sources of stress (e.g., multiple roles, unequal power relations with men) associated with womanhood[11]. The lifetime risk of anxiety disorders is 2 to 3 times higher in females as compared to males.[12] Among suicides that occurred in India in 2010, 56% were young women (between the ages of

[4]Census of India 2011
[5]World Health Organization. Women's Mental Health: An evidence-based review. WHO/MSD/MDP/00.1. http://apps.who.int/iris/bitstream/10665/66539/1/WHO_MSD_MDP_00.1.pdf
[6]World Health Organization Gender and women's mental health. Gender disparities and mental health: The Facts. http://www.who.int/mental_health/prevention/genderwomen/en/
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[8] Chandra PS, Deepthivarma S, Carey MP, Carey KB, Shalinianant MP. A Cry from the Darkness: Women with Severe Mental Illness in India Reveal Their Experiences with Sexual Coercion. Psychiatry. 2003 ; 66(4): 323–334.
[9] Chandra PS, Herrman H, Fisher J, Kastrup M, Niaz U, Rondon M, Okasha A. Contemporary topics in women's mental health. Global perspectives in a changing society. World Psychiatric Association. 2009. Wiley-Blackwell. ISBN 978-0-470-75411-5.
[10]World Health Organization Gender and women's mental health. Gender disparities and mental health: The Facts. Ibid.
[11]Patel et al 2006
[12]Pigott TA. Anxiety disorders in women. Psychiatr Clin N Am. 2003; 26:621-672.

15 and 29 years).[13]Suicide has replaced maternal causes as the leading cause of death in India among women between the ages of 15 and 49 years[14].

Box 1. Women and Mental Health: Facts[15,16]

- Depression, anxiety and somatic complaints are more prevalent in women and need an active public health response.
- Depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common among women as compared to men, across most societies and social contexts.
- The disability associated with mental illness falls most heavily on women compared to men.
- Lifetime prevalence rates of violence against women range from 16% to 50%. Some studies report even higher prevalence.
- One in 3 women between 15 to 49 years has experienced physical violence and 1 in 10 has experienced sexual violence. Nearly 2 out of 5 married women have experienced physical or sexual violence from their husband.
- At least one in five women suffers rape or attempted rape in their lifetime.
- Suicide has replaced maternal causes as the leading cause of death in India among women between the ages of 15-49 years.

Severe Mental Disorders

The most common severe mental disorders (SMDs) include psychoses, particularly schizophrenia and mood disorders.

Schizophrenia is one of most serious mental disorders that affect both men and women. Around 1 in 100 people develop this disorder during their life time. Although women have a later age of onset of schizophrenia as compared to men and are generally reported to have a more favourable outcome, social consequences such as stigma, and abandonment by husband, separation, homelessness, vulnerability to sexual abuse[17], and exposure to HIV contribute to the difficulties in the rehabilitation of women treated for schizophrenia[18]. The prevalence rates for sexual and physical abuse of women with severe mental illnesses are twice that observed in the general population for women.

[13] Patel V, Ramasundarahettige C, Vijayakumar L, Thakur JS, Gajalakshmi V, Gururaj G, et al. Suicide mortality in India: a nationally representative survey. Lancet 2012;379:2343-51.
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[17] Chandra PS, Deepthivarma S, Carey MP, Carey KB, Shalinianant MP. A Cry from the Darkness: Women with Severe Mental Illness in India Reveal Their Experiences with Sexual Coercion. Psychiatry. 2003; 66(4): 323–334.
[18]Malhotra S and Shah R. ibid.

Human rights violations are extremely common among women with mental illness and illness and poverty further worsens such violations.[19,20,21]

A qualitative study of 76 women with schizophrenia[22]who were separated or divorced showed that 40 (53%) had been rejected/abandoned by their spouses without going through any formal divorce/separation. Only 16 women had been legally divorced, 5 had their marriages annulled by local rural governing bodies (Panchayath), 7 had their cases pending in court. Three women had been granted *Talaq* by the Muslim Court. Many of the husbands (44%) had remarried after separation from the ill women. The responses of the women included denial, shock, deep depression and suicidal thought and attempts. Hostility and criticism from parents and siblings who openly ridiculed their lack of usefulness to the family further reinforced their sense of being a burden to their families. This study brought into focus some issues that confront women with chronic mental illness in developing countries. The issues include: a) a lack of awareness of the illness and its disabilities, resulting in a widespread belief that marriage is panacea for all ills leading to non-disclosure of illness before marriage; b) Absence of legal protection including maintenance for such women; c) The burden of care falling on the parents who are aged and often financially strained; d) Lack of welfare programmes to offer physical, financial security to these women. The authors highlight the need for national policies and programme to take care of such women whose families are unable to care them and provide them suitable shelter to prevent these women land on the streets and become prey to sexual abuse and other high risk activities.

Unipolar depression is twice as common among women compared to men. Explanation for the increased occurrence among women include biological factors (hormonal factors related to the reproductive cycle), as well as psycho-social factors such as marital discord, family violence, adverse experiences in childhood, depression and anxiety in childhood and adolescence, physical illness, life events such as child birth and maternal roles, repeated pregnancies, miscarriages, abortions, menopause, lack of social support, and decreased coping skills.

Substance Abuse

Women who abuse substances (alcohol or drugs) are doubly stigmatised, both on account of their use of substances and on account of failure to comply with gender expectations. There are only a few Indian studies that have examined the pattern of use, clinical conditions and psychosocial issues among women with substance use disorders. A Rapid Assessment Study in 2008[23] of 1865 women from across India who were currently using substances found that alcohol and tobacco were the most commonly abused substances, followed by heroin, dextropropoxyphene and benzodiazepines. Various psychosocial factors such as childhood

[19] Math et al 2000
[20]Vijayalakshmi et al 2013
[21]Vijayalakshmi et al 2014

[22]Thara R, Kamath S, Kumar S. Women with schizophrenia and broken marriages--doubly disadvantaged? Part I: patient perspective. Int J Soc Psychiatry. 2003 Sep;49(3):225-32.

[23]Murthy P. Women and Drug Use in India. Substance, women and high risk assessment study. https://www.unodc.org/documents/southasia/reports/UNODC_Book_Women_and_Drug_Use_in_India_2008.pdf.

difficulties, peers/partner(s) influence, physical and emotional distress, role transition lifestyle changes, financial hardships and domestic violence contributed to substance abuse among these women. Alcohol and drug use was often associated with high risk sexual behaviours and a greater vulnerability to HIV infection. Women and girls who abuse alcohol and drugs have higher rates of HIV and AIDS, and those who inject drugs are even more at risk. Women who drink alcohol are more likely to be infected with HIV than those who do not drink, are at higher risk for engaging in unprotected sex, sex in exchange of money, experience more violence and have higher rates of unwanted pregnancies[24,25,26]. Comprehensive services to assist women with substance abuse are limited despite increasing rates of substance abuse in India. Existing treatment centres are not designed to address gender-sensitive needs. Moreover, barriers and stigma attached to women who abuse alcohol or drugs, negative attitudes of health providers limit access to timely treatment.

Women in custodial care

Concerns for persons with mental illness was first brought into recent public consciousness through public interest litigations (PILs) involving women. Upendra Baxi, who writes about Social Action Litigation (SAL) traces primary initiatives focused on women to newspaper articles highlighting these issues. In 1980, two professors of law wrote a letter to the editor of the Indian Express describing the barbaric conditions of detention in the Agra Protective Home for Women, the basis for a Writ Petition under Article 21[27]. This was followed by a similar petition for the Delhi Women's Home, by a third year law student in Delhi Law School and a social worker[28]. The Upendra Baxi Vs State of UP and Ors still continues to provide dividends in mental health care reform in the country.

Mental health care for women in custody

The National Commission for Women in its document on Custodial Justice for Women (1993) highlights the need to plan better welfare amenities in jails for women. Its review of the facilities in different prisons pointed to a lack of basic facilities in *some* jails at that time: lack of good sanitation (e.g., Meghalaya) overcrowding (e.g., Assam, New Delhi), lack of medical/recreational facilities (e.g., Bihar). Incarceration leads to a severe amount of psychological distress. A study[29] commissioned by the National Commission for Women

[24] Lightfoot E, Maree M, Ananias J. Exploring the relationship between HIV and alcohol use in a remote Namibian mining community. African J AIDS Research 2009; 8 (3):321-327.
[25]Murthy P Ibid.
[26] Weiser S D, Leiter K, Heisler M et al. A population-based study on alcohol and high risk sexual behaviours in Botswana. Plos Medicine 2006; 3 (10) e:392.
[27] Dr. Upendra Baxi v. State of Uttar Pradesh, 3 S.C.A.L.E. 1136 (1981)
[28]Uhinnamma Sivdas v. State (Delhi Administration), W.P. 2526 of 1982; initiated by Ms. Nandita Haksar, who later also assisted the Court by surveying the conditions in the Home as a Member of the Committee headed by the District Judge, Delhi.
[29]Murthy P, Chandra P, Bharath S, Sudha SJ, Murthy RS. Manual of Mental Health Care for women in custody. National Institute of Mental Health and Neuro Sciences and National Commission for Women 1998.

(NCW) and carried out by the National Institute of Mental Health and Neuro Sciences (NIMHANS) in 1998 showed high levels of psychological distress among prisoners. Feelings of unhappiness, worry, worthlessness, poor sleep and appetite, headache, tiredness, inability to work, anxiety and thoughts of ending life were problems reported by 44-73% of under trial women prisoners in the Bangalore Central Jail.

Reasons for such psychological distress included being brought out of their house for the very first time into a strange environment, being illiterate and not being aware of legal procedures, concerns for their children and families, lack of financial help, worries about stigma and rejection by their families.

Mental health and substance use problems in prison

NIMHANS, in collaboration with the Karnataka Legal Services Authority carried out an assessment of mental health and substance use problems[30] in the Parappana Agrahara in Bangalore in 2011. This study included in-depth assessment of 5200 prisoners, including 210 women prisoners.

Box 2. Level of satisfaction with living situation and care among Women Prisoners (Bangalore Prison Study 2011)

Living and toilet area	80%
Quality of food	51%
Staff attitude	80%
Ease of accessing medical services in prison	80%
Access to rehabilitation	20%
Being made aware of legal charge	70%
Lawyer made available	80%

In general, women were significantly more likely to be satisfied with the living conditions and facilities, more accepting of the slow paces at which their cases progressed as compared to men. Quality of food and access to rehabilitation were the only areas of dissatisfaction.

Of the women prisoners, 197 were interviewed in the study. Nearly half (49.7%) was illiterate, and more than half (53%) from rural areas. A majority was married (81.2%). One in four was either underweight (25.3%) or overweight (26.3%).

About one-third (32.1%) of the women had a diagnosable mental disorder or substance use problem. Lifetime tobacco use, mainly chewing, was reported by 17.9%. The most common current psychiatric diagnosis was major depressive episode (16.7%). Random urine screening was carried out in 60 women to detect drugs of abuse. Thirty percent tested positive for one or other drug (Benzodiazepines 21.7%, cocaine 5% and opioids and amphetamines 3.3%). The women were asked about their satisfaction with the living facilities in prison. About one in four women reported being dissatisfied with the living and toilet area. As compared to men, however, women prisoners were significantly more likely to be satisfied with the cleanliness, living, sleeping and toilet areas (their living spaces were far less crowded than the men prisoner's barracks). A significant number (49%) was not satisfied with the quality of the food. One in five felt the staff did not treat them with dignity and respect. About 20% of the women felt medical services in the prison were difficult to access. However, a substantial

[30] Badamath S, Murthy P, Parthasarathy R, Kumar NC, Madhusudan S. Mental health and substance use problems in prisons: Local lessons for national action. National Institute of Mental Health and Neuro Sciences, Karnataka Legal Services Authority, Department of Prisons, Govt of Karnataka 2011. NIMHANS publication No 78, ISBN No81-86430-00-8.

number (45%) reported that their health care needs were better met in the prison rather than in the community. Women prisoners were less satisfied compared to men with regard to access to sports and entertainment. A majority (89%) reported not having been exposed to any form of rehabilitation or occupational therapy. Nearly one in three women was not even aware of the legal charges against her. Twenty percent had no lawyer. While nearly half was dissatisfied with the pace at which their case was proceeding in court, and a majority (80%) felt that there were no escorts to take them to the court), in general, women seemed more accepting of the slow pace at which their cases progressed compared to the men.

Institutional care of persons with mental illness

Outside of the family, residential care for women with mental illness has almost entirely been in institutions. Mental health institutions have constantly been under the radar for decades. The fact that such institutions have served as the most common refuge for persons with severe mental illness has been eclipsed by the abysmal living conditions and human rights violations that have occurred in these institutions. A report by the National Human Rights Commission of conditions in the mental hospitals in 1998[31] highlighted the unfavourable conditions in mental hospitals throughout the country. A slew of reforms occurred in these institutions following the Erwadi tragedy[32] and the interventions of the Supreme Court of India. A decade later, several positive changes could be recorded in many of these hospitals, both in terms of infrastructure and living conditions.

Box 3. Areas of significant change within the mental health care institutions between 1998-2008[33]

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 facilities in many hospitals
Recreation and rehabilitation	Lack of post graduate training
Greater collaboration with NGOs	
Regular community level activities	
Improved budgetary allocations	

However, inadequacy of human resources, lack of psychosocial interventions, the presence of closed wards and lack of post-graduate training were highlighted as areas of poor progress. It was emphasized that hospitals that were regularly monitored by the NHRC showed the greatest progress.[34]

[31] National Human Rights Commission. Quality Assurance in Mental Health. Channabasavanna SM, Isaac M, Chandrashekar CR et al. NIMHANS and National Human Rights Commission 1999.
[32]Murthy RS. Lessons from the Erwadi tragedy for mental health care in India. Indian Journal of Psychiatry, 2001,43 (4), 362-377
[33] National Human Rights Commission. Mental Health Care and Human Rights. Nagaraja D, Murthy P (eds). National Human Rights Commission 2008.
[34] National Human Rights Commission. Care and treatment in mental health institutions. Some glimpses in the recent period. National Human Rights Commission 2012.

General directions for mental health care in the country

Current mental health policy which advocates a public health approach focuses on the re-strategisation of the community mental health programme[35]. The National Mental Health Policy formulated by the Ministry of Health and Family Welfare, Govt of India, covers all pertinent issues related to mental health including amending/ replacing laws related to mental illnesses, rights based approaches in providing wide-ranging services for patients, families or caregivers, creating assisted living services and removing barriers to enable full participation of persons with mental illnesses. While doing so, it recognizes women, children, and persons living in custodial institutions as vulnerable populations.

Restrategised NMHP

Although India started the National Mental Health Programme (NMHP) way back in 1982, till date, only a fraction of the districts have a functional NMHP. There are several operational difficulties that still pose barriers to the successful implementation of the NMHP.

Mental illness and disability

United Nations Convention on the Rights of Persons with Disabilities, 2006[36]**,** calls for a radical change from 'Charity' based approach to 'Rights' based approach for persons with disability. India, having ratified this convention is in the process of amending its legislations related to mental illness and disabilities, including the Persons with Disability Act (PWDA), 1995 and Mental Health Act, 1987. Under article 6, the CRPD obligates states parties to take due cognizance of the multiple discrimination that women and girls with disabilities endure and to take the required measures to ensure the "full development, advancement and empowerment of women," for the purpose of guaranteeing them the exercise and enjoyment of all human rights and fundamental freedoms. The convention additionally mandates availability of health services that are gender-sensitive for persons with disabilities.

Existing laws on disability and mental health

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 provides for disability certification and pension, for prevention and early detection of disabilities, education, reservation in employment, framing of schemes towards housing, setting up businesses, etc. The Rights of Persons with Disabilities Bill (RPD Bill) which is due to replace the PWDA, 1995, seeks alignment with the UNCRPD 2006.

The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 is another legislation which has a provision for appointing guardians for persons with disabilities.

[35]Mental Health Policy Group Recommendations. 2014. Ministry of Health and Family Welfare, Govt. of India. http://www.mohfw.nic.in/index1.php?lang=1&level=2&sublinkid=4723&lid=2964

[36]United Nations. Convention on the Rights of Persons with Disabilities. 2006. http://www.un.org/disabilities/convention/conventionfull.shtml

The relatively older Mental Health Act 1987 mainly focused on regulation of admission and treatment of patients with psychiatric illness. Nearly three decades later, some states have still not formulated the mental health rules under the Act. Meanwhile, to synchronise provisions within a rights based framework, a new Mental Health Care Bill has been formulated and is awaiting parliamentary clearance.

In addition to these, many other Acts have relevance to mental health including the Narcotic Drugs and Psychotropic Substances Act, 1985; Protection of Children from Sexual Offences Act 2012, as well as several civil laws.

Support for disability

Various support schemes/benefits available to persons with mental illnesses include disability certification and monthly disability pension, other entitlements (such as travel concessions, income tax exemptions, selected reservations in government jobs etc). Housing schemes both for individuals and group stay are available for those with intellectual disabilities. These are under the 'Samarth' and the 'Gharaunda' schemes respectively under the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act (1999). There are a few health insurance schemes namely the 'Niramaya' scheme (under the National Trust Act, 1999) and the 'Swavalamban' insurance scheme (New India Assurance Company Limited, wholly owned by the Government of India). Conspicuously, specific benefits for women with mental illnesses are absent.

Need for comprehensive services to address women's mental health needs

A national seminar was conducted by the National Commission of Women (NCW)[37], on the eve of International Women's Day in 2007, to discuss and generate ideas to handle the complex issue of women with mental illness, in particular stigma, discrimination and homelessness. President Abdul Kalam who inaugurated the seminar emphasized the need for the development of shelters for women with mental illness who had been abandoned by their families and the need for co-ordination between the Ministries of Health and Family Welfare, Social Justice and Empowerment and Women and Child Welfare in this regard. He suggested that the NCW create a website for women with mental illness who were destitute and engage potential agencies which could be involved in their rehabilitation. He emphasized the importance of rehabilitation to prevent homelessness and charged the NCW and the State Commissions for Women (SCW) to work with the NGOs and corporates, to have such schemes established. He also stressed the need for awareness among the family members and early detection of illness.

Three main working groups focused on the quality of care in institutions, de-institutionalization and de-custodialization, laws related to mental health and issues pertaining to the homeless mentally ill.

[37]National Commission for Women. Report on the national seminar on mentally ill women- is destitution the only answer? http://ncw.nic.in/PDFFiles/Mental_health_is_destitution_the_only_answer.pdf.

Table I. Recommendations of working groups at the NCW National Seminar 2007

	Problem areas identified	Recommendations
Quality of Care in Institutions, De-institutionalisation & De-Custodialisation	(i) Inadequate capacity (ii) Inadequate Staffing (iii) Poor quality of services (iv) Inadequate half –way homes; no provision for essential care facilities (v) No communication between different bodies (vi) Absence of monitoring committees (vii) Confusing dual licensing policies for treatment/rehabilitation centre	(i)NHRC report should be looked into. The suggestions made in the report, extent of implementation, persisting gaps etc. should be identified and reasons for deviation identified, before taking corrective measures (ii) There should be active networking between all sectors. A unique "link system" should evolve to ensure that ensures continuity of care to the patients (iii) Smooth transition from one stage – only medical assistance inadequate Need for government assistance through schemes, NGO rehabilitation, family care and support (iv) Continuous involvement of family – key to deinstitutionalization (v) Encouragement of the private sector in rehabilitation (vi) State Commissions to be more active (vii) An independent monitoring authority (Government, Rehabilitation Council, NGO, NCW)
Laws related to Mental Health	(i) Mental Health Act 1987 concerned with treatment and little else (ii) Evidence of being admitted destroys the woman's civil rights (iii) Many women with mental illness kept in beggar's homes. Subject to various kinds of abuse	(i)Charter of Human Rights of women with mental illness (Respect for dignity, voluntary access to local care and support, right to womanhood, right to vocational guidance and recreation, right against denial of civil rights, psychosocial support, sustainable livelihood, community rehabilitation (ii)Law must provide a link between mental hospitals and other institutions (iii)Special homes for women with mental illness must be established
Issues pertaining to homeless mentally ill	(i) Lack of public sensitisation and community initiatives	(i)Aggressive media campaigns to highlight the issue (ii)Core group from NCW to moderate the media campaign and raise need to preserve the dignity of women who are mentally ill (iii)Increase in the number of night shelters with 25% reserved for women with mental illness (iv)Vocational training for this group (v)Reservation in employment (vi)Railway concessions and other entitlements

Although these recommendations were made nearly a decade ago, not much has changed yet in terms of the lot of women with mental illness.

A decade later

As of now, outside of the beds within the psychiatric institutes and the general hospital psychiatric units, there are absolutely no alternatives in the form of organized community care. There are some scattered initiatives in the form of well-established and resourced rehabilitation services (NIMHANS, Bangalore), mobile mental health services (IHBAS, New Delhi), some rehabilitation facilities in the private sector and a few help lines for women. A few states like Karnataka and Kerala have initiated rehabilitation schemes, namely the Asha Kirana and Asha Bhavans. In a few states like Karnataka, attempts are being made to start *Manasakendras*, short term stay-facilities for persons with mental disorders and the *Manasadharas*-day-care centres at all district headquarters. Initiatives for the homeless mentally ill have been taken up by NGOs like The Banyan in Chennai, The Karuna Trust in Mysore, Karnataka, Anjali, Paripoornatha, Ishwar Sankalp in Kolkata and a few others.

There are destitute/protection homes throughout the country (which also house persons with mental illness), many of which are overcrowded and improperly managed by the inadequate staff. Hardly any have staff with mental health training, let alone gender-sensitive training.

Needs of women with mental illness

Women with mental illness are often deprived of very basic needs like food and shelter, let alone satisfaction of their emotional, belongingness and participatory needs. Few social welfare programmes reach such women[38]. The needs of homeless mentally ill women are complex and need to address stay, financial support, education, employment and rehabilitation.

Caring for women with mental illness

As in many Asian countries, a large part of the care of the mentally ill occurs through families in India. This often involves lifelong care and in the absence of support services in the community, means tremendous burden on the family members.

Neither the central nor the state governments run any medium or long stay facilities for persons with mental illnesses. The only places one may find women with mental disorders or intellectual disabilities who are not with their families is in the shelter homes (beggars homes/homes for destitute women/relief and rehabilitation centres) or on the street (homeless mentally ill).Thus, alternatives to psychiatric institutional care are still hardly existent.

Terminology in the report

In the following report, the phrases mental hospital, mental health care institution and psychiatric institution are used interchangeably.

The term ‘inmates’ has been avoided because of its custodial implications.

Human resources has replaced ‘manpower’.

[38]Poreddi V, Ramachandra, Thimmaiah R, Math SB. Human rights violations among economically disadvantaged women with mental illness: An Indian perspective. Indian J Psychiatry 2015;57:174-80

2. BACKGROUND TO THE STUDY

Concerns regarding the condition of care in the psychiatric institutions have been voiced for decades.

The National Human Rights Commission (NHRC) for more than two decades has been focusing on the inadequacy of institutional care for persons with mental illness in the country. Two reports of the NHRC mentioned earlier (NHRC 1999 and NHRC 2008) have highlighted the problems in mental hospitals with regard to infrastructure, outpatient and inpatient facilities, physical and mental health care, diet, activities including recreation and rehabilitation, development of specialized services, issues of overcrowding, problems of long-stay patients as well as staffing. The NHRC continues to be involved, along with the oversight from the Supreme Court, with improving the overall mental health services in the country, both in institutional and community-based settings.

However, the mandate being so enormous, there has not been any specific focus on gender-related aspects of mental illness and mental health care, particularly in institutional settings.

Human Rights Watch Report, December 2014[39]

The Human Rights Watch in December 2014 published a report titled 'Treated Worse than Animals'. The report focused on abuse against women and girls with 'psychosocial or intellectual disabilities' in institutions in India. The report was based on visits to 24 mental hospitals and state residential care facilities in Delhi, Mumbai, Pune, Kolkata, Bengaluru and Mysore between December 2012 and November 2014 and interviews with 52 women and girls with psychosocial or intellectual disabilities, their families, caregivers, mental health professionals, service providers, officials from the government and the police force. The report mentions that there has been 'forced institutionalisation' of all the women interviewed. It mentions that many patients face a range of violations and abuse, including the incarceration itself, unsanitary and unhygienic conditions, overcrowding and total lack of rehabilitation facilities.

Box 4. Violation of human rights

Although the Human Rights Watch 2014 report highlights instances of abuse and the gross inadequacies in the institutional care of women with mental disability, it must be remembered that violation of the rights of women with mental disorders can occur in any setting- institution, family and community.

The report attributes deceit on the part of the family by 'dumping' such women into institutions, treatment without consent, etc.

About 'forced treatment and denial of adequate and appropriate healthcare', the report says that patients are coerced to comply with medication; they are force-fed food and drinks, use of electroconvulsive therapy as a threat to coerce people to take medications. The report also

[39]Human Rights Watch. "Treated worse than animals". Abuses against women and girls with psychosocial or intellectual disabilities in institutions in India. 2014.

mentions that patients had faced physical, sexual and verbal abuse at the hands of institutional authorities (and also family members). According to the report, out of 128 cases of 'institutional abuse' documentation, nobody filed a First Information Report (FIR). Most of the interviewed women were not even aware of mechanisms to seek redressal.

It must be remembered at this point that human rights violations can occur in any setting – institutional, family as well as community. Tales of apathy, neglect and indifference to women's needs and basic rights are common.[40]

Nevertheless, with the stark findings highlighted in the Human Rights Watch report, the focus thus shifts back, once again, to institutional care of mental illness in the country.

The Human Rights Watch Report notes that lack of adequate monitoring of state run mental hospitals and residential care institutions for women is a key issue. It advocates: (a) monitoring of the overall 'mental health care' of the country by both state agencies as well as independent bodies such as National Human Rights Commission. (b) urgent amendments of the laws so that full compliance to the United Nations Conventions on Rights of Persons with Disabilities (UNCRPD), 2006 (c) international donations to fund programmes and services related to mental health in India. (d) guidelines for hygiene, sanitation and other basic living arrangements inside these institutions (e) prohibition of involuntary electroconvulsive therapy (ECT) (f) timely and regular meetings of the central and state mental health authorities (g) consideration of views of the disabled persons' organizations and advocates representing users before implementing the pending bills (h) recognition of the legal capacities of persons with disabilities on an equal footing to those of others.

Similar recommendations have been noted by several agencies, including the NHRC and the NCW, which call for governmental action, inter-sectoral co-ordination and NGO collaboration.

It is now necessary to determine whether the anecdotal findings mentioned in the Human Rights Watch report are generalizable across institutions. It is also an opportunity to turn the gaze within psychiatric institutions towards women who have been admitted there, to examine the circumstances of their admission, their care in the hospital and most importantly, their discharge and post-admission care and well-being.

Origin of the study

The National Commission for Women is mandated to safeguard the interest of women in the country. Under Section 10 (1) g, *the NCW is mandated to inspect or call to be inspected a jail, remand home, women's institution or other place of custody were women are kept as prisoners or otherwise and take up with the concerned authorities for remedial action if found necessary*.

[40]Kanchan Kumari. Women and children: mental health dimensions. In Mental Health and Human Rights. Nagaraja D and Murthy P (eds). National Human Rights Commission 2008.

The Commission has in the past initiated a study addressing mental health of women in prison (NCW 1995). The focus of the present initiative was to study the situation and needs of women admitted to psychiatric institutions. The National Institute of Mental Health and Neurosciences (NIMHANS), now an Institute of National Importance, is a multidisciplinary institute for patient care and academic pursuit in the areas of Mental Health and Neuro Sciences. NIMHANS was approached by the National Commission for Women in July 2015, with a request to study the issue of 'women patients getting incarcerated inside mental institutions of India for prolonged periods of time' and formulate a report along with recommendations to improve the scenario.

A multi-disciplinary team of faculty members was formed in order to carry out this work. Dr. Pratima Murthy, Professor of Psychiatry was the team leader. Other members of the team were: Dr. Prabha S Chandra, Professor of Psychiatry; Dr. Srikala Bharath, Professor of Psychiatry; Dr. Suresh Bada Math, Additional Professor of Psychiatry; Dr. Poornima Bhola, Associate Professor of Psychiatry, Dr. Sailaxmi Gandhi, Associate Professor of Nursing; Dr. C Naveen Kumar, Associate Professor of Psychiatry and Dr. M. N. Vranda, Assistant Professor of Psychiatric Social Work. Dr. T. S. Jaisoorya, Associate Professor of Psychiatry and Dr. Ajit Dahale, Assistant Professor of Psychiatry also participated in this endeavour.

The planning, execution and report writing was carried out by NIMHANS, in discussion with the Commission. The Member Secretary, Ms. Preeti Madan and the Senior Research Officer, Ms. Richa Ojha, co-ordinated the study from the NCW. The funding for this study was provided by the NCW. The draft report was presented to the Commission and the observations of the Members were included in the final report.

3. OBJECTIVES OF THE STUDY

To explore the clinical, social, cultural, familial, economic and legal factors likely to affect the lives of women with mental illnesses admitted to mental hospitals in India.

The specific objectives were to:

1. Assess the level of care of women admitted to government psychiatric institutions in terms of living spaces, basic care including health care, access to contemporary treatment, access to recreation and rehabilitation, legal, and economic assistance, through hospital based reports and physical visits to select facilities.

Specific areas of enquiry included:

2. Personal care (hygiene including menstrual care, toilet facilities, clothing)
3. Violence and use of restraints; processes to deal with violent behaviour; responses to deviant behaviours
4. Adherence to appropriate consenting mechanisms
5. Participation of the women in treatment procedures (understanding of procedures, consent, procedures in cases of inability to consent
6. Medical co-morbidities and access to appropriate medical care
7. Attention to women with special needs (physically disabled, women with intellectual deficiency, pregnant women, women with infants, elderly, destitute)
8. Presence/absence of complaints/redressal mechanisms
9. Consent for participation in research, documentaries
10. Gender sensitivity in terms of care givers (women staff, women security)
11. Examine the circumstances of their admission (including earlier help seeking behaviours) through interviews with the women, interviews with health care providers and with carers where available.
12. Ascertain the involvement or lack of involvement of family caregivers during and after treatment and to examine reasons for lack of involvement, if any.
13. Use a case-study approach for in-depth studies of women who have been admitted with malafide intent to the mental hospital, or against their wishes if they did not require inpatient admission.
14. Prepare a set of recommendations regarding the care, admission and discharge of women to psychiatric institutions, as well as recommendations to existing laws and policies or programmes related to the mental health of women in order to reduce stigma, facilitate their recovery and re-integration as well as protect their rights in an equitable manner.
15. Protect the rights of women with mental illness both within the institution and in the community, including free legal aid, access to disability benefits, travel, safe living spaces, work opportunities, etc.

4. METHODOLOGY

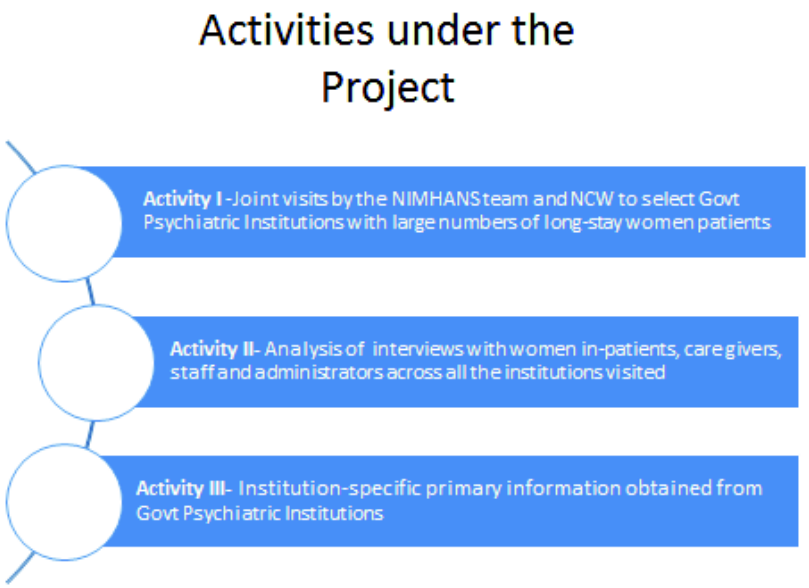
The work was conducted in the following three activities:

1. Activity 1: Ten institutions with a large number of long-stay women patients were pre-selected for a physical visit by the NIMHANS team (along with a designated Member of the Commission). The team conducted an on-site inspection of the hospitals and facilities, interacted with the patients, their care-givers, staff and administrators.
2. Activity 2: The research officers interviewed about25 women with mental illnesses in such facilities. Apart from the patients, the health care providers and caregivers (wherever available) were also interviewed through a semi-structured proforma (Annexure-1: Questionnaire for patients; Annexure-2: Questionnaire for care givers; Annexure-3: Questionnaire for service providers/administrators).

3. Activity 3: A questionnaire was designed and sent to all government mental health care institutions in the country. This questionnaire pertained to basic enumeration details of women with mental disorders evaluated and treated at these institutions, with a focus on the previous year. NCW sent this questionnaire to the respective institutions soliciting their responses.

The information obtained is presented as follows:

Section 1- Individual hospital visits- introduction, concerns of service-providers / administrators; interviews with patients; on-site visit observations; summary and specific recommendations.
Section 2 - Consolidated summary of the interviews with patient respondents across all the ten institutions visited; consolidated summary of the interviews with care providers across all the institutions visited; consolidated summary of the interviews with service providers/administrators across all the institutions visited
Section 3 - Summary of the self-reported information from the government mental health institutions pertaining to women patients.



Timelines and activities

The proposal was approved by the NCW in August 2015. Following this, the research staff was recruited through advertisement and personal interview. Simultaneously, the draft proforma for the interviews were prepared and finalised with mutual discussion among the team members and in consultation with the NCW. The research staff was provided training on carrying out the interviews through on-site training at NIMHANS where patients, health providers and care-givers were interviewed following informed consent. Relevant refinements were carried out in the interview formats.

By December 2015, responses were received from 43 institutes to whom the NCW had sent the institution proforma.

Selection of institutions for on-site visits

The NCW sought information from the Ministry of Health and Family Welfare, Govt of India, with regard to the Inspection Committee Report prepared by the Ministry following visits to the various mental health institutions in the country during mid-2015. Data from this report pertaining to long-stay patients (specifically women) was extricated. From each of the regions in the country (north, south, east, west, central), hospitals which had the highest number of women long-stay patients were chosen for the site visits.

On-site visits

The on-site visits to the mental health institutions occurred between December 2015 and February 2016.

Discussion with the Commission

The preliminary findings of the on-site visits were presented to the NCW on 1st March 2016. Suggestions and the personal observations of the Members were sought for incorporation into the final report.

Ethical Issues:

The NCW is mandated to carry out periodic surveys in institutions, and this study was carried out under that mandate. However, strict confidentiality was maintained during the interviews and the interviews were conducted after ensuring privacy. Individual identities have not been revealed anywhere in the Report. In case of specific case-based action being required by the NCW, such information was made known to the NCW, with information to and consent from the woman to whom it pertains. The Institutional Ethics Committee of NIMHANS was informed of the study.

5. FINDINGS OF THE STUDY

The findings are presented in 3 sections:

1. Observations of on-site visits (Section 1)
2. Interviews with women inpatients, care givers and service providers (Section 2)
3. Analysis of the questionnaires received from the psychiatric institutions (Section 3)

SECTION 1
NCW/NIMHANS ON-SITE VISITS TO PSYCHIATRIC INSTITUTIONS

OBSERVATIONS OF THE MULTIDISCIPLINARY TEAMS

INTRODUCTION

Section 1 pertains to the observations of the multidisciplinary teams that visited ten psychiatric institutions throughout the country.

Selection of hospitals for on-site visit

The NCW sought information regarding the long-stay women patients in different psychiatric institutions around the country from the information available in the Inspection Reports of the Ministry of Health and Family Welfare, Government of India. From each region of the country, hospitals which had the highest number of women long-stay patients were chosen for the on-site visits.

For each hospital, the report is arranged in 5 parts-

- Introductory comments about the institute
- Concerns of administrators and service providers
- Feedback through personal interviews with women inpatients (this includes an overall rating of satisfaction in each domain, as well as specific feedback. Where 20% or more patients express dissatisfaction, the areas of dissatisfaction are specifically mentioned).
- Observations of the visiting team
- Summary

Table Multi-disciplinary teams that carried out on-site visits

Sl. No	Name of Institution visited	NIMHANS Faculty	NCW Representative	Project Staff	Dates
1	Regional Mental Hospital, Yerwada, Pune	Dr. Ajit Dahale	Ms. Laldingliani Sailo	Dr. Harshita, Ms.Venkatlakshmi and Ms. Farha	09-12-2015 & 10-12-2015
2	Government Mental Health Centre, Kozhikode, Kerala	Dr. T S Jaisoorya	Ms. Rekha Sharma	Dr. Harshita, Ms. Farha and Ms.Venkatlakshmi	18-12-2015 & 19-12-2015
3	Thane Mental Hospital, Thane	Dr. Prabha S Chandra	Mr. Tripathi	Dr. Harshita, Ms. Venkatlakshmi and Ms. Farha	4-1-2016 5-1-2016
4	Institute of Psychiatry & Human Behaviour, Bambolim, Goa	Dr.Suresh Badamath	Ms. Preeti Madan	Dr. Harshita and Ms. Farha	6-1-2016 8-1-2016
5	Calcutta Pavlov Hospital, Kolkata	Dr. Poornima Bhola	Ms. Preeti Madan	Dr. Harshita and Ms. Farha	15-01-2016 to 16-01-2016
6	Mental Hospital, Berhampore, Murshidabad, West Bengal	Dr. Poornima Bhola	Ms. Sushma Sahu	Dr. Harshita and Ms. Farha	18-01-2016 to 19-01-2016
7	Ranchi Institute of Neuropsychiatry and Allied Science (RINPAS), Kanke, Ranchi, Jharkhand	Dr. Vrinda M N	Ms. Sushma Sahu	Dr. Harshita, Ms. Farhaand Ms. Venkatlakshmi	21-01-2016 22-01-2016
8	Institute of Mental Health & Hospital, Agra, Uttar Pradesh	Dr. Naveen Kumar		Dr. Harshita, Ms. Farha and Ms. Venkatlakshmi	25-01-2016 27-01-2016
9	Mental Hospital Bareilly, Uttar Pradesh	Dr. Naveen Kumar	Ms. Richa Ojha	Dr. Harshita, Ms.Farha and Ms. Venkatlakshmi	28-01-2016 29-01-2016
10	Institute of Mental Health (Govt. Mental Hospital), Amritsar PUNJAB	Dr. Sailaxmi Gandhi	Ms. Rekha Sharma	Dr. Harshita, Ms. Farhaand Ms.Venkatlakshmi	03-02-2016 to4-02-2016

The Institute of Mental Health Chennai also has a high number of long-stay patients. However, because of the aftermath of the flooding in December 2015, the scheduled visit to the hospital could not occur.

1. REGIONAL MENTAL HOSPITAL (RMH) YERWADA, PUNE, MAHARASHTRA

INTRODUCTION

The visit to RMH Pune was conducted on 9.12.2015 and 10.12.2015. The visit began with an introduction, explaining the purpose and need of the study to the hospital medical superintendent, senior psychiatrist and authorities of Department of Health (Deputy Director of Health Services, Pune) as well as Department of Women and Child Development (Divisional Deputy Commissioner, Pune). Their concerns regarding conditions of women patients in psychiatric institutions were discussed.

The Regional Mental Hospital (RMH) at Yerawada was established in 1907. It was initially located in Colaba and shifted to Yerawada, Pune, in 1915. Over the years, the bed strength increased from 700 to 1200, then 1700 and then to 2540.

The NHRC Report of 1999[41] which rated the different hospitals on a 4 point scale of 1 Very Poor to 4 Good) based on living conditions, food, clothing, maintenance and medical care, rated the RMH, Yerawada as poor. Recommendations for the hospital had included downsizing in a phased manner into functional and manageable units, simplification of admission procedures and encouragement of voluntary admissions, separate facility for children with mental health problems, appointment of clinical psychologists, setting up of occupational therapy and rehabilitation units, setting up of day-care and sheltered workshops with NGO involvements and continuous professional training for staff.

The NHRC Report of 2008[42] noted that new dormitories had been constructed for indoor patients, new internal roads had been laid, bathrooms, toilets and kitchens had been renovated, a separate children's ward had been established, rehabilitation units had been set up for males, diet had been improved. However, the issue of overcrowding had not been addressed and the post of psychologist was still vacant.

Concerns of Administrators and Service Providers

A major concern of the administrators and service providers is the issue of human resources.

Human resource shortage

One of the main reasons for difficulty in patient care is inadequate staff in the hospital at all levels and slow and erratic recruitment process for the same. Additionally, no permanent recruitment has been done by the state government for the last few years. The current medical superintendent has been given additional overall charge of the hospital. The financial powers allotted to the medical superintendent are not keeping in with the time and need of the hospital. It was also reported that no psychologist has been recruited for the past 15 years in

[41]National Human Rights Commission. Quality assurance in mental health. 1999. Ibid.
[42]National Human Rights Commission. Mental health and human rights, 2008, Ibid.

the hospital. The hospital does not have a single security guard, although there are more than 1600 patients and hundreds of hospital staff, which is a major anomaly.

Safety and security

Incidents of miscreants entering the hospital and robbing people and creating nuisance have occurred. Number of hospital attendants are also very less and their recruitment is apparently stuck in bureaucratic hurdles.

Lack of residential facilities

Another major issue is the lack of good post-discharge residential facilities for women who cannot be reintegrated with family. It was reported that a proposal for such facilities was given to state government a few years back but action is still pending.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table 1a: Basic Facilities

Description	Yes- N (%)	No- N (%)	Not answered*-N (%)
Is there adequate light during day time?	25 (100)	0	0
Is there adequate light during night time?	25 (100)	0	0
Is hot water given for bathing regularly?	24 (96)	1 (4)	0
Is safe drinking water provided?	20 (80)	5 (20)	0
Are bathroom and toilets adequate?	19 (76)	5 (20)	1 (4)
Are bathroom and toilets cleanly maintained?	22 (88)	2 (8)	1 (4)
Is there space for washing and drying clothes?	20 (80)	4 (16)	1 (4)
Is the ward cleaned regularly?	20 (80)	4 (16)	1 (4)
Is linen changed regularly?	22 (88)	2 (8)	1 (4)
Is there overcrowding in the ward?	17 (68)	7 (28)	1 (4)
Are patient allowed to go outside the ward regularly?	18 (72)	6 (24)	1 (4)
Is there adequate space for walking outside the ward?	22 (88)	1 (4)	2 (8)
Is there a locker facility provided?	2 (8)	23 (92)	0

*These patients were uncooperative and did not respond.

Overall rating of basic facilities: Overall, 88% rated the basic facilities as good or very good, 4% as poor and 8% as very poor. One in five said the drinking water was unsafe, that bathrooms and toilets were inadequate. Nearly a quarter said patients were not allowed to go out regularly. Most (92%) said there were no locker facilities.

Table 1b. Food

Description	Yes – N (%)	No –N (%)	Not answered*-N (%)
Is the food provided adequate?	22 (88)	3 (12)	0
Is there sufficient variety in the daily menu?	22 (88)	1 (4)	2 (8)
Is quality of food satisfactory?	21 (84)	2 (8)	2 (8)
Are you satisfied of frequency of food provided?	21 (84)	2 (8)	2 (8)
Are you served with special food served on special occasions?	22 (88)	1 (4)	2 (8)
Are you served non-vegetarian meals on request?	3 (12)	20 (80)	2 (8)
Are food serving staffs are polite?	20 (80)	3 (12)	2 (8)
Is there a separate dining area?	16 (64)	7 (28)	2 (8)
Are facilities provided in the dining area?	1 (4)	22 (88)	2 (8)
Are the utensils and dining room cleanly maintained?	20 (80)	3 (12)	2 (8)

*These patients were uncooperative and did not respond.

Overall rating of food and service: Overall, 4% rated the food and related services as very good, 68% as good and 28% as poor. Dissatisfaction was mainly in not being served non-vegetarian food and lack of dining facilities.

Table-1c: Personal Hygiene

Description	Yes – N (%)	No- N (%)	Not answered* –N (%)	Not applicable** - N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	19 (76)	4 (16)	2 (8)	0
Are sanitary napkins provided regularly?	15 (60)	1 (4)	2 (8)	7 (28)
Is information provided on proper disposal of sanitary napkins by nursing staff?	13 (52)	2 (8)	2 (8)	8 (32)
Are basic toiletry articles provided?	23 (92)	2 (8)	0	0
Are you permitted to wear own clothes?	5 (20)	13 (52)	2 (8)	5 (20)
Are you given a choice of clothes what to wear?	5 (20)	18 (72)	2 (8)	0
Are you provided inner garments?	23 (92)	2 (8)	0	0
Is winter wear provided for you?	23 (92)	0	2 (8)	0
Is footwear provided for you?	23 (92)	2 (8)	0	0
Are basic cosmetics provided for you?	22 (88)	1 (4)	2 (8)	0

*These patients were uncooperative and did not respond. **These patients had reached menopause. Some do not want to wear inner garments.

Overall rating of attention to personal hygiene and basic comforts: Overall, 84% rated attention to personal hygiene and basic comforts as good or very good. Sixteen percent rated these facilities as poor. Dissatisfaction was mainly in not being allowed to wear own clothes (52%) and lack of a choice of clothes (72%). A smaller number was dissatisfied with the privacy available.

Table 1d. Sleeping and Resting Facilities

Description	Yes – N(%)	No- N (%)	Not answered*-N(%)
Is the ward quiet at night?	23 (92)	2 (8)	0
Are you provided with separate cot, mattress, pillow and blanket?	22 (88)	1 (4)	2 (8)
Are fans provided when it is hot?	25 (100)	0	0
Are heaters provided?	0	23 (92)	2 (8)
Do you have facilities to sit and rest during the day?	12 (48)	11 (44)	2 (8)
Does the ward have bedbugs, cockroaches, or mosquitoes?	14 (56)	9 (36)	2 (8)
In case of serious physical and mental problems, is immediate help provided?	19 (76)	4 (16)	2 (8)

*These patients were uncooperative and did not respond.

Overall rating of sleeping and resting facilities: Overall, 80% rated these facilities as good and 20% as poor. Areas of dissatisfaction included heaters not being provided (92%), lack of facilities to sit and rest during the day (44%), presence of pests (36%) and lack of emergency help for physical and mental problems (16%).

Table 1e. Medication and treatment

Description	Yes (N%)	No (N%)	Not answered (%) *	Not applicable (%) **
Does the nursing staff help you in taking medications?	24 (96)	0	1 (4)	0
Have you been given explanation by treating team about medicines and side effects?	12 (48)	10 (40)	2 (8)	1 (4)
Is a female nurse/attendant present when you are physically examined by a male doctor?	22 (88)	1 (4)	2 (8)	0
In case of a medical problem, is immediate attention provided?	17 (68)	6 (24)	2 (8)	0

*These patients were uncooperative and did not respond. **One patient found it difficult to understand this question.

Overall rating of medication and treatment facilities: Overall, 84% rated this as good or very good and 16% as poor. Several patients (40%) reported not having been given any explanation about the medicines being given and their side-effects. Nearly a quarter was dissatisfied with the prompt emergency medical attention provided for both mental and physical problems.

Table 1f. Emotional Needs

Description	Yes- N (%)	No- N (%)	Not answered* - N (%)	Not applicable** - N (%)
Do the members of treating team address you properly?	25 (100)	0	0	0
Does the treating team spend enough time listening to you?	25 (100)	0	0	0
Does the treating team show adequate concern?	25 (100)	0	0	0
Are you permitted to have personal possessions?	12 (48)	9 (36)	4 (16)	0
Do you have access to a phone in ward?	24 (96)	0	0	1 (4)
Do you have permission to receive calls and letters?	10 (40)	12 (48)	0	3 (12)
Does the staff read your letters or listen to phone conversation?	9 (36)	11 (44)	5 (20)	0
Does the staff provide pen and paper for letter writing?	6 (24)	10 (40)	9 (36)	0

*These patients were uncooperative and did not respond. ** These patients were either destitute or orphaned.

Overall rating on emotional concerns: Overall, 80% reported satisfaction with attention to their emotional needs, but 20% rated this as poor. Common areas of dissatisfaction included not being allowed to send or receive letters (48%), not being able to keep their personal possessions (36%). About a third reported that the staff listened to their phone conversations/read their letters.

Table-1g: Coercion and related issues

Description		**Yes - (N %)**	**No - N (%)**	**Not answered -N (%)**	**Not applicable** *- N (%)**
Were you ever threatened by hospital staff?		2 (8)	23 (92)	0	0
Did the hospital staff use bad language that hurt you?		2 (8)	23 (92)	0	0
Were you ever beaten by any hospital personnel?		2 (8)	23 (92)	0	0
Did anyone from the treating team ever make sexual advances towards you?		1 (4)	24 (96)	0	0
Were you ever restrained physically?		2 (8)	23 (92)	0	0
Were you informed about the need for restraint?		0	2 (8)	0	23 (92)
Were you told about alternatives like chemical restrains/seclusion?		0	1 (4)	1 (4)	23 (92)
Was any staff present while you were being restrained?		2 (8)	0	0	23 (92)
Staff present during restraint	Male	0	0	0	23 (92)
	Female	2 (8)			
Were you left unattended more than 2 hrs?		0	2 (8)	0	23 (92)
Were restraints padded?		0	2 (8)	0	23 (92)
Did the staff check restraints frequently?		0	2 (8)	0	(92)

* These patients were uncooperative and did not respond. **These patients had not been restrained during their stay in the hospital.

Two patients each reported being threatened and beaten by the hospital staff, and one reported that sexual advances had been made. Most were not able to share experiences of restraint as they had not been in such a situation.

Table 1h. Social Needs (Level of satisfaction)

Description	Very poor –N (%)	Good –N (%)	Very good- N (%)	Not applicable**- (N%)
Permission to attend family functions	4 (16)	13 (52)	1 (4)	7 (28)
Group activities	1 (4)	1 (4)	18 (72)	5 (20)
Outdoor activities	2 (8)	20 (80)	2 (8)	1 (4)
Participation in sports/games/cultural activities during hospital stay	2 (8)	18 (72)	5 (20)	0
Provision of separate visiting room	2 (8)	15 (60)	1 (4)	7 (28)

**These patients were either destitute or orphaned. Some patients' addresses had not been traced; Due to their illnesses, some patients did not have insight, slept more and had a lack of interest in these activities.

A majority was satisfied with the group and indoor activities and provision of a separate visitor's room. However, a few reported lack of satisfaction with permissions to attend family functions.

Table 1i. Ethical, Spiritual and other needs

Description	Yes - N (%)	No- N (%)	Not answered*- N (%)	Not applicable- N (%)
Is there permission for religious/spiritual activities?	17 (68)	8 (32)	0	0
Are you treated with consideration, respect and care?	23 (92)	2 (8)	0	0
Were you treated against your wish?	2 (8)	23 (92)	0	0
Are you allowed to read newspaper and magazines?	19 (76)	2 (8)	1(4)	3 (12)[#]
Are you allowed to take health care decisions?	7 (28)	17 (68)	1(4)	0
Was your haircut done without consent?	10 (40)	15 (60)	0	0
Were you permitted to represent legal matter in court?	1 (4)	7 (28)	0	17 (68)^
Did you get information about patients' rights in hospital?	0	25 (100)	0	0
Was confidentiality maintained during hospitalization by treating team?	7 (28)	18 (72)	0	0
Did staffs ask bribes or gifts?	0	25 (100)	0	0
Have you felt any discrimination by treating team based on your religion?	1 (4)	24 (96)	0	0
Were your hobbies encouraged during the hospital stay?	17 (68)	5 (20)	3 (12)	0
Is informed consent taken for treatment?	9 (36)	16 (64)	0	0
Is informed consent taken for research?	0	0	0	25 (100)[@]
Is pre- test HIV/STI/OTHER test done?	1 (4)	24 (96)	0	0

* These patients were uncooperative and did not respond. [#] Illiterate; ^ These patients did not have any legal issues; [@] No research has been undertaken on these patients.

A majority said they were treated with consideration, respect and care. About a third felt there was no explicit permission for religious and spiritual activities. More than two-thirds felt they were not able to take their own health care decisions. More than two-thirds said that informed consent was not taken before treatment. Forty percent said that their hair had been cut without their consent. None had received information about patient rights. Nearly three-fourth said that confidentiality was not maintained by the treating team.

None had been asked for bribes. Most did not feel discriminated on the basis of their religion. More than two-thirds said their hobbies were encouraged by the staff. None had experience in participation in research and very few had experience of legal matters.

OBSERVATIONS OF THE VISITING TEAM

The visit to the female wards was conducted by the team along with the hospital authorities on the evening of the first day. The female section has a gate where female attendants keep a watch over the visitors. The female section has 7 different wards or sub-sections.

All the wards are closed wards and no open wards are available where women can stay with caregivers. Most admissions appeared to be involuntary (brought by reception order, non-governmental organizations and local residents). There is no provision of any rest home for family members of the patients. As on 30 November 2015, there were 673 female patients, of whom 106 were staying for more than 20 years. 313 were staying for less than a year. Female wards have only female nursing staff and attendants.

Access

Although the condition of the roads in the female section is very bad, yet the surrounding was fairly clean. The team visited some of the female wards. The first ward visited was for the

geriatric patients. The patients reported in general that the facilities were decent and had no complaints. There is adequate space for the patients to walk outside of the wards but the roads had many potholes and lighting is not enough to walk in the night time.

Building and beds

Some wards were poorly lit and musty, with inadequate space and number of beds. Hence many patients needed to sleep on floor mattresses. As per the staff, this happened as some of the buildings have become uninhabitable and patients from those buildings have been relocated. This has led to overcrowding of wards with more than 30 women staying in a single ward. Many of the buildings are 100 years old. The walls are damp and shabby; the air is moist inside the ward as it is very old. One new building has been made for women patients, but is not in use as it is far from the other wards and without a proper approach road. The patients also complain that the wards are overcrowded. Since there are an inadequate number of beds, two patients have to sleep on one bed. Separate mattresses and pillows are not provided for them.

Lighting, ventilation and water supply

The lighting facilities are also very poor in the wards as well within the campus, and many of the fans are not in working condition. Hot water is not provided because the water heater is not in a working condition. Water facilities for bathing and washing clothes are very much inadequate. Patients report that they have access to safe drinking water.

Toilets

The number of toilets is also less and some are outside the ward. Some patients were seen defecating and urinating outside in open. Though the wards are relatively clean, the cleanliness of the toilets has scope for improvement. The bathrooms are inadequate, slippery and not geriatric friendly (in the geriatric ward).

Pests

The team noticed lot of mosquitoes in the wards but patients denied any problem and denied the presence of any bed-bugs, cockroaches or other insects. However, some patients report that their sleep is disturbed by the insects and mosquitoes in the wards.

Food and dining facilities

Patients get adequate food but they say that the taste of food is bad. In particular, they have complaints regarding the quality of chapatti and vegetables. Patients say they do not get non-vegetarian food. The ones who provide the food are polite towards the patients. The dining facilities are poor. They do not have a dining hall throughout the campus. Patients sit outside the wards and have food on the floor, as there is no provision for tables and chairs. This space is full of house-flies. The patients have to wash the utensils themselves because of the inadequate staffing. The team was told that the hospital has to compulsorily buy grocery from the government supply and the quality of wheat is not good.

Personal appearance

Their dresses are clean and neat. However, they are not allowed to wear their own clothes. They are given uniforms. Some of these are torn and dirty. Some of the elderly are unable to wear these properly, because the dresses do not allow them to walk or sit comfortably.

Personal care and privacy

Patients do not have privacy while bathing, using the toilets, or while changing their clothes because the bathroom doors are partially broken. The staffs make them stand in a line and gives bath to a group 4-5 patients, because bathrooms are inadequate.

Sanitary napkins are provided, but the patients are not educated regarding the disposal of the napkins. Some patients try to wash them before disposing. They are provided toiletries, winter wear and slippers.

Patients have permission for religious/spiritual activities. There is a room which allows multi-faith worship. However, one of the patients reported that she could not perform her Namaaz because the prayer mat was not available and her clothes were unclean.

Treatment

Rounds by doctors/professionals happen very rarely because the staff is few. The nursing staffs provide medications generally without any explanation about their side-effects. Patients say that when they have any health problem like cold, stomach or headache etc., only the attendants would be with them. It was reported that there is only one psychiatrist or medical officer on duty at night for the whole hospital. From the discussion with medical superintendent and senior psychiatrists, it appears that the vacancies for psychiatrists have not been filled. Further, there are five psychiatrists who are working in the 'medical officer' (lower cadre than the post of psychiatrists), which the service providers term as ironical and unfortunate. Also the number of posts available for medical officers is 24 and for psychiatrists is only 12, which is inappropriate for a psychiatry hospital with such a huge capacity. The existing doctors, nursing staff and attendants have no training programmes to update their knowledge and skills. There are no post-graduate courses despite RMH Pune being such a big hospital with a large number of patients. Earlier attempts were made for post graduate courses but did not materialize due lack of post-graduate teachers and other inadequacies.

As per the nursing staff and psychiatric social workers, regular psycho-education and group counselling sessions are conducted for the patients and their family members when they visit. No patients reported any sort of physical abuse by the staff or by the other patients.

Rehabilitation

The hospital has an occupational therapy or rehabilitation section where patients are involved in different activities like painting, reading and making bags, diyas etc. The involvement of an NGO named Parivartan for the purpose of starting a rehabilitation ward with capacity of around 20 patients is noteworthy. Nursing staff conducts group activities like singing, exercises etc. for the patients in the wards itself.

There are four shelter homes [two government and two private] in the city for women who are symptomatically better and wish to be independent and have no family support. However, until now, only 3 women have been placed in these shelter homes.

Concerns about discharge

Most patients report that their worries are not about hospital facilities, but mainly relate to family members not taking them home or coming to meet them. This was particularly noted

in the case of women coming from well to do families, where multiple attempts at reintegration with the family failed because of the family's refusal to take the patient back home.

Many patients report that they want to go home and stay with family. One unfortunate part is that the majority of patients here are brought by reception orders and their addresses are not documented or cannot be traced. Many of them have been abandoned by their families. Some families who do not want to take the patients back have provided wrong addresses at the time of admission.

Many patients do not have families; they feel that this is their world and they are getting best facilities as they are here from 15 to 20 years and have not seen the outside world since their admission here.

Specific observations and suggestions of Ms. Laldingliani Sailo, Member, National Commission of Women

Serial No.	Subject / brief details	Observations / suggestions
1	Special needs of female patients— Total number of Out Patients registered during FY 2014-15—4210 males and 2037 females. [Total capacity of beds for admitted patients 1540 males and 1000 females. In 2014-15 there were 784 female admissions as inpatients.]	The number of female patients is fairly high [1/3rd in case of OPD]. The number of female inpatients is also similarly high. (i)Therefore, the facilities should take appropriate care of specific needs of women such as privacy of toilets, personal safety, provision of sanitary napkins, etc. (ii) The staff—both doctors and support staff should have an appropriate gender balance—this is a general recommendation for all mental hospitals. In the Regional Mental Hospital, Yerwada, the gender balance at all levels is good.
2	Long-stay patients—As many as 451 inpatients [1000 bed capacity] are long-stay or 'chronic cases' who have been inpatients for longer than 6 months, and out of this, 230 were there for more than 5 years. Some of the patients who the member NCW met had been in the hospital for decades and said that their families hardly ever came to see them. Examples— (i)A was admitted to RMH at the age of 50 when her mother died, had 4 brothers but they did not want her in their lives. (ii)B has 2 daughters—both married —living locally but could not take their mother with them. Her house was dilapidated. She had to stay in RMH after her husband's death. (iii) C was admitted to RMH repeatedly by her relatives who said that they have given her to RMH and that she had to stay there. She was happy to be in RMH.	The problem of long-stay female inpatients is a result of different reasons—from medical reasons such as severe schizophrenia to family reluctance to take them home. This family reluctance needs to be especially addressed. Other reasons for long stay are—patients come to RMH when their illness has progressed and hence the prognosis is poor, poverty, etc. (i)Social workers should visit the families of patients and persuade them to take the women patients home, when they are fit for discharge after effective treatment; and where discharge is not medically recommended, then the families should be persuaded to visit the patients regularly. (ii) Social volunteers should be involved in visiting patients regularly so that the patient has some sense of belonging.

3	Medical Staff etc. Psychiatrists —sanctioned 13. In position 5 [2 male & 3 female]. Medical officers with MBBS —sanctioned 24 / in position is 24 [11 male and 13 female] Clinical psychologist—2 sanctioned/ nil in position Trained psychiatric nurses— 32 sanctioned / 22 in position Hospital attendants / assistants — 562 sanctioned / 418 in position Vocational therapist— 12 sanctioned/ 6 in position The Medical Supt said that The State Govt had not been recruiting for last 3 years (ii) The posts which are filled by Maharashtra Public Service Commission, have not been advertised for a long time (iii) The salaries of contractual workers are very low, so candidates are not applying for contractual work in RMH.	With such a large shortage of psychiatrists, clinical psychologists, trained psychiatric nurses and hospital attendants, it is very difficult to cope with the patients especially because most of them need special care and treatment. The Pune hospital informed the Member, NCW that psychiatrists are difficult to get. This issue needs to be addressed at the national level because the number of mental illness is increasing by the day. Possible steps could include— (i)State Govt and State Public Commission should hold a special fast track recruitment drive to fill all vacancies. (ii) Increase seats of psychiatry in medical colleges Incentivize psychiatrists through better pay and facilities (iv) Set apart seats in nursing college for psychiatric nurses
4	Cleanliness / hygiene— Toilets are not clean and not well maintained. There were no proper latch / bolt in the toilets of women in-patients. For female inpatients, the toilet ratio is 13 patients per toilet. [Although as part of their centenary celebrations, the hospital had spruced up the toilets and the campus as a whole this may not always be the case.]	Medical Supt said that the toilets are very inadequate. And after having received sanction of funds, the PWD is constructing new toilets. Specific norms for toilet ratios should be laid down and strictly followed as this affects the very basic dignity of women. All mental hospitals need to maintain a very high level of hygiene, cleanliness and an overall pleasant atmosphere in terms of well painted walls and doors, well- kept gardens, clean / hygienic bathrooms, good kitchens, good lighting to give the patients a feel-good factor. Toilets need urgent repair to bear a well-kept look.
5	Deaths at RMH— 35 women in-patients died in the Pune hospital in one year—the hospital says that these were all natural deaths. The Medical Supt explained that there were very large number of patients with chronic schizophrenia who have been there for 30 to 40 years and they are only given palliative supportive	The instructions for ensuring the safety of patients must be strictly followed. The patients with possible suicidal or homicidal tendencies should be listed and closely watched. The hospital staff should be constantly refreshed about the drill for securing the safety of in-patients.

	treatment; and the reason for their death is debility. In the last 10 years, there was only 1 suicide and 2 homicides [unnatural deaths] which is a very small number.	
6	Property / financial issues concerning female inmates— One in-patient said that she has a brother but he does not take her home. She had some land in her name which was sold off. The money is in the bank and her brother is the nominee for the bank account. Dr. Madhulika Bahale, RMH, Yerwada, said that it is difficult to discern or establish any motive of depriving women in-patients of their property or financial rights, by relatives who bring them to the hospital. Also, with the passage of time in the hospital as an in-patient, she loses contact with the family as they do not come to see her and this may blur her ability to assert or even accurately recall her rights to property or financial assets.	There is a general perception that mentally ill are being deprived of their property and money rights. The Commission has received complaints that families of some women patients admit them to mental hospitals to deprive them of their property and financial rights. This perception was also borne out by a few one-on-one talks with inmates. It is sometimes possible that some patients may not be able to accurately perceive or describe these matters and some may even imagine such things, but such malfeasance by relatives cannot be ruled out. So, this particular aspect should be the subject matter of a special study to be conducted by not just going to the hospitals but also visiting their families, their friends, and their neighborhoods.
7	Half Way Homes Member NCW was informed that for want of a better alternative, many female in-patients are sent to Shelter Homes when they are fit for discharge but their families are not willing to take them home. Similarly, patients whose identity are not known and have recovered are also sent to Shelter Homes. A resident can stay in the Shelter Home for a maximum of 3 years—so she is shifted to another Shelter Home after 3 years. A proposal was submitted for a Half Way Home near RMH in 2008, but it is still to materialize.	The Shelter Homes are not suitable for mentally ill patients because many women living in Shelter Homes may be 'rough' and mentally ill women feel very insecure there and express a desire to return to the mental hospital, where they feel safe. A good alternative is to set up half-way homes which as the name suggests are half way to life back in their own homes. Admitted patients should be reviewed periodically for possible transfer to 'half-way homes' as a stepping stone to going back to their families and society. Half Way Homes should be set up as a link facility for each Mental Hospital. Half Way Homes are provided for u/s 19 of the Mental Health Care Bill of 2013 which is before Parliament.
8	Budget / finances / delegation of financial and administrative powers During discussions with the staff of the Regional Mental Hospital, Yerwada, Member NCW was informed that there are often budgetary constraints that affect the functioning of the hospital and welfare of the patients. Not only are there budgetary constraints but even	(i)There should be adequate budget for the full medical needs of the hospital, as well as the proper upkeep of the hospital premises including its gardens, kitchens, toilets, bathing areas, etc (ii) The Heads of all Mental Hospitals in the government should be declared Head of Departments and all financial powers as per

	within the allocated budget, there is hardly any delegation of financial powers.	GFR should be delegated to them. (iii) Similarly, all administrative powers concerning the hospital should vest in the Head of the Mental Hospital. (iv) The Medical Supt suggested that there should be budgetary allocation for dropping patients home when they are discharged in cases where the relatives do not come to take them home.
9	Infrastructural facilities— The Head of the Regional Mental Hospital, Yerwada said that the infrastructure was inadequate to support the in-patients and out-patients who were treated. The RMH was built 100 years ago and thus is not operated at optimal capacity utilization and needs major renovation and up-gradation.	(i)Adequate infrastructure should be provided in all mental hospitals. (ii) The norms for provision of infrastructure should be reviewed periodically and revised so as to keep them at par with latest developments and with the work/ patient load. (iii) The budget provision should be revised each year to cater to the enhanced infrastructure.
10	Visitors Committee The Act of 1987 provides for 'Visitors' committee to visit the hospital every month and inspect the hospital and examine every minor in-patient and as far as circumstances permit, every in-patient. 'Visitors' are provided under Section 37 / 38 of the Mental Health Act of 1987	(i) The Lakshmidhar Mishra committee which reviewed the performance of the Regional Mental Hospital, Yerwada in 2008 had suggested that the Visitors Committee should also inspect the kitchen, wards [both male and female], OPD etc and give suggestions and instructions. (ii) This is a very good suggestion and must be followed in letter and in spirit in all mental hospitals. (iii) The Visitors committee should examine each patient every month including those patients who may be violent, after taking suitable precautions. (iv) An SOP and check-list should be prepared for the Visitors Committee

11	Rehabilitation of patients post discharge—both economic and family / social
	Once the patient is considered fit for discharge, she has to be rehabilitated -
	
	(i) by helping her get a job based on skill development that she should have acquired while she was in hospital and Half Way Home
	
	(ii) By facilitating restoration to family life and life in her neighborhood and society.
		For (i), there is need for well-thought out skilling programmes, accompanied by a placement system where the confidentiality of her medical history is ensured.
		
		For (ii), periodic counseling of the family by doctors and social workers while the in-patient is in hospital and in the run-up to the discharge.
		
		There should be a general and persistent media campaign to allay the fears and stigma associated with mental illness.

SUMMARY

Overall, it appears that there are still multiple deficiencies in the delivery of basic mental and physical health care for the women patients in the Regional Mental Hospital, Pune. Problems include shortage of staff and financial resources, lack of continuous professional training of staff, stigma, scarce rehabilitation facilities and negligent attitude of families, all of which have in turn has led to demoralization of hospital staff.

Lack of autonomy and slow processing of proposals were important lacunae pointed out by administrative staff and service providers.

A majority of patients interviewed expressed satisfaction in most of the areas they were in a position to comment upon. Most were happy with the basic facilities. About one-fourth classified the food as unsatisfactory. Dissatisfaction was mainly in the lack of non-vegetarian food and lack of dining facilities. There was overall a high response of satisfaction to personal hygiene and comforts, although a substantial number was dissatisfied over not being given a choice of clothes to wear. A majority said they were given basic toiletries. A majority rated the sleeping and resting facilities as good. However, dissatisfaction was experienced by some in terms of the lack of facilities to sit and rest, presence of mosquitoes and other insects and lack of help for emergency physical and mental problems. Most were satisfied with the treatment. One area of dissatisfaction was that side-effects were not explained. A majority felt satisfied with the attention to their emotional needs. Areas of dissatisfaction for some were not being able to send and receive letters, or be able to keep their personal possessions. A third felt staff listened to their private conversations and violated their privacy when they wrote letters. There were only a couple of patients who reported incidents of being threatened by the staff. Most were not able to share issues with respect to restraint. A majority was satisfied with how their social needs were met. A majority reported being treated with consideration, respect and care. A small number felt that they were not permitted to pursue religious and spiritual activities. More than two-thirds said informed consent had not been taken and none had received information on patient rights. Forty percent had their hair cut without consent. Most felt that confidentiality was not maintained by the staff.

None had been asked for bribes and most felt that there was no discrimination on the basis of religion. More than two-thirds expressed that the staff encouraged their interests and talent.

The visiting team noted glaring deficiencies in infrastructure, facilities and care, although patients themselves expressed dissatisfaction only in a few areas. The major observations of the visiting team was that the roads were poorly maintained, wards were all closed wards, lighting was inadequate; wards were overcrowded, beds and mattresses were inadequate, some fans were not working, hot water was not provided, water for bathing and washing clothes was inadequate. The team noted that there were some outside toilets; that the bathrooms were inadequate; that there were mosquitoes in the ward; the dining facilities were inadequate and the eating area was full of flies; patients had to wear compulsory uniforms and these were sometimes torn and dirty; there was a lack of privacy during bathing; though sanitary napkins were provided, some patients did not know how to dispose them and would

wash them; adequate toiletries were provided; patients were provided some space for their spiritual and religious activities; patients told the team that medical rounds were infrequent; they were poorly informed about the side-effects of medicines and emergency medical attention was inadequate; patients were engaged in some occupational therapy, but only a few destitute patients have been rehabilitated. Most of the patients that the team spoke to expressed concerns not about the care in the hospital, but whether their families would take them home or visit them. A majority wanted to go home to their families. Wrong addresses, cases of abandonment were not uncommon. For the women who had been in the hospital long-term and had not seen the world outside, they perceived that they were getting the best facilities.

Solutions suggested by staff and care providers includes greater autonomy in decision making in order for better resolution of problems and more prompt action by government of the various proposals submitted by the hospital for improvement.

The hospital has been celebrating its centenary year in 2015. This is an important time for the hospital to bring about positive changes for the patients as well as the staff.

2. GOVERNMENT MENTAL HEALTH CENTRE (GHMC), KOZHIKODE, KERALA

INTRODUCTION

This hospital was established in 1872 and celebrated its 125th year in November 1997. It was originally started with 9 beds as a lunatic asylum under the Inspector of Jails. Its bed strength has gradually increased and in 1970, it was increased to 700 beds. It was governed by the Madras Presidency till 1945 and later came under the Government of Kerala.

In the NHRC review of 1999[43], GMHC Kozhikode was rated among the Very Poor category of hospitals based on a rating of all mental hospitals in the country on the basis of living conditions, food, clothing, maintenance and medical care.

The hospital was reviewed by the DGHS in 2004 which recommended the replacement and renovation of old buildings, attention to staff deficiencies which was having an impact on patient care and the strengthening of rehabilitation.

The hospital came under a monitoring committee set up by the High Court of Kerala

The NHRC review in 2008[44] showed that the budget had been enhanced only slightly; two wards, a canteen, a nurse's hostel, a flour mill had been constructed; some buildings had been renovated, power generation had been set up; a new medical records section had been set up; a rehabilitation facility was set up; a waiting shed for OPD patients was constructed; telephone and intercom facilities were set up; MD students from the Kozhikode Medical College and MSc students from the Government College of Nursing were posted. Open ward facility was established

The 2008 report mentions that cells still continue and overcrowding is still present.

The inspection was carried out on 18.12.2015 and 19.12.2015. The GMHC administration and staff had been informed prior to the team's visit and had made adequate arrangements to ensure access to all areas, staff, patients and records. The Medical Superintendent of the institution Dr. N. Rajendran and the Deputy Medical Superintendent Dr. Sivadasan K. K. were present all through the survey.

Concerns of Administrators and Service Providers

The team interacted with the medical superintendent, resident medical officer, two psychiatrists, one psychologist, one social worker and two nurses. The major concern for administrators and service providers was their inability to discharge out of state women after recovery from their mentally illness. The lack of a proper system of transferring these patients despite their best efforts led to overcrowding and all its negative consequences. Even though the staffing pattern of medical and nursing staff was adequate, there was a serious shortage of attenders, cleaners and female security staff.

[43]National Human Rights Commission. Quality assurance in mental health. 1999. Ibid.
[44]National Human Rights Commission. Mental health and human rights, 2008. Ibid.

The administration was also hampered by their inability to provide consistent support for physical illness within the hospital.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N =25)

Table2a. Basic Facilities

Description	Yes- N (%)	No- N (%)	Not answered* - N (%)	Not applicable** -N (%)
Is there adequate light during day time?	24(96)	1(4)	0	0
Is there adequate light during night time?	24(96)	1(4)	0	0
Is hot water given for bathing regularly?	8(32)	17(68)	0	0
Is safe drinking water provided?	14(56)	11(44)	0	0
Are bathroom and toilets adequate?	22(88)	3(12)	0	0
Are bathroom and toilets cleanly maintained?	23(92)	2(8)	0	0
Is there space for washing and drying clothes?	22(88)	2(8)	1(4)	0
Is the ward cleaned regularly?	24(96)	1(4)	0	0
Is linen changed regularly?	20(80)	4(16)	1(4)	0
Is there overcrowding in the ward?	13(52)	12(48)	0	0
Are patient allowed to go outside the ward regularly?	12(48)	13(52)	0	0
Is there adequate space for walking outside the ward?	20(80)	1(4)	0	4(16)
Is locker facility provided?	2(8)	23(92)	0	0

* These patients were uncooperative and did not respond. **These patients are locked up in cells.

Overall rating of basic facilities

Overall, 84% of the patients rated the facilities as good and 8% rated the basic facilities as being poor. With regard to specific areas, more than two-thirds said there was no hot water for bathing; nearly half said that the drinking water was unsatisfactory; nearly half said there was overcrowding in the ward and more than half said the patients were not allowed to go out regularly; most said there was no locker facility.

Table-2b: Food

Description	Yes - N (%)	No – N (%)	Not applicable**- N (%)
Is the food provided adequate?	25(100)	0	0
Is there sufficient variety in the daily menu?	23(92)	2(8)	0
Is quality of food satisfactory?	18(72)	7(28)	0
Are you satisfied of frequency of food provided?	22(88)	3(12)	0
Are you served with special food served on special occasions?	24(96)	1(4)	0
Are you served non-vegetarian meals on request?	21(84)	3(12)	1(4) ^
Are food serving staff polite?	25(100)	0	0
Is there a separate dining area?	23(92)	1(4)	1(4) @
Are facilities provided in the dining area?	12(48)	12(48)	1(4) @
Are the utensils and dining room cleanly maintained?	25(100)	0	0

^This patient is vegetarian. @ This patient is given food in cell.

Overall rating on food and related issues

Overall, 80% of the patients rated the food and related services as good, whereas 20% rated it as poor or very poor. Nearly half said there were no facilities in the dining area. 28% found the food unsatisfactory. Otherwise, there seemed to be high levels of satisfaction with the food and the way it was served by the staff.

Table2c. Personal Hygiene

Description	Yes –N (%)	No- N(%)	Not applicable**- N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	22(88)	3(12)	0
Are sanitary napkins provided regularly?	4(16)	17(68)	4(16)
Is information provided on proper disposal of sanitary napkins by nursing staff?	9(36)	12(48)	4(16)
Are basic toiletry articles provided?	24(96)	1(4)	0
Are you permitted to wear own clothes?	17(68)	8 (32)	0
Are you given a choice of clothes what to wear?	15(60)	10(40)	0
Are you provided inner garments?	12(48)	12(48)	1(4)
Is winter wear provided to you?	5(20)	20(80)	0
Is footwear provided to you?	20(80)	5(20)	0
Are basic toiletries provided to you?	9(36)	16(64)	0

** These patients had reached menopause. Some do not want to wear inner garments

Overall rating on personal hygiene and related issues

Overall, 80% rated the attention paid to personal hygiene as good or very good while 20% rated it as poor. With regard to specific aspects of personal hygiene, more than two-thirds said that sanitary napkins were not provided regularly and nearly half said they had no information on proper disposal of napkins. About a third said they were not allowed to wear their own clothes. Forty percent said they did not have a choice of clothes. Nearly half said they were not provided inner garments. A majority said they were not provided winter wear (this is hardly ever needed in Kerala). A fifth said they were not provided footwear and two-thirds said they were not provided basic toiletries.

Table2d.Sleeping and Resting Facilities

Description	Yes – N (%)	No- N (%)
Is the ward quiet at night?	24(96)	1(4)
Are you provided with separate cot, mattress, pillow and blanket?	17(68)	8(32)
Are fans provided when it is hot?	24(96)	1(4)
Are heaters provided?	1(4)	24(96)
Do you have facilities to sit and rest during the day?	12 (48)	13 (52)
Does the ward have bedbugs, cockroaches, mosquitoes?	22 (88)	3 (12)
In case of serious physical and mental problems immediate help provided?	23 (92)	2 (8)

Overall rating on sleeping and resting facilities

Overall, three-fourth of patients were satisfied with the sleeping and resting facilities. Among the specific areas of dissatisfaction, nearly a third said separate cots, mattress, pillow and blanket were not provided. Lack of facilities to sit and rest during the day was perceived by more than half.

Table2e. Medication and treatment

Description	Yes- N (%)	No- N (%)
Does the nursing staff help you in taking medications?	25 (100)	0
Have you been given explanation by treating team about medicines and side effects?	9 (36)	16 (64)
Is a female nurse/attendant present when you are physically examined by a male doctor?	22 (88)	3 (12)
In case of medical problem, is immediate attention provided?	22 (88)	3 (12)

Overall rating of medication and treatment

Overall, 88% rated the medication and treatment facilities as good. Specific areas of dissatisfaction was the lack of explanation on the side-effects of the medicines they were

prescribed. Otherwise, they appeared satisfied with the rapidity of medical attention and all expressed that the nursing staff were helpful in taking the medication.

Table2f. Emotional Needs

Description	Yes – N (%)	No- N (%)	Not answered** –N (%)	Not applicable –N (%)
Do the members of treating team address you properly?	25(100)	0	0	0
Does the treating team spend enough time to listen?	23(92)	1(4)	1(4)	0
Does the treating team show adequate concern?	24(96)	1(4)	0	0
Are you permitted to have personal possessions?	4 (16)	14 (56)	2 (8)	5 (20)**
Do you have access to phone in ward?	1 (4)	23 (92)	0	1 (4)**
Do you have permission to receive calls and letters?	3 (12)	15 (60)	0	7 (28)**
Do the staff read your letters or listen to phone conversation?	4 (16)	17 (56)	0	3 (12)**
Does the staff provide pen and paper for letter writing?	17 (68)	4 (20)	0	4 (12)**

* These patients were uncooperative (due to their illness) and did not respond ^ Illiterate;** these patients were either destitute or orphans.

Overall rating of meeting of emotional needs

Overall, 76% of the patients felt that the efforts to meet their emotional needs could be rated as good or very good. Specific areas of dissatisfaction were not being allowed to keep personal possessions (56%), no access to phones (92%), not being allowed to receive calls and letters (60%). Patients generally perceived the staff as helpful and respecting their privacy of communication. More than half said staff listened to their conversations/read their letters (56%).

Table-2h: Coercion and related issues

Description	Yes – N (%)	No- N (%)	Not answered*- N (%)	Not applicable**- N (%)
Were you ever threatened by hospital staff?	2 (8)	23 (92)	0	0
Did the hospital staff hurt you by using bad language?	2 (8)	23 (92)	0	0
Were you ever beaten by any hospital personnel?	2 (8)	23 (92)	0	0
Did anyone from the treating team ever made sexual advances towards you?	2(8)	23 (92)	0	0
Were you restrained physically?	2 (8)	23 (92)	0	0
Were you informed about the need of restraint?	0	2 (8)	0	23 (92)
Were you told about alternatives like chemical restraints/seclusion?	0	1 (4)	1(4)	23 (92)

Was any staff present while being restrained?		1 (4)	1(4)	0	23 (92)
Staff present during restraint	Male	0	0	0	23 (92)
	Female	2 (8)			
Were you left unattended for more than 2 hrs?		1(4)	1(4)	0	23 (92)
Were restraints padded?		0	2 (8)	0	23 (92)
Did the staff check restraints frequently?		1(4)	1(4)	0	23 (92)

* This patient was uncooperative and did not respond. **These patients had not been restrained during their stay in the hospital.

Most patients said they had never been threatened or abused by the hospital staff. Two patients reported that staff had made sexual advances. Most did not have any experience of being restrained.

Table-2i: Social Needs (Level of satisfaction)

Description	Very poor- N (%)	Good – N (%)	Very good- N (%)	Not applicable ** -N (%)
Permission to attend family functions	22 (88)	2(8)	1(4)	0
Group activities	2(8)	5(20)	17(68)	1(4)
Outdoor activities	3(12)	6(24)	14(56)	2(8)
Participation in sports/games/cultural activities during hospital stay	2(8)	19(36)	13(52)	1(4)
Provision of separate visiting room	8(32)	4(16)	2(8)	11(44)

**These patients were either destitute or orphans. Some patients' addresses had still not been traced; due to their illnesses, these patients either lacked insight, slept more or had less interest in these activities.

Most patients said they did not have permission to attend family functions. A majority was satisfied with the group activities as well as outdoor activities. A large percentage (44%) did not receive any visitors. However, a third was dissatisfied with the visiting room.

Table-2j: Ethical, Spiritual and other needs

Description	Yes – N (%)	No – N (%)	Not answered*- N (%)	Not applicable** -N (%)
Is there permission for religious/ spiritual activities?	18(72)	6(24)	1(4)	0
Are you treated with concern, respect and care?	25(100)	0	0	0
Were you treated against your wish?	6(24)	19(86)	0	0
Are you allowed to read newspaper and magazines?	6(24)	18(72)	0	1(4)[#]
Are you allowed to take health care decisions?	3(12)	22(88)	0	0

Was your haircut done without consent?	9(36)	14(56)	0	1(4)
Were you permitted to represent legal matter in court?	3(12)	11(44)	0	11(44) ^
Did you get information about patients' rights in hospital?	0	25 (100)	0	0
Whether confidentiality maintained during hospitalization by treating team?	6 (24)	13 (52)	2 (8)	4(16)[#]
Did the treating team provide any education about your illness?	1(4)	12 (48)	0	12 (48)[#]
Did staff ask bribes or gifts?	0	25 (100)	0	0
Have you felt any discrimination by treating team based on your religion?	0	25 (100)	0	0
Were your hobbies encouraged during the hospital stay?	3 (12)	22 (88)	0	0
Is informed consent taken for treatment?	7 (28)	18 (72)	0	0
Is informed consent taken for research?	0	0	0	25 (100)[@]
Is pre- test counselling for HIV/ STI/OTHER tests done?	10 (40)	11 (44)	0	4 (16)

* These patients were uncooperative and did not respond. [#] Illiterate; ^ These patients do not have any legal issues; [@] No research has been undertaken on these patients.

All patients said they were treated with concern, respect and care. Most said they were permitted to carry out religious activities of their preference, although nearly a quarter felt this was not allowed. About a quarter said they had been treated against their wishes. A majority recorded lack of access to newspapers or magazines. Most said they had no participation in their health care decisions. None had been given information on patient rights and 44% said they had not been permitted to make any legal representations. More than half said confidentiality had not been maintained. Nearly half had not received any education regarding their illness. None of the patients felt discriminated against because of their religion. Nearly three-fourth said informed consent had not been taken prior to treatment. Most felt that their hobbies had not been encouraged. A significant number (44%) said pre-test counselling for HIV was not carried out.

OBSERVATIONS OF THE VISITING TEAM

Circumstances of admission

Maximum number of admissions is involuntary (brought by reception order, NGOs, and local residents). GMHC Calicut has many patients from other states such as West Bengal, Rajasthan, Orissa, Karnataka etc. These patients are found in a wandering psychotic state and taken to custody by police and then brought to the hospital.

Basic facilities

All the wards had proper lighting and fan facilities. Wards were generally clean. Patients are provided hot water for bathing as well as for drinking.

Though the wards were relatively clean, the cleanliness of the toilets and dining area had scope for improvement. Bathrooms and toilets were inadequate and unclean in all the wards.

There were no proper seating facilities for patients outside wards. However, most patients reported as 'satisfactory' with regards to the basic facilities.

The central kitchen was clean, spacious, with adequate physical infrastructure and staff. On the day of inspection, there were sufficient stores and all preparations on the menu were culturally appropriate and prepared freshly from locally procured government supplies. Most of the patients said that the food is adequate and the taste of food is also not bad. Some patients from north India requested chapattis in the menu. Patients reported that they are getting non-vegetarian food as well. The staff who served the food were polite towards the patients. The dining facilities are satisfactory.

Personal Hygiene

Patients do not have privacy while bathing, using the toilets and even while changing clothes as the bathroom doors were seen to be partially broken. However, the staff report that the doors are deliberately kept in order to reduce the risk of suicidal attempts.

Sanitary napkins are not provided. Patients are instead provided cloth. However, they are not educated regarding the disposal. Some patients wash these cloths after using. Patients are not provided toiletries. Sweaters were being provided although a significant number of patients said they were not getting winter wear.

Sleeping and resting

The wards are quiet during the nights but some patients report disturbance by the other patients. There are also many bedbugs and mosquitoes in the wards. There are lesser beds-mattresses as the number of patients. Consequently, patients have to sleep on mattresses on the floor. Many a times, pillows are also not provided for them. Fans are very old and some of them are not in working condition. Though Kerala is a hot place, there is no provision for coolers.

Admissions in open as well as closed wards

Women patients in GMHC, Kozhikode are in three wards [One open (family ward) & two closed wards]. The open female ward functions like any general medical ward with patients being admitted with an accompanying family member for short duration, followed by routine discharges. There is adequate care on the part of the family and the staff. About 20% of open wards patients are shifted to closed wards for brief periods mostly on clinical grounds and rarely for social reasons (eg: marriage in the family) with concurrence from the family. Since almost all of them come from the local community, this sub-group of female patients are

discharged back to their families without any difficulty. There are no concerns with regard to these patients.

The two closed wards at the GMHC for women has a total capacity of 140 beds. On the day of the visit, there were 208 in the two wards. That was **48.5% over its capacity** (the reason for overcrowding is discussed later**)**. Consequent to this, many patients were sleeping on mattresses on the floor. Even if cots were procured for all these patients, the space within the wards would not be sufficient to put them.

Cells are still in use.

Human Resources

The professional human resources, which has been sanctioned for GMHC, Calicut, is based on its total capacity of approximately 474 beds. From the records, it was apparent that at all points of time, the admissions exceeded the capacity of the institution by 20-30% with almost 70% of the in-patients were in the closed wards.

Most (90%) of the sanctioned posts in the different cadres, ie. Medical, Nursing and paramedical, have been filled. However, the number of nursing assistants, hospital attenders and other lower category staff is not proportionate to the number of patients who require care. There are gross deficiencies in staffing pattern in certain areas, for example, there is no female security staff. The sanctioned posts of security staff for the whole institution is only 4 which is grossly inadequate considering that the physical estate of the institution is around 20

acres with approximately 600 inpatients present at any given point in time. There are only 3 sweepers and one driver for the whole hospital.

Given this excess in the closed wards, the staffing pattern is inadequate to manage the patients in an institutional setting. The existing staff, including the medical personnel, nursing staff, hospital assistants and attenders, appears well experienced and committed.

Treatment

Drugs: The supply of medicines is through a central distribution network and is fairly satisfactory. The Medical Superintendent has the option to procure medications by local purchase for in-patients. This arrangement is ensuring a fairly regular supply of medications (both psychiatric and medical) to the patients.

Medical input: The major lacuna with regard to treatment is with regards to input for patients from non-psychiatric medical & surgical specialties. There are no regular arrangements for providing any medical or surgical care. While the treating psychiatrists often provide basic clinical management, any specialised management will require shifting patients to the Government Medical College, which is 6 km away. **Ensuring adequate and regular non-psychiatric medical input for in-patients is the single most important area of concern which requires immediate attention**.

Psychological Therapies: There are only 3 clinical psychologists and 2 social workers for the whole institution. The 2 social workers deal with admission and discharge of patients which leaves them with little time for any other work. The clinical psychologists mainly deal with patients in the out-patient department. Hence the in-patients receive very little inputs.

Rehabilitation

There is no structured rehabilitation for inpatients in the institution. A few patients who are 'well' help in ward work, garden, kitchen etc. All the other patients simply sit around with little physical activity. This could have long-term consequences for their physical health. Hence, there is a need to improve facilities both in terms of infrastructure/staff so that in-patients are constructively engaged.

Discharge/Community Rehabilitation

The major issue that the institution is facing is with regard to over-crowding. This is mainly owing to the institution's inability to discharge a significant number of out-of-state patients who are mostly admitted as 'wandering mentally ill'. In most cases, there is a significant language barrier. In a few patients where this in surmounted, there is a lot of difficulty in identifying the whereabouts of the patients through the legal system. The institution only manages to send back 30% of these wandering patients to their states of origin. The rest join the larger group of chronic in-patients who have no place to go.

A few community rehabilitation centres run by the Government are available locally with limited beds, mainly for the wandering homeless but they are generally not willing to take psychiatric patients as they don't have the staff or infrastructure to look after them. A few small NGO's with limited capacity take patients who are psychiatrically stable but broadly community rehabilitation facilities are inadequate.

The restitution of out of state patients to their own state of origin for various logistic reasons appears to be an issue which needs to tackled with a broader inter-state consensus. The mechanisms that can be employed include developing a single point of discharge to a named hospital in each state (if the state of origin can be identified – which is generally easier) from where the local whereabouts can be traced. Another interesting suggestion given is to have a national platform/social media account where photographs of these patients can be uploaded so that it would be easier for families to trace their near and dear.

This would need to be secure and privacy-related issues must be respected.

Family Support

Family support for women who have been admitted on a long term basis is virtually absent. Some of them have a rare visit by their family members, who might be elderly parents or ill siblings who themselves are restricted in many ways to be of any help to the patient. The rest of them have no place to go. The family/social support for patients in open wards is adequate.

Funds

The funds for the institution are from the State Budget. The fund availability is often disjointed so often there is a delay in payment of electricity/water bills etc., which creates minor administrative issues. If there is a method of fund collection through the Hospital Development Committee, which is functioning, the local administration will have the flexibility in carrying out many small activities, which will definitely improve the quality of care and life of patients in the institution.

Concern about discharge (patient's perspective)

Many patients reported that they want to go home and stay with their families. Sadly, the majority are brought by reception order. Either their addresses cannot be traced because of their illness, or they have been deliberately abandoned by their families. Some families do not want to take the patients back and provide wrong addresses at the time of admission.

Specific observations and suggestions of Ms. Rekha Sharma, Member, National Commission of Women

During the visit to the hospital, the following have been observed: Very poor hygiene, inmates who are bedridden were kept without proper medical assistance, hospital was allowing school children to have a round of hospital, lack of space as inmates were not left hospital even after recovering, shortage of staff and specialists, no mid way homes, unwanted visitors from schools were allowed to come in just to have a look and see the condition of women inmates, few women were in lock up, some women were running around without cloths.

SUMMARY

Overall, the institution is well run, given the constraints it works under. Many of the issues facing the institution are aspects that require decision-making at a higher level.

Concerns of the administrative staff and service providers include difficulties with discharge and rehabilitation of out-of-state patients; the serious shortage of female attenders, cleaners and female security staff and the lack of specialised medical care for the patients.

A majority of the women patients report satisfaction across most areas. However, nearly two-thirds report a lack of hot water for bathing and nearly half say that the drinking water is unsatisfactory. This is at variance to what is reported to the visiting team. Overcrowding is a problem that many patients themselves report. Lack of sanitary napkins, lack of inner wear and lack of sweaters, lack of toiletries was reported by a substantial number. A third was dissatisfied with the lack of mattresses, pillows and blankets and more than half with the lack of resting facilities. Patients themselves are mostly satisfied with the medical care and treatment except for the lack of explanation of medication side-effects. While they are generally happy with staff attitudes, more than half express that they do not have a space for their personal belongings. Most say they have no access to phones and nearly two-thirds say they are not allowed to receive calls and letters. Two of the patients reported that the staff had made sexual advances towards them. A majority are satisfied with the group activities. A large number (44%) do not have any visitors. All patients say they are treated with concern, respect and care. Most say they are permitted to carry out religious activities of their choice, although a quarter do not feel so. About a quarter say they have been treated against their wish and most say informed consent is not taken prior to treatment initiation. Most patients say they have not participated in health care decisions. A majority say they have no access to newspapers and magazines. A significant number say pre-test counselling is not carried out.

From the on-site visit, the major aspects that need immediate attention are mechanisms to provide regular non-psychiatric medical care, streamlining discharge procedures for out of state patients, more community rehabilitation units and providing rehabilitation facilities for in-patients. The work of the staff to ensure quality service even in these conditions needs to be positively highlighted.

3. REGIONAL MENTAL HOSPITAL, THANE, MAHARASHTRA

INTRODUCTION

The Regional Mental Hospital (RMH), Thane, was established in 1901, with a philanthropic grant of Rs 30,000/-. It is one of the largest mental hospitals in the country with a bed strength of 1880 in 1998.

The NHRC Report of 1999[45] rated the RMH Thane as Poor. Custodial environment, all closed wards, poor maintenance, poor facilities, human resource shortage influenced this rating. The recommendations had included better inpatient and outpatient services, reduction in involuntary admissions, better psychosocial interventions and enhancement of human resources, particularly psychologists.

In the NHRC 2008 Report[46], RMH Thane had not reported any infrastructure improvements in the interim period. It continued to have 1850 beds. Overcrowding had reduced however. A majority of the admissions still occurred through courts. The hospital had given proposals for up-gradation which were awaiting approval, the laundry had been upgraded, roads had been repaired and the kitchen had been repaired. There was an increase in outpatient treatments. A separate geriatric facility had been started, but emergency services had not been initiated. The post of clinical psychologist was still vacant. There were still no open wards.

The total strength of women patients is around 750 and these have been divided into two clinical units. There are separate wards for the acutely ill, for those who have stabilised a bit, for women with intellectual disabilities and epilepsy and for patients who are long stay.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

The team interviewed the superintendent 2 psychiatrists, one psychiatric social worker and a nurse. The major concerns were the fact that patients were often brought long after illness onset, when chronicity had set in and were then dumped. Deficiencies in infrastructure and lack of recreational facilities were issues of which the staff was acutely aware. Human resource constraints continued to be present. Although long stay facilities existed, patients could not be sent there without the order of the courts. Poor involvement by families was a huge handicap in caring for the chronic mentally ill. Lack of financial resources was a great hindrance. The staff wanted better medical facilities for the inpatients.

[45]National Human Rights Commission. Quality assurance in mental health , 1999. Ibid.
[46]National Human Rights Commission. Mental health and human rights, 2008, Ibid.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table3a. Basic Facilities

Description	Yes - N (%)	No – N (%)
Is there adequate light during day time?	25 (100)	0
Is there adequate light during night time?	25 (100)	0
Is hot water given for bathing regularly?	20 (80)	5 (20)
Is safe drinking water provided?	20 (80)	5 (20)
Are bathroom and toilets adequate?	18 (72)	7 (28)
Are bathroom and toilets cleanly maintained?	17 (68)	8 (32)
Is there space for washing and drying clothes? *	14 (56)	4 (16)
Is the ward cleaned regularly?	20 (80)	5 (20)
Is linen changed regularly?	21 (84)	4 (16)
Is there overcrowding in the ward?	11 (44)	14 (56)
Are patients allowed to go outside the ward regularly?	21 (84)	4 (16)
Is there adequate space for walking outside the ward?	23 (92)	2 (8)
Is there a locker facility provided?	3 (12)	22 (88)

* These patients' clothes are washed in laundry.

Overall rating of basic facilities

Overall, 92% of the patients rated the basic facilities as good. However, there was dissatisfaction on specific facilities. A majority (88%) said that there was no locker facility available. A substantial proportion (44%) reported overcrowding in the wards. Nearly a third was dissatisfied with the upkeep of the toilet and bathrooms. A fifth of the patients said the water for drinking was unsatisfactory and that there was no hot water for bathing.

Table-3b: Food

Description	Yes - N (%)	No- N (%)
Is the food provided adequate?	23 (92)	2 (8)
Is there sufficient variety in the daily menu?	23 (92)	2 (8)
Is quality of food satisfactory?	18 (72)	7 (28)
Are you satisfied with the frequency of food provided?	25 (100)	0
Are you served with special food served on special occasions?	25 (100)	0
Are you served non-vegetarian meals on request?	24 (96)	1 (4)
Is the food serving staff polite?	25 (100)	0
Is there a separate dining area?	16 (64)	9 (36)
Are facilities provided in the dining area?	1 (4)	24 (96)
Are the utensils and dining room cleanly maintained?	20 (80)	5 (20)

Overall rating of food and related facilities

Nearly one-quarter of patients rated the overall quality of food and related services as poor. A majority (96%) said there were no dining facilities, and 28% were not satisfied with the quality of food. A fifth said that the utensils and dining area were not well maintained.

Table3c. Personal Hygiene

Description	Yes –N (%)	No- N (%)	Not applicable**- N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	19 (76)	6 (24)	0
Are sanitary napkins provided regularly?	19 (76)	0	6 (24)
Is information provided on proper disposal of sanitary napkins by nursing staff?	17 (68)	3 (12)	5 (20)
Are basic toiletry articles provided?	24 (96)	1 (4)	0
Are you permitted to wear own clothes?	5 (20)	19 (80)	0
Are you given a choice of clothes to wear?	5 (20)	20 (80)	0
Are you provided inner garments?	19 (76)	6 (24)	0
Is winter wear provided to you?	19 (76)	6 (24)	0
Is footwear provided to you?	11 (44)	14 (56)	0
Are toiletries provided to you?	21 (84)	4 (16)	0

**These patients had reached menopause. Some do not want to wear inner garments

Overall rating of attention to personal hygiene and basic comforts

Overall, 72% said that the attention was paid to personal hygiene and basic comforts. A majority (80%) said they were not allowed to wear their own clothes or given a choice of clothing. More than half (56%) said no footwear had been provided. About one-quarter said there was a lack of privacy, that they were not provided inner wear or winter wear. A small number (16%) said they were not provided toiletries.

Table-3d. Sleeping and Resting Facilities

Description	Yes- N (%)	No – N (%)
Is the ward quiet at night?	22 (88)	3 (12)
Are you provided with separate cot, mattress, pillow and blanket?	19 (76)	6 (24)
Are fans provided when it's hot?	25 (100)	0
Are heaters provided?	1 (4)	24 (96)
Do you have facilities to sit and rest during the day?	7 (28)	18 (72)
Does the ward have bedbugs, cockroaches, mosquitoes?	11 (44)	14 (56)
In case of serious physical and mental problems, is immediate help provided?	19 (76)	6 (24)

Overall rating of sleeping and resting facilities

Overall, more than three-fourth reported these facilities as good. However, a significant number (44%) reported that the word had pest problems. A majority (72%) said there were no facilities to rest during the day. Most (96%) said that heaters were not provided. About a quarter said the bedding was not satisfactory. A similar proportion said that emergency medical and psychiatric care was not provided immediately.

Table-3f: Medication and treatment

Description	Yes –N (%)	No – N (%)
Does the nursing staff help you in taking medications?	25 (100)	0
Have you been given explanation by treating team about medicines and side effects?	10 (40)	15 (60)
Is a female nurse/attendant present when you are physically examined by a male doctor?	25 (100)	0
In case of a medical problem, is immediate attention provided?	24 (96)	1 (4)

Overall rating of medication and treatment

Practically all interviewed patients (96%) were satisfied with the medication and treatment. However, a majority (60%) answered that they had not been given any information on the side-effects of treatment.

Table3g. Emotional Needs

Description	Yes- N (%)	No – N (%)	Not answered* - N (%)	Not applicable** - N (%)
Do the members of treating team address you properly?	24 (96)	1 (4)	0	0
Does the treating team spend enough time to listen?	23 (92)	2 (8)	0	0
Does the treating team show adequate concern?	23 (92)	2 (8)	0	0
Are you permitted to have personal possessions?	10 (40)	10 (40)	1 (4)	4 (16)
Do you have access to phone in ward?	11 (44)	13 (52)	0	1 (4)
Do you have permissions to receive calls and letters?	12 (48)	6 (24)	1 (4)	6 (24)
Does the staff read your letters or listen to phone conversation?	7 (28)	6 (24)	1 (4)	11 (44)
Does the staff provide pen and paper for letter writing?	13 (52)	1 (4)	1 (4)	10 (40)

*These patients were uncooperative (due to various illness related factors) because of which they could not respond. ** These patients were either destitute or orphans

Overall rating of meeting of emotional needs

Practically all patients (96%) said that the efforts of the staff to meet their emotional needs were good. Some of them said they were not allowed to keep any personal possessions and more than half (52%) said they did not have any access to a phone. Among those who did write letters, a majority expressed that the staff provided them with materials for writing. A little more than one-quarter (28%) said the staff do listen to their phone conversations or read their letters.

Table 3h. Coercion/Physical Abuse

Description		Yes - N (%)	No – N (%)	Not applicable**- N (%)
Were you threatened by hospital staff?		7 (28)	18 (72)	0
Did the hospital staff use bad language that hurt you?		3 (12)	22 (88)	0
Were you ever beaten by any hospital staff?		1 (4)	24 (96)	0
Did any hospital staff ever made sexual advances towards you?		0	(100)	0
Were you restrained physically?		2 (8)	0	23 (92)
Were you informed about the need for restraint?		0	2 (8)	23 (92)
Were you told about alternatives like chemical restraints/seclusion?		0	2 (8)	23 (92)
Was any staff present while you were being restrained?		2 (8)	0	23 (92)
Staff present during restraint	Male	0	0	0
	Female	2 (8)		23 (92)
Were you left unattended more than 2 hrs?		0	2 (8)	23 (92)
Were restraints padded?		0	2 (8)	23 (92)
Did the staff check restraints frequently?		2 (8)	0	23 (92)

**These patients were not restrained during their stay in the hospital.

A fourth of the respondents reported having been threatened by the hospital staff. A small number (12%) reported having been abused verbally.

Table 3i. Social Needs (Level of satisfaction)

Description	Very poor – N (%)	Good- N (%)	Very good- N (%)
Permission to attend family functions	20 (80)	3 (12)	2 (8)
Group activities	11 (44)	12 (48)	2 (8)
Outdoor activities	9 (36)	15 (60)	1 (4)

Participation in sports/games/cultural activities during hospital stay	16 (64)	6 (24)	3 (12)
Provision of separate visiting room	5 (20)	8 (32)	12 (48)

The levels of dissatisfaction with social activities were relatively higher in RMH Thane, with 44% rating the group activities as very poor and 64% rating physical activities as very poor. A third was dissatisfied with the outdoor activities. A majority was satisfied with the visiting areas. Most said they did not receive permission to attend family functions.

Table-3j. Religious/Spiritual/Ethical needs

Description	**Yes – N (%)**	**No- N (%)**	**Not applicable**-N (%)**
Is there permission for religious\spiritual activities	21 (84)	4(16)	0
Are you treated with concern, respect and care?	25 (100)	0	0
Were you treated against your wish?	6 (24)	19 (76)	0
Are you allowed to read newspaper and magazines?	14 (56)	6 (24)	5 (20)[#]
Are you allowed to take health care decisions?	25 (100)	0	0
Was your haircut done without consent?	4 (16)	18 (72)	3 (12)**$**
Were you permitted to represent legal matter in court?	19 (76)	0	6 (24)^
Did you get information given about patients' rights in hospital?	0	25 (100)	0
Is confidentiality maintained by the treating team?	0	16 (64)	9 (36)
Did the treating team given education to patient and families about illness?	2 (8)	15 (60)	8 (32)
Did any staff ask for bribes and gifts?	2 (8)	23 (92)	0
Have you felt any discrimination from the treating team because of your religion or culture?	2 (8)	23 (92)	0
Were your hobbies encouraged in hospital stay?	9 (36)	16 (64)	0
Is informed consent taken for treatment?	9 (36)	16 (64)	0
Is informed consent taken for research?	2 (8)	0	23 (92)[@]
Is pre- test HIV/STI/OTHER test counselling done?	0	25 (100)	0

[#]Illiterate; ^ These patients do not have any legal issues;$ these patients hair cut was not done.[@] No research has been undertaken on these patients.

With respect to spiritual and religious freedom, a majority (84%) said they were permitted to carry out their rituals and did not feel discriminated on account of their religious background

(92%). All respondents said they were treated with concern, respect and care. They all felt they were allowed to take health care decisions. One-fourth, however, said they had been treated against their wish. Moreover, two-thirds (64%) said the treatment had occurred without their consent. A small number (16%) said their hair had been cut without consent. None of them had received any pre-test counselling for HIV and other tests. Very few had participated in any research. Most were of the opinion that they were permitted to represent legal matters. More than two-third says confidentiality is not maintained.

OBSERVATIONS OF THE VISITING TEAM

Infrastructure and Basic Facilities

The female wards are very old, leaking and dilapidated. There is crowding- with 55-60 patients in a small area and no separate dining areas. This is especially true for the acutely ill patients. Patients sleep on the floor on mattresses and there is no assigned bed for any of them, especially in the acute ward. There is no mosquito mesh and only one toilet for 50women.

However, in the long stay wards there are beds. Some of the long stay patients are in what is termed a `Geriatric Ward". However, there are no specific facilities in these wards for the elderly and the segregation is mainly on the basis of age. Women with dementia are not admitted here.

The status of the chronic wards is slightly better. They are larger, more airy and there are beds. Water supply in the hospital is only between 7-9 am in the morning and causes difficulty for bathing, washing and sanitary issues. Women are bathed in threes and fours because of this. Water is stored in the only toilet in the acute wards for women to use during the day, but this is often insufficient. However, the floors were clean and so were the bed sheets and mattresses.

The staff reported that many parts of the wards were inhabitable as they were old. During the rains, there is leakage and it is very difficult to ensure hygiene and cleanliness as the wards become very damp.

ECTs are used often and there is a full time anaesthetist available. However, the ECT room needs more space, especially for recovery areas.

Recommendation- the buildings are unfit for use and need to be condemned. The leakage and poor ventilation can be a breeding ground for poor health in already compromised patients. The OPD had adequate waiting space but the doctor's rooms were crowded with little or no privacy.

Food

Patients were satisfied with the food provided. The kitchen was clean and several patients were identified as `Helpers'. There was a dietician and the menu appeared to be balanced. Non vegetarian food was provided two days in a week. However, there were no separate dining areas in any of the wards. Most of the patients are satisfied with food adequacy, timing

and the quality but some inmates wanted better quality food, they are getting special food in some special occasions.

Personal Hygiene

In the Thane hospital, patients have no privacy while bathing, using the toilets, changing the clothes because of the limited water supply. Bathrooms are very old and not geriatric friendly. Some of the bathrooms do have doors and cleanliness needs to improve.

Sanitary napkins are not provided; patients get inner wear only during their menstrual period and they are not educated about proper disposal. They get toiletries, winter wear and slippers. Uniforms are supplied by the government. These are not properly designed. Patients have difficulty walking in these attires. Some patients who are over-weight particularly face difficulty with these uniforms.

Leisure activities and Occupational Therapy

While there is a lot of space for patient activities outside the ward, the space can be utilised much better. The team did not see any active games or play areas. The recreational facilities

are very poor, there is no library, though a newspaper is provided to each ward. The nurses do morning yoga and exercise. For a select few, some form of rehabilitation is available every alternate day for two hours, but this is very inadequate. Patients do not have much recreational activities and because of crowding and not much to do, tend to either have fights or become withdrawn.

Facilities for the Medically Ill

There is a Sick Room for women who are physically unwell and this has emergency drugs as well as oxygen supply and suction machines. However, this space could be organised much better. Currently, women with serious physical health problems occupy one space; women with physical disability or frailty are in another room and women with tuberculosis are on the

first floor. Despite there being a medical doctor full time in the Sick Room, combining those with acute medical illness and other disabilities is not a good idea.

Human resources

There is great shortage of staff-very few psychiatrists for the large number of patients. There are medical officers but they too are small in number. The psychiatrists manage only acute care issues and are not able to do any therapeutic work or even detailed mental status examination. Nurses are also less in number. There are 6 occupational therapists, one psychiatric social worker. There is no clinical psychologist.

Facilities for patients

The dresses are not suitable and the *petticoat- kurta* which the government has provided is uncomfortable and women tend to fall or trip.

Emotional Needs

The ayahs appeared to share a good relationship with patients in the long stay wards. However, in the acute wards, women often had to tend to their own needs as they were brought there when they were acutely ill and there are not enough nurses or doctors to explain what is happening and to ensure emotional support. Student nurses are posted and provide some conversation and unstructured emotional support. There are no PG students and more medical officers than psychiatrists, limiting the type of psychological care that patients receive. There are no facilities for psycho education or any form of structured group or individual work other than what the psychiatric social worker provides.

Placement and reuniting issues

Most patients are from Thane and Mumbai and live in small homes and nuclear households. The elderly, as well as those with intellectual problems are more prone to being abandoned. Also, during the long duration of hospital stay, a lack of stimulation leads to more negative symptoms and an inability to adjust to the demands of a home environment. This probably leads to negative expressed emotions, poor drug compliance and readmission because of relapse. Once this happens twice or thrice, the patient is abandoned. The social worker mentioned several attempts at placement, very few of them being successful. She felt the lack of internet facilities for the staff which might help in locating families through electoral rolls and police stations. There was also no facility for phones and all phone calls within and outside Maharashtra had to be made from the superintendent's office.

NGO support

There are two NGOS providing support - Neptune and Tarasha. Neptune helps with placement but the terms and conditions of this relationship are unclear. There appear to be

some concerns about ownership and taking credit for the placements by the NGO and not keeping the hospital social workers in the loop all the time. However, the staff agreed that the NGO had been helpful in reuniting some women. Tarasha is a TISS initiated project that appears to have been successful in rehabilitating a few women with jobs and skills.

Specific observations of the member-secretary of the Maharashtra State Commission for Women

The following points were noted by Mr. A. N. Tripathy, Member Secretary I/C, MSCW during his visit to RMH Thane on 4 January 2016:

1. Hospital is facing problems of staff and lack of infrastructure.
2. In most cases, no efforts have been made to reunite the patients with their family and rehabilitate them. In some cases, patients have been ignored by their relatives in order to grab their properties.

   On behalf of the State Commission he proposed that:

   1. Patient details to be obtained in order to reunite them with their family and for this the services of the concerned officers in the police, revenue department, NGOs and social workers to be taken. Help of the electronic and print media and similar agencies to be taken.
   2. Authorities to share the details of the patients and the appropriate plan of action.
   3. Appropriate authorities from the district to be instructed to search for the properties of such patients which are in their name or can be transferred by way of inheritance to their names
   4. Sufficient staff and infrastructure to be made available.

SUMMARY

Overall, though patients expressed generally high levels of satisfaction with regard to the facilities, areas of relative dissatisfaction with regard to basic needs included overcrowding, state of the toilet and bathrooms, potable water and hot water for bathing and lack of locker facility. A majority opined that the dining facilities were inadequate and a quarter rated the overall quality of food and related services as poor. A majority said they were not allowed to wear their own clothes. More than half did not receive any footwear. A quarter said they lacked privacy during bath and use of toilets. A similar proportion said they were not provided inner wear of winter wear. A small proportion said they were not provided any toiletries. A considerable proportion of patients reported that they were pests in the ward. A majority said they were no places to rest. A majority said heaters were not provided. About a quarter said the bedding was not satisfactory and that emergencies were not immediately attended. There was a high level of satisfaction with the treatment. However, a majority said they had not been explained the side-effects of treatment. Patients were practically all satisfied with the way the staff responded to them, and felt that all the staff maintained confidentiality with respect to their treatment. However, some of them said they were not allowed to keep personal possessions and over half did not have access to phones. Half of

them felt there was no privacy in their private conversations and communication. A fifth reported having been threatened by the staff and a small number reported verbal abuse. There was relatively higher dissatisfaction with respect to outdoor activities. Most patients did not feel discriminated on account of their religion and most felt they had the freedom to practice their own religion. Two-thirds expressed that treatment had occurred without their consent.

The team visiting RMH Thane feel that there are genuine problems in an urban mental hospital such as Thane, where patients are kept for long periods and families cannot take them home. **Poor infrastructure, old dilapidated buildings and lack of basic hygiene facilities, make the experience dehumanising. Women do not have recreational facilities or occupational therapy which leads to lack of skills and institutionalisation**. However, some aspects of care were good- adequate medical care, humane staff, no incidents of violence towards patients, adequate food, regular dental and dermatology camps for patient.

4. INSTITUTE OF PSYCHIATRY AND HUMAN BEHAVIOUR, BAMBOLIM, PANAJI, GOA

INTRODUCTION

The Institute of Psychiatry and Human Behaviour (IBHP) is a relatively new 300-bed hospital constructed at Bambolim in 2001. Earlier the mental hospital was in Altinho. The hospital is under the administrative charge of the Goa Medical College.

The NHRC 1999[47] report rated the IPHB Goa as 'Good'. At that time the staffing was generally perceived as adequate. There were arrangements to address patient grievances. Rights were communicated to voluntary patients. The budget was perceived as adequate. The hospital had emergency psychiatric services. Outpatient services were present. Inpatient basic facilities appeared inadequate. Almost all patients received free treatment. Adequate attention was being paid to the preparation and serving of food. The hospital had a separate laboratory. There was a separate medical records section. There were, however, no library facilities for patients. There were occupational therapy and rehabilitation facilities, but no day care centre. The hospital had a community programme. Problems faced by the facility at Bambolim include proximity to the busy highway and the presence of an adjoining quarry, both of which posed security risks for the patients. At that time, the NHRC recommended the introduction of special facilities for substance use and for children; improving of services for the criminally mentally ill; more extensive rehabilitation services; sensitisation of the staff regarding the rights of the mentally ill; better liaison with NGOs and regular administrative staff meetings to improve staff morale.

By the time of the NHRC 2008 review[48], the beds had been decreased to 190. Many of the wards, however, continued to be closed wards. The hospital had made a proposal for a day care rehabilitation centre. A substance use treatment centre had been proposed. The hospital reported that it was liaising with NGOs. A citizen's charter, outlining patient rights was issued. Interim reports of the NHRC suggested that 'Given the right kind of dynamic and imaginative leadership, the IPHB can become a major centre for training mental health professionals including clinical psychologist, PSWs and psychiatric nurses.' The IPHB was shifted to a newly built premises measuring 27.60 Hectares of land on 28th May 2001, in close proximity with the Goa Medical College (GMC), Bambolim -Goa. It is financially independent from Goa Medical College and it is able to function very well in terms of day-to-day issues. An in-charge director and in-charge Medical Superintendent look after this hospital.

[47]National Human Rights Commission. Quality assurance in mental health report, 1999. Ibid
[48]National Human Rights Commission. Mental Health and Human Rights, 2008. Ibid

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

At the IPHB, the Head of Psychiatry, the medical superintendent, nursing superintendent and the psychologists and psychiatric social workers were interviewed. The staffs, in general, were satisfied with the infrastructure, human resource and administrative support to run the hospital. They expressed satisfaction with the budget. Main concerns were the non-availability of community facilities for patients post-discharge. They also perceived the need to start specialised inpatient services for children and for addiction.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table4a. Basic Facilities

Description	Yes - N (%)	No -N (%)	Not answered** - N (%)
Is there adequate light during day time?	25 (100)	0	0
Is there adequate light during night time?	25 (100)	0	0
Is hot water given for bathing regularly?	24 (96)	1 (4)	0
Is safe drinking water provided?	23 (92)	2 (8)	0
Are bathroom and toilets adequate?	13 (52)	12 (48)	0
Are bathroom and toilets cleanly maintained?	22 (88)	3 (12)	0
Is there space for washing and drying clothes?	16 (64)	5 (20)	4 (16)
Is the ward cleaned regularly?	23 (92)	1 (4)	1 (4)
Is linen changed regularly?	24 (96)	1 (4)	0
Is there overcrowding in the ward?	14 (56)	11 (44)	0
Are patients allowed to go outside the ward regularly?	13 (52)	12 (48)	0
Is there adequate space for walking outside the ward?	9 (36)	16 (64)	0
Is a locker facility provided?	20 (80)	5 (20)	0

*These patients were uncooperative and did not respond.

Overall rating of basic facilities

Almost all patients (96%) rated the overall basic facilities as good. With regard to specific areas, all reported satisfaction with the lighting during the day and night. Most reported satisfaction regarding availability of hot water for bathing (96%), changing of linen (96%), (ward cleanliness (92%), drinking water (92%). However, nearly half felt that the toilets and bathrooms were inadequate. More than two-third felt there was no adequate space for walking outside the ward. Overcrowding was perceived by 44%. Nearly half said they were

not allowed to go out regularly. Most were satisfied with the locker facility, although 20% said they did not have this facility.

Table4b.Food

Description	Yes – N (%)	No – N (%)
Is the food provided adequate?	25 (100)	0
Is there sufficient variety in the daily menu?	25 (100)	0
Is quality of food satisfactory?	21 (84)	4 (16)
Are you satisfied of frequency of food provided?	25 (100)	0
Are you served with special food served on special occasions?	25 (100)	0
Are you served non-vegetarian meals on request? *	24 (96)	0
Are food serving staff polite?	23 (92)	2 (8)
Is there a separate dining area?	6 (24)	19 (76)
Are facilities provided in the dining area?	2 (8)	23 (92)
Are the utensils and dining room cleanly maintained?	19 (76)	6 (24)

* One patient was vegetarian

Overall feedback on food and dining facilities

Overall, most respondents (96%) were satisfied with the overall food and dining facilities. Specific area of dissatisfaction was with not having a good dining facility. About a fourth was dissatisfied with the maintenance of the utensils and dining room.

Table-4c: Personal Hygiene

Description	Yes – N (%)	No – N (%)	Not applicable**- N (%)
Is privacy maintained while bathing, using the toilet, changing clothes?	23 (92)	2 (8)	0
Are sanitary napkins provided regularly?	15 (60)	0	10 (40)
Is information provided on proper disposal of sanitary napkins by nursing staff?	14 (56)	1 (4)	10 (40)
Are basic toiletry articles provided?	25 (100)	0	0
Are you permitted to wear own clothes?	1 (4)	24 (96)	0
Are you given a choice of clothes to wear?	0	25 (100)	0
Are you provided inner garments?	11 (44)	14 (56)	0
Is winter wear provided to you?	8 (32)	17 (68)	0
Is footwear provided to you?	20 (80)	5 (20)	0
Are basic cosmetics provided to you?	23 (92)	2 (8)	0

**These patients had reached menopause. Some do not want to wear inner garments.

Overall feedback on personal hygiene and basic comforts

Most of the respondents expressed overall satisfaction with the facilities addressing their personal hygiene and comfort. All of them said they were provided basic toiletries and most (92%) were provided basic cosmetics. Most (80%) were provided footwear. However, most were not permitted to wear their own clothes and not provided a choice of hospital clothes. More than half said they were not provided inner garments and more than two-thirds said they did not get warm clothing.

Table4d. Sleeping and Resting Facilities

Description	Yes –N (%)	No - N (%)	Not answered*- N (%)
Is the ward quiet at night?	24 (96)	1(4)	0
Are you provided with separate cot, mattress, pillow and blanket?	25 (100)	0	0
Are fans provided when it is hot?	25 (100)	0	0
Are heaters provided?	0	24 (96)	1 (4)
Do you have facilities to sit and rest during the day?	19 (76)	5 (20)	1 (4)
Does the ward have bedbugs, cockroaches, mosquitoes exist in the ward?	16 (64)	9 (36)	0
In case of serious physical and mental problems, is immediate help provided?	25 (100)	0	0

*These patients were uncooperative and did not respond.

Overall rating of sleeping and resting facilities

A majority (96%) was satisfied with the sleeping and resting facilities. However, more than two-thirds said there were pests in the ward. There are no heaters in the ward (Goa does not need any!)

Table 4e. Medication and treatment

Description	Yes - N (%)	No – N (%)
Does the nursing staff help in taking medications?	25 (100)	0
Have you been given explanation by treating team about medicines and side effects?	10 (40)	15 (60)
Is a female nurse/attendant present when you are physically examined by a male doctor?	25 (100)	0
In case of medical problem, is immediate attention provided?	25 (100)	0

Overall feedback regarding medication and treatment

All patients rated the facilities for medication and treatment ad good or very good. As in the other hospitals a majority (60%) said they had not been explained the side effects of medications.

Table4f. Emotional Needs

Description	Yes- N (%)	No- N (%)	Not answered * - N (%)	Not applicable **- N (%)
Do the members of treating team address you properly?	24 (96)	1 (4)	0	0
Does the treating team spend enough time to listen?	24 (96)	1 (4)	0	0
Does the treating team show adequate concern?	25 (100)	0	0	0
Are you permitted to have personal possessions?	1 (4)	9 (36)	1 (4)	14 (56)
Do you have access to phone in ward?	8 (32)	4 (16)	0	13 (52)
Do you have permissions to receive calls and letters?	2 (8)	4 (16)	0	19 (76)
Does the staff read your letters or listen to phone conversation?	4 (16)	0	0	21 (84)
Does the staff provide pen and paper for letter writing?	0	5 (20)	0	20 (80)

*These patients were uncooperative and did not respond.** These patients were either destitute or orphans.

Overall feedback regarding meeting of emotional needs

A majority (96%) felt that overall their emotional needs were well met. Since a large number interviewed were destitute or orphaned, questions pertaining to calling or writing to family were not relevant. A majority said the treating team treated them well. A third said they were not able to keep any personal possessions.

Table 4g. Coercion/Physical Abuse

Description	Yes - N (%)	No- N (%)	Not applicable**- N (%)
Were you threatened by hospital staff?	3 (12)	22 (88)	0
Did the hospital staff use bad language that was hurtful to you?	2 (8)	23 (92)	0
Were you ever beaten by any hospital personnel?	0	25 (100)	0
Did the hospital staff ever make sexual advances towards you?	0	25 (100)	0
Were you ever restrained physically?	1 (4)	0	24 (96)

Were you informed about the need for restraint?		0	1 (4)	24 (96)
Were you told about alternatives like chemical restrains/seclusion?		1 (4)	0	24 (96)
Was any staff present while being restrained?		1 (4)	0	24 (96)
Staff present during restraint -Female/Male	Male	0	0	0
	Female	1 (4)		24 (96)
Were you left unattended more than 2 hrs?		0	1 (4)	24 (96)
Were restraints padded?			1 (4)	24 (96)
Did the staff check restraints frequently?		0	1 (4)	24 (96)

**These patients were not been restrained during their stay in the hospital.

Overall feedback regarding coercion/abuse

A couple of patients answered that they had been threatened or verbally abused. None of the patients had been physically abused.

Table4h. Social Needs (How much you are satisfied)

Description	Very poor – N (%)	Good – N (%)	Very good- N (%)	Not applicable**- N (%)
Permission to attend family functions	5 (20)	0	0	20 (80)
Group activities	4 (16)	19 (76)	1 (4)	1 (4)
Outdoor activities	8 (32)	8 (32)	0	9 (36)
Participation in sports/games/cultural activities during hospital stay	6 (24)	15 (60)	1 (4)	3 (12)
Provision of separate visiting room	5 (20)	1 (4)	0	19 (76)

**These patients were either destitute or orphans. Some patients' addresses were still not traced; they do not have anybody. Some patients are ill, too sleepy or lack interest in these activities.

Overall rating of Social Needs

A third was not satisfied with the outdoor activities and a fourth with the organisation of physical and cultural activities. As many were destitute, questions related to visitor's room and permission to attend family functions were not relevant.

Table 4i. Ethical, Spiritual and other needs

Description	Yes – N (%)	No- N (%)	Not answered*- N (%)	Not applicable- N (%)
Is there permission for religious\spiritual activities?	17 (68)	8 (32)	0	0
Are you offered considerate respect and care?	23 (92)	2 (8)	0	0
Are you allowed to read newspaper and magazines?	6 (24)	4 (16)	0	15 (60)[#]
Are you allowed to take health care decision?	1 (4)	21 (84)	3 (12)	0
Was your haircut done without consent?	10 (40)	15 (60)	0	0
Were you permitted to represent legal matter in court?	1 (4)	7 (28)	0	17 (68)^
Did you get information given about patients' rights in hospital?	0	25 (100)	0	0
Whether confidentiality maintained during hospitalization by treating team?	0	16 (64)	9 (36)	0
Was your haircut done without consent?	10 (40)	15 (60)	0	0
Were you permitted to represent legal matter in court?	1 (4)	7 (28)	0	17 (68)^
Did you get information given about patients' rights in hospital?	0	25 (100)	0	0
Whether confidentiality maintained during hospitalization by treating team?	0	16 (64)	9 (36)	0
Did the treating team given education to you about the illness?	3 (12)	11 (44)	0	11 (44)[#]
Did staffs ask for bribes and gifts?	0	25 (100)	0	0
Have you felt any discrimination by treating team for religion or culture?	1 (4)	24 (96)	0	0
Were your hobbies encouraged in hospital stay?	17 (68)	5 (20)	3 (12)	0
Is informed consent taken for treatment?	9 (36)	16 (64)	0	0
Is informed consent taken for research?	18 (72)	0	0	7 (28)
Is pre- test HIV / STI / OTHER counselling done?	1 (4)	18 (72)	0	6 (24)

* These patients were uncooperative and did not respond. [#] Illiterate; ^ These Patients do not have any legal issues; [@] No research has been undertaken on these patients.

Overall rating on spiritual and other areas

While a majority said there was no discrimination on the basis of religion, nearly a third felt there was no permission for carrying out their religious/spiritual activities. Most said they were treated with respect and care. While several were illiterate, some said they did not get newspapers and magazines to read. A majority (84%) said they were not allowed to make health care decisions. A significant number (60%) said their hair was cut without consent. Although IPHB was the first to develop a patient's charter, all the patients said they had not been given information about their rights. Two-third felt that confidentiality was not maintained. Eleven patients (44%) said they had not been educated about their illness. None had been asked by any of the staff for bribes or gifts. Two-thirds said informed consent had not been taken prior to starting treatment and nearly three-fourth said that pre-testing counselling for HIV and other tests was not done.

OBSERVATIONS OF THE VISITING TEAM

It is note-worthy that hospital administration is completely looked after by two lady medical officers, the Head of Psychiatry and The Medical Superintendent (in-charge). The post of the Director and the Medical Superintendent is vacant since long. However, the in-charge medical superintendent is able to fulfil her clinical obligation and administration role with the support of the HOD of Psychiatry.

Inspection was carried out on 6th, 7th & 8th January 2016, by representatives from NCW as well as NIMHANS.

It is note-worthy that hospital administration is looked after by two lady medical officers, the Head of Psychiatry and the Medical Superintendent (in-charge). The post of the Director and the Medical Superintendent is vacant since a long time. However, the in-charge medical superintendent is able to fulfil her clinical obligation and administrative role with the support of the HOD of Psychiatry.

Crowded Out-patient Department

The OPD registration timings are from 09:00 AM - 01:00 PM. However, OPD is opened till 5.00PM. The OPDs are conducted on all working days except Sundays and public holidays. However, 24 hours emergency services are also provided. Approximately 120-180 patients (female and male) are seen daily on OPD basis. There are separate consultation rooms but the waiting hall for patients is too small and needs to be upgraded.

In-patient ward

It is 190-bedded hospital (160 closed ward and 30 open ward), of which 80 beds are for women. There were 80 female patients admitted in closed ward. Total number of reception order (Magistrate order) patients admitted under Mental Health Act, 1987 in closed wards were 129 of which 65 were female patients. Majority of the reception order patients are destitute and many of them belong to other states. Hospital administration finds it difficult to trace the family members / address of the patient admitted in the closed ward.

Each ward has clean toilets and bathrooms, however they are inadequate in number and some of them are inoperable. Water supply is erratic and needs to have separate centralized water tank facility for the hospital. All women patients are given uniform to wear but it would be appropriate for the hospital authorities to allow the patients to wear their own clothes rather than providing hospital uniform. Unfortunately, hospital do not have their own laundry, they have to depend upon the Goa medical college for cleaning of the clothes and linen once a week. As per the hospital administration report, all female patients are provided with inner-garments and sanitary napkins in adequate number. All patients do get adequate bed and covering clothes appropriate to the weather conditions. Hospital infrastructure needs to be elderly and disabled friendly so that they can access services. Even, the ward toilets need to be disabled friendly.

Children's ward

There is no children ward inside the campus. Children are not usually admitted, however if they require admission they are admitted with adult patients. This issue needs to be taken up seriously and separate children ward needs to be built with modern facilities to cater the needs of the children.

Peri-Natal ward

Mental illnesses are common during pregnancy and child birth. There is an urgent need to have a small mother-child unit available for providing care.

De-addiction ward

There is no separate de-addiction ward inside the campus. De-addiction patients are usually admitted with adult patients. A separate 100 bedded de-addiction ward proposal has been submitted by the hospital authorities many years back but still it is pending for approval from the higher authorities.

Inadequate Infrastructure

Inpatient wards are built in a disorganized manner without any dining area, recreational activity area or exercise area. There is no library inside the ward. These are all minimal basic needs. The wards are small and overcrowded. Though the inpatient ward is built recently (two decades ago), it is not planned properly. The buildings are very poorly built and in many places tell-tale signs of water seepage can be seen across all the wards. The hospital authorities have addressed this issue of water leaking during the rainy season, but still the problem still exists.

There is a need to phase out the existing wards and build new state of the art psychiatry open wards. The emphasis should be on increasing open ward beds and keeping closed ward facilities limited to forensic patients and very violent patients. Locking up of the patients, who are destitute, is a violation of the fundamental rights of the recovered patients. At least 70-80% of the closed ward patients are reception order patients under MHA 1987. Majority of them are cured (but on prophylaxis) and they do not have any family members, hence they

are kept in the closed ward. Hospital administration has plans to relocate them to a long stay home 'Provedoria', but this has not materialized because of bureaucratic hurdles.

The available space within the campus needs to utilized for building a dining hall, occupational therapy centre, opens wards, recreational areas and specialized facilities (De-addiction unit, forensic psychiatry ward, children ward).

Forensic Psychiatry Ward in female closed ward!!!

Forensic ward (both for male and female) is situated inside the female closed ward. This causes major inconvenience to the female patients because of presence of police escorts and other male prison patients; therefore there is an urgent need to shift the forensic ward out of the female closed ward. During the visit it was noted that police escorts have kept firearms and ammunitions inside the closed ward, which is dangerous to other patients and staff.

Occupational Therapy Unit

The occupational therapy unit is very small and basic in nature. This facility is available only for few inpatients. Day care patients cannot utilize this facility. There is a need to have full-fledged occupational therapy unit for women with separate infrastructure and rehabilitation specialists. There is also need to upgrade the occupational therapy unit facility, so that day care patients can also use this service. There is an urgent need to liaise with NGO's so that recovered patients can be placed appropriately in the community.

Medicine Supply

Free medicines are provided for one month to all patients, irrespective of the economic status. However, ensuring continuous non-interrupted supply of medicine is a serious problem, in spite of separate funding for procuring medicines. There are many bureaucratic hurdles in procuring medicines. This needs to be made simple in order to smoothen the process so that their supply is uninterrupted.

Laboratory services

The hospital has basic laboratory services situated in the OPD complex. Complete haemogram and biochemistry services are done. Other lab investigations are done at Goa Medical College and it takes at least 7days to obtain the results. IPHB does not have facilities to perform serum lithium, valproate and carbamazepine levels. IPHB needs to procure latest lab equipment to perform these tests, which are important in patients on long-term treatment.

Library services for inpatients

Library services are available only in the OPD building to students and staff of the hospital. Internet services are available. This library is not open for patients since it is a professional medical library. There is an urgent need to start a general library for patients so that patients get the opportunity to read current affairs, read for entertainment, pursue education, search for employment and to stimulate their intellectual growth. Such a general library can offer

newspapers, weekly and monthly magazines, novels, story books, educative books on mental illness and so forth in multiple languages for the benefit of the patients.

Long Stay Home for women

Goa does not have any long-stay homes for persons with mental illness. There is no NGO working with women with mental illness. There are a few long-stay homes for the elderly. IPHB had made several attempts to liaise with other governmental and non-governmental agencies, but none of them materialized because of technical issues, stigma, financial issues and lack of adequately trained human resources to run the services. One of the dream projects of IPHB was to relocate the recovered mentally ill to a long stay home called 'Provedoria', but this is yet to be implemented.

Other Services

IPHB also has an excellent modified electro-convulsive therapy unit with fulltime-dedicated anaesthetist. They also have good kitchen facilities, canteen within the outpatient department. This kitchen can be used to rehabilitate women with mental illness. The institute has post-graduate training in both MD and DPM in Psychiatry.

De-addiction services

Although Goa faces a big problem with both alcohol and other drug misuse, there are no dedicated government run substance use de-addiction facilities in the State. Even the IPHB does not have a dedicated addiction treatment ward. Many patients do not seek treatment because of stigma. There are only ten beds each in district hospital to provide inpatient de-addiction care. Addiction treatment services are required for both men and women. As proposed, the 100 bed addiction treatment centre with separate beds for women needs to be initiated at the IPHB.

SUMMARY

IPHB, Goa has been among the better psychiatric institutions in the country. Service providers are generally satisfied with the infrastructure and functioning of the hospital, but are dissatisfied with the near absence of community rehabilitation facilities in the country.

Overall most of the inpatient respondents indicate satisfaction with most of the facilities. Areas of dissatisfaction among many of the respondents include inadequate toilets and bathrooms, lack of walking spaces, overcrowding, lack of a good dining facility, compulsory hospital clothes and pests in the ward. There was a great amount of satisfaction regarding the attitude of the staff, provision of toiletries and lack of discrimination. However, many respondents said they had not been explained the side-effects of medicines and their consent had not been obtained prior to initiating treatment. A few patients said they had been threatened and verbally abused. A third was not satisfied with the outdoor activities. A third said there was no permission to carry out their religious/spiritual activities. A majority said they were not allowed to make health care decisions. Ironically, though IPHB was the first to make a patient's charter, all the patients said they had not received information about their

rights. Two-thirds felt that confidentiality was not maintained and a significant number said they had not received any information regarding their illness. A majority said their hair had been cut without consent. Most said pre-test counselling was not carried out during HIV and similar testing.

The visiting team was generally appreciative of the running of the hospital.

Recommendations of the team include:

1. Filling up of vacant posts
2. Proper out-patient waiting area
3. Better planned inpatient spaces
4. Attention to poor quality construction and re-building if required
5. Increase in the open ward facilities
6. Initiation of specialised services for addiction, for children and forensic psychiatry
7. Setting up of community rehabilitation and long-stay facilities for the patients
8. Steps to ensure uninterrupted medication supply for patients
9. Strengthening of the District Mental Health Programme
10. Greater inter-sectoral collaboration with NGOs and government to trace patients' families
11. Active inputs from the Ministry of Social Justice and Empowerment, Ministry of Women and Child Welfare and the Ministry of Tourism for rehabilitation, given that Goa is a tourist-economy driven state.
12. Regular inspection from the NCW/SCW

5. CALCUTTA PAVLOV HOSPITAL, KOLKATA, WEST BENGAL

INTRODUCTION

The Calcutta Pavlov Hospital was established in 1966, earlier as the Hospital for Mental Diseases and prior to that the building housed the Albert Victor Leper Hospital, started in the previous century. It was renamed the Pavlov Hospital in 1985 and from 1996, it is managed by the Government of West Bengal.

The NHRC 1999 Report[49] rated this hospital, with a bed strength of 250, as 'Average'. At that time, the hospital building was over a century old; there were only closed wards; the staff strength was inadequate; the hospital had both court-directed and voluntary admissions; there were no emergency services; the hospital had outpatient services; inpatient services were inadequate; it was reported that patients were informed of their rights. Despite the deficiencies, this hospital was found to be the best in the State of West Bengal, with a good liaison with the medical college hospital. The maintenance was reasonable and patients had no complaints. Recommendations at that time were to start rehabilitation services, to improve laboratory facilities and to establish it as a training institute.

The NHRC 2008 Report[50] notes that there were interim inspections of the hospital by the DGHS in 2004. It was noted that though the building and facilities were adequate, the hospital required a lot of improvements. The female wards needed improvement. Recreation and rehabilitation facilities were absent. The kitchen and dining hall required repairs. The hospital had not developed laboratory services. It reported having developed a rehabilitation facility but no details were provided. The staff was short and apart from 3 social welfare officers, there were no psychologists, psychiatric social workers or psychiatric nurses. The hospital had developed emergency and outpatient services. It did not have a separate medical records section. There were still no open wards. In the wards, the toilets were still inadequate. Dining, running water and fans were reported to be adequate. Uniforms were compulsory, but there was no laundry facility. Food budget had improved.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

The team interviewed the medical superintendent, the nursing superintendent, 2 psychiatrists and psychologists.

The interviews with the medical superintendent and service providers indicated overall satisfaction with recent improvements due to its status as a training institute, construction of additional floors in the closed inpatient facility and the links with non-governmental organisations for rehabilitation and discharge. The primary concerns were regarding the difficulties in tracing and interacting with family members to facilitate discharge, the need for income-generating options for a segment of the inpatients, the need for more open wards as well as increase of open spaces and improved drainage for women in the closed facility, the

[49]National Human Rights Commission. Quality assurance in mental health, 1999. Ibid
[50]National Human Rights Commission. Mental Health and Human Rights, 2008. Ibid

lack of psychiatric social work faculty and the inadequate training and professional development opportunities, particularly concerning rehabilitation.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table 5a. Basic Facilities

Description	Yes – N (%)	No – N (%)
Is there adequate light during day time?	25 (100)	0
Is there adequate light during night time?	25 (100)	0
Is hot water given for bathing regularly?	4 (16)	21 (84)
Is safe drinking water provided?	19 (76)	6 (24)
Are bathroom and toilets adequate?	22 (88)	3 (12)
Are bathroom and toilets cleanly maintained?	18 (72)	7 (28)
Is there space for washing and drying clothes?	5 (20)	20 (80)
Is the ward cleaned regularly?	18(72)	7 (28)
Is linen changed regularly?	14 (56)	11 (44)
Is there overcrowding in the ward?	19 (76)	6 (24)
Are patients allowed to go outside the ward regularly?	13 (52)	12 (48)
Is there adequate space for walking outside the ward?	8 (32)	17 (68)
Is a locker facility provided?	2 (8)	23 (92)

Overall feedback on basic facilities

Overall, about three-fourth of respondents rated the basic facilities as good, but one-fourth rated them as poor. All of them said the lighting was adequate. A majority (84%) said there was no hot water for bath, no place for washing and drying clothes, no adequate space to walk outside the ward (68%) and no locker facility (92%). One-fourth said the drinking water was not safe and that there was overcrowding. Nearly half said that patients were not allowed to go out of the wards. More than one-fourth said the ward was not cleaned regularly. A majority felt that the toilets were adequate, although more than one-fourth said they were not cleaned regularly. Nearly half (44%) said that the linen was not changed regularly.

Table 5b. Food

Description	Yes – N (%)	No – N (%)
Is the food provided adequate?	23 (92)	2 (8)
Is there sufficient variety in the daily menu?	24 (96)	1 (4)
Is quality of food satisfactory?	15 (60)	10 (40)
Are you satisfied with the frequency of food provided?	24 (96)	1 (4)
Are you served with special food on special occasions?	25 (100)	0
Are you served non-vegetarian meals on request?	25 (100)	0

Are the food serving staff polite?	21 (84)	4 (16)
Is there a separate dining area?	25 (100)	0
Are facilities provided in the dining area?	25 (100)	0
Are the utensils and dining room cleanly maintained?	21 (84)	4 (16)

Overall feedback on food and dining facilities

Overall, 92% rated these facilities as good. Most of the domains were positively rated except the quality of food which was rated unsatisfactory by 40% of the respondents.

Table 5c.Personal Hygiene and basic comforts

Description	Yes - N (%)	No – N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	9 (36)	16 (64)
Are sanitary napkins provided regularly?	9 (36)	16 (64)
Is information provided on proper disposal of sanitary napkins by nursing staff?	4 (16)	21 (84)
Are basic toiletry articles provided?	24 (96)	1 (4)
Are you permitted to wear own clothes?	25 (100)	0
Are you given a choice of clothes what to wear?	11 (44)	14 (56)
Are you provided inner garments?	17 (68)	8 (32)
Is winter wear provided for you?	25 (100)	0
Is footwear provided for you?	23 (92)	2 (8)
Are basic cosmetics provided for you?	17 (68)	8 (32)

Overall feedback on personal hygiene and basic comforts

A majority (92%) rated this domain as good. On specific areas, two thirds said that privacy was not maintained while bathing, using the toilets and changing clothes. The same proportion also said that sanitary napkins were not provided regularly and most patients (84%) were not provided information on how to dispose sanitary napkins. All patients said they were permitted to wear their own clothes and most said they were provided basic toiletry articles. For those who received clothes from the hospital, more than half (56%) said they were not provided a choice of clothes. A third said they were not given inner garments. None of them were provided winter wear. A majority (92%) said they were provided footwear. A third said they were not provided basic cosmetics.

Table 5d.Sleeping and Resting Facilities

Description	Yes- N (%)	No- N (%)
Is the ward quiet at night?	21 (84)	4 (16)
Are you provided with separate cot, mattress, pillow and blanket?	23 (92)	2 (8)
Are fans provided when it is hot?	25 (100)	0
Are heaters provided?	1 (4)	24 (96)
Do you have facilities to sit and rest during the day?	9 (36)	16 (64)
Does the ward have bedbugs, cockroaches, mosquitoes?	23 (92)	2 (8)
In case of serious physical and mental problems, is immediate help provided?	20 (80)	5 (20)

Overall feedback on sleeping and resting facilities

Nearly three-fourth (72%) rated the overall sleeping facilities as good. However, a majority (96%) said that heaters were not provided. Nearly two-thirds said that the resting facilities were not adequate. A majority (92%) said there were pests in the ward. One-fifth said that emergency help was not available immediately for physical and mental problems.

Table 5e. Medication and treatment

Description	Yes – N (%)	No- N (%)
Does the nursing staff help in taking medications?	25 (100)	0
Have you been given explanation by treating team about medicines and side effects?	1 (4)	24 (96)
Is a female nurse/attendant present when you are physically examined by a male doctor?	24 (96)	1 (4)
In case of medical problem, is immediate attention provided?	22 (88)	3 (12)

Overall rating on medication and treatment

A majority of patients (92%) rated the availability of medication and the overall quality of treatment as good. All of them said the nursing staff helps them take medications. Most (96%) said a female attendant was present during medical examination. However, a majority (96%) said they had not been explained about the medicines and their side-effects.

Table 5f. Emotional Needs

Description	Yes – N (%)	No- N (%)	Not answered*- N (%)	Not applicable**- N (%)
Do the members of treating team address you properly?	22 (88)	3 (12)	0	0
Does the treating team spend enough time to listen?	22 (88)	3 (12)	0	0
Does the treating team show adequate concern?	23 (92)	2 (8)	0	0
Are you permitted to have personal possessions?	8 (32)	4 (16)	0	13 (52)
Do you have access to phone in ward?	1 (4)	13 (52)	0	11 (44)
Do you have permissions to receive calls and letters?	1 (4)	7 (28)	0	17 (68)
Does the staff read your letters or listen to phone conversation?	1 (4)	2 (8)	1 (4)	21 (84)
Does the staff provide pen and paper for letter writing?	0	2 (8)	1 (4)	22 (88)

*These patients were uncooperative and did not respond. ** These patients were either destitute or orphans.

Overall feedback on meeting emotional needs

Overall, a majority (84%) felt their emotional needs were met. A majority felt that staff members addressed them respectfully (88%), spent enough time with them (88%) and showed adequate concern (92%). A fifth were not able to answer the question on whether the treating teams maintained confidentiality, while the rest mostly felt confidentiality was maintained. Only a third said they were permitted to keep personal possessions. More than half (52%) did not have access to phones. Permission to write and receive letters were also limited. A majority (84%) did not answer the question on privacy to have their conversations and communication (perhaps because they neither made or received calls nor received or wrote letters).

Table 5g. Coercion and related issues

Description	Yes - N (%)	No – N(%)
Were you threatened by hospital staff?	5 (20)	20 (80)
Did the hospital use bad language that was hurtful to you?	5 (20)	20 (80)
Were you ever beaten by any hospital personnel?	5 (20)	20 (80)

Did any of the staff ever make sexual advances towards you?		0	25 (100)
Were you restrained physically?		0	25 (100)
Were you informed about the need of restraint?		0	0
Were you told about alternatives like chemical restraints/seclusion?		0	0
Was any staff present while being restrained?		0	0
Staff present during restraint	Male	0 0	0
	Female		
Were you left unattended more than 2 hours?		0	0
Were restraints padded?		0	0
Did the staff check restraints frequently?		0	0

Overall feedback on coercion and related issues

One-fifth of the patients at Pavlov Hospital said they had been threatened by the ward staff, had been verbally abuse and beaten. None of them had been subjected to sexual abuse. None had been restrained physically.

Table5h. Social Needs (How much you are satisfied)

Description	Very poor- N (%)	Good - N (%)	Very good- N (%)	Not applicable** -N (%)
Permission to attend family functions	1 (4)	0	0	24 (96)
Group activities	5 (20)	15 (60)	3 (12)	2 (8)
Outdoor activities	9 (36)	6 (24)	1 (4)	9 (36)
Participation in sports/games/cultural activities during hospital stay	6 (24)	15 (60)	2 (8)	2 (8)
Provision of separate visiting room	0	2 (8)	1 (4)	22 (88)

**These patients were either destitute or orphans. Some patients' addresses were still not traced; Due to their illnesses, over sedation and lack of motivation, these patients had less interest in these activities

Overall feedback on social needs

A third rated outdoor activities as very poor and a fifth rated group activities as very poor. As many patients were destitute or orphaned, issues like family visits were irrelevant.

Table 5i. Ethical, Spiritual and other needs

Description	Yes - N (%)	No - N (%)	Not answered*- N (%)	Not applicable** - N (%)
Is there permission for religious/spiritual activities?	12 (48)	13 (52)	0	0
Are you offered concern, respect and care?	17 (68)	8 (32)	0	0
Were you treated against your wish?	1 (4)	24 (96)	0	0
Are you allowed to read newspaper and magazines?	8 (32)	13 (52)	0	4 (16)[#]
Are you allowed to take health care decisions?	2 (8)	23 (92)	0	0
Was your haircut done without consent?	12 (48)	10 (40)	3 (12)	0
Were you permitted to represent legal matter in court?	0	11 (44)	14 (56)	0
Did you get information about patients' rights in hospital?	0	25 (100)	0	0
Whether confidentiality maintained during hospitalization by treating team?	3 (12)	15 (60)	4 (16)	4 (20)
Did the treating team give education to you?	0	13 (52)	0	12 (48)[#]
Did staff ask for bribes or gifts?	0	25 (100)	0	0
Have you felt any discrimination by the treating team based on your religion?	1 (4)	24 (96)	0	0
Were your hobbies encouraged during the hospital stay?	19 (76)	6 (24)	0	0
Is informed consent taken for treatment?	13 (52)	12 (44)	0	0
Is informed consent taken for research?	0	0	0	25 (100)[@]
Is pre- test counselling done for HIV/STI/OTHER tests?	12 (48)	8 (32)	0	5 (20)**$**

* These patients were uncooperative and did not respond. [#]Illiterate; ^ These Patients don't have any legal issues; [@] No research has been undertaken on these patients. $ HIV test is done only for suspected population

Overall rating of ethical, spiritual and other needs

More than half the respondents said that they did not have permission to pursue religious/spiritual activities. However, a majority (96%) said they were not discriminated on

the grounds of their religion. A third did not feel they were offered concern, respect and care. A majority said they had not been treated against their will. Over half said they did not read newspapers or magazine. A majority (92%) said they did not make health care decisions. Nearly half (48%) said that their hair had been cut without their consent. A few patients said they had not been able to represent their legal matters in court. All (100%) said they had not been given information on patient rights. Nearly two-thirds said that confidentiality was not maintained by the treating team. More than half said they received no psycho education. None of the patients had been asked for gifts or bribes. About three-fourths said their hobbies were encouraged by the staff. With regard to informed consent, 44% said informed consent for treatment was not taken. About a third said no pre-test counselling was carried out during HIV and other testing.

OBSERVATIONS OF THE VISITING TEAM

Circumstances of Admission

The admissions to Pavlov Mental Hospital are usually involuntary. Most patients are from remote areas of West Bengal, but a proportion come from Uttar Pradesh and Bihar as well. Most patients have psychotic or affective illnesses with a small proportion having intellectual disabilities. There is good cooperation from the police and usually doctors are not required to go to the court. On occasion, there have been court summons to go and see patients in their homes in remote villages and this causes difficulties. Information about the percentage of patients who were homeless was not available.

Basic facilities

In the past one and a half to two years, there have been some improvements in the basic facilities. There are a total of about 270 women who are housed in a three-storey building with a small space around it and a locked gate.

There is no lift and the stairs are difficult to climb for some patients and also makes supervision a problem. Typically, the older women with mobility restrictions are housed on

the ground floor. The top floor is newly constructed and currently there is no significant overcrowding. However, admissions over capacity are anticipated as the hospital is unable to refuse new admissions due to “legal, police and political pressures”. The drainage system reported to be inadequate due to the lack of funds and difficulties in getting speedy responses from the PWD. Mosquito vector borne diseases are a concern and the situation is particularly difficult in the monsoon season. The natural and artificial lighting is adequate and there are fans. There is no heating system for the winter season. The toilets are tiled and clean. All women were provided new clothes a few days prior to our visit. Our interviews indicated that they were previously wearing hospital gowns but there has been a shift to salwar kameez lately. There was a large proportion of women who were inadequately clothed/naked earlier. On the first day of our visit, two or three women were observed to be naked. It was difficult to get consistent information on the number of sets of clothes available to each woman.

There is running water in the bathrooms but no geysers for hot water. There was differing information about the frequency of bathing and there was group or sequential bathing due to the limited bathing spaces. The toilets were clean, particularly on the top floor but were inadequate in number. There were lockable grills at the entrance to the sleeping areas. There is no storage space for clothes and any personal belongings, so these are carried in dirty bags or pieces of cloth wrapped around the waists due to fear of theft.

Many women perceived the amount and frequency of soap/shampoo provided as inadequate. Cosmetic and care products such as powder, bindi or personal combs are not provided. Due to the recent association with the National Medical Hospital, there is a currently a 30 bedded open "Academic Ward" with cases with less severe conditions, e.g. conversion, OCD, depression, and shorter durations of stay of a few weeks to months. At the time of the visit, there were thirteen female and male patients admitted in the Academic Ward. The Outpatient facility operates every day and is usually quite crowded.

Food

The food has seen some improvements in the recent past and is usually served from the dining area in the courtyard on the ground floor. This is too small to accommodate all the women and many sit on the floor of the courtyard and eat, sometimes near the drains. The serving of meals is difficult to monitor and supervise and some women may snatch the food meant for others, particularly the non-vegetarian food provided.

Personal Hygiene

Personal hygiene products are not provided available to all. These may be provided to some patients by the nursing or other staff at their personal expense. Combs may be shared between women and this exacerbates the problem of lice. A barber visits every few weeks and cuts hair short. Although 'consent' is taken from the women, many expressed that this was something they did not want.

There is an intermittent bed bug problem and this has been attributed to the women carrying belongings wrapped in dirty clothes on their person and refusing to give them for cleaning.

Undergarments that are provided for the patients are sent to laundry all together and distributed among the women on return. They do not have undergarments marked for their personal use.

Sanitary napkins given when asked for or on observation by the nursing staff. A covered box is kept in the bathrooms for disposal but this is inadequate and sometimes not used.

According to one of the post-graduate psychiatry residents, "*They (the women) deserve the type of life like what we get at home. We should provide that kind of infrastructure to say we have achieved something.*"

Sleeping and resting

Currently, the women have separate beds to sleep on, with a reasonable distance between each bed. There is no separate area for sitting or rest during the day apart from the small courtyard on the ground floor.

Medication & treatment

Following the recent association with the National Medical College, there are more psychiatrists and psychiatry residents now associated with Pavlov hospital. There is a predominant focus on medical management and ECT is rarely carried out. Each psychiatrist/resident is allotted a number of male and female patients under their care, typically about 40 patients.

The clinical psychologists are involved in the outpatient services. On the days that they visit the inpatient facility, they conduct small psycho-education groups for discussions about medication compliance. There is some limited therapeutic work with select patients on independent and self-help skills. It was felt that the responsibility for discharge planning lies with psychiatric social workers. Currently, Pavlov Hospital has no social workers.

The documentation was adequate in case files and the psychiatrists, psychologists and nursing staff knew patients' names and brief details of their case history.

However, the staff: patient ratio means that the interactions are often brief and intensive case management is difficult. The link with the National Medical College has facilitated the treatment of any medical ailments among patients and one ambulance is available.

Emotional needs

The nursing staff felt that much of their time is spent in dispensing medication, bed-making and keeping a close watch to prevent violence. This leaves little time for one to one interactions and an empathic response to individual needs.

There were varying perspectives about sexual interactions between women patients. While some staff denied that this occurred, others felt that this was inevitable and no specific response was required from the hospital. The Medical Superintendent expressed that this should not be allowed, had contemplated putting CCTVs to monitor this but eventually desisted because of possible human rights concerns.

Emotional abuse/ Physical abuse/Sexual abuse

Physical violence between inmates was more common during the time of overcrowding and there have been serious injuries. Currently this has improved but is still a concern for the nursing staff. Sedation is used to address any violence and there is no seclusion or physical restraint.

Emotional abuse is not common but patients have disclosed that the staffs sometimes make derogatory remarks during mealtimes.

There was a report of sexual abuse of a woman patient by a support staff a few years ago. The patient was transferred to IOP, Kolkata and an FIR was filed. Other details are not available and there have been no reported incidents recently.

Social needs

There have been a few recent attempts to respond to patients' social needs but these are still sporadic. There is a television for all the women but as this is very small and mounted high on the wall it is difficult for them to watch. The process to acquire the television took a year due to apprehensions about possible damage by the patients. There is a "library", a small

cupboard with a few books and magazines and a daily newspaper in a small space in the ward. This is used by very small segment of about 25 patients. The carom board is new and nursing trainees/volunteers engage patients in colouring/craft/group activities. The designated space is very small and very few may be engaged in this activity. Some women are interested in cooking but there are safety concerns from the hospital's side. Most of the women live in an environment of under-stimulation.

Rehabilitation is seen largely as the responsibility of social welfare officers, who are not available at the hospital. The involvement of NGOs Anjali and Paripurnita has had a positive impact and they report that many women are keen and able to engage in productive work. The NGO Anjali has set up a tea stall in the hospital premises with a manager. Women patients have been trained to help at the tea stall and a bank account has been set up for them to deposit their earnings. There is some resentment among patients who have not been selected for this venture as many more women want to be engaged meaningfully. There is a plan to set up a laundry as a government-NGO collaboration but this may be planned primarily for the male patients. The NGO also engages with the women occasionally for dance therapy, singing, and skills training and this has been received very positively by the women.

Religious needs

There is no facility to women to practice their religious faith. Once a year, the women are taken on a bus tour to view the Durga Puja pandals.

Concern about discharge (hospital perspective/ patients' perspective/ consultants' perspective)

The primary question from all women is about their return home. During their interviews, they describe memories of their homes, the food they would eat, their parents or children and express helplessness about living away from home for such long periods.

The hospital administration recognizes that a high percentage of women are "chronic", but have experienced many difficulties in facilitating discharge. Family attitudes as seen as the biggest barrier; patients are seen as a burden and there is low family awareness about mental illness and prognosis. The family members concerns are potential aggression and violence, medication management and compliance issues and financial burden. The families often give incorrect contact information and this is viewed as deliberate. Women are much less likely to be taken back by families. According the Medical Superintendent, only 10% of those fit to be discharged are reintegrated with families and only 1% would have been with active and sustained efforts from the hospital. There is a lack of transport, designated staff or other resources to make home visits to connect with families. Letters are sometimes sent through the local police stations but usually there is no response or follow-up. Families may sometimes send legal notices indicating that they are unable to care for the patient and take her home. The hospital administration strongly suggested that there should be something legally binding on families to come to the hospital where they have left their ward. Some patients try to escape from the ward but are brought back by security. There is a risk of

burnout among the professionals with the same cases seen on a long term basis. The hospital perspective is that "*Issues of discharge are part of larger social issues and human rights issues. Taking only a legal position will not be helpful*."

There have been successful efforts from the NGO Anjali to facilitate discharge; there have been 39 patients discharged and rehabilitated from January 2012-January 2016, through the efforts of the NGO Anjali. These include both men and women and most are living with their family members on follow-up. Some women are also placed in an external NGO for one month, "*just as a change, for freedom of movement and an independent life*." The women are happy there and often may not want to return.

Overall, the visit suggested that the issue of discharge is not a priority for the hospital. There are no sustained efforts to contact family members, apart from the NGO efforts which are laudable. The treating professionals have limited contact with families and had limited views on family needs, perspectives and ways to engage them in the treatment and discharge process. The lack of psychiatric social workers and a clearly defined set of steps for discharge planning means that this is not addressed adequately; women with adequate symptom control and repeated expressed desires to return home are told this is not possible without family involvement.

Specific observations and suggestions of Ms. Rekha Sharma, Member, National Commission of Women

The management and hygiene are very poor, the intake capacity of the hospital is far less than the actual number of patients, mounts of garbage was lying in the vicinity of hospital, an open pond with dirty water and full of garbage near to the hospital with broken protection wall, people urinate in open area, ice cream vendors from outside were selling ice cream without any entry pass as there was no entry checking to enter, severe shortage of staff were observed. Overall the hospital needs immediate attention as the women inmates are in bad condition.

SUMMARY

In personal interviews, patients rate the lighting as adequate, but the main deficiencies highlighted are the lack of hot water for bath, lack of places to wash and dry clothes, lack of lockers to keep their possessions. Many say they cannot go out for a walk. Some say the ward is not cleaned regularly and that the toilets are not cleaned regularly. Many patients said the linen is not changed regularly. The food and service has been generally rated as good although the quality of food has been rated as unsatisfactory by 40% of respondents. Many patients say privacy is not maintained during bathing, using toilets and changing clothes. Sanitary napkins are not provided regularly and most patients are not told on how to dispose them. Patients are permitted to wear their own clothes, provided basic toiletry articles. Those who get hospital clothes have no choice. Some say they do not get inner garments. A majority say they are given winter wear as well as footwear. Some say they are not provided basic cosmetics. Most describe the sleeping arrangements as good but many say the resting arrangements are not adequate. Most say that there are pests in the ward. Some say

emergency help is not immediately available. A majority is satisfied with the medication and the help from the staff to take the same. However, they have not been explained the side-effects of the medicines. A majority are happy with the way staff behaves towards them. Many do not have access to phones. A majority did not answer questions related to privacy. Some patients report having been threatened, verbally abused and beaten by the staff. A small number rate the outdoor facilities as poor. Some express that they are not permitted to pursue religious/spiritual activities. Some also express that they have not been treated well. A majority feel that they are not allowed to make health care decisions. Many feel their hair has been cut without their consent. A majority says they have not been provided information on their rights. Some of them say that informed consent has not been taken prior to treatment initiation.

The visiting team observed that there are a proportion of out-of-state patients. There are infrastructural deficiencies with respect to access to the top floors, poor drainage system, mosquitoes and other pests, lack of heaters and hot water, lack of lockers. Care appears to have improved following the involvement of the National Medical Hospital. Food has improved, but there are no designated dining spaces. Hair is cut short, often against the patient's wishes, though informed consent 'is taken'. Undergarments are shared. Sanitary napkins are inadequate. Sleeping arrangements seem satisfactory. Medicines are available. There are clinical psychologists involved in care. But there are no psychiatric social workers. Documentation in the case files is adequate. Reduction in overcrowding has reduced incidents of violence. Staff shortage is still a problem. Although there are some recreational avenues, under-stimulation is a great problem. Rehabilitation is unsatisfactory although two NGO's, Anjali and Paripurnita have had a positive impact on engaging the women in productive work. Most of the preoccupation of the women is about returning home. Only a very small percentage of patients here seem to get discharged to their homes.

Recommendations by the visiting team

Some increase in staff also to prevent overcrowding in the future – make more rooms, increase discharge and also some mechanisms to restrict admissions beyond capacity; social skills and vocational skills training for patients; collaboration with NGO useful. Patients can be sent to nearby medical college to work as attenders or be engaged in gardening work; lastly, there is a need more outside space.

Facilities:

1. Assistance required from PWD for changes in the external drainage system.
2. Assistance required from the Forest Department for horticulture inputs in the hospital premises.
3. Need to expand space for women outside the ward
4. Setting up an Occupational Therapy section.
5. Storage space for the women so that they do not have to carry their belongings with them.

Human resources and Training:

1. There is a significant shortage of social welfare officers/ psychiatric social workers (currently no post is filled) and these personnel can be involved in discharge planning. Recruitment of Group D staff (currently there is a 50% shortage) is needed for improving patient care.
2. The clinical psychologists have been employed after a Master's programme and do not have an MPhil degree as per RCI regulations. They would benefit from training in focused behaviour therapy and psychological interventions and other recovery-oriented perspectives.
3. There needs to be greater opportunities for Continuing Development Programmes for all trainees and faculty, other than the regular in-house seminars being held.

Family involvement:

1. Address verification and liaison with the local police stations at the initial phase of engagement with the family.
2. Family psycho-education groups with a focus on medication management, addressing violence/aggression, and government disability benefits. Assessment and processing of disability benefits need to be done systematically. Community level awareness programmes to reduce stigma and development of local support through PHCs.

Medication:

1. The vendor supply system for medications needs to be modified to ensure timely supply.
2. The need for third generation antipsychotics could be reviewed.

Rehabilitation:

1. The strongest recommendations are in the area of rehabilitation. There need to be sustained recreational, leisure, skill training and vocational training activities to address the needs of more women.
2. The NGO involvement and collaboration could be expanded as their initiatives have been useful, systematic and sustained.
3. The hospital administration suggested that some women could be employed as contract helpers or on a daily wage basis to work as support staff within the hospital. Their earnings may be deposited in a bank account and their functional recovery could help facilitate family acceptance and discharge.
4. The setting up of supervised half way homes with income generation possibilities, within the community.

Discharge Planning:

1. The hospital expressed the need for transport to facilitate home visits.
2. The development of clear processes, time lines, staff and other resources to facilitate the discharge process. This is a major area where changes would be helpful.

6. BERHAMPORE MENTAL HOSPITAL, MURSHIDABAD

INTRODUCTION

This mental hospital was earlier a special jail and was converted to a government mental hospital in 1980, with a bed strength of 150, later increased to 230 (116 female and 114 male). This is probably the only hospital in the country with more female than male beds.

The NHRC Report of 1999[51] rated this as one of the Very Poor hospitals. Old and poorly maintained buildings, cells, overcrowding, open drains, extremely inadequate toilet facility, inadequacies on all fronts-electricity, drainage, water, canteen, telephone, library, characterised this hospital. There were many staff vacancies. The budget was inadequate. There were solely court admissions. During the visit, the conditions were found to be abysmal, with human excreta, infestation with lice, which made colonies on the wall, inadequate privacy, shaving of head, flagrant violation of the rights of the mentally ill. Many patients were infested with scabies. Staff nurses were short. The Report recommended improvement in all spheres. It also raised the need to develop a good work culture among the staff.

The NHRC Report of 2008[52] records the interim observations of the DGHS in 2004. '"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". Subsequently, the hospital has had a new building. OPD canteen facilities have been developed, but there is no place for relatives to stay. In the update from the hospital, none of the recommendations of the 1999 report had been addressed. Only some recreational activities had been introduced and one NGO had got involved.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

The team interacted with the medical superintendent, the nursing superintendent, one psychiatrist, one psychologist and a couple of staff. A psychiatric social worker has recently been appointed but was not available on the days of the visit. The administrators and service providers had multiple concerns; the political and legal pressures related to admissions and discharges, overcrowding, poor hygiene and discharge related difficulties, the shortage of cleaning, other support staff, occupational therapists, nursing staff and unfilled posts of other service providers and the absence of any recreational, leisure or vocational activities (besides the efforts of the NGO Anjali which is limited to a few patients).

[51]National Human Rights Commission. Quality assurance in mental health, 1999. Ibid.
[52]National Human Rights Commission. Mental Health and Human Rights, 2008. Ibid

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=20)

Table 6a. Basic Facilities

Description	Yes – N (%)	No - N (%)
Is there adequate light during day time?	20 (100)	0
Is there adequate light during night time?	20 (100)	0
Is hot water given for bathing regularly?	15 (75)	5 (25)
Is safe drinking water provided?	12 (60)	8 (40)
Are bathroom and toilets adequate?	14 (70)	6 (30)
Are bathroom and toilets cleanly maintained?	8 (40)	12 (60)
Is there space for washing and drying clothes?	0	20 (100)
Is the ward cleaned regularly?	12 (60)	8 (40)
Is linen changed regularly?	3 (15)	17 (85)
Is there overcrowding in the ward?	12 (60)	8 (40)
Are patients allowed to go outside the ward regularly?	9 (45)	11 (55)
Is there adequate space for walking outside the ward?	6 (30)	14 (70)
Is a locker facility provided?	13 (65)	7 (35)

Overall rating of the basic facilities

On the overall rating of the basic facilities, 60% said they were good, but 40% said the facilities were unsatisfactory. All respondents were satisfied with the lighting in the ward, both during the day and night. All respondents said there was no space for washing and drying clothes. A majority (85%) said linen was not regularly changed, that space to walk outside was inadequate (70%), that bathroom and toilets were poorly maintained (60%). Many patients (65%) said that locker facilities were available and that hot water was provided (75%).

Table 6b. Food

Description	Yes –N (%)	No – N (%)
Is the food provided adequate?	16 (80)	4 (20)
Is there sufficient variety in the daily menu?	13 (65)	7 (35)
Is quality of food satisfactory?	8 (40)	12 (60)
Are you satisfied of frequency of food provided?	16 (80)	4 (20)
Are you served with special food on special occasions?	15 (75)	5 (25)
Are you served non vegetarian meals on request?	20 (100)	0
Are the food serving staff polite?	18 (90)	2 (10)
Is there a separate dining area?	20 (100)	0
Are facilities provided in the dining area?	20 (100)	0
Are the utensils and dining room cleanly maintained?	14 (70)	6 (30)

Overall rating of food and dining facilities

Overall, just over half (54%) rated the food as good. Most (80%) perceived the food as adequate, but a third said there was no sufficient variation in the daily menu. A majority (60%) said the quality of the food was not satisfactory. All patients said there was a separate dining area and that non vegetarian food was served on special occasions. A fifth was not satisfied with the frequency of food provided and a third said the utensils and dining area were not well maintained.

Table 6c. Personal Hygiene

Description	Yes – N (%)	No –N (%)	Not applicable** - N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	2 (10)	18 (90)	0
Are sanitary napkins provided regularly?	15 (75)	2 (10)	3 (15)
Is information provided on proper disposal of sanitary napkins by nursing staff?	0	17 (85)	3 (15)
Are basic toiletry articles provided?	15 (75)	5 (25)	0
Are you permitted to wear own clothes?	18 (90)	2 (10)	0
Are you given a choice of clothes to wear?	9 (45)	11 (55)	0
Are you provided inner garments?	0	20 (100)	0
Is winter wear provided to you?	17 (85)	3 (15)	0
Is footwear provided to you?	17 (85)	3 (15)	0
Are basic cosmetics provided to you?	0	20 (100)	0

**These patients had reached menopause. Some do not want to wear inner garments

Overall feedback on personal hygiene and basic comforts

Only 20% rated this area overall as good. More than two-third (65%) rated it as poor and 15% rated it as very poor. A majority (90%) said there was no privacy while using the bathroom or toilet and while changing clothes. A majority (75%) said that sanitary napkins were provided, but that there was no instruction on their disposal (85%). A fourth said that basic toiletries were not provided. Most (90%) patients said they were permitted to wear their own clothes. However, with hospital clothes, more than half (55%) reported no choice. None of the patients was provided inner wear, and a small number (15%) said winter wear and footwear were not provided. None of the patients were given any basic cosmetics.

Table 6d. Sleeping and Resting Facilities

Description	Yes - N (%)	No – N (%)
Is the ward quiet at night?	16 (80)	4 (20)
Are you provided with separate cot, mattress, pillow and blanket?	20 (100)	0
Are fans provided when it is hot?	0	20 (100)
Are heaters provided?	0	20 (100)
Do you have facilities to sit and rest during day provided?	18 (90)	2 (10)
Does the ward have bedbugs, cockroaches, mosquitoes?	19 (95)	1 (5)
In case of serious physical and mental problems, is immediate help provided?	19 (95)	1 (5)

Overall rating of sleeping and resting facilities

Overall, more than two-thirds (68%) rated the sleeping facilities as good. They all said they were provided separate mattresses, pillows and blankets. All of them said fans were not available when it was hot, heaters not available when it was cold. A majority (95%) reported that there were pests in the ward. Most respondents (95%) said emergency help was immediately available.

Table 6e. Medication and treatment

Description	Yes – N (%)	No –N (%)
Does the nursing staff help you in taking medications?	20 (100)	0
Have you been given explanation by treating team about medicines and side effects?	1 (5)	19 (95)
Is a female nurse/attendant present when you are physically examined by a male doctor?	19 (95)	1 (5)
In case of a medical problem, is immediate attention provided?	19 (95)	1 (5)

Overall rating of medication and treatment

Most patients (92%) rated the availability of medication and treatment as good. All said the nursing staff helped them with taking the medicines. A majority said that there was a female chaperone during examination by a male doctor, and that immediate attention was paid to medical problems (95%). However, most (95%) had not been provided any explanation by the treating team on the medicines and side-effects.

Table 6f. Emotional Needs

Description	Yes - N (%)	No- N (%)	Not applicable** -N (%)
Do the members of treating team address you properly?	17 (85)	3 (15)	0
Does the staff spend enough time to listen?	13 (65)	7 (35)	0
Does the staff show adequate concern?	14 (70)	6 (30)	0
Are you permitted to have personal possessions?	8 (40)	0	12 (60)
Do you have access to phone in ward?	4 (20)	8 (40)	8 (40)
Do you have permissions to receive calls and letters?	5 (25)	5 (25)	10 (50)
Does the staff read your letters or listen to phone conversation?	2 (10)	4 (20)	14 (70)
Does the staff provide pen and paper for letter writing?	1 (5)	3 (15)	16 (80)

** These patients were either destitute or orphans.

Overall rating of emotional needs

Overall, 80% rated satisfaction with the services to meet their emotional needs in the wards. About a third of patients (35%) said the treating team did not listen to them, did not show them adequate concern (30%), and a few said they did not address them properly (15%). A fifth said confidentiality was not maintained. Those who had personal possessions said they were allowed to keep them. While many patients did not have families and did not use telephone calls or write letters, among those that did, some expressed not having access to phones (40%) or permission to write and receive letters (25%).

Table 6g. Coercion and related issues

Description		Yes -N (%)	No -N (%)	Not applicable** - N (%)
Were you threatened by hospital staff		2(10)	18 (90)	0
Did the hospital staff use bad language that was hurtful to you?		2(10)	18(90)	0
Were you ever beaten by any hospital personnel?		5(25)	15(75)	0
Did any of the staff ever made sexual advances towards you?		0	20 (100)	0
Were you restrained physically?		0	0	20 (100)
Were you informed about the need of restraint?		0	0	20 (100)
Were you told about alternatives like chemical restraints/seclusion?		0	0	20 (100)
Was any staff present while being restrained?		0	0	20 (100)
Staff present during restraint	Male	0	0	20 (100)
	Female	0		
Were you left unattended more than 2 hrs?		0	0	20 (100)
Were restraints padded?		0	0	20 (100)
Did the staff check restraints frequently?		0	0	20 (100)

*Others did not respond ** These patients were not restrained during their stay in the hospital.

Overall feedback on coercion and related issues

Two patients said they had been threatened by the staff and that the staff had used hurtful abusive language. One-fourth reported being beaten by the staff. None reported any sexual abuse. None had any experience of being restrained.

Table 6h. Social Needs (How much you are satisfied)

Description	Very poor – N (%)	Good – N (%)	Very good – N (%)	Not applicable** - N (%)
Permission to attend family functions	2 (10)	0	0	18 (90)
Group activities	20 (100)	0	0	0
Outdoor activities	20 (100)	0	0	0
Participation in sports/games/cultural activities during hospital stay	20 (100)	0	0	0
Provision of separate visiting room	11 (55)	0	0	9 (45)

**These patients were either destitute or orphaned. Some patients' addresses were still not traced.

Overall rating on meeting of social needs

Patients expressed satisfaction with the group and outdoor activities. Those who got visitors were satisfied with the visiting room. A majority (90%) have unfulfilled social needs as they have no family visiting.

Table 6i. Ethical, Spiritual and other needs

Description	Yes -N (%)	No – N (%)	Not answered* - N (%)	Not applicable** - N (%)
Is there permission for religious/spiritual activities?	1 (5)	19 (95)	0	0
Are you offered concern, respect and care?	0	10 (50)	10 (50)	0
Were you treated against your wish?	3 (15)	17 (85)	0	0
Are you allowed to read newspaper and magazines?	0	20 (100)	0	0
Are you allowed to take health care decisions?	0	20 (100)	0	0
Was your hair cut without consent?	1 (5)	19 (95)	0	0
Were you permitted to represent legal matter in court?	7 (35)	12 (60)	0	1 (5)^
Did you get information about patients' rights in hospital?	0	11 (55)	0	9 (45)#
Whether confidentiality maintained during hospitalization by treating team?	0	10 (50)	6 (30)	4 (20)
Did the treating team give education to you?	1 (5)	19 (95)	0	0

Did staffs ask bribes or gifts?	0	10 (50)	10 (50)	0
Have you felt any discrimination by treating team based on your religion?	3 (15)	17 (85)	0	0
Were your hobbies encouraged during the hospital stay?	0	20 (100)	0	0
Is informed consent taken for treatment?	0	20 (100)	0	0
Is informed consent taken for research?	0	0	0	20 (100)[@]
Is pre- test HIV/STI/OTHER test done?	7 (35)	12 (60)	0	1 (5)**$**

* These patients were uncooperative and did not respond. [#] Illiterate; ^ This patient does not have any legal issue; [@] No research has been undertaken on these patients. [$] HIV test has been done only for selective population.

Feedback on ethical, spiritual and other needs

Most respondents (95%) said there was no permission for religious/spiritual activities. Half the patients here did not answer the question on whether they were shown concern, respect and care, and the rest said they were not shown such consideration. A majority (85%) said they were treated against their will. All of them said they had no access to newspapers or magazines. All of them said they were not allowed to make health decisions. Majority (95%) said their hair had been cut without consent. While 45% did not answer the question related to being provided information on rights, those that did all said they had not been provided any information. Again, with regard to confidentiality, those that responded all said that confidentiality was not maintained by the treating team. A majority (95%) said they had not been provided any psycho education. This was perhaps the only hospital where patients actually reported that the staff had asked for bribes or gifts. All the patients said no informed consent had been taken prior to initiating treatment. None felt her hobby was encouraged. A small number (15%) reported discrimination on the basis of religion.

OBSERVATIONS OF THE VISITING TEAM

Circumstances of Admission

The admissions are largely involuntary; 10% of the patients are homeless and brought by the police. The remaining are usually brought by family members from Middle and North Bengal and also from neighbouring states. The process of obtaining reception orders is relatively smooth. On occasion, there are reception orders brought without the signature of the judge and this causes difficulties.

Basic facilities

The women with a relatively more stable psychiatric status live on the ground floor and a larger number of women are on the first floor. The building is less than five years old, but looks more worn out than that. The natural and artificial lighting is adequate and there are fans.

All women were provided new clothes a few days prior to our visit.

There is running water in the bathrooms and water is heated via immersion rods. The amount of hot water provided is inadequate and the soap or shampoo is usually dissolved in the water. There is no storage space for clothes and these are hung on the windows or on the bed rails. There are no mirrors and personal effects (e.g. powder, bindi) are not provided.

The number of toilets is inadequate and the hygiene levels are also inadequate. Some patients may defecate in the corridors and cleaning is often delayed. Some bathing spaces appeared unused with spider webs. On the second day of our visit, we observed that most women were bathed together in front of the taps in the corridor.

Some window grills are broken and the protruding metal could pose a safety risk. The space around the building is unclean and a health risk to the women.

Food

The food is cooked in a separate facility close to the ward which is fairly hygienic.

The food chart suggests that non-vegetarian food is also served. We observed the women being served breakfast in the dining facility. The dining area has granite tables and seating space and looks new and well-constructed.

Breakfast		Lunch		Dinner	
Raw weight	Serving quantity	Raw weight	Serving quantity	Raw weight	Serving quantity
Milk 250 ml in pouch	Boiled Milk 250 ml	Rice 160 gms	Cooked Rice 400 gms	Atta or Rice 100 gms	4 Chapatis or cooked rice 300 gms
Egg*	Boiled egg 50 gms	Dal 20 gms	Cooked Dal 100 gms	Dal 20 gms	Cooked Dal 100 gms
Banana - 1	Peeled ripe Singapuri Banana 100 gm	Potato 70 gms	Mixed vegetable curry 225 gms	Potato 70 gms	Mixed vegetable curry 225 gms
Bread 50 gms	Sliced white sandwich Bread 50 gms	Mixed vegetable curry 100 gms		Mixed vegetable 100 gms	
Sugar in packet 100 gms	Sugar in packet 100 gms	Fish 75 gms	Fried fish 50 gms in 100 ml gravy	Egg*	Fried egg 50 gms in 100 ml gravy

As the space was inadequate, many were eating on their beds or in the corridor. Our interviews indicated that this resulted in food spills and some patients would lick the milk off the floor.

Reports suggested that food quality has improved in the recent past but there were some complaints about the quality and the lack of snacks in between meals.

Personal Hygiene

There are significant concerns regarding personal hygiene. Women are not provided undergarments. Sanitary napkins are provided when patients either ask for them or when the need is observed by the nursing staff. A few patients dispose used napkins in a plastic bucket while many throw them out of the window. There is no specific education on disposal. As there are many long-stay patients, very few have their own clothes.

Lice infestations are common and women's hair is cut short by a barber regularly, apart from chemical anti-lice treatments.

Sleeping and resting

Overcrowding is a major concern with 188 woman on two floors (40 on the ground floor, 148 on the first floor), and each woman does not have a separate bed. Mattresses, pillows and blankets are provided. Small room heaters are present in the nurses' observation rooms adjoining the wards but would not be adequate for the ward space. Tarpaulin sheets are hung across some of the windows in order to protect from the cold. There are no specific steps taken inside the ward to address the issue of mosquitoes. There is no separate space for the women to sit or rest although most women responded that this was adequate.

Medication and treatment

Detailed interviews with the staff and the women inpatients suggest that there are many lacunae in the area of medication and treatment. A majority of the psychiatrists tend to review the medications based on nurses' reports and there is inadequate face-to-face interaction with their patients. One of the nurses remarked how most treating psychiatrists are unable to identify their patients, recall details of their history or look into issues of discharge. On a positive note, there are one or two psychiatrists who have a positive engagement with their patients and a very good system of recording and documentation.

There is very limited involvement of the clinical psychologist in the inpatient setting, apart from select psychological assessments for legal purposes. The treatment is primarily pharmacological. The psychologist has a small room in the outpatient facility but there is no available space for interventions like progressive muscle relaxation. The sole psychiatric social worker had joined the job less than a week ago and was not available for interview.

Most mental health faculty are in engaged in private practice outside the hospital.

Medication supervision is done by the nurses and water taken in a mug from a bucket. Women in-patients were unaware of medication side-effects. Medication is sometimes thrown out of the window by some patients. The shortage of nursing staff makes it very difficult to ensure compliance, despite their efforts.

Treatment arrangements for persons with medical illnesses appear inadequate. We observed a patient with a stroke lying on a bed near the entrance with catheter and IV lines. Patients are typically shifted to the medical college hospital for care only in select situations; e.g. head injury or fracture. There is one ambulance available to shift patients and this is reported as adequate.

On a positive front, the process of documentation and recordkeeping has improved recently. Following the deaths of patients in the winter of 2010, there has been an improvement in the medical equipment; e.g. stethoscopes, blood pressure monitors, nebulisers.

The medication supply is relatively regular. Risperidone is not provided, although Clozapine is available. "*Medications more suitable for persons who have medical comorbidities (e.g. diabetes); Amisulpiride, Ziprasidone, are not being supplied*," according to one psychiatrist.

The outpatient facilities are small and patients lack privacy for interactions with doctors. However, the outpatient facilities are clean, with reasonable seating area for patients.

Emotional needs

Patients are treated inconsistently; their care is largely the nursing staff's domain. Nurses do respond with care and concern but this is not always sustained. The concept of confidentiality was difficult for the patients to understand. Women are provided pen and paper on request and use this to write letters to their families asking for discharge.

Emotional abuse/ Physical abuse

There are times when the patients are verbally abused. One patient shared some comments with us; for e.g. "*You bitch, do you think this is your father's house*?" Physical fights sometimes occur between the patients and this is handled by the Group D and nursing staff, usually through physical separation. No physical restraints are used and any injuries are provided the appropriate treatment. Physical abuse by staff is not common but some patients reported that nurses occasionally used a thin stick to push them aside.

Social needs

There is significant deprivation of social needs. Family members of about 10-15% of patients visit infrequently and are currently not permitted to bring food. There is no separate visiting room.

The ground floor also has provision for speakers for music to be played.

Women patients are let out in the lawn in front of the ward for a few hours only during the winter season. There are no group activities or interactions or any vocational rehabilitation initiatives. The nursing staffs are keen to initiate gardening or yoga with the help of occupational therapists (currently not available) but expressed frustration with the lack of resources and the degree of responsivity from the hospital administration. One of the mental health faculty remarked about the women "*leading a stagnant life*."

A positive development at Berhampore Mental Hospital is the involvement of the NGO *Anjali: Mental Health Rights Organisation.* The NGO has two clean rooms in the OPD and engages about 20 patients from the ward in a range of social and recreational activities. This includes singing, training in social interaction skills, grooming, craft activities like knitting, crochet, block-printing and painting. The women are provided with clean clothes and

undergarments and treated with warmth and compassion. For these select patients there has been a significant improvement in their quality of life.

Religious needs

There is no provision for any religious practices in or around the ward. Once a year, the patients are taken in a bus to view the Durga Puja installations.

Concern about discharge (hospital perspective/ patients' perspective/ consultants' perspective)

Over 70% of patients have been admitted for a period between one and twenty years. Many of them constantly ask to be discharged and reunited with their families and can provide varying degrees of information about their address.

Consultants shared various barriers to discharge: incorrect or incomplete address of family members, family member' intent to abandon patient, property/inheritance issues, overall lack of awareness and stigma in the community, lack of long-acting medications at discharge, lack of staff (particularly psychiatric social workers) for communication, home visits and discharge planning, pressure from judiciary to readmit patients on family request.

Apart from these perspectives, our observations were that there was a lack of clear algorithms or processes to facilitate discharge of patients. Family psycho education or provision of information about government disability benefits appears inadequate. The lack of stimulation, crowded inadequate facilities, and absence of any rehabilitation efforts had also served to deskill patients and this complicates discharge further. The judicial system also appears to be taking a custodial position, with the most primary concern about women's sexual safety post-discharge. In this context, the efforts of NGO *Anjali: Mental Health Rights Organisation* are noteworthy. A total of 58 women inpatients have been discharged and reunited with their families with their participation since March 2013. At present, all except one patient continue to live with their families.

Involvement of other department/ potential support

Discharge related issues were discussed previously with the NHRC and this requires follow-up and continued interactions.

The DHFW system's support is sought for development of community-based homes and for rehabilitation initiatives.

The DWCH should make regular visits to the hospital.

Specific observations of Ms. Sushma Sahu, Member, National Commission for Women

Following is a summary of the specific observations of the Member of the NCW:

- Patients had given new clothes, blankets to the patient after we arrived.
- They humiliate patients and serve food in a bad way.

- There are fewer beds than the number of patients.
- Many patients are without clothes.
- Food quality is very poor. Milk is just like water.
- The problems relating to hygiene, sanitation and water of entire hospital is interconnected with the health care and welfare of the patients.
- Doctors and attendants are not handling patients properly.
- There are bushes near the boundary wall. According to residents there are snakes here.
- Condition of toilets is very bad. Institution is not providing any type of sanitary napkins, under garments etc. to the patients.
- Patients need rehabilitation.
- The overall condition of the Mental hospital is terrible.
- The condition of the hospital is pathetic and it might lead to further deterioration of the patients.
- Window panes are broken. Kitchen is housed in a dirty place.

SUMMARY

The Berhampore Mental Hospital, Murshidabad, which was rated as one of the very poor hospitals in the NHRC report of 1999, continues to have gross inadequacies and flagrant violation of human rights. Although women respondents in many of the hospitals were likely to be quite easily satisfied with the facility, higher proportion of respondents here rated many of the services as poor, reflecting the very sorry state of affairs.

Poor maintenance of toilets, lack of space for washing and drying clothes, unchanged linen, inadequate spaces to walk, lack of locker facilities are some of the basic facilities many patients express dissatisfaction about. While most rate the food as adequate, there is considerable dissatisfaction over the variety and quality of food. All patients are satisfied that non vegetarian food is occasionally provided. There is concern about the maintenance of the dining area and utensils. Attention to personal hygiene is an area of high dissatisfaction. Lack of privacy while bathing and using the toilet, irregular supply of sanitary napkins, lack of instruction on their disposal, lack of inner wear and non-availability of basic cosmetics are areas of discontent. Most say they are permitted to wear their own clothes and are given winter wear. While patients say the sleeping facilities are mostly adequate, the team visit showed how they were all huddled up on the floor close to one another. Most say they have facilities to sit and rest during the day. A majority also say that emergency help is immediately provided. Mosquitoes and other pests are a major problem. Availability of medication is rated as good by majority of the patients, who also say the nursing staff helped them to take the medications. However, most have not been explained the reason for medication and side-effects. Although many patients rate that the facilities meet their emotional needs satisfactorily, some express that the treating staff does not show concern, does not address patients properly and a couple of patients report verbal abuse and threats by the staff. Nearly one in four reports physical abuse. A majority have no contact with their

family but is satisfied with the group and outdoor activity in the ward. Other areas of discontent include lack of permission to practice religious/spiritual activities, institution of treatment without proper consent, poor involvement in health decision making, cutting of hair without consent and lack of information on rights. A majority say they have not been educated about their illness and are silent on issues relating to confidentiality.

The visiting team observed that admissions are largely involuntary. Some of the basic facilities like hot water, drying areas, toilets, sleeping arrangements are inadequate. Lack of cleanliness is appalling. Patients are not provided with any personal effects. Lack of privacy is glaring, with community bathing. Food is adequate in quantity, but eating spaces are inadequate. The quality of food has improved although some patients complain of a lack of variety. Sanitary napkins are inadequate and thrown randomly. Very few patients have their own clothes. Hair is cut short. Sleeping arrangements are inadequate. There is no heating provided. There is little face-to-face interaction with the treating team and little positive engagement. However, the record keeping is good. Most mental health faculty are engaged in private practice outside the hospital. There is a shortage of nurses and psychiatric social workers. Medical management of physically ill patients is inadequate. There are instances of patient abuse by the staff. Recreation and rehabilitation activities are very minimal. An exception is the involvement of an NGO, Anjali, which engages a few patients with a range of social and recreational activities. Women in this ward appear cleaner and socially more responsive. For most patients, their constant preoccupation is discharge and the hope of being reunited with their families. There are many barriers to discharge.

The recommendations of the visiting team are as below:

Basic Facilities: This needs to be addressed on an urgent priority basis in the context of human rights. The reduction in overcrowding and provision of individual beds, more toilets and space is extremely important. Improvement in cleanliness and hygiene of both the facilities and the women needs to be addressed.

Human resources: Patient care will be facilitated by recruitment to fill vacant posts (7 psychiatrist, 1 psychologist, 5 psychiatric social workers, 132 Group D staff). More sanctioned posts are required for clinical psychologists and nurses. Change of status to a teaching hospital could address some human resource needs.

Training: Rehabilitation focused continuing development training would be useful for all personnel. More trained psychiatric nurses would be helpful. Clinical psychologists are employed post-Masters, have limited clinical exposure and this is contrary to the RCI guidelines.

Medication: A committee could review the available medications and include long acting medications that would be useful in discharge planning. Information about medication compliance could be made available in all OPDs and also as part of community awareness programmes.

Rehabilitation perspective: There is significant under stimulation of the patients and this is another area that needs to be addressed as a priority.

A recovery-oriented perspective that focuses on functional recovery is essential. This could include various aspects; vocational rehabilitation during admission, a stepped care model with different environments for patients at different stages of recovery, the setting-up of open wards, multidisciplinary team approach and greater focus on individual and group psychosocial interventions for inpatients, recreational and leisure activities, networking with NGOs, provision of half-way homes in the community with income generation options for the women.

The NGO involvement could be expanded as it seems to be doing exemplary work both in terms of rehabilitation and integration of patients back with their families and in the community.

Discharge Planning: There should be clear guidelines, timelines and algorithms for discharge which should ally with the provisions of the Mental Health Act. The steps may include verification of family contact information, home visit teams, medication planning, family psycho education and information about disability benefits, developing networks of community nurses to look into issues of medication management and compliance.

Legal perspectives: A Legal Aid Cell to look into property issues, rights issues (e.g. pregnant inpatients and adoption process) etc. Engagement with the state judiciary regarding admission and discharge as per law is necessary.

Specific recommendations made by the Member, NCW, Ms. Sushma Sahu included the following:

(i) The hospital needs cleanliness, sewage disposal, adequate sanitation, patients need proper health diet and adequate clothes, emergency medicines and so on;
(ii) Increase in number of beds.
(iii) Doctors and attendants should take care of patients in a proper and humane way.
(iv) Patients need separate attention and rehabilitation. A NGO, namely, ANJALI is working on it, but some more needs to be done in this area.
(v) Relocate the kitchen in a better place.
(vi) Window panes should be repaired. Mosquito meshes to be installed.

7. RANCHI INSTITUTE OF NEURO - PSYCHIATRY & ALLIED SCIENCES (RINPAS), JHARKHAND

INTRODUCTION

The history of this institute[53] dates back to 1975 AD when the Lunatic Asylum was established in Monghyr. It was shifted to Patna in November 1821. Subsequently the Lunatic Asylum was shifted to its present location at Kanke, Ranchi in 1925. After independence the hospital came under the government of Bihar. It 1958, the name Institute of Mental Health (IMH) was changed to Ranchi Mansik Arogyashala (RMA). RMA was notified as an autonomous institute on 29th September 1994 under the direction and order of the Supreme Court. In January 1998, the name of RMA was changed to Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS). It is presently located in Jharkhand.

The NHRC 1999[54] Report rated RINPAS among the 'Good' Hospitals. This hospital was under monitoring of the NHRC consequent to the orders of the Hon'ble Supreme Court. It was structurally like a jail, with closed wards. A big road separated the female wards from the male wards. There were 4 wards for females as compared to 11 wards for males. Parts of the hospital were under renovation. Printed linen, mosquito mats, regular consultation from medical specialists, dietician overseeing food arrangements, adequate diagnostic facilities, a systematic medical records section, an active Board of Management, vocational and rehabilitation services, and attention to basic facilities in the inpatient were the positive features. However, the hospital had problems with drainage, electricity and water supply. Toilets were inadequate. Recommendations of the NHRC included improvement of the basic facilities, setting up of an estate management committee, filling up of staff vacancies, arrangements for discharge of patients whose families could be traced, open ward facilities, sensitisation of staff to the rights of persons with mental illness, setting up vocational units and rehabilitation facilities and starting of community services.

During the NHRC 2008 Review[55], it was reported that the hospital had been downsized. The laundry had been mechanised. A mineral water plant and incinerator to manage bio-medical waste had been installed. The laundry had been outsourced. Rehabilitation had been improved. According to the report of the special rapporteur, Mr. L. Mishra, his "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". RINPAS had developed a sub-committee to oversee rehabilitation. Specialised services had been started for children, elderly and persons with substance use. The hospital was coordinating one of the districts for the District Mental Health Programme. Hospital budgets had improved. Post graduate training had also improved.

[53]Brief history of RINPAS. http://rinpas.nic.in/history.html
[54]National Human Rights Commission. Quality assurance in mental health, 1999. Ibid
[55]National Human Rights Commission. Mental health and human rights, 2008. Ibid

The visit to Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS), Jharkhand was carried out on 21.1.2016 and 22.1.2016, by the representatives of National Commission Women (NCW) and the team from the National Institute of Mental Health and Neuro Sciences (NIMHANS). The team first met the Director and Medical Superintendent and some of the other service providers.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

The total bed strength of the hospital is about 600 of which 200 beds are for women. The current occupancy of beds is about 595 out of which 382 are male and 213 female patients. 60% of the female beds in the wards are currently occupied by women staying here for more than 10 years. A full-fledged 50 bedded halfway home each for recovered female and male patients has been built in the hospital but is not in operation due to lack of human resources.

One of the main issues causing difficulty in patient care of female patients is the inadequacy of staff in the hospital at all levels. It has been reported that the institute never had a full term tenured Director in the past few years. The current in-charge Director, who is also an Additional Professor at the Department of Psychiatry, RINPAS is looking after the management and administration of the hospital. The Medical Superintendent is the overall in-charge of the hospital. It is also reported that no recruitments have been made since 2004 in the hospital. The reasons for delay in recruitment of staff are at the policy level and administrative. The total sanctioned posts for the hospital is 671 (which include 70 teaching staff; 600 non-teaching staff) and current working existing staff strength is only 264 (which includes 18 teaching staff; 246 non-teaching staff). The remaining 407 sanctioned vacant posts needs to be filled to meet huge demands of OP and IP care of the hospital.

There are totally 11 qualified psychiatrists working in the hospital comprising of 2 Additional Professors, 7 Senior Residents (2 are deputed from the State Government) and 2 Medical Officers (psychiatry) against the sanctioned 27 posts. This reflects a gross inadequate representation of the psychiatrist-patient of 1: 100 in the hospital. Of the total 12 and 26 sanctioned posts of clinical psychologists and psychiatrist social workers respectively, only 6 (4 male, 2 female), and 11 (5 male, 6 female) respectively are currently occupied.

One of the main issues causing difficulty in patient care of female patients is the inadequacy of staff in the hospital at all levels. Staffing is inadequate in all the female wards. Each ward is managed by one nurse, one attender and 3 security guards on a shift basis with three shifts in a day. The nurses and attenders also work on shift basis. Nurse and others staff expressed professional burnout due to increased work load, long working hours, inadequate holiday and leave availability, inability to avail leave due shortage of staff, inadequate recognition of the work done, difficulty in managing the large number of patients, non-stimulating working conditions and lack of promotions and increments. In most of the wards, security guards are helping nursing staffs in taking care of patients.

There is also a huge shortage of nursing staff. Of the sanctioned 130 nurses posts, only 47are filled. Among the 47 nurses, 43 are females. Out of sanctioned posts of 119 hospital attenders, only 47 are employed, of which only 12 are female. Nearly 50-60 % of teaching and non-teaching sanctioned vacancies at various levels are vacant. The present nurse-patient ratio is 1: 80.

The hospital does not have adequate infrastructure facilities for female patients both within as well as outside the hospital. The female section has 4 different wards/sub-sections i.e. Infirmary Ward, Halfway Ward, Block-2 and Block-3. The buildings are very old having been constructed 80-90 years back and need to be modernized. Although the wards are open, none of the wards provide facilities for patients to stay with their family member/caregiver. Prior to the admission, detailed information about the patient's illness is collected from the family and the family members are also educated about the illness both at the time of admission and before discharge.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N= 25)

Table 7a. Basic Facilities

Description	Yes - N (%)	No -N (%)
Is there adequate light during day time?	25 (100)	0
Is there adequate light during night time?	25 (100)	0
Is hot water given for bathing regularly?	9 (36)	16 (64)
Is safe drinking water provided?	22 (88)	3 (12)
Are bathroom and toilets adequate?	20 (80)	5 (20)
Are bathroom and toilets cleanly maintained?	22 (88)	3 (12)
Is there space for washing and drying clothes?	21 (84)	4 (16)
Is the ward cleaned regularly?	21 (84)	4 (16)
Is linen changed regularly?	20 (80)	5 (20)
Is there overcrowding in the ward?	11 (44)	14 (56)
Are patient allowed to go outside the ward regularly?	22 (88)	3 (12)
Is there adequate space for walking outside the ward?	25 (100)	0
Is a locker facility provided?	9 (36)	16 (64)

Overall rating of basic facilities

A majority (92%) provided an overall rating of 'good' for the basic facilities. All patients were satisfied with the lighting provided. However, two-thirds (64%) said they did not get regular hot water. A majority (88%) said water was safe to drink, toilets were adequate (80%) and well maintained (88%), space was provided to wash and dry clothes (84%), ward was regularly cleaned (84%), linen changed regularly (80%). However, a significant proportion (44%) said there was overcrowding. Two-thirds said that lockers were not provided. All of them said there was adequate walking space around the ward.

Table 7b.Food

Description	Yes - N (%)	No - N (%)
Is the food provided adequate?	25 (100)	0
Is there sufficient variety in the daily menu?	25 (100)	0
Is quality of food satisfactory?	23 (92)	2 (8)
Are you satisfied of frequency of food provided?	25 (100)	0
Are you served with special food served on special occasions?	25 (100)	0
Are you served non-vegetarian meals on request?	25 (100)	0
Are food serving staff polite?	22 (88)	3 (12)
Is there a separate dining area?	24 (96)	1 (4)
Are facilities provided in the dining area?	20 (80)	5 (20)
Are the utensils and dining room cleanly maintained?	24 (96)	1 (4)

Overall rating of food and dining facilities

All the patients rated the food related services as being good overall. There were hardly any complaints regarding the adequacy and variety of food, the quality of food and the frequency of food provided. Patients were served non vegetarian food on special occasions. A majority was satisfied with the dining facility. A small number (12%) said that the staffs were not polite and one-fifth said that the dining room facilities were inadequate.

Table 7c.Personal hygiene and basic comforts

Description	Yes -N (%)	No - N (%)	Not applicable** - N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	15 (60)	10 (40)	0
Are sanitary napkins provided regularly?	11 (44)	4 (16)	10 (40)
Is information provided on proper disposal of sanitary napkins by nursing staff?	4 (16)	11 (44)	10 (40)
Are basic toiletry articles provided?	23 (92)	2 (8)	0
Are you permitted to wear own clothes?	10 (40)	14 (56)	1 (4)
Are you given a choice of clothes to wear?	14 (56)	11 (44)	0
Are you provided inner garments?	1 (4)	24 (96)	4
Is winter wear provided to you?	23 (92)	2 (8)	0

Is footwear provided to you?	24 (96)	1 (4)	0
Are basic cosmetics provided to you?	21 (84)	4 (16)	0

**These patients had reached menopause. Some do not want to wear inner garments

Overall rating on personal hygiene and comfort

A majority (88%) rated the facilities designed to provide personal hygiene and comfort as good. However, specific areas of dissatisfaction were in privacy for bathing, changing and toilet (40%), not being permitted to wear own clothes (56%), not providing a choice in hospital clothing (44%) and not being provided inner garments (96%). A majority said they were provided winter wear (92%) and footwear (96%) and basic cosmetics (84%). A significant proportion (44%) said instructions on sanitary napkin disposal were not provided. A small proportion (16%) said that supply of napkins was irregular.

Table 7d. Sleeping and Resting Facilities

Description	Yes - N (%)	No - N (%)
Is the ward quiet at night?	21 (84)	4 (16)
Are you provided with separate cot, mattress, pillow and blanket?	25 (100)	0
Are fans provided when it is hot?	23 (92)	2 (8)
Are heaters provided?	3 (12)	22 (88)
Do you have facilities to sit and rest during the day?	7 (28)	18 (72)
Does the ward have bedbugs, cockroaches, mosquitoes?	15 (60)	10 (40)
In case of serious physical and mental problems, is immediate help provided?	24 (96)	1 (4)

Overall rating of sleeping and resting facilities

All respondents provided an overall rating of good for the sleeping and resting facilities. However, with regard to specific issues, a majority (88%) said heaters were not provided, facilities to sit and rest were inadequate (72%). Some of the patients (40%) said there were pests in the ward. A majority concurred that immediate services were available during emergencies.

Table 7e.Medication and treatment

Description	Yes -N (%)	No -N (%)
Do the nursing staffs help you in taking medications?	25 (100)	0
Have you been explained by the treating team about medicines and side effects?	6 (24)	19 (76)
Has a female nurse/attendant been present when you are being physically examined by a male doctor?	24 (96)	1 (4)
In case of a medical problem, is immediate attention provided?	24 (96)	1 (4)

Overall rating of medication and treatment facilities

Overall, 84% rated the treatment facilities as good or very good. All concurred that medical staff helped in taking medication. A majority said a female chaperone was present during medical examination by a male doctor and that immediate attention was provided in case of a medical problem (96%). However, three-fourth (76%) said the treating team had not explained about the medicines and the side effects. More than half did not answer the question on confidentiality, but those who did said that the treating team maintained confidentiality. A small proportion (28%) said they were not permitted personal belongings. Half the respondents (52%) said they did not have access to phones and did not have permission to receive or send letters. Nearly half said that the staff listened to their conversation or read their communication.

Table 7g. Coercion and related issues

Description		Yes – N (%)	No - N (%)	Not answered- N (%)	Not applicable**- N (%)
Were you threatened/fear by hospital staff		2 (8)	23 (92)	0	0
Did the hospital staff use bad language that was hurtful to you?		2 (8)	23 (92)	0	0
Were you ever beaten by any hospital personnel?		2 (8)	23 (92)	0	0
Did members of the treating team ever made sexual advances towards you?		1 (4)	24 (96)	0	0
Were you restrained physically?		2 (8)	23 (92)	0	0
Were you informed about the need of restraint?		0	2 (8)	0	23 (92)
Were you told about alternatives like chemical restrains/seclusion?		0	1 (4)	1(4)	23 (92)
Was any staff present while being restrained?		2 (8)	0	0	23 (92)
Staff present during restraint	Male	0	0	0	23 (92)
	Female	2 (8)			
Were you left unattended more than 2 hrs?		0	2 (8)	0	23 (92)
Were restraints padded?		0	2 (8)	0	23 (92)
Did the staff check restraints frequently?		0	2 (8)	0	23 (92)

* These patients were uncooperative (due to various illness related factors) because of which they could not respond.
**These patients had not been restrained during their stay in the hospital.

Feedback on coercion

Most patients said they had not been threatened by the staff in any manner, nor were addressed in a hurtful manner (92%). One patient reported an attempt at sexual advances. Only two patients reported to have been restrained.

Table 7h. Social Needs (How much you are satisfied)

Description	Very poor – N (%)	Good-N (%)	Very good – N (%)	Not applicable** - N (%)
Permission to attend family functions	0	4 (16)	0	21 (84)
Group activities	1 (4)	20 (80)	0	4 (16)
Outdoor activities	8 (32)	15 (60)	0	2 (8)
Participation in sports/games/cultural activities during hospital stay	7 (28)	14 (56)	0	4 (16)
Provision of separate visiting room	0	12 (48)	0	13 (52)

**These patients were either destitute or orphans. Some patients' addresses were still not traced; Due to their illnesses, over-sedation or low motivation, they lacked interest in these activities.

Overall rating on social needs

Most patients had no contact with families. With regard to group and outdoor activities, a majority (80% and 60% respectively) said that such activities were good. Those who received visitors were satisfied with the visiting room arrangements.

Table 7i.Ethical, Spiritual and other needs

Description	Yes- N (%)	No – N (%)	Not answered *- -N (%)	Not applicable ** -N (%)
Is there permission for religious activities?	19 (76)	6 (24)	0	0
Are you offered adequate respect and care?	24 (96)	1 (4)	0	0
Were you treated against your wish?	2 (8)	23 (92)	0	0
Are you allowed to read newspaper and magazines?	13 (52)	5 (20)	0	7 (28) #
Are you allowed to take health care decisions?	1 (4)	24 (96)	0	0
Was your haircut done without consent?	6 (24)	18 (72)	0	1 (4) $$$
Were you permitted to represent legal matters in court?	0	6 (24)	0	19 (76) ^
Did you get information about patients' rights in hospital?	1 (4)	24 (96)	0	0
Was confidentiality maintained during hospitalization by the treating team?	0	14 (56)	5 (20)	6 (24)
Did the treating team educate you about your illness?	2 (8)	6 (24)	0	17 (68) ~
Did staff ask for bribes and gifts?	0	25 (100)	0	0

Have you felt any discrimination by the treating team with regard to your religion or culture?	0	25 (100)	0	0
Were your hobbies encouraged during hospital stay?	20 (80)	4 (16)	0	1 (4)
Is informed consent taken for treatment?	14 (56)	10 (40)	0	1 (4)
Is informed consent taken for research?	0	0	0	25 (100) @
Is pre- test counselling for HIV/STI/OTHER tests done?	15 (60)	5 (20)	0	5 (20) $

* These patients were uncooperative (due to various illness related factors) and did not respond.
# Illiterate; $$$ This patient's haircut is not done; ^ These Patients do not have any legal issues; ~ These patients' family members have not come up at all, so education to families cannot be given; @ No research has been undertaken on these patients; $ HIV test is done only for select populations.

Overall feedback on spiritual and other issues

About one- quarter said they were not permitted to carry out religious/spiritual activities. A majority (96%) said they were treated with respect. A majority said they were not treated against their wishes. A fifth said they had not access to newspapers and magazines. A majority (96%) said they were not allowed to take health care decisions. A quarter of the respondents said their hair had been cut without their consent. Among those who responded, none had been permitted to make a legal representation. A majority said they had not received any information about patient rights. Nearly three-fourth (72%) said that confidentiality was not maintained. A quarter said they had not been educated about the illness (the rest did not reply as they thought this pertained to their families, who never turned up). None had felt discriminated on grounds of religion. A majority (80%) said the nursing staff had encouraged their hobbies. A significant proportion (40%) said that informed consent had not been taken prior to treatment. None had been included in any research. A majority (60%) said pre-test counselling was done for HIV and other tests while 40% said that counselling was not done.

OBSERVATIONS OF THE VISITING TEAM

The following are team's observations regarding the facilities available for female patients in the wards and about the concerns and needs of the care providers with specific reference to female in-patients in the hospital:

Circumstances of admission

70% female patients who are admitted as in-patients in the hospital are admitted by the police through an order from the magistrate. The rest are admitted by relatives. The women who are found wandering on the streets or at bus stands are brought by the police. On the day of the visit, the total number of female inpatients was 213, out of whom 141 were admitted as long-stay patients in the wards. 85 % of the long-stay in- patients have been admitted though a reception order, and 15 % admitted by the family members. Of the 141 long-stay

patients,35are in the hospital for more than 6 months; 39 women for 2 years and above; 20 women are admitted for more than 5 years, 6 of them for more than 10 years and 31 patients for 15 years and above. Majority of the long stay female patients are destitute, admitted under reception order and belonged to other states.

Basic Facilities:

A big road separates the male and female ward. On the left side of the Hospital main road is the male inpatient ward and on the right side is the female inpatient ward. The architecture of the hospital resembles that of a prison; it is surrounded by huge walls with a large closed entrance manned by a security guard. The female section has 4 different wards / sub-sections, i.e. Infirmary Ward, Halfway Ward, Block-2 and Block-3. The buildings are very old (they were constructed 80-90 years back) and need to be modernized. The total bed strength of the hospital is about 600 of which 200 beds are for women. All the wards are open wards; however there are no facilities for the patients to stay with a family member/caregiver during the admission.

Narrow alleys connect different parts of the hospital.

The living arrangements for the patients and maintenance of wards are fairly adequate. Each ward has sufficient and clean toilets (both Indian and Western closets). However the bathrooms are inadequate in number in all the wards. It was reported that patients are bathed in groups due to shortage of bathrooms and attenders in the wards.

Toilets are situated outside the ward where most of the patients complained of difficulty in going out during the night.

Solar heater with a capacity of 250 litres has been installed in all the wards to provide hot water facility for bathing. In some wards, the patients complained of not getting supply of hot water.

This issue was brought to the notice of the Director immediately by the visiting team and the Director assured the team that it would be rectified within a few days. Water supply in the wards is adequate. Fans and lights are present in the wards, but the numbers are inadequate. Patients are provided with purified water for drinking from the institute Mineral Water Plant Unit. Water Cooler is also available in the wards. However, these are not well maintained.

Food

Food is served in steel plates in adequate quantity. Seating arrangement is on the floor, which is difficult for older or infirm patients. The hospital has a well-equipped pantry with separate storage facilities. Food is prepared using LPG under the supervision of a dietician and is tested by a staff member every day before being served to the patients. A requirement of approximately 3100 calories and 100 gram of protein per patient per day is met. Egg and milk are provided routinely. For non-vegetarian patients, fish/chicken is served thrice a week and for vegetarian patients, paneer (cottage cheese) is given five times in a week. 100 gm of curd is given to all the patients thrice a week. Besides this, seasonal fruits are routinely given to all the patients. In the evenings, 50 gm bun/2 pieces of rusk/2 biscuits are served along with tea. Special foods are served during festivals to all the patients. The quality of food served is nutritious and adequate.

The institute has very good agriculture and horticulture section spread over 105 acres of land where pulses, paddy, vegetables and fruits are grown. The cultivated products are used for hospital purpose and surplus produce is sold in the market. Milk, butter, curd and chicken are supplied from the Poultry and Dairy Unit of the hospital.

Personal Hygiene:

Personal hygiene of the patients is adequate. Reportedly the patients are given bath daily and apparels are changed once in two days. However, on enquiry with the patients, it was found that patients by the attenders and ward nurses to take bath one in a week because of non-availability of hot water.

Patients are provided with different kinds of uniforms like saris, nighties and chudidhars, but are not allowed to use their own personal clothes during the hospital stay. Patients are also provided with sufficient toiletries, a pair of footwear and adequate number of sanitary napkins. It was observed during the visit that sanitary napkins were thrown outside the windows by the patients.

Warm clothes are provided to all the patients. It was visible during our visit where all most all the patients are seen wearing sweater, woollen cap and covered with shawl. It was found out that patients are not provided with inner-garments.

Sleeping and Resting:

Each patient has adequate living space, cot, mattress, pillow, linen, blanket, mosquito net, and locker to keep their personal belongings. Bed linen is reportedly changed once in a week. We observed a lot of mosquitoes, cockroaches or other insects in the wards and even a snake in the toilet. There is a need to install a wire-mesh on windows to provide better protection against mosquitoes. There is no separate rest room for the patients in the ward.

Emotional Needs:

Patients reported that they are treated well by hospital staff. The patients are allowed to make phone calls or write to the family members. There are however no wards available where patients can stay with a family member/caregiver. It was reported that before the admission, detailed information about the patient's illness is collected from families. They are also provided information about mental illness both at the time of admission and discharge. After admission, the family members are called only at the time of discharge and are not involved in treatment of the patients. This lack of adequate involvement of family members prevents the utilization of the family as a resource for assisting in the treatment and in the process of rehabilitation and reintegration. This practice needs to be changed in order to bring about a change in the attitude of family members towards mental illness. There is an urgent need to

start Family Treatment Model in the hospital spanning areas of care, treatment, and rehabilitation of patients.

Emotional abuse/ Physical abuse:

No incidence of emotional or physical abuse has been reported either by the patients or the staff during our visit in the wards. Instead, these patients have been subject to sexual abuse and violence by family members and community, which is sometimes reported at the time of admission. There are 2 HIV positive female patients in the ward, who are on regular anti-retroviral treatment from a Government medical hospital. There have been a few incidents of patients having tested positive for pregnancy at the time of admission and these pregnancies were due to sexual abuse by strangers. Currently, there is one unknown patient whose pregnancy was discovered after admission. She delivered a child in the hospital. At present, separate living arrangements have been made for the mother and child in a single room in the ward. The hospital must have a separate Mother-Child unit in the ward in order to provide specialized care and services to women admitted for mental illness during their pregnancy and the postpartum period.

Social Needs:

The hospital has a separate occupational therapy and rehabilitation unit for female patients. Patients are categorized as skilled, semi-skilled and unskilled based on a formal assessment and provided incentives based on this. Skilled patients get Rs.50, semi-skilled get Rs. 30 and unskilled get Rs. 20 each day. The money is kept separately in each patient's account and is given to them at the time discharge. The patients are also allowed to use the money to buy personal things. On the day of visit there were 35 patients availing the services in the unit. Patients are involved in different activities such as tailoring, knitting, embroidery, basket weaving, mushroom cultivation, paper bag making, shawl making, jute bag making and making Pitonji mala. This facility is not available for day boarders. The occupational therapy and rehabilitation unit is very small and overcrowded with inadequate staffing and facilities. There is one OT instructor, nurse and attender each involved with the unit. There is an urgent

need to fill up the vacant posts and also create additional posts such as rehabilitation specialists and vocational therapists so that patients could be trained intensively in income generating activities and reintegrated with the community through the support of NGO's. Attractive items have been prepared in the rehabilitation centre.

Religious needs:

Patients are allowed to practice religious activities. Apart from this, major festivals like Holi, Diwali and Christmas, as well as regional festivals are celebrated with the patients. There is a separate prayer hall outside the ward where patients can perform prayers according to their faith. This hall is also used for conducting recreation activities for patients.

Diagnosis and treatment related issues

Most of the female patients have been diagnosed with Paranoid Schizophrenia, Psychosis NOS, Bipolar Affective Disorder, Undifferentiated Schizophrenia or Mental Retardation with Psychosis and behavioural problems. Few of these women have medical co-morbid conditions such as hypertension, diabetes, epilepsy, other neurological problems and Sexually Transmitted Diseases including HIV. A separate case file is maintained for each patient.

However, the contents in the files are inadequate. There is no duty doctor room in the wards. No duty doctors are posted during the night time

The Bio-Psychosocial Model is adopted for the treatment of women in the OP and IP settings where a multi-disciplinary team of psychiatrists, clinical psychologists, psychiatric social workers, nurses and occupational therapists offer their services to the patients and their families. The clinical psychologists do psychological testing, psychotherapy and behavioural interventions while group therapy, family interventions, psycho education, home visits, admission and discharge issues are handled by the psychiatric social workers. Pharmacotherapy is adequate and ECTs are administered. Currently due to non-availability anaesthetist, ECT is not been given to patients. Patients are managed by oral and injectable drugs appropriately. Violent female patients are managed primarily through medication. Nurses conduct regular structured activities for the women patients in the ward apart from other additional ward activities. The hospital conducts regular meetings with all categories of staff. Regular academic programmes including seminars, case conferences are also conducted as a part of teaching programmes with students from different disciplines. In addition to psychiatric services, the services of specialists such as Physician, Ophthalmologist, Dentist, Physiotherapist and specialists in Tropical Medicine are also available for both IP and OP patients.

Specify issues pertaining to human rights/ ethical concern: NIL

Outpatient services

The outpatient waiting areas are very crowded.

Discharge related issues and absence of family involvement

The involvement of family members in the care of female patients is inadequate, with most of the families abandoning them in the hospital. This could presumably be due to reasons like stigma towards mental illness, lack of knowledge about mental illness, negative attitude towards the person with mental illness, poverty, financial difficulties, illiteracy, lack of resources for rehabilitation in the community, inadequate social support, gender barriers, long distance, lack of transportation facilities to bring patients for follow-up, lack or inadequacy of welfare measures, lack of supported employment opportunities for recovered patients in the community, family burden and poor coping and problem solving skills. Family members and relatives abandon some of them after giving false residential addresses.

Few of the women and girls with mental retardation are institutionalized for unique gender-specific reasons. The staff reported that families sometimes prefer to leave their daughters with intellectual disabilities in the custody of the hospital permanently where they feel the women are safe and out of fear that they may become easy targets for sexual abuse at home. Sometimes, it has been reported that few of the discharged women are readmitted on voluntary admission due to rejection be family, physical abuse by their spouses and/or in-laws and remarriage of their spouses.

Multiple efforts made by the social workers and hospital administration to trace the family members with help of police and attempts at reintegration have failed due to incorrect address, language barriers in tracing the families of patients belonged to outside states, women with severe intellectual disability being unable to give their contact details and family's reluctance to accept the recovered patients. It is also reported that the families sometimes refuse to accept the women patients due to difficulties in bringing them for follow-up from a long distance and lack of psychiatric treatment services available in the government general hospitals in the community.

The homes run by the Government do not provide shelter care for women with mental illness. Two local NGOs - Nav Bharat Jagriti Kendra & Sanjeevini Gram Trust are helping the team in identification of patients and providing follow-up services in the community extension programme of the hospital.

SUMMARY

According to the administrators and service providers, no fresh staff recruitments have been made at RINPAS since 2004. There has been no full-time director for many years. A third of inpatient beds are for women and 60% of these beds are occupied by women staying here for more than 10 years. A halfway home has been constructed but is not functional due to lack of staff. Human resource shortages are across all staff cadres. The working staff strength is only 264, while the allocated staff strength is 671. The psychiatrist bed ratio is 1:100 and the nurse bed ratio is 1:80, grossly inadequate. Many positions of psychologists and psychiatric social workers are also unfilled. The shortage of staff, particularly the nurses, leads to professional burnout.

The service providers feel that infrastructure facilities for women with mental illness in the hospital are also inadequate. There is no active involvement of families.

Feedback from the patient respondents indicates high levels of satisfaction (92%) with basic facilities. There are high or reasonable levels of satisfaction as far as safe drinking water (88%), toilet maintenance (88%), toilet adequacy (80%), ward cleanliness (84%), changing of linen (80%) and space for washing and drying clothes (84%) are concerned. However areas which many women rate as unsatisfactory are lack of hot water (64%), provision of lockers (66%) and they complain of overcrowding (44%).

With regard to food, all the respondents are satisfied with the overall quality, frequency and service of food. One-fifth, however, said that the dining room facilities are inadequate.

In the area of personal hygiene, 88% rate the facilities as good. However, privacy for bathing, use of toilet and change of clothes are rated as poor (40%). Not being able to wear own clothes (56%), lack of choice in hospital clothing (44%) and not being provided inner garments (96%) are areas of relatively high dissatisfaction. A majority say they are provided winter wear (92%), footwear (96%) and basic cosmetics (84%). However, although a majority say that sanitary napkins are regularly provided (84%), many say there are no instructions on their proper disposal (44%).

Sleeping facilities are overall rated as satisfactory by all respondents. However a majority (88%) say that heaters are not provided, facilities to sit and rest are inadequate (72%) and many (40%) complain of pests in the ward. A majority concur that immediate services are provided during emergencies.

Treatment services are rated as good by a majority (84%). Patients perceive that nursing staff are helpful and assist them in taking medication. Most say that a female chaperone (96%) is available when male doctors examine patients. However, most patients (76%) say that they have not been explained the effects and side-effects of medicines.

A majority (72%) express overall satisfaction with the way their emotional needs are addressed. All respondents say that the treating staff addresses them properly, shows adequate concern and most (96%) say they listen to them patiently. Many (more than half) did not answer the questions related to confidentiality. Those that have generally report that confidentiality is maintained. Most patients say they are permitted to retain their personal belonging, although 28% say they are not. Half (52%) say they have not access to phones or other forms of communication outside. Nearly half say their phone calls or communication is not kept private.

With regard to social interactions, most do not have any contact with families. Many rate group activities as satisfactory, although 40% say outdoor activities are poor. Those who receive visitors are satisfied with the visitors' room arrangements.

Most patients do not report any form of coercion.

Although there is a multi-faith hall and none feels discriminated on account of their religion, nearly a quarter says they are not permitted to carry out their religious or spiritual activities. A fifth says there is no access to newspapers and magazines. A majority (96%) feel they are not allowed to make health care decisions. A high proportion (40%) says that informed consent has not been taken prior to treatment. A majority have not received any information on human rights. A quarter says hair cut occurs without consent. While a majority says that education about illness has been provided, a quarter says it has not. A majority (80%) feels that hobbies are encouraged by staff. While a majority says that pre-test counseling for HIV and other similar conditions is done, 40% say it is not.

The visiting team observed that many of the long-stay patients are from out of station. Although the ambience is prison like, the wards within are open. The buildings are very old. Ward maintenance is adequate. Patients are bathed in groups. Toilets are situated outside the wards and patients complain of difficulties in going out at night. Water supply is adequate. Fans and lights are inadequate. Drinking water is adequate. However, the water coolers are not well maintained. The food is hygienically served and adequate. But the dining hall seating facility is not comfortable for elderly and those with orthopaedic problems. The hospital uses its large campus to generate a lot of produce for hospital use. Though personal hygiene appears generally adequate, patients say bathing is irregular because of lack of hot water. Patients are not allowed to wear their own clothes but provided with a range of uniforms. They are also given sufficient toiletries, footwear as well as adequate sanitary napkins. But the team observed that these are not disposed properly. While patients are provided with warm clothing, inner garments are not provided.

The sleeping facilities are adequate, although pests are an issue. Patients appear to be treated well and the team did not come across any cases of abuse during their visit. On the contrary, there were many stories of patients being abused by a family member or someone in the community, coming into hospital with an HIV infection, or a pregnancy discovered after admission.

The team observed that involvement of the family is minimal. Although pre-admission and pre-discharge counseling is done with the families, absence of a family ward prevents effective family engagement.

The team was generally appreciative of the hospital staff for their dedicated work in providing quality care to the patients despite having limited human resource.

Recommendations by the team

1. There is an urgent need to fill up the vacant positions for smooth functioning of the hospital. It is imperative to fill up existing vacant posts for both teaching and non-teaching staff immediately. The institution is awaiting the State Government's passing of RINPAS Bye-Law, No. 3. RINPAS Recruitment rules and No. 4. RINPAS Staffing Pattern 2004 in order to recruit more staffs and also create new posts to meet patient requirements. It is essential to appoint a full term Director for the smooth functioning of hospital administration.
2. While the overall facilities are generally good. However, with specific reference to women patients, facilities are inadequate in terms of bed strength, availability of staff and rehabilitation services. There is an urgent need for more and better provisions to improve the quality of services to women patients. These include:
    - Adequate room heaters for the cold winters in Jharkhand
    - Adequate bathrooms with buckets, mugs, towel rods etc.
    - Ensure patient privacy will bathing, using the toilet and changing
    - Proper sanitary pad disposal
3. Posting of duty doctor to the women's wards
4. Family Oriented Treatment Model should be started in the hospital. This prevents institutionalization and abandoning of women in the ward. New open wards for accommodating the family should be built and they should be involved in the treatment, care and rehabilitation of patients.
5. Rehabilitation staff should be appointed immediately to initiate work at the already established long stay facilities for the recovered women and men in the hospitals.
6. There is also a need to open day care centers and sheltered workshops for patients outside the hospital in collaboration with non-governmental organizations and voluntary bodies with regular monitoring by the rehabilitation committee.
7. Facilities for women with special needs, e.g. Mother and Child Care Unit needs to be established.
8. Information, awareness, communication (IEC) materials on mental health and illness for awareness using video facilities in both outpatient and inpatient settings.
9. Greater NGO collaboration for rehabilitation.
10. Greater focus on psychosocial interventions to reduce hospital stay and disability.
11. Engagement of the Ministry of Social Justice &Empowerment, Ministry of Women and Child Welfare, towards starting day care centres and long term homes for destitute, homeless patients for successful rehabilitation in the community. The departments should also encourage and support local NGOs and private organizations to open rehabilitation homes and start up income generating skills-training program for women patients. This should be closely monitored through frequent inspections by the State Commission for Women/National Commission for Women to ensure that the women with mental illness receive quality care.
12. Focused attempts to track families of patients along with collaboration with the police, legal authorities and NGO' s to restore lost patients to their families.

13. In order to support families to take care of their relatives, there is a need to make available treatment and care close to where they stay. There is also a need to establish halfway homes, long stay homes, as well as day care rehabilitation facility available for mentally ill female patients in the community. Currently, a full-fledged 50 bedded halfway home each for recovered female and male patients has been built in the hospital but is not in operation due to lack of staff and human resources.
14. The departments should explore new, innovative and sustainable income generation activities, provide supported employment and introduce welfare schemes for the recovered homeless, abandoned women in the community. There is also a need to initiate work on a comprehensive Rehabilitation Policy and Programmes by the departments, which help in the reintegration of women patients into society. The departments could also fund NGOs and encourage them to start up day care centres, sheltered workshops and shelter homes in the community for women patients with mental illness.

8. INSTITUTE OF MENTAL HEALTH AND HOSPITAL (IMHH), AGRA

INTRODUCTION

This hospital was started as an asylum in 1859. An important reason attributed to its inception by the British is said to have been 'the lunacy' of the Lt. Governor of Agra, Mr. J. R. Colvin in 1857[56]. During the initial period of the 20th century, it developed as an active academic centre of psychiatry, with many innovations, including the concept of open ward care, innovations in electroconvulsive therapy and one of the sites for the International Pilot Study of Schizophrenia, initiated by the World Health Organization[57]. However, during the late 1970s and 80s, there was a decline in its functioning. A PIL filed in the Hon'ble Supreme Court against Gwalior Mental Arogyashala in 1986 was extended to include the Agra Mental Hospital in 1994. The Hon'ble Court drafted and directed a petition for major changes in the structure, objectives, and functioning of the Mental Hospital, Agra in its judgment of September, 1994. The Mental Hospital, Agra was renamed as Agra Mansik Arogyashala. In 1995, its status was converted from a State-owned hospital into an autonomous Institution. It was renamed the Institute of Mental Health and Hospital, Agra, in 2001.

The NHRC Report in 1999[58] noted, that despite the granting of status of an autonomous institute, the hospital faced many problems. It rated the hospital as Average. There was a shortage of staff and the staff was poorly motivated. Free drugs were not provided in the outpatient. Buildings required repair and basic facilities required improvement. Rehabilitation

[56]Kumar S., Kumar R. Institute of mental health and hospital, Agra: Evolution in 150 years. Indian Journal of Psychiatry. 2008; 50(4):308-312. doi:10.4103/0019-5545.44759.
[57]Sartorius N. The International Pilot Study of Schizophrenia. Schizophrenia Bulletin, 1974 (11): 21-33
[58]National Human Rights Commission. Quality Assurance in Mental Health 1999. Ibid.

services required to be started. There was a need to have more open wards and family facilities. Recreational facilities required to be improved. Modern methods of record keeping and file retrieval needed to be initiated.

The NHRC Report of 2008[59] noted that IMHH had been under the supervision of the NHRC since 1997. Several monitoring visits were carried out by the special rapporteurs of the NHRC, who also interfaced with the State Government. The Apex Court had also directed the complete revamping of the hospitals in Gwalior, Agra, Ranchi, Tezpur and Delhi. In the intervening decade, 10 visits were carried out by the NHRC/SHRC. Several developments occurred at Agra. A family ward and a short stay ward was built. Outpatient facilities were improved and facilities for families to stay were constructed. Diet and dining facilities improved. Many patients were united with their families through the efforts of the staff in collaboration with volunteers of Action Aid India. Two occupational therapy units were set up. Specialized facilities for children and the elderly were set up. Human resources were improved. Several aspects of patient care also improved, a faster pace of training and greater focus on rehabilitation. A halfway home had been constructed. The L. Mishra report of 2007 notes the persistent lack of hot water and poor quality of linen. His report suggested that there should be better community engagement. The DGHS, in its 2004 report noted that psychology services were just being developed and psychiatric social work services were inadequate. Specific to women, the Mishra report notes 'that the female patients are treated in a separate compound and the main door is always kept locked with a female chowkidhar'. The NCW/NIMHANS team visited IMHH Agra between 25.01.2016 and 27.01.2016.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

The hospital is spread across the area of 170 acres. The family wards have increased and most importantly, postgraduate training is has been strengthened. Additionally, there has been significant improvement in the hospital's infrastructure. Community mental health services have also started. Overall, currently, IMHH Agra is considered one of the better psychiatric institutes of the country.

The admissions to IMHH are usually involuntary. There are 10 wards with each ward housing 30 patients. Most patients are from remote areas of Uttar Pradesh. Most patients have psychotic or affective illnesses with a small proportion having intellectual disabilities. There is good cooperation from the police and usually doctors are not required to go to the court. Admissions are consequent upon the reception orders by the chief judicial magistrates. Another source of patients are the women's protection homes throughout the state of UP. Any inmate inside such homes who is found to have 'abnormal behaviour' are brought here and admitted. A minority of patients are admitted in family wards where family members do stay with patients during the acute phases and take patients back home once they become better. Local clubs, social workers, NGO and local residents also bring the patients.

[59]National Human Rights Commission. Mental Health and Human Rights 2008. Ibid

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table 8a. Basic Facilities

Description	Yes - N (%)	No - N (%)
Is there adequate light during day time?	25(100)	0
Is there adequate light during night time?	25(100)	0
Is hot water given for bathing regularly?	11(44)	14(56)
Is safe drinking water provided?	24(96)	1(4)
Are bathroom and toilets adequate?	24(96)	1(4)
Are bathroom and toilets cleanly maintained?	23(92)	2(8)
Is there space for washing and drying clothes?	16(64)	9(36)
Is the ward cleaned regularly?	24(96)	1(4)
Is linen changed regularly?	12(48)	13(52)
Is there overcrowding in the ward?	14(56)	11(44)
Are patient allowed to go outside the ward regularly?	20(80)	5(20)
Is there adequate space for walking outside the ward?	24(96)	1(4)
Is a locker facility provided?	2(8)	23(92)

Overall rating of basic facilities

Overall, most of the respondents (96%) of the IMHH Agra rated the basic facilities as Good. All perceived that lighting was adequate. Most (96%) said that drinking water was safe and a similar proportion said that the bathrooms and toilets were adequate; that the ward was cleaned regularly and that the toilets were cleaned regularly (92%). While a majority (80%) said they were allowed to go out regularly, the rest disagreed. A substantial proportion (44%) said there was overcrowding, more than half (52%) said that linen was not changed regularly, more than half (56%) said hot water was not regularly available for bath and a third (36%) said there was not adequate space for washing and drying clothes.

Table 8b.Food Facilities

Description	Yes - N (%)	No - N (%)
Is the food provided adequate?	25 (100)	0
Is there sufficient variety in the daily menu?	24 (96)	1 (4)
Is quality of food satisfactory?	17 (68)	8 (32)
Are you satisfied with the frequency of food provided?	25 (100)	0
Are you served with special food on special occasions?	25 (100)	0
Are you served non-vegetarian meals on request?	8 (32)	17 (68)

Are the food serving staff polite?	22 (88)	3 (12)
Is there a separate dining area?	20 (80)	5 (20)
Are facilities provided in the dining area?	16 (64)	9 (36)
Are the utensils and dining room well maintained?	22 (88)	3 (12)

Overall rating of food and dining facilities

A majority (72%) rated the food as good. More than a third (35%) rated it as poor. While all the respondents said the food provided was adequate in quantity, the frequency of food provided was adequate (100%) and there was sufficient variety in the daily menu (96%), a third (32%) were dissatisfied with the quality of food; more than two-thirds said they were not served non-vegetarian food on request. While a majority (88%) said the staff serving the food was polite, that there was a separate dining area (80%), and that the dining room and utensils were cleanly maintained (88%), a third (36%) were not satisfied with the facilities provided in the dining area.

Table 8c. Personal Hygiene and basic comforts

Description	Yes –N (%)	No - N (%)	Not applicable* -N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	15 (60)	10 (40)	0
Are sanitary napkins provided regularly?	18 (72)	0	7 (28)
Is information provided on proper disposal of sanitary napkins by nursing staff? *	6 (24)	12 (48)	7 (28)
Are basic toiletry articles provided?	22 (88)	3 (12)	0
Are you permitted to wear your own clothes?	4 (16)	21 (84)	0
Are you given a choice of clothes to wear?	5 (20)	20 (80)	0
Are you provided inner garments?	15 (60)	10 (40)	0
Is winter wear provided to you?	25 (100)	0	0
Is footwear provided to you?	25 (100)	0	0
Are basic cosmetics provided to you?	13 (52)	12 (48)	0

*These patients had reached menopause 7 (28%).

Overall rating on facilities for personal hygiene and comfort

A majority of respondents (96%) rated the overall arrangements for personal hygiene and comfort as satisfactory. With respect to specific areas, 40% said there was no privacy for bathing, using toilets and changing clothes; 28% said sanitary napkins were not provided

regularly and nearly half (48%) said they were not informed about proper disposal. Most (88%) said that basic toiletries were provided. A majority (88%) said they were not allowed to wear their own clothes nor given a choice of clothes if provided by the hospital (80%). Unlike other hospitals visited, a greater proportion of respondents here (60%) said they were provided inner garments. All of them said winter wear and footwear were provided. About half (48%) said basic cosmetics were not provided.

Table 8d. Sleeping and Resting Facilities

Description	Yes - N (%)	No – N (%)
Is the ward quiet at night?	24 (96)	1 (4)
Are you provided with separate cot, mattress, pillow and blanket?	25 (100)	0
Are fans provided when it is hot?	25 (100)	0
Are heaters provided?	3 (12)	22 (88)
Do you have facilities to sit and rest during the day?	21 (84)	4 (16)
Does the ward have bedbugs, cockroaches, mosquitoes exist in the ward?	22 (88)	3 (12)
In case of serious physical and mental problems, is immediate help provided?	25 (100)	0

Overall feedback on sleeping and resting facilities

Overall, about three-fourth (72%) rated these arrangements as Good. They all said they were provided with separate cots, mattresses, pillows and blankets, that fans were provided when it was hot and that immediate help was available if there was an emergency. A majority (84%) said they had facilities to sit and rest during the day. However, most of the respondents (88%) complained that there were pests in the ward and a similar proportion said they were no heaters.

Table 8e. Medication and treatment

Description	Yes – N (%)	No – N (%)
Does the nursing staff help you in taking medications?	24 (96)	1 (4)
Have you been given explanation by treating team about medicines and side effects?	11 (44)	14 (56)
Is a female nurse/attendant present when you are physically examined by a male doctor?	24 (96)	1 (4)
In case of medical problems, is immediate attention provided?	25 (100)	0

Overall feedback on medication and treatment

Overall, nearly all respondents (96%) said that the treatment was good. The same proportion said that nursing staff were helpful in taking medicines, that there was a chaperone when women were being examined by male doctors. All of them said medical problems were

immediately attended. Although the proportion here was comparatively less than in other hospitals, even here, 56% said they had not been explained about the medicines and their side-effects.

Table 8f. Emotional Needs

Description	Yes – N (%)	No – N (%)	Not answered* -N (%)	Not applicable** -N (%)
Do the members of the treating team address you properly?	25 (100)	0	0	0
Does the treating team spend enough time to listen to you?	25 (100)	0	0	0
Does the treating team show adequate concern?	24 (96)	1 (4)	0	0
Are you permitted to have personal possessions?	4 (16)	13 (52)	0	8 (32)
Do you have access to phone in ward?	0	18 (72)	0	7 (28)
Do you have permission to receive calls and letters?	4 (16)	13 (52)	0	8 (32)
Do the staffs read your letters or listen to phone conversation?	1 (4)	14 (56)	0	10 (40)
Do the staffs provide pen and paper for letter writing?	9 (36)	6 (24)	0	10 (40)

*These patients were uncooperative (due to various illness related factors) because of which they could not respond. Also could not understand the question on confidentiality. ** These patients were either destitute or orphaned.

Overall feedback regarding meeting of emotional needs

Overall nearly all (96%) said their emotional needs were well met. All the respondents concurred that they were addressed properly by the staff and that the staff members gave them enough time and listened to them. Nearly all (96%) said the treating team showed adequate concern. Many (48%) did not answer the question on confidentiality, but those that did said confidentiality was maintained. More than half (52%) said they were not permitted to have personal possessions. Nearly three-fourth (72%) said they had no access to a phone and over half (52%) said they had no permission to write or receive calls and letters. More than half (56%) said that the staff read their letters or listened to their phone conversations.

Table 8g. Coercion and related issues

Description		Yes -N (%)	No -N (%)	Not applicable*- N (%)
Were you ever threatened by hospital staff?		0	25 (100)	0
Did the hospital staff ever use bad language that was hurtful to you?		2 (8)	23 (92)	0
Have you ever beaten by any hospital personnel?		0	25 (100)	0
Did any of the treating team ever make sexual advances towards you?		0	25 (100)	0
Were you restrained physically?		1 (4)	0	24 (96)
Were you informed about the need of restraint?		0	1 (4)	24 (96)
Were you told about alternatives like chemical restraints/seclusion?		0	1 (4)	24 (96)
Was any staff present while being restrained?		0	1 (4)	24 (96)
Staff present during restraint	Male	0	0	
	Female	1 (4)		24 (96)
Were you left unattended for more than 2 hours?		1 (4)	0	24 (96)
Were restraints padded?		0	1 (4)	24 (96)
Did the staff check restraints frequently?		0	1 (4)	24 (96)

*These patients had not been restrained during their stay in the hospital.

Overall feedback on coercion and related issues

None of the respondents reported ever having been threatened by the staff, beaten or having been subject to any sexual advances. While most (92%) said they had not been subjected to any bad language, two of the respondents reported such incidents.

Table 8h. Social Needs (How much you are satisfied)

Description	Very poor (N %)	Good (N %)	Very good (N %)	Not applicable (N %) *
Permission to attend family functions	3 (12)	0	0	22 (88)
Group activities	3 (12)	17 (68)	2 (8)	3 (12)
Outdoor activities	9 (36)	13 (52)	1 (4)	2 (8)
Participation in sports/games/cultural activities during hospital stay	9 (36)	13 (52)	0	3 (12)
Provision of separate visiting room	1 (4)	10 (40)	0	14 (56)

*These patients were either destitute or orphans. Some patients' addresses were still not traced; Some patients lacked insight, were sedated or were poorly motivated.

Overall rating on extent of satisfaction with meeting social needs

More than two-thirds said that group activities are adequate. A third said that outdoor physical activities were inadequate. Many who received visitors were satisfied with the visitor's room arrangements.

Table 8i. Ethical, Spiritual and other needs

Description	Yes - N (%)	No - N (%)	Not answered * - N (%)	Not applicable - N (%)
Is there permission for religious/spiritual activities?	22 (88)	3 (12)	0	0
Are you offered adequate respect and care?	24 (96)	1 (4)	0	0
Were you ever treated against your wish?	0	25 (100)	0	0
Are you allowed to read newspaper and magazines?	6 (24)	13 (52)	0	6 (24) #
Are you allowed to take health care decisions?	0	24 (96)	0	1 (4)
Was your hair cut without your consent?	8 (32)	14 (56)	0	3 (12)
Were you permitted to represent legal matter in court?	2 (8)	6 (24)	0	17 (68) ^
Did you get information about patients' rights in hospital?	1 (4)	24 (96)	0	0
Was confidentiality maintained during hospitalization by the treating team?	1 (4)	18 (72)	4 (16)	2 (8)
Did the treating team educate you about your condition?	2 (8)	10 (40)	0	13 (52) #
Did staff ask for bribes or gifts?	0	25 (100)	0	0
Have you felt any discrimination by the treating team on account of your religion?	0	25 (100)	0	0
Were your hobbies encouraged during the hospital stay?	11 (44)	11 (44)	3 (12)	0
Is informed consent taken for treatment?	15 (60)	8 (32)	0	2 (8)
Is informed consent taken for research?	18 (72)	0	0	7 (28) @
Is pre- test counselling for HIV/STI/OTHER tests done?	4 (16)	21 (84)	0	0

* These patients were uncooperative and did not respond. # Illiterate; ^ These patients do not have any legal issues; @ No research has been undertaken on these patients.

Overall feedback on meeting of ethical, spiritual and other needs

None of the respondents said they had ever felt discriminated on account of their religion. None of them complained that they had ever been asked by the staff for bribes or gifts. None

reported having ever been treated against her wish. Most (88%) said there was permission to carry out religious/spiritual activities. Most (96%) said they were offered adequate respect and care. Over half (52%) said they did not have access to newspapers and magazines. About a third (32%) said their hair had been cut without consent. A majority (96%) said they had not been allowed to take health care decisions and a similar proportion said they had not been provided information on patient rights. A third (32%) said that informed consent had not been taken prior to treatment. While more than half did not answer the question relating to being educated about their illness, 40% said they had not been educated about their illness. A majority among those who responded to the question on research said that informed consent was taken. As far as pre-test counselling for HIV and similar tests was concerned, a majority (84%) said that such consent was not taken. Half of those who responded regarding encouragement of their hobbies answered in the affirmative.

OBSERVATIONS OF THE VISITING TEAM

Basic facilities

The basic facilities provided to the patients are good overall. Wards appear a little dark; however, they are kept clean. Patients get hot water for bathing (this is in contrast with their responses regarding availability of hot water), bathrooms and toilets are clean and adequate. Patients report that linen is not changed regularly. There is a separate area for washing the clothes, but no proper space for drying them. There is adequate space for walking. The drainage system is reported to be adequate. The natural and artificial lighting is adequate and there are fans. There is no heating system for the winter season. The toilets are tiled and clean. There is running water in the bathrooms but no geysers for hot water. However, the team was informed that provision is made for hot water. There is adequate space for clothes and personal belongings. The outpatient facility operates every day and is usually quite crowded.

Food

Patients are satisfied with the quality of food overall; menu is changed regularly. Patients report that they get clean and tasty food but some of them said the taste of food has to be better. They get egg as non-vegetarian food. There are a couple of dining halls which are clean but are inadequate for all the patients. Some of them sit outside the wards on the floor and eat.

Personal Hygiene

Patients have poor privacy while taking bath because of inadequate number of bathrooms and 2-3 patients have to bathe at a time (in the morning). Sanitary napkins are provided but patients have poor knowledge about proper use and disposal. Toiletries are provided to patients. They are provided uniforms and do not have choice to wear their own clothes. Cosmetics are not provided to all. Combs may be shared between women. Winter wear and footwear are provided regularly.

Sleeping and resting

Currently, the women have separate beds to sleep on, with a reasonable distance between each bed. There is adequate space for sitting or rest during the day. During winter, two blankets are provided to patients instead of room heaters.

Medication and treatment

Medication management and other treatment modalities are carried out in a fashion consistent with any post-graduate institution. There are regular ward rounds which are generally multidisciplinary in nature (though there is a shortage of human resources especially in the area of psychology and psychiatric social work). Junior residents are given primary responsibilities of looking after designated ward/wards and are supervised by the senior

residents and consultants. Another notable aspect is a ‘dedicated’ wing for electroconvulsive therapy (ECT). This facility is fully air-conditioned and state of the art ECT machines are available. Another good thing is the availability of a full time anaesthetist dedicated to ECT services in the institute. This gives a lot of flexibility and gives scope for excellent training in ECT and other brain stimulation techniques. The team was informed that they are in the process of procuring an rTMS (repetitive transcranial magnetic stimulation) device.

A dedicated library also is situated inside the campus.

However, the psychosocial management has scope for expanding. The main challenge in this area is related to the lack of human resources and their training. The documentation adequate in the case file is adequate and the psychiatrists, psychologists and nursing staff know the patients’ names and brief details of their case history.

Emotional needs

The nursing staffs feel that much of their time is spent in dispensing medication, bed-making and keeping a close watch to prevent violence. This leaves little time for one to one interactions and an empathic response to individual needs. Patients are however, satisfied with the attention provided by the staff as evidenced by their responses.

Patients generally feel that they are getting empathic responses from the members of the treating team. As majority of patients are involuntary in nature, their family members are not present and do not visit frequently. In fact, the most common desire of patients is to go back to their families.

The issue of 'discharge' to the community of those who do not have families is, however, a complex one. Multiple medical, social, economic, administrative and political considerations are intertwined ultimately leading women to remain in the hospital.

Emotional abuse/ Physical abuse/Sexual abuse

Physical violence between inmates does occur occasionally; however, serious injuries were not noted. Sedation is used to address any violence and there is no seclusion or physical restraint. Emotional abuse is not common but few patients have disclosed that the staff sometimes makes derogatory remarks.

Social needs

Staff members arrange group activity for the patients; the women also participate in the cultural activities during various celebrations. In fact, on the day of the visit, there was an annual sports and cultural meet organized by the institute. This was to celebrate Republic Day. The administration said that this was one of the biggest festive occasions at the institute. The whole campus was decorated beautifully. Staffs were particularly active in the arrangements. Each ward supervisor (or another designated person) had taken in-charge of the nearby area and had innovatively decorated both the wards as well as the surrounding areas. There was a sports event as well. Patients and staff of the institute took active part in these events. Multiple events including cricket, track and field events were conducted. During the valediction ceremony, winners were given prizes.

As regards the rehabilitation unit, there is a small unit where an occupational therapist teaches the patients to stitch, embroider, knit etc. Some of the articles prepared by patients are very attractive. However, there is ample scope for expanding the rehabilitation facilities. Human resource shortage is the biggest deficit and if addressed, can help to improve the rehabilitation facilities.

Religious needs

Patients are free to practice their religion without coercion. There is also a temple inside the premises.

Concern about discharge

The most important issue in most women's thoughts and conversation is about their return back to their homes. However, as previously mentioned, this is a complex issue for which there seem to be no immediate clear answer. While the administration realizes this need, they face multitude of barriers to facilitate this issue. One reason is reluctance and resistance from family members. Patients are perceived as a burden, particularly when they are women. Lack of financial productivity, perception as a liability, the disturbances caused at home due to illness, the expenses of long-term care, poor social support for the families, declining attachment towards patients (because of long-term hospitalisation) all play a role in this. It was also noted that families often give incorrect contact information Letters are sometimes

sent through the local police stations but usually there is no response or follow-up. The local gram panchayat officials are also contacted sometimes.

SUMMARY

The IMHH Agra is an old mental institution, which has undergone tremendous recent transformation following the monitoring of the hospital by the NHRC and conversion from a state-owned hospital to an autonomous institution. It is located on a large campus. Through regular monitoring and enhance funding, much has been possible- family ward, improved facilities for patients, better outpatient services, greater focus on rehabilitation and specialised services. Although human resources have improved, they are far from sufficient, particularly in the specialities that deliver psychosocial intervention (clinical psychologists and psychiatric social workers).

Most admissions are still involuntary and many of the long stay patients with severe mental disorders are from out-of-state.

Personal interviews with patients reveal a high degree of overall satisfaction with basic facilities (lighting, water, toilets and maintenance). However, hot water continues to be a problem according to more than half the respondents; linen is not changed regularly according to more than half and a third say that the facilities for washing and drying clothes are insufficient.

While a majority rate the food as good, all say the food is enough in quantity, served regularly, adequately variable, but a third say the quality is poor and two-thirds say they are not served non-vegetarian food. A majority say the staffs serving food are polite.

While a majority is satisfied with the overall arrangements in the area of personal hygiene, 40% say the hospital lacks privacy; nearly one in three say the sanitary pad provision is unsatisfactory and nearly half say there is no information on proper disposal. All of them are provided winter wear and footwear and a majority say they are provided basic toiletries. A majority say that they are not allowed to wear their own clothes, and are not provided with an adequate choice of hospital clothes. A greater proportion of patients here compared to other hospitals are provided inner wear, but 40% say they are not provided inner wear and nearly half say they are not provided any cosmetics.

More than three-fourths are satisfied with the sleeping arrangements and most said the resting facilities are good. However, a majority complains of pests in the ward and a lack of heaters during the cold season.

Nearly all respondents say the treatment is good and that the nurses are helpful, that a female chaperone is present during medical examination. All feel emergencies are promptly attended. However, more than half say they have not been explained about the medicines and their side-effects.

Almost all patients say their emotional needs are met in the hospital, that staff members listen to them, show adequate concern and address them politely. However, nearly half did not answer the questions related to confidentiality. Those that answered say confidentiality is maintained. More than half say they are not allowed to have personal possessions. Nearly three-fourth say they do not have access to a phone and more than half say they have no permission to make or receive calls and letters. More than half say the staffs listen to their conversations and read their letters.

None of the respondents reports any threats by the staff, any physical abuse or any sexual advances. Two patients report being subjected to bad language.

Most patients are satisfied with the group activities, but a third said that outdoor physical activities are inadequate. Patients who receive visitors are satisfied with the visitor's room arrangements.

None feels discriminated on account of their religion or report pressure from the staff for bribes or gifts. None reports having been treated against her wish. Most feel that they are offered adequate respect and care. Most say there is permission to carry out religious/spiritual activity. However, more than half say they do not have access to newspapers and magazines. A third says their hair was cut without consent. Most feel they are not allowed to take health care decisions and a third says informed consent was not taken prior to treatment. While more than half did not answer the question related to whether they were educated about illness, 40% said they had not been educated. A majority say that pre-test counselling for HIV and other tests is not done.

The visiting team observe that overall basic facilities are good. Wards are clean, hot water is available and bathrooms and toilets are adequate and well maintained. There are facilities for washing clothes, but inadequate place to dry them. Lighting is adequate. There are fans but no heaters. There is running water but no geysers for hot water. There are lockers. Food is adequate. Dining halls are present but overcrowded.

Patients have to bathe together. Patients are not aware of sanitary pad disposal and proper use. Toiletries are provided. Hospital uniforms are compulsory. Winter wear and footwear are regularly provided. Cosmetics are provided to some.

Sleeping and resting arrangements are satisfactory. Medication and other treatment modalities are up to date. There is a library. However, psychosocial interventions need further improvement and the biggest barrier for this is the lack of human resources and their training. Records are well maintained. Although the staff feels there is little time to interact with patients, patients feel the staff is empathetic and responsive.

Minor incidents of physical violence are occasionally reported. Social and religious needs are reasonably met. There is a small rehabilitation unit, but human resource for rehabilitation is a big constraint.

However, almost unanimously, the uppermost desire expressed by patients is a desire to return home.

RECOMMENDATIONS

The following are the recommendations by the team that visited IMHH Agra:

1. Increase in human resources, especially the psychologists, social workers and office staff; addressing issues of cadres/grades of the personnel.
2. Expand PG training to include all courses.
3. There needs to be greater opportunities for Continuing Development Programmes for all trainees and faculty, other than the regular in-house seminars being held
4. Expand rehabilitation facilities
5. NGO involvement and collaboration could be initiated
6. The hospital administration suggests that some women could be employed as contract helpers or on a daily wage basis to work as support staff within the hospital. Their earnings may be deposited in a bank account and their functional recovery could help facilitate family acceptance and discharge.
7. The setting up of supervised half way homes with income generation possibilities, within the community.

9. MENTAL HOSPITAL (MH), BAREILLY

INTRODUCTION

The Mental Hospital at Bareilly was established in 1862 as a mental asylum. It has a jail type architecture.

The NHRC Report of 1999[60] rated the MH Bareilly Very Poor. At that time the hospital had 408 beds, of which 112 was for women. More than one-third of the total patients constituted long stay patients. The hospital had no separate budget for any developmental activities. There were no posts of clinical psychologists, psychiatric social workers, psychiatric nurses or occupational therapists. No free drugs were given. Record keeping was poor. Inpatients were all locked up. Uniforms were compulsory. Toilets were inadequate. Direct ECT treatments were given. The hospital was one of the poorest in terms of inpatient care in all domains. There were no recreational facilities. There was no dining facility. There were constant complaints about food. There were no laboratory facilities. All supportive services were poor. The Report suggested immediate improvement in living conditions, abolition of single cells, open wards where families could stay, modified ECTs, medical superintendent to be a psychiatrist, creation of posts of mental health professionals, establishment of rehabilitation and recreational facilities, facilities for laboratory and other investigations, improvement in supportive services and improved budget.

According to the NHRC 2008 Report[61], only two interim visits were made. As per the update of the Hospital, kitchen facilities had improved, laundry (manual) had improved, cells had been abolished, diet had improved, investigative facilities had been provided, modified ECT

[60]National Human Rights Commission. Quality Assurance in Mental Health, 1999. Ibid
[61]National Human Rights Commission. Mental Health and Human Rights, 2008. Ibid

was being given, recreational facilities were improved. A 30 bed open ward was started. A few nurses had been recruited, but not Clinical Psychologists and Psychiatric Social Workers.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

In Bareilly, the team met with the Director of the Mental Hospital who was a psychiatrist. Members also interacted with another psychiatrist, a lady medical officer and another medical officer who was a radiologist by training. The hospital has a huge shortage of human resources. From the service providers' perspective, the following were the concerns:

(a) An overwhelming majority of female patients are closed ward patients, a good number have mental retardation and not mental illness. They face a big hurdle in discharging them as patients are not wanted by their families. The team was given an illustrative example. *A patient was discharged after an in-patient stay lasting more than a year. She was escorted by the hospital staff/police to her house, a photograph was taken with the patient and family members for documentation. However, after about six months, the patient was found wandering near the hospital premises.* The Director said that her family had abandoned her altogether. Since then, that patient continues to stay inside the hospital.

(b) The Director also spoke about the misuse of government machinery by the relatives by bringing in a lot of 'external pressure' to admit female patients.

(c) Another major concern was the 'red-tapism' of the government. For each and every minor decision, the file needs to go to the Directorate in the capital, resulting in inordinate delays in implementation. He also raised concerns about pendency of files related to recruitment of human resources for some years now. Also, according to the reports by the service providers, the state government is planning a super specialty hospital inside the premises of the mental hospital and according to the sources, the file is in a very advanced stage of processing. This is very detrimental for any scope of developing the Bareilly Mental Hospital.

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table 9a.Basic Facilities

Description	Yes – N (%)	No – N (%)
Is there adequate light during day time?	25(100)	0
Is there adequate light during night time?	25(100)	0
Is hot water given for bathing regularly?	1(4)	24(96)
Is safe drinking water provided?	18(72)	7(28)
Are bathroom and toilets adequate?	23 (92)	2(8)
Are bathroom and toilets cleanly maintained?	16 (64)	9 (36)
Is there space for washing and drying clothes? *	15 (60)	8 (32)
Is the ward cleaned regularly?	20 (80)	5 (20)

Is linen changed regularly?	11 (44)	14 (56)
Is there overcrowding in the ward?	8 (32)	17 (68)
Are patient allowed to go outside the ward regularly?	20 (80)	5 (20)
Is there adequate space for walking outside the ward?	24 (96)	1 (4)
Is there a locker facility provided?	4 (16)	21 (84)

*These patients' clothes are given to laundry 2 (8)

Overall rating of basic facilities

All the patients rated the basic facilities as being good. All said the lighting was adequate, most (92%) said the toilets and bathrooms were adequate, that the wards were cleaned regularly (96%) and there was enough space to walk (96%). Three-fourth (72%) said they were provided with safe drinking water. A majority (96%) said the hot water was inadequate, more than a third (36%) found the space for washing and drying clothes inadequate, more than half (52%) said that the linen was not changed regularly. A significant proportion (44%) said there was overcrowding. One in five said that they were not allowed to go out regularly. A majority (92%) said there was no locker facility.

Table 9b. Food

Description	Yes – N (%)	No – N (%)
Is the food provided adequate?	24 (96)	1(4)
Is there sufficient variety in the daily menu?	22 (88)	3 (12)
Is quality of food satisfactory?	14 (56)	11 (44)
Are you satisfied of frequency of food provided?	24 (96)	1 (4)
Are you served with special food served on special occasions?	22 (88)	3 (12)
Are you served non vegetarian meals on request?	5 (20)	20 (80)
Are food serving staff polite?	22 (88)	3 (12)
Is there a separate dining area?	25 (100)	0
Are facilities provided in the dining area?	25 (100)	0
Are the utensils and dining room maintained well?	22 (88)	3 (12)

Overall rating of food and dining facilities

Overall, all the patients said that the food and dining services were good. Almost all patients (96%) said the food was adequate, so was the frequency. Most (88%) said there was sufficient variation in the daily menu and that special food was served on special occasions. A sizeable proportion (44%) was not happy with the quality of the food. A majority said they were not provided non vegetarian food on request. All said there was a separate dining area with facilities and a majority (88%) said that utensils and the dining area were adequately maintained.

Table 9c. Personal hygiene and basic comforts

Description	Yes – N (%)	No*- N (%)	Not applicable**- N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	15 (60)	10 (40)	0
Are sanitary napkins provided regularly?	20 (80)	0	5 (20)
Is information provided on proper disposal of sanitary napkins by nursing staff?	2 (8)	18 (72)	5 (20)
Are basic toiletry articles provided?	25 (100)	0	0
Are you permitted to wear own clothes?	7 (28)	18 (72)	0
Are you given a choice of clothes what to wear?	1 (4)	24 (96)	0
Are you provided inner garments?	3 (12)	22 (88)	0
Is winter wear provided to you?	25 (100)	0	0
Is footwear provided to you?	25 (100)	0	0
Are basic cosmetics provided to you?	3 (12)	22 (88)	0

*These patients were uncooperative and did not respond. **These patients had reached menopause.

Overall rating of facilities to maintain personal hygiene and basic comforts

A majority of the respondents (80%) rated this as good or very good. However, 40% said that privacy was not maintained while bathing, using the toilet and changing clothes. While 80% said that sanitary napkins were regularly provided, 72% said that information on their proper disposal was not provided. All the respondents said that basic toiletry articles, winter wear and footwear were provided. Three-fourth (72%) said they were not permitted to wear their own clothes and almost all (96%) said they were not given a choice in the hospital given clothes. Most (88%) said they were not provided inner garments. Most (88%) said basic cosmetics were not provided.

Table 9d. Sleeping and Resting Facilities

Description	Yes - N (%)	No - N (%)
Is the ward quiet at night?	23 (92)	2 (8)
Are you provided with separate cot, mattress, pillow and blanket?	23 (92)	2 (8)
Are fans provided when it is hot?	25 (100)	0
Are heaters provided?	4 (16)	21(84)
Do you have facilities to sit and rest during the day?	17 (68)	8 (32)
Does the ward have bedbugs, cockroaches, mosquitoes?	22 (88)	3 (12)
In case of serious physical and mental problems, is immediate help provided?	23 (92)	2 (8)

Overall rating on sleeping and resting facilities

All the patients were satisfied with the sleeping and resting facilities. Almost all (92%) said they were provided with a separate cot, mattress, pillow and blanket. All of them said fans were provided. A majority (84%) said that heaters were not available and that there was a problem of pests (88%). A third (32%) was not satisfied with the resting facilities. Most (92%) said that emergency help was immediately available.

Table 9e. Medication and treatment

Description	Yes – N (%)	No – N (%)
Does the nursing staff help you in taking medications?	25 (100)	0
Have you been given explanation by the treating team about medicines and side effects?	9 (36)	16 (64)
Is a female nurse/attendant present when you are physically examined by a male doctor?	25 (100)	0
In case of a medical problem, is immediate attention provided?	25 (100)	0

Overall rating of facilities for medication and treatment services

All respondents thought the facilities for medication and treatments were good. All said the nursing staff helped them to take their medicines that a female chaperone was present when they were physically examined and that medical problems were immediately attended. However, nearly two-third said they had not been provided adequate explanation by the treating team regarding the medications and side-effects.

Table 9f.Emotional Needs

Description	Yes –N (%)	No –N (%)	Not answered* N (%)	Not applicable** -N (%)
Do the members of the treating team address you properly?	20 (80)	5 (20)	0	0
Does the treating team spend enough time to listen?	19 (76)	6 (24)	0	0
Do the treating team members show adequate concern?	20 (80)	5 (20)	0	0
Are you permitted to have personal possessions?	0	18 (72)	0	7 (28)
Do you have access to phone in ward?	0	19 (76)	6 (24)	0
Do you have permissions to receive calls and letters?	1 (4)	17 (68)	0	7 (28)
Do the staffs read your letters or listen to phone conversation?	1 (4)	15 (60)	0	9 (36)
Does the staff provide pen and paper for letter writing?	10 (40)	6 (24)	0	9 (36)

*These patients were uncooperative and did not respond. ** These patients were either destitute or orphaned.

Overall rating of facilities to meet emotional needs

While 80% rated these facilities as good, 20% rated it as poor or very poor. Most respondents said the staff addressed them properly and showed adequate concern (80%). About a quarter (24%) felt staff did not spend enough time with them. Nearly three-fourth (72%) said they were not permitted to keep personal possessions, did not have access to phones (76%), and did not have permission to receive calls or letters. Most (60%) said the staff did not read their letters or listen to their conversations.

Table 9g. Coercion and related issues

Description		Yes – N (%)	No – N (%)	Not Applicable* - N (%)
Were you threatened by hospital staff?		3 (12)	22 (88)	
Did the hospital staff use bad language that was hurtful to you?		5 (20)	20 (80)	
Were you ever beaten by any hospital personnel?		4 (16)	21 (84)	
Did anyone from the treating team ever make sexual advances towards you?		0	25(100)	
Were you restrained physically?		0	25 (100)	
Were you informed about the need of restraint?		0	0	
Were you told about alternatives like chemical restraints/seclusion?		0	0	25 (100)
Was any staff present while being restrained?		0	0	25 (100)
Staff present during restraint	Male	0	0	25 (100)
	Female	0	0	
Were you left unattended for more than 2 hours?		0	0	25 (100)
Were restraints padded?		0	0	25 (100)
Did the staff check restraints frequently?		0	0	25 (100)

*These patients had not been restrained during their stay in the hospital

Overall feedback about coercion and related issues

Although most (88%) said they had not been threatened by the staff, had not been spoken to in bad language (80%) never been beaten (84%), not been treated in a sexually inappropriate manner and never been physically restrained, a fifth said the staff had used bad language and 3 respondents said they had been threatened by the staff.

Table 9h. Social Needs (How much you are satisfied)

Description	Very poor - N (%)	Good -N (%)	Very good - N (%)	Not applicable* - N (%)
Permission to attend family functions	12 (48)	2 (8)	11 (44)	0
Group activities	23 (92)	0	0	2 (8)
Outdoor activities	21 (84)	4 (16)	0	0
Participation in sports/games/cultural activities during hospital stay	18 (72)	5 (20)	0	2(8)
Provision of separate visiting room	15(60)	0	0	10 (40)

*These patients were either destitute or orphaned. Some patients' addresses were still not traced; Some patients lacked insight, were sedated or poorly motivated to join activities.

Feedback on social needs

Half of the respondents said that they were not permitted to attend family functions. A majority felt that group activities (92%) and outdoor activities (84%) were very poor. Nearly three-fourth (72%) said the physical and cultural activities were very poor. Although a significant proportion had no visiting relatives, 60% said the visiting room facilities were very poor.

Table 9i. Religious Needs, Spiritual and other needs

Description	Yes – N (%)	No*- N (%)	Not applicable –N (%)
Is there permission for religious/spiritual activities?	16 (64)	9 (36)	0
Are you offered adequate respect and care?	19 (76)	6 (24)	0
Were you treated against your wish?	1 (4)	24 (96)	0
Are you allowed to read newspapers and magazines?	6 (24)	13 (52)	6 (24)#
Are you allowed to take health care decisions?	25 (100)	0	0
Was your hair cut without consent?	5 (20)	20(80)	0
Were you permitted to represent legal matter in court?	9 (36)	0	16 (64)^
Did you get information about patients' rights in the hospital?	0	25 (100)	0
Was confidentiality maintained during hospitalization by treating team?	19 (76)	6 (24)	0
Did the treating team educate you about your illness?	2 (8)	8 (32)	15 (60)#
Did staff ask for bribes or gifts?	0	25 (100)	0
Have you felt any discrimination by the treating team on the basis of your religion?	2 (8)	23 (92)	0
Were your hobbies encouraged during the hospital stay?	7 (28)	18 (72)	0
Is informed consent taken for treatment?	11 (44)	14 (56)	0
Is informed consent taken for research?	1 (4)	0	24(96)@
Is pre- test counselling for HIV/STI/OTHER tests done?	16 (64)	1 (4)	8 (32)**$**

did not answer; @had not participated in research; $did not respond.

Feedback on religious, spiritual and other needs

About two-third (64%) said they were permitted to carry out religious and spiritual activities of their choice. Three-fourth said they were treated with respect. Practically all (96%) said they had not been treated against their wish. But a third and quarter respectively felt they did not have freedom to carry out religious activities and that they were not treated with respect. Surprisingly, all the respondents here said they were allowed to take health care decisions. One-fifth said their hair was cut without consent. More than half said they were not allowed to read newspapers and magazines. A third said they were permitted to represent a legal matter. However none of them had received any information on their rights in the hospital. While three-fourth said confidentiality was maintained, a quarter said it was not. Most did not answer the question on whether they had been educated about their illness and nearly a third (32%) specifically said they had not been educated. Most (92%) did not report any discrimination based on their religion. More than half (56%) said informed consent had not been taken prior to initiation of treatment. Nearly three-fourth said their interests (hobbies) were not encouraged. A majority did not answer the question on research. More than two-thirds said pre-test counselling for HIV and other tests was done.

OBSERVATIONS OF THE VISITING TEAM

Circumstances of admission

Maximum numbers are patients who are found wandering on the streets. Consequently, they are involuntary admissions. Once they are admitted, the administrators become their custodians. A reception order is obtained from the jurisdictional magistrate. Most of them turn out to be chronic. Though there is an open ward, admissions there are very few in number. Patients come from various parts of UP. Women's' protection homes are another source of referral of patients to this hospital.

Basic facilities

The basic facilities provided in Bareilly hospital are not at all satisfactory. Wards are shabby, doors and windows are porous. This leads to uncomfortable chilly weather, especially during the winters. Many patients complain that water is unsafe for drinking. Some patients want hot water for drinking, which is also not available. The bathrooms and toilets are inadequate; some patients report that they take bath outside the wards in an open space where there is only a side-wall without a roof. The toilets are dirty; wards are not cleaned regularly; patients do not get hot water for bathing, so that they take bath once in 3-4 days. Many patients responded that wards are overcrowded. They have adequate space to walk and sit outside of the ward. Locker facility is not present but some patients said they got some space to keep their belongings. There are no mirrors and personal products (e.g. powder, bindi) are not provided.

Food: They have an open dining area with cemented benches and it is difficult to have food in the rainy season. The dining space is inadequate. Some patients sit in the wards or outside and have food. The patients themselves wash their plates and glasses. Some patients are not satisfied with the food quality and menu. Some patients complain about attendants, and say they misbehave with them, especially in the dining area. Use of derogatory language is common; staffs are reportedly not polite towards the patients but the staff report that when they get violent and uncontrollable they sometimes have to scold them.

Personal Hygiene: The hygiene level is poor. They do not have privacy while bathing. Sanitary napkins are provided but proper disposal information is not given to the patients. Toiletry items are inadequate. Many patients complained that they do not get soap and shampoo regularly. The M.O. is also of the view that toiletry items are inadequate.

Sleeping and resting: The overall sleeping facilities reported by patient as being satisfactory. The patients are provided with separate cots, mattress and blankets. Though Bareilly becomes

very cold during winters, room heaters are not provided. Though there is a lot of open space, adequate resting and recreation facilities have not been developed.

Medication and treatment

This issue is linked to the grossly inadequate staff, both professional as well as non-professional. For example, at the time of the visit, there was neither a psychologist nor a psychiatric social worker in the pay roll of the institute. The number of psychiatrists was also inadequate. Similarly, there is also shortage of nursing staff and group-D staff as well. Hence, the quality of care inside the hospital appeared suboptimal. Patients report they are not satisfied with the treatment. Some patients complain that doctors come to see them very rarely. The physical complaints of the patients are also not taken care.

Emotional needs/abuse

Patients said that their emotional needs are not met. The treating team members were perceived to show very little concern towards the patients' emotional needs. They do not get time to share their problems with doctors. One patient reported that the doctor scolded her when she went to tell her something. Staffs are rude towards the patients; some reportedly use bad language routinely to address patients. Some patients report that they get scolded by the staff for minor issues. No physical abuse is reported by the patients but sometimes occurs between the patients but the staff separate them.

Social needs

The hospital has a small recreation section but the team found that recreation activities are almost non-existent. Newspapers are not provided to the wards. Patients have to sit the whole day without any activities. Hospital has some staff in the recreation section but they are not keen about rehabilitating the patients.

Religious needs
There are no facilities for prayer in the campus. There is no separate place for prayer. Only at recreational room, patients listen to Bhajans on television.

Patient feedback
Many patients do not seem satisfied with the facility and treatment provided. A patient told the team that the ayahs misbehave with her. They use very humiliating words when patients refuse to work. Another patient shared that they are forced to work in the wards. Whenever they refuse to work, they are punished. They are locked in a room with 2-3 other patients who also refuse to work. One patient reported that she developed a severe pain in her stomach and though she reported this to the nurse, no one did anything. Doctor's visits are also very rare. Some patients said they were not getting proper medication.

SUMMARY

The Mental Hospital, Bareilly, is a very old hospital, the conditions of which were rated very poor in the NHRC report of 1999. In the review a decade later, it was observed that kitchen and laundry facilities had improved, diet had improved, cells had been abolished, laboratory investigations had become available and modified ECTs were being given. An open ward had been started and a 30 bedded ward had been opened. The human resource shortage continued to remain.

During the present interaction, the hospital administrators and service providers express difficulties in discharging patients, particularly those with mental retardation. They express concern about the misuse of government machinery to admit patients, the bureaucratic hurdles in decision implementation, particularly in human resource enhancement.

In the feedback from patient respondents, although a majority rate the overall basic facilities as good, at least a fourth say drinking water is unsafe to drink; a majority said that hot water for bathing is inadequate; a third of inadequate space to wash and dry clothes, more than half that linen is not changed regularly and a considerable proportion say there is overcrowding. Most say there is no locker facility and one in five complain of not being able to go out regularly.

With regard to food, while overall satisfaction is expressed by 100%, a sizeable proportion is not happy with the quality of food and a majority say they are not supplied non vegetarian food on request. A majority is satisfied with the dining facilities.

As regards personal hygiene, a majority rate the overall facility as satisfactory. However, a sizeable proportion say there is no privacy during bathing, use of toilet and bathroom. While sanitary napkins are provided, nearly three-fourth says the patients are not instructed about proper disposal. A majority says they are not permitted to war their own clothes. Neither are they given a choice of clothes to wear. Most are not provided inner garments. Most are not provided basic cosmetics.

All the patient respondents are satisfied with the sleeping and resting facilities (except a third who express dissatisfaction about the resting facilities). An area of concern is that heaters are not provided in winter.

All rate the arrangements of medication and treatment as good. They perceive that nursing staffs are helpful, that female chaperones are present during examination and that medical problems are immediately attended. However, nearly two-third say they are not provided adequate explanation by the treating team regarding medication and side-effects.

While a majority rates the overall level of satisfaction with meeting of emotional needs as good, about a quarter feel the staff does not spend adequate time with them. Most did not answer the question of confidentiality. Most say there are not permitted to keep personal possessions or to receive calls and letters. A significant proportion here says their letters and conversations are not read or listened to by the staff.

Although most say they have not been mistreated in any way by the staff, about a fifth say they have been subjected to verbal abuse. A few (16%) report having been beaten and 3 respondents report having been threatened by the staff.

A majority says that outdoor activities here are very poor and that visiting facilities are also very poor. A majority feels that there is permission to carry out their religious/spiritual activity and that they are not discriminated on account of their religion. Practically all say they have not been treated without consent. However a third feels that they are not permitted to practice their personal religion and a fourth feel they are not treated with respect. All patients here say they are allowed to take health care decisions, but more than half say informed consent has not been taken prior to initiation of treatment. A fifth say hair is cut without consent. More than half say they have no access to newspapers and magazines. None of them has received any information on their rights in hospital. More than two-thirds say that pre-test counselling for HIV and other tests is done

The NCW study team observed many areas of deficiency in the basic facilities, although a majority of the respondents rate them as being good. The wards are not well maintained and damp, making it difficult in the chilly weather, particularly in the absence of heaters. Patients complain about safety of drinking water and the lack of hot water. Toilets are inadequately maintained. Patients sometimes have to take bath in the open. There is overcrowding. Basic cosmetics are not provided to the patients. The dining space is inadequate. Some of the patients complain of staff rudeness, particularly in the dining area. Staffs justify rudeness because patients are sometimes violent and uncontrollable. Sleeping facilities are adequate. The lack of human resources, particularly psychologists, psychiatric social workers and psychiatric nurses is glaring. Some patients complain that doctors do not see them regularly. The hospital has a small recreation section but the activities are non-existent. The team observes that the staffs are not keen on rehabilitating patients. There are no separate facilities for prayer. Some patients feel humiliated by the staffs, who punish them if they do not work in the ward.

The recommendations by the visiting team are part of the general recommendations.

10. INSTITUTE OF MENTAL HEALTH (GOVT.MENTAL HOSPITAL), AMRITSAR, PUNJAB

INTRODUCTION

Govt. Mental Hospital Amritsar was established in the year 1948 when non- Muslim patients admitted at the Mental hospital, Lahore were transferred to Amritsar and were initially housed in an old building which was once used for juvenile offenders[62]. The Government of Punjab established an 811 bedded hospital in an area of 108 Acres. In the year 2001, the administrative control of the hospital was transferred to Punjab Health Systems Corporation and a new building for a 450 bedded hospital was built in 2003. The hospital has been named the Institute of Mental Health (Govt. Mental Hospital) Amritsar. It is presently spread over an area of 60 Acres and caters to the mental health needs of states of Punjab, Haryana and Chandigarh Union Territory, according to the Director IMH. The NCW Project team visited IMH, Amritsar on 03.02.2016 and 04.02.2016. After introducing the team and the purpose of the visit in a meeting with the Director – Dr. B. L. Goyal, issues related to female patients were discussed. Dr. Goyal is 74 years old and his post has been extended several times due to lack of suitable replacement. He took over in 2001.

CONCERNS OF ADMINISTRATORS AND SERVICE PROVIDERS

There is no DMHP in the State. Hence, there are few facilities for the treatment of mental disorders. The hospital receives patients from the State as well as surrounding areas. There are also patients from far away states like Karnataka, Tamil Nadu, West Bengal, Uttar Pradesh etc. Financial support from the state is generous. Some of the problems are prolonged power cuts, no transport facilities to drop patients home, high levels of stigma towards mental illness, lack of qualified mental health professions, contractual nature of posts and few NGOs.

Specific concerns of the director was the shortage of staff. Although posts were advertised there were no qualified staff fulfilling the criteria. However, there was no dearth of finances. The medical superintendent was of the view that conversion to a teaching hospital with the accompanying designation/pay scales/manpower would improve quality of patient care. He noted that long power cuts during summer and winter made it difficult to manage aggressive patients as well as difficult for staff to work in the extreme climatic conditions (hot/freezing). Families were quite happy leaving the patients in the hospital for long duration. The nursing superintendent expressed satisfaction over the working of the hospital and said that things were adequate.

[62] Institute of Mental Health, Amritsar: http://www.imhamritsar.org/

FEEDBACK THROUGH PERSONAL INTERVIEWS WITH WOMEN INPATIENTS (N=25)

Table 10a. Basic Facilities

Description	Yes – N (%)	No – N (%)
Is there adequate light during day time?	25(100)	0
Is there adequate light during night time?	25(100)	0
Is hot water given for bathing regularly?	15(60)	10(40)
Is safe drinking water provided?	18(72)	7(28)
Are bathroom and toilets adequate?	25(100)	0
Are bathroom and toilets cleanly maintained?	25(100)	0
Is there space for washing and drying clothes*?	15(60)	6(24)
Is the ward cleaned regularly?	25(100)	0
Is linen changed regularly?	21(84)	4(16)
Is there overcrowding in the ward?	11(44)	14(56)
Are patient allowed to go outside the ward regularly?	14(56)	11(44)
Is there adequate space for walking outside the ward?	25(100)	0
Is there a locker facility provided?	2(8)	23(92)

** These patients' clothes are given to laundry.

Overall rating of basic facilities

All the patient respondents rated the overall basic facilities as Good. All said the facilities were good, that toilets and bathrooms were adequate and well maintained. All agreed that there was adequate space to walk around outside the ward. While a majority said hot water for bath was provided regularly, 40% did not agree. Most patients (72%) said the water was safe, but about one-quarter disagreed. A majority (60%) said there was space to wash and dry clothes, but a quarter disagreed. Most patients (84%) said linen was changed regularly. Although there is a lot of space to walk, a considerable proportion of patients (44%) said they were not allowed to go outside the ward regularly. Most (92%) said there was no locker facility.

Table 10b. Food

Description	Yes - N (%)	No – N (%)
Is the food provided adequate?	25(100)	0
Is there sufficient variety in the daily menu?	25(100)	0
Is quality of food satisfactory?	20(80)	5(20)
Are you satisfied with the frequency of food provided?	24(96)	1(4)
Are you served with special food on special occasions?	24(96)	1(4)
Are you served non vegetarian meals on request?	1(4)	24(96)
Are the food serving staff polite?	24(96)	1(4)
Is there a separate dining area?	25(100)	0
Are facilities provided in the dining area?	1(4)	24(96)
Are the utensils and dining room cleanly maintained?	25 (100)	0

Overall rating of food and dining facilities

Almost all patients rated the food and dining facilities as adequate. All said the food was adequate, menu was varied, food served in a separate area, which practically all the respondents rated satisfactory (96%). Almost all respondents (96%) said that the staffs serving food was polite, that the frequency of serving food was adequate and that special food was served on special occasions. Eighty percent said the quality was good, but 20% said it was unsatisfactory. Almost all patients (96%) said no non vegetarian food was served on request.

Table 10c. Personal Hygiene and basic comforts

Description	Yes – N (%)	No - N (%)	Not applicable - N (%)
Is privacy maintained while bathing, using the toilets, changing clothes?	23(92)	2(8)	0
Are sanitary napkins provided regularly?	14(56)	1(4)	10(40)**
Is information provided by nursing staff on proper disposal of sanitary napkins?	8(32)	8(32)	9(36)**
Are basic toiletry articles provided?	25(100)	0	0
Are you permitted to wear your own clothes?	25(100)	0	0
Are you given a choice of clothes what to wear?	25(100)	0	0
Are you provided inner garments?	15(60)	9(36)	1(4) ^
Is winter wear provided to you?	25(100)	0	0
Is footwear provided to you?	25(100)	0	0
Are basic cosmetics provided to you?	16(64)	9(36)	0

. **These patients had reached menopause. ^ This patient does not want to wear inner garments.

Overall feedback on facilities relating to personal hygiene and basic comforts

All respondents rated these facilities as Good. All were satisfied with the basic toiletries provided, said they were permitted to wear their own clothes, and if they did not have any, were given a choice of what to wear from what was provided by the hospital. All said they were provided winter wear, as well as footwear. Almost all patients (92%) said that privacy was maintained while bathing, changing or using the toilet. While as significant number said they were provided basic cosmetics, a third (36%) said this was not provided. A similar proportion said inner garments were not provided, although a majority (60%) said they were provided in this hospital. While more than half (56%) said sanitary napkins were regularly provided, a significant proportion did not respond to this question. At least a third said information was provided on proper disposal, whereas a similar proportion said that such information was not provided.

Table 10d. Sleeping and Resting Facilities

Description	Yes – N (%)	No – N (%)
Is the ward quiet at night?	24(96)	1(4)
Are you provided with separate cot, mattress, pillow and blanket?	25(100)	0
Are fans provided when it is hot?	25(100)	0
Are heaters provided?	10(40)	15(60)
Do you have facilities to sit and rest during the day?	8(32)	17(68)
Does the ward have bedbugs, cockroaches, mosquitoes?	11(44)	14(56)
In case of serious physical and mental problems, is immediate help provided?	24(96)	1(4)

Overall feedback on sleeping and resting facilities

Overall, almost all patients (96%) rated the sleeping and resting facilities as being good. They said they were provided with cots, mattresses, pillows and blankets. Fans were provided. Almost all (96%) said that emergency care, if needed, was immediately provided. Almost all said the ward was quiet at night. A majority (60%) said room heaters were not provided. More than two-third said that the resting facilities during the day were inadequate. More than half (56%) said there were pests in the ward.

Table 10e. Medication and treatment

Description	Yes – N (%)	No – N (%)	Not applicable** - N (%)
Do the nursing staffs help you in taking medications?	25(100)	0	0
Have you been given explanation by the treating team about medicines and side effects?	9(36)	16(64)	0
Is a female nurse/attendant present when you are physically examined by a male doctor?	25(100)	0	0
In case of medical problems, is immediate attention provided?	25(100)	0	0

Overall feedback regarding medication and treatment

All respondents expressed satisfaction regarding the medication and treatment provided. With regard to specific questions about medication, all respondents said the nurses helped them in taking medicines, that there was a female chaperone always present when male doctors were carrying out an examination and that medical attention was immediately provided when needed. However two-thirds said that they had not been provided any explanation on the medicines or their side-effects.

Table 10f. Emotional Needs

Description	Yes - N (%)	No- N (%)	Not applicable* - N (%)
Do the members of the treating team address you properly?	25(100)	0	0
Does the treating team spend enough time to listen?	25(100)	0	0
Does the treating team show adequate concern?	25(100)	0	0
Are you permitted to have personal possessions?	23(92)	2(8)	0
Do you have access to phone in ward?	6 (24)	14(56)	5(20)
Do you have permission to receive calls and letters?	15(60)	4(16)	6(24)
Does the staff read your letters or listen your to phone conversation?	10(40)	9(36)	6(24)
Does the staff provide pen and paper for letter writing?	15(60)	4(16)	6(24)

* These patients were either destitute or orphaned**.**

Overall rating on meeting of emotional needs

Overall, all patients (100%) said their emotional needs were satisfactorily met. On specific questions, all said they were addressed properly by the treating team, that the treating team listened to them and showed adequate concern. Most respondents (92%) said they were permitted to have personal possessions. More than half (56%) said they had no access to phones. A majority (60%) said they had permission to receive calls and letters and that the staff provided them stationery to write. A significant proportion (40%) said the staff did listen to their conversations or read their letters.

Table 10g. Coercion/Physical Abuse

Description	Yes – N (%)	No - N (%)	Not Applicable -N (%)*
Were you threatened by the hospital staff?	0	25(100)	
Did the hospital staff use bad language that was hurtful to you?	0	25(100)	
Were you ever beaten by any hospital personnel?	0	25(100)	
Did any member of the treating team ever make sexual advances towards you?	0	25(100)	
Were you restrained physically?	0	25 (100)	
Were you informed about the need for restraint?	0	0	25 (100)

Were you told about alternatives like chemical restrains/seclusion?		0	0	25 (100)
Was any staff present while being restrained?		0	0	25 (100)
Staff present during restraint	Male	0	0	25 (100)
	Female	0	0	
Were you left unattended more than 2 hours?		0	0	25 (100)
Were restraints padded?		0	0	25 (100)
Did the staff check restraints frequently?		0	0	25 (100)

*These patients had not been restrained during their stay in the hospital

Overall feedback regarding coercion and abuse

None of the patients reported being threatened by the staff, never had bad language used against them, never been beaten or restrained and not been victim to any kind of sexual advances.

Table 10i. Social Needs (How much you are satisfied)

Description	Very poor -N (%)	Good – N (%)	Very good - N (%)	Not applicable* - N (%)
Permission to attend family functions	6 (24)	3(12)	5(20)	11(44)
Group activities	11(44)	8(32)	0	6(24)
Outdoor activities	14(56)	0	0	11(44)
Participation in sports/games/cultural activities during hospital stay	17(68)	7(28)	0	1(4)
Provision of separate visiting room	1(4)	10(40)	5(20)	9(36)

*These patients were either destitute or orphans. Some patients' addresses were still not traced; Some patients lacked insight, were over sedated or poorly motivated to join any activities.

Overall feedback regarding meeting of social needs

More than two-third (68%) rated the physical and cultural activities as very poor and more than half (56%) was dissatisfied with the outdoor activities. A third (32%) expressed that they were allowed permission to attend family functions, although for a significant proportion, this was not applicable. While more than a third (36%) did not receive visitors, a majority (60%) said the visiting facilities were good or very good.

Table 10j. Ethical, Spiritual and other needs

Description	Yes - N (%)	No – N (%)	Not answered * -N (%)	Not applicable** - N (%)
Is there permission for religious/spiritual activities?	18(72)	7(28)	0	0
Are you offered adequate respect and care?	24(96)	1(4)	0	0
Were you treated against your wish?	1(4)	24(96)	0	0
Are you allowed to read newspaper and magazines?	13(52)	6(24)	0	6(24)[#]
Are you allowed to take health care decisions?	3(12)	22(88)	0	0
Was your hair cut done without your consent?	5(20)	15(60)	0	5(20)~
Were you permitted to represent any legal matter in court?	1(4)	8(32)	0	16(64)^
Did you get information about patients' rights in hospital?	0	25(100)	0	0
Was confidentiality maintained during hospitalization by the treating team?	0	22(88)	0	3 (12)
Did the treating team give educate you about your illness?	6(24)	6(24)	0	13(52)[#]
Did staff ask for bribes or gifts?	0	24(96)	1(4)	0
Have you felt any discrimination by the treating team based on your religion?	0	24(96)	1(4)	0
Were your hobbies encouraged during the hospital stay?	7(28)	18(72)	0	0
Is informed consent taken for treatment?	15(60)	10(40)	0	0
Is informed consent taken for research?	14(56)	0	0	11(44)[@]
Is pre- test counselling done for HIV/STI/OTHER and other tests?	10(40)	8(32)	0	7(28)**$**

* These patients were uncooperative and did not respond. [#] Illiterate; ~ Hair cut is not done for these patients, ^ These patients do not have any legal issues; [@] No research has been undertaken on these patients. $ HIV test is done only for specific patients.

Overall rating on ethical, spiritual and other needs

Almost all patients (96%) said they had been offered adequate respect and care. While a majority said they were permitted to practice their religion, about one-fourth (28%) replied this question in the negative. Almost all (96%) said they were not treated against their will, although one person said she had been treated against her will. More than half (52%) said they were permitted to read newspapers and magazines (24% were illiterate, hence this was not applicable). A majority (88%) said they did not make health decisions. One in five said her hair was cut without her consent. All the patients said they had not been informed about their rights. Most (88%) said that confidentiality was not maintained. More than half (52%) did not answer the question pertaining to their being educated about their illness and one-fourth said they had not been informed. Almost all (96%) denied being asked for bribes or gifts by the staff. Almost no one expressed any discrimination on the basis of their religion. While majority (60%) said informed consent was taken prior to treatment, the remaining said it was not. Those who answered the question on informed consent for research, said such consent was taken. With respect to pre-test counselling for HIV and other similar tests, while 40% said such counselling was done, almost a third (32%) said it was not.

OBSERVATIONS OF THE VISITING TEAM

Circumstances of admission

A majority **(**90%) of the admissions are reception order patients. They are either wandering mentally ill or from the state protection home. Patients are admitted for 89 days and the next day discharged or they re-apply for the reception order. Patients come from various parts such as Punjab, Chandigarh and Amritsar. Since Himachal Pradesh had monetary arrears to the Punjab Government which they were unable to settle, the government had directed IMH, Amritsar not to receive patients in the non-paying category from Himachal Pradesh. Hence, many patients from this state had given local addresses in order to get admission.

Basic facilities

Cleanliness is one special feature in this hospital. The floor, the wards, the beds, the patients were all clean. However, the ceilings, floor and walls are cracked; need renovation and in bad need of painting. Fans are very dirty. Tube lights are missing in many places. Some wards have only one hot air blower. Bathrooms and toilets are clean. There is one toilet and one bathroom for about 25 patients. Power cuts occur for prolonged periods (10 hours or more) with no technician available during the night to operate the emergency back-up. Hence, during summer, patients and staff have to endure the scorching heat and in winter, the freezing cold.

The water tank is rarely cleaned and many patients suffer from diarrhoea and skin fungal ailments. There is only one phone for the entire IMH, which is located in the Director's office. Everyone communicates using their personal mobile. However, the Director had mentioned during the visit with the NCW nodal officer that the State Government had provided phones to all but did not provide the details. There is only one computer for the entire IMH, only in the Director's office. Whoever needs to sit can have access. The PSW uses the computer and phone to trace whereabouts of patient at times. Most of the time, they use their personal mobiles for this. Patients cannot communicate with their relatives either.

There is no ATM facility, no bank, no phone booth, no photocopying facility in the campus. There is a temple.

Food

There are 4 cooks, however there is no dietician. The menu for the week is displayed on the wall. The kitchen is very clean; all the vessels are well-scrubbed and shining. There were three huge vessels; two with rice mixed with vegetables and one with dhal on the stove. Chapattis are prepared by two cooks with head covered. Patients help in taking the food to the wards.

Piped-in gas supply is available. Patients receive one fruit (banana or apple), vegetables, chapatti and rice every day. Milk and egg is given as special diet when ordered.

Breakfast is served at 7 AM, lunch at 1 PM and dinner at 7 PM with milk at mid-morning and tea in the evenings. The kitchen and store room was very clean with vessels neatly arranged as seen below.

The walls and ceiling need painting and some engineering repair work Patients have their food seated on a mat in a separate room.

Sleeping and resting

Each patient has a cot, mattress and pillow with blankets. Blowers as well as fans are fixed in each ward, but without power supply they are not of much use. Patients did not complain about mosquitoes or bed bugs.

Personal Hygiene

Patients looked clean and well dressed, many with lipstick and eyeliner (supplied by student nurses) in coloured clothes (supplied by the hospital) and winter wear (sweater, shawl, socks, gloves and muffler – all from the hospital). Soap and powder is provided for the patients. Bath is supervised by the warders. Patients wore slippers and some had shoes too. Doctors and nurses reported that they were given undergarments and sanitary napkins, but it was not clear how these undergarments were washed and segregated. Sanitary napkins are given to those who ask for them. Others use cloth napkins. There was a packet of under-garments which seemed to be new.

Medication and treatment

Patient rounds are done once a week and patient assessments once in two weeks. Night emergencies are attended by an on-call SR. There is no separate ward for older women, pregnant women, new mothers with their babies and women with physical disabilities. Girls and female adolescents are seen only in the OPD. There is a family ward with 25 beds. However this presently had only 4-5 patients. All other wards are closed wards. There were 12-13 forensic patients of whom there was a recently discharged female patient. There is 24 hour coverage by two police in mufti between 8 AM – 8 PM and 8 PM – 8 AM. A room is provided for the police.

The team was informed that they do not have weapons. However, loaded rifles were found covered with a dirty cloth in a room given for the policemen close to the ward, posing serious safety risks.

Quite a few chronic patients were hirsute. Some of the chronic patients had drooling of saliva and tremors, lip smacking and rubbing their hands. The DNB student reported that atypical antipsychotics, as well as haloperidol and trifluoperazine were prescribed. Free drugs were issued to poor patients, while paying patients had to buy their drugs. Patient medication administration is done by the warders and parenteral drugs are given by the nurses. No health teaching programmes are conducted for the patients and family.

There is one pharmacist who is a permanent staff. All drugs are supplied by the State Government. The Director informed the team that drugs are purchased from the *'User charger account'*. He stated that there were no issues related to supply of drugs which is done on the first of every month once the indent is received. Drugs not supplied by the state government are purchased from local stores as local indent.

Indent forms from the ward reflecting the monthly indent show that Clozapine is commonly used as well as iron tablets. Patients are also prescribed olanzapine and risperidone.

Modified ECT is given on alternate days as well as when required. Sometimes ECT is not given on scheduled days because of non-availability of the visiting anaesthetist.

Emotional needs

Patients seem to be quite happy and said they were treated respectfully. However, they had no access to phone and got pen/paper from the visiting nursing students.

Abuse

During the interviews carried out by the team, there were no incidents of abuse reported. The Director mentioned that in 1995, there had been one incident of sexual abuse by a warder where the patient conceived and delivered. The concerned warder was dismissed.

Social Needs

Hindu patients are taken to temple once or twice a year. There is no recreational activity provided despite the lavish availability of open space. There is no exercise or yoga programmes either. No picnics or outings are arranged for the patients. There are no indoor or outdoor games facilities. There is one small TV in a small hall. Here too the walls, ceiling and floor need renovation. There is one room for occupational therapy where woollen work was displayed on the table. There is one tailor who is employed for this purpose.

The PSW said that in 2003 when she had joined, there was a separate building for rehabilitation. Now this building is converted to a school of nursing for GNM nursing

students. There were 7 instructors (2 male & 5 female) at that time. Soap, phenol, surf (this was sufficient for the hospital needs) paper bags, teddy bears, sweaters, earthen pots were made here. However, over time all retired and none were recruited since then. Three patients were seated on mats in the corridor leading to this room knitting.

The entrance to the wards has a security guard with duty doctors contact numbers displayed. A small visiting room can be seen in the picture.

Concerns about discharge

The mental health professionals reported that family members do not want to take the patients home and want the hospital to take care of the patients life- long. Some family members take the patient home on parole for few days. However they are not willing to keep them at home due to stigma, socio-economic compulsions and specifically concerns of sexual abuse when unsupervised (instances of men in the locality visiting the homes and demanding sexual favours from the woman with mental illness). Patients in the acute and intermediate wards express the desire to be with their family and want to talk to them. They want love and affection from the family. All wards except the 25 bedded family ward are closed wards which seems to make it easier for family to leave the patient.

There are no half way homes, no long stay homes and no NGOs in this city. There are '*Nari Nikethans'* – these are for juvenile offenders, women who have run away from their homes and homeless women but these do take in mentally ill women. These are state protection homes. They have 2-3 staff who are not trained. The staff does not supervise medication properly in these centres, according to the Director.

There are '*Pingalwaras'* – with nearly more than 3000 beds scattered all over, the closest one is 10kms away, with 500 beds. Women kept here are also from other states such as Karnataka, Tamil Nadu, West Bengal, UP, etc. The mentally ill among them are brought to

IMH for follow up. They are not charged. In return, the *Pingalwaras* supply free medications to patients referred to them from the IMH (3-4/day, an agreement between IMH and the *Pingalwaras*)

Issues pertaining to human rights/ ethical concerns

About 2-3 patients die each year. The causes are old age, medical problems, dehydration, one female suicide (with a towel inside the duty doctors' room), aspiration and dysentery. There is one huge overhead water tank which is rarely cleaned.

To deal with the problem of pediculosis, hair is kept short for women chronic patients.

Patients are unable to communicate with family members, many times contact numbers given by family are changed or false. Patients who come with legal issues are not admitted till the legal issue is resolved. There is no separate legal cell attending to patient's legal issues.

SUMMARY

The 450 bedded IMH at Amritsar encompassing 60 acres of land at Amritsar is the only psychiatric hospital catering to needs of people from Chandigarh, Punjab, Haryana and other states. The hospital has made great strides in the last decade, and from a rating of Very Poor in the NHRC Report of 1999, it has made sustained improvements in many areas of functioning. Most importantly, the patients here are happy.

According to the administrators and service providers, funds are adequate. Many patients are out-of-state. There are problems related to human resources, prolonged power cuts, lack of transportation to drop patients home and the stigma associated with mental illness and other factors leading to abandonment.

All patient respondents rate the overall basic facilities as being good. Areas of relative dissatisfaction are not having adequate hot water for bath (40%), inadequate space for drying linen (25%), not being freely allowed to go out to walk (44%) and not having a locker facility (92%).

Almost all rate the food and dining facilities as adequate and the staff serving the food as polite. While a majority rate the food quality as good, a fifth say it is unsatisfactory. Almost all say that non-vegetarian food is not served even on request.

As regards facilities to address personal hygiene, all respondents say these are good. Toiletries are provided, own clothes are permitted, inner wear, winter wear and footwear is provided, according to most (although a third say cosmetics are not provided, 40% that inner wear is not provided). Most are satisfied with the privacy. While more than half say sanitary napkins are provided, many did not answer this questions (some perhaps have a preference for using cloth).

Almost all rate the sleeping and resting facilities as being good. Patients are provided with mattresses, pillows and blankets. Most say emergency care is available. A majority say room heaters are inadequate. More than two-thirds say facilities to sit and rest are inadequate. More than half say there were pests in the ward.

All patient respondents are satisfied with the medication and treated provided, the presence of a female chaperone during medical examination, as well as prompt medical attention. However, two-third report not been provided explanation about the medicines or their side-effects.

All of them say their emotional needs are satisfactorily met, that staff show concern, and that access to personal possessions are permitted. More than half have no access to phones, but a majority says there is permission to receive calls and letters. While a majority says that their calls and communication is not listened to or read by the staff, a proportion say this does occur.

None of the respondents reports any threat or abuse by the staff.

More than two-third respondents rate the outdoor physical and cultural activities as inadequate. A majority who receive visitors say the visiting room facilities are adequate.

All patient respondents affirm that there is no discrimination based on religion and most say they are permitted to practice their religion. Practically everyone says they have not been treated against their will. More than half say they are permitted to read newspapers and magazines. However, a majority say they are not involved in making health decisions. One in five says her hair is cut without her consent. None of the patients say they have been informed of their rights. Most say confidentiality is not maintained. Many do not answer the question on whether they have been educated about their illness. Practically no one has been asked for bribes or gifts. A majority say that informed consent was taken prior to treatment; however, 40% say it was not. Some say pre-test counselling for HIV and other tests is done, but a third said it is not.

The NCW project team observed that a majority are involuntary patients, including out-of-state patients. The team observed that the premises are clean. Patients seem to be happy. The laundry and kitchen are well-maintained. There seems to be a lot of support from *Pindalwaras*. The team observed that there are prolonged power cuts with no back up leading to distress due to heat/freezing cold. Floor and ceilings need renovation.

The food is adequate, but there is no dietician. It is wholesome and hygienic. Resting facilities are adequate. Attention to personal care and medical care is adequate. But there are no rehabilitation programmes.

Water tank needs cleaning. There are 3 PSWs whose services are not made use of appropriately. There is no provision for vehicle to make home visits and they are not allowed to do detailed work ups in the OPD either. The predominant issue seems to be high stigma levels, family detachment from the patients' needs, and lack of sufficient number of qualified mental health professionals, NGOs and contract posts. Considering the number of beds, this could become a teaching hospital with courses in DPM, MD Psychiatry, M. Phil social work and clinical psychology, M.Sc. in Psychiatry nursing and DPN. The trainees would also become a huge source of human resources and quality of patient services would also improve once this becomes a teaching hospital.

The biggest concern for patients and staff is the discharge of patients who need not stay in the hospital.

Specific recommendations of the visiting team:

The team made some specific recommendations for the IMH Amritsar.

Staffing:

1. Human resources (all categories of staff starting from Director) recruitment according to minimum requirements for a psychiatric hospital
2. Posts of Medical Superintendent and Administrative Officer
3. Speedy recruitment process – it is to be noted that recent interview in January 2016 was held only after initiation of NCW project
4. Permanent posts for mental health professionals as this will enhance motivation and quality work
5. Academic designation and salary on par (DNB course is already in place here and requests have been sent for permission to start DPM course). There are 3 psychiatrists with MD qualification and 10 years' experience post MD.
   DPN course also can be initiated as already there are 3 qualified DPN staff (from NIMHANS). With sufficient staff, M. Phil., PSW and CP also can be initiated. There is rich clinical experience (450 beds) which is the justification for initiating the training programmes.
6. DPN qualified staff have not received increments or promotions based on their qualification. This is already in place in Maharashtra and Punjab too can initiate this.
7. Appointment of dietician and instructors for rehabilitation sections.

Infrastructure:

1. Renovation of flooring, ceiling and walls, tiles in bathroom and toilets.
2. More number of bathroom and toilets
3. More hot air blowers as winter has near zero temperature and proper maintenance.
4. 24 hour power supply as there are power cuts for 8-10 hrs and this can be distressing for patients and staff during both winter and summer
5. More number of fans or coolers as summers are extremely hot (in OPD especially)
6. Phone and computer facility wherever required

7. Provision of vehicle to make home visits

Facilities for patients:

1. Recreation (both indoor and outdoor) facilities for patients
2. Provision of sanitary napkins for all who require them
3. Cleaning of water tanks on a regular basis

Rehabilitation

1. There is a need for rehabilitation services within the hospital as well as the community.
2. For patients who have recovered, there is a need to develop community care facilities including half way homes, long stay homes and day care centres with NGO support.

SECTION II

SUMMARY OF INTERVIEWS WITH WOMEN INPATIENTS,

CARERS,

SERVICE PROVIDERS

ACROSS ALL THE VISITED INSTITUTIONS

II A. Summary of interviews with women patients

In this section, a summary of the interviews with the women in-patients across all the 10 hospitals is provided.

A total of 245 respondents (inpatient women) were interviewed across the ten hospitals. Wherever more than 10% of respondents expressed dissatisfaction, those institutions are specifically mentioned. The responses from the individual institutions have already been mentioned in Section I.

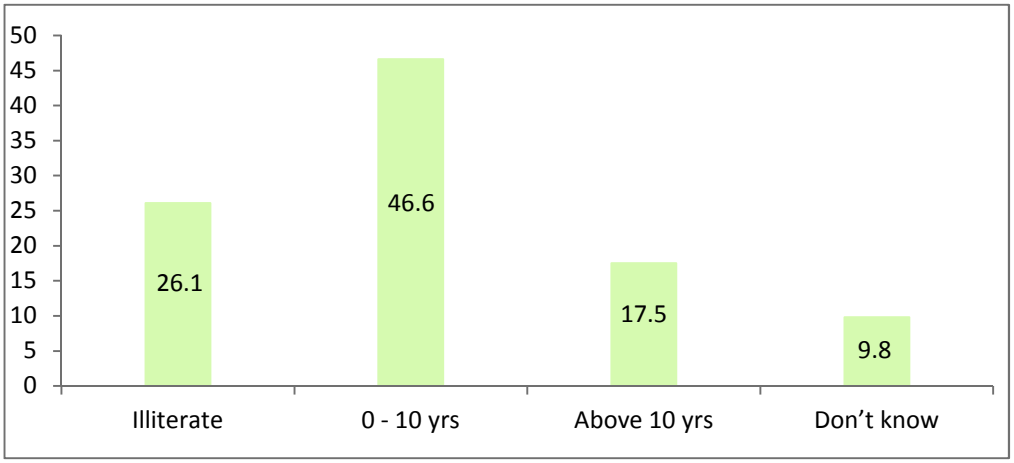
Box 6: Summary of institutions where personal interviews were conducted (N=245).

1. Regional Mental Hospital, Yerawada Pune 2. Govt. Mental Hospital, Kozhikode 3. Regional Mental Hospital, Thane 4. Institute of Psychiatry and Human Behaviour, Goa 5. Calcutta Pavlov Hospital, Kolkata 6. Berhampore Mental Hospital, Murshidabad	7. Ranchi Institute of Neuro-Psychiatry And Allied Science, Ranchi 8. Institute of Mental Health And Hospital, Agra 9. Mental Hospital, Bareilly 10. Institute of Mental Health (Govt. Mental Hospital), Amritsar

Socio – demographic information

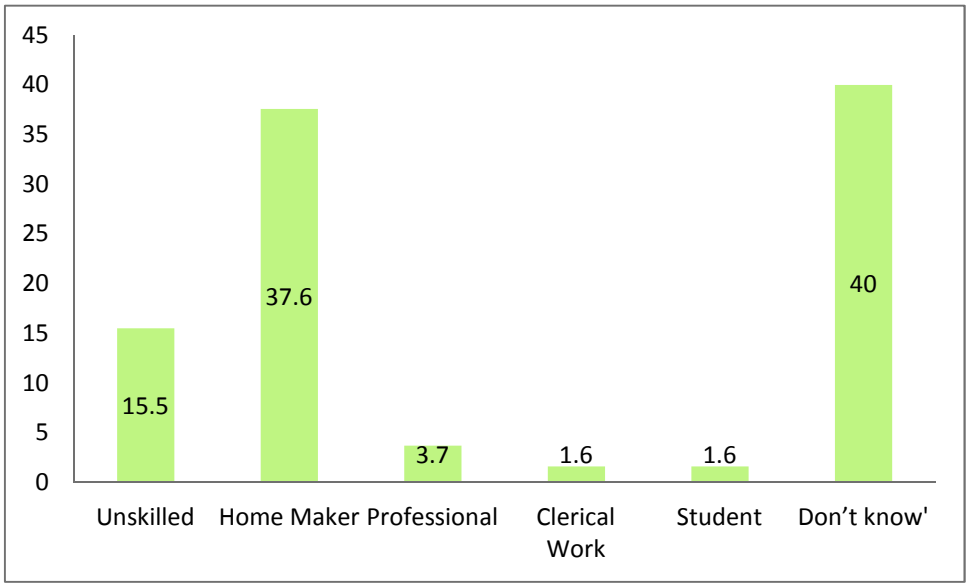
The graphs below provide a simple graphical representation of the socio-demographic backgrounds of the women inpatient respondents across the 10 institutions.

Figure 2. Education of women respondents across the 10 institutions (%)



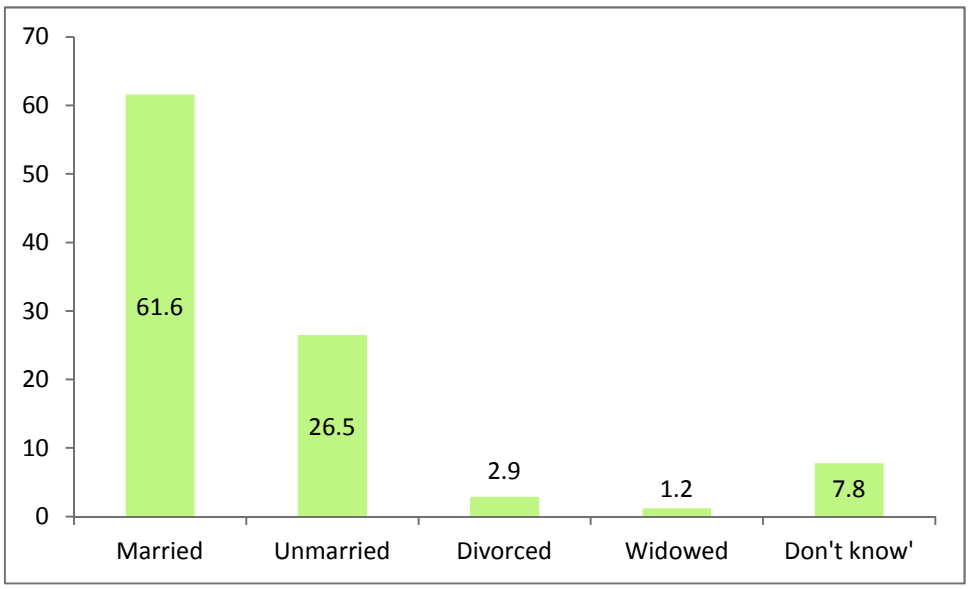
About one-fourth of the women inpatient respondents were illiterate. Nearly half reported having had some level of education. Nearly a fifth had completed school. A small number were unable to answer this question.

Figure 3. Occupation before coming to the hospital (%) - respondents across institutions



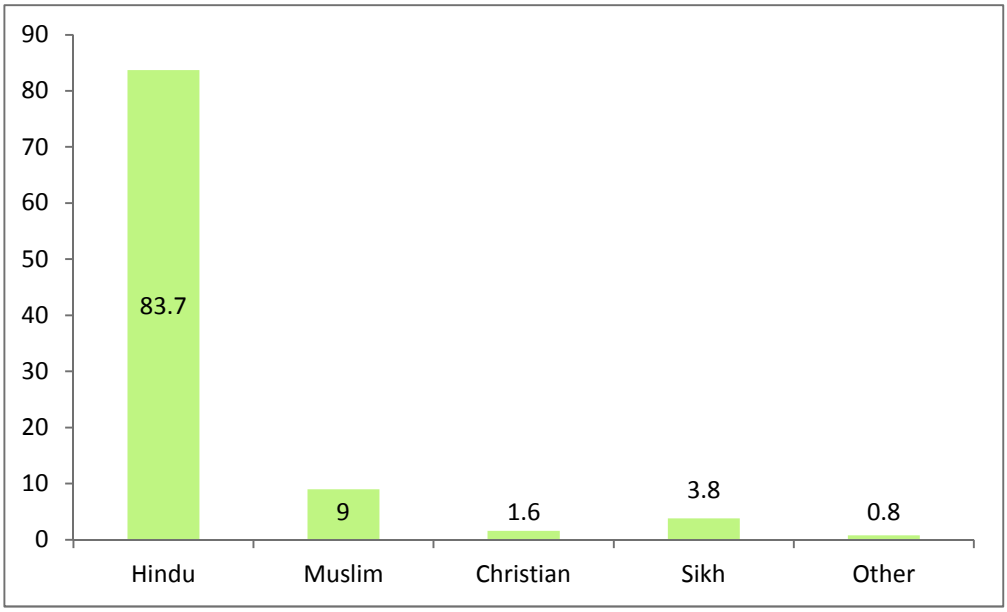
One-third constituted home makers while some of them (15.5%) were unskilled workers. There were a few professionals as well. Forty patients (16.3%) provided 'Don't Know' responses.

Figure 4. Marital status (%) of respondents across the 10 institutions



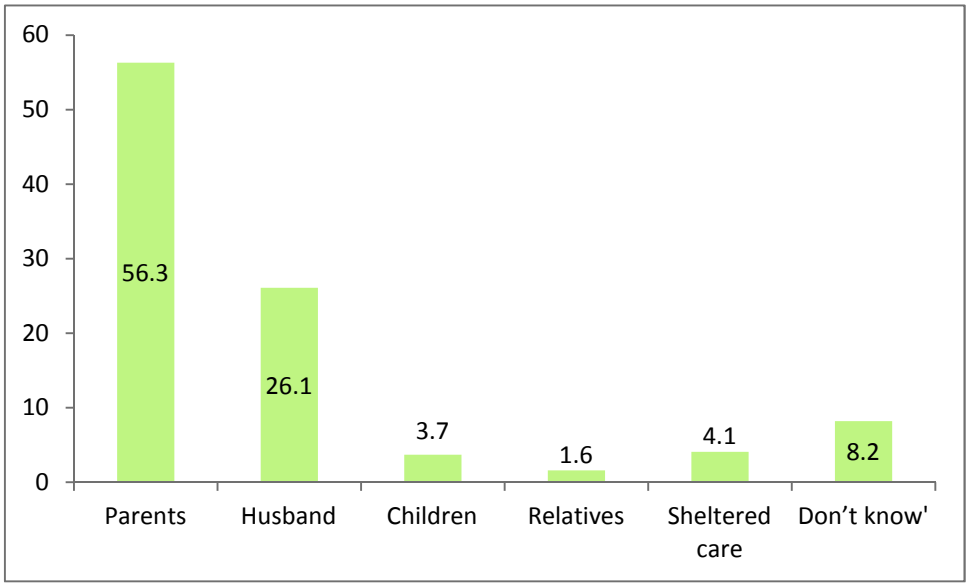
A majority were married (61.6%). A small number (7.8%) were not able to indicate their marital status.

Figure 5. Religion (%) of respondents across the 10 institutions



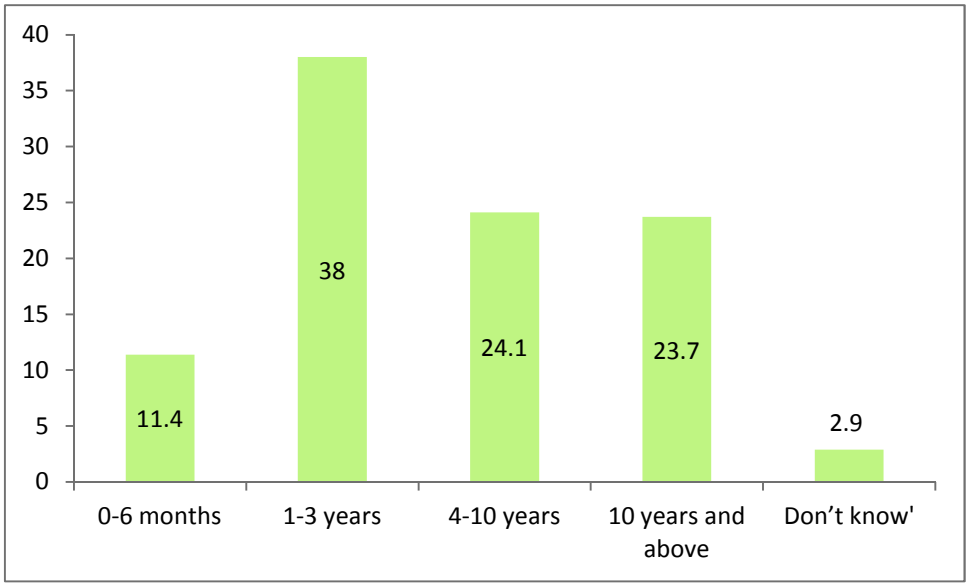
The women were mostly Hindus (83.7%).

Figure 6. With whom the patient stayed before coming to the hospital (%)



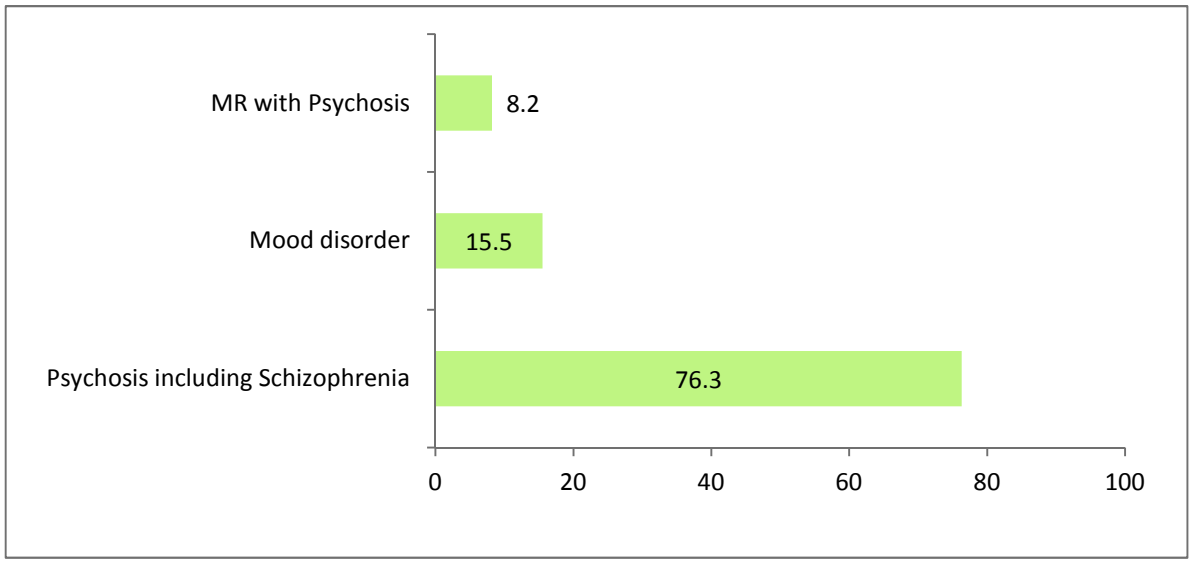
More than half (56.3%) had stayed with their parents prior to hospitalisation. About a quarter (25.6%), were staying with their husbands.

Figure 7. Duration of stay in hospital (%)



A small number of respondents could not even recall how long they had been in the hospital. A majority had been in the hospital for more than a year and about a quarter of the respondents (23.7%) had been in the hospital for 10 years and above.

Figure 8. Psychiatric Diagnosis (%)



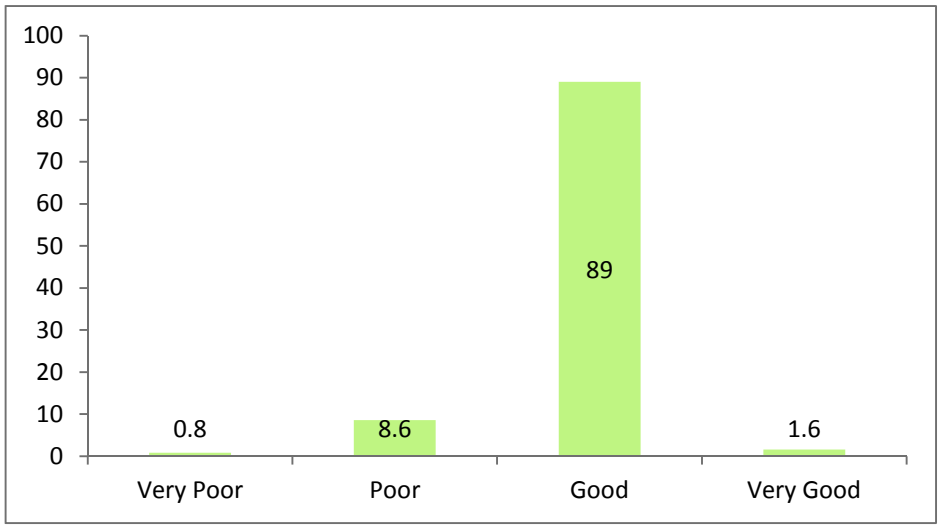
The most common diagnosis was psychosis (usually schizophrenia) in about three-quarters of the women. Mood disorder was the other common diagnosis (15.5%). A small number had intellectual disability (MR) with associated behavioural disorder.

Levels of satisfaction

The respondents were asked questions on various aspects related to their care within the hospital. Hospitals where 10% or more of the patients was dissatisfied with a particular aspect have been specifically mentioned.

Figure 9. Satisfaction with basic facilities (%)

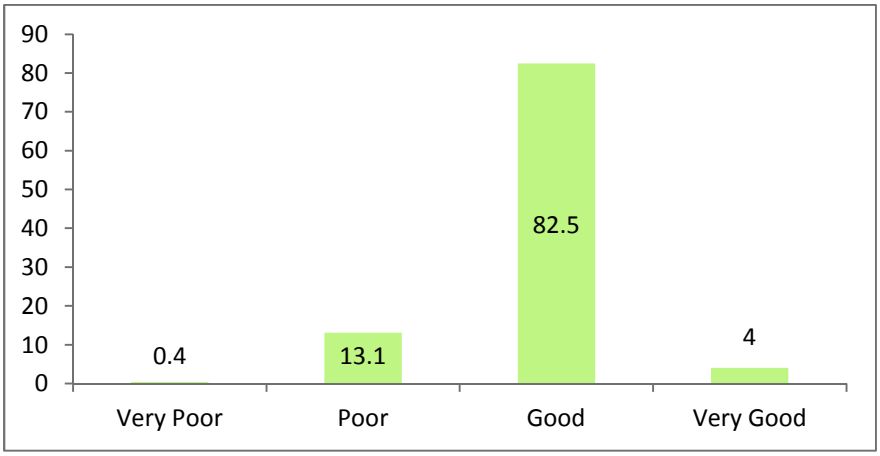
The women were asked to express their level of satisfaction with some of the basic facilities provided in the hospital. These included adequacy of space in the ward, ward lighting, potable water, hot water for bathing, toilet adequacy, cleanliness and maintenance, ward cleaning, regular changing of linen and provision of locker facilities.



A majority rated the facilities in the ward as being good**.**

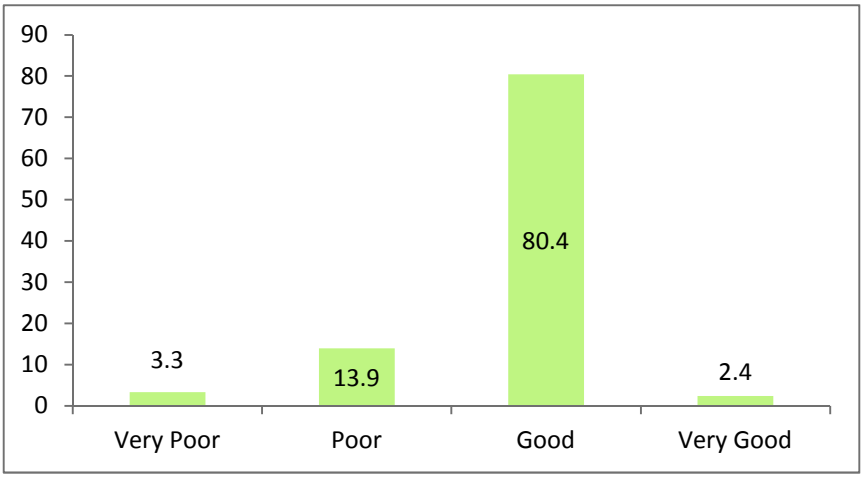
Dissatisfaction with the basic facilities was high in BMH Murshidabad (40%), Pavlov Hospital Kolkata (24%) and RMH Yerawada (12 %)

Figure 10. Satisfaction with food and dining facilities (%)



Questions with respect to food including the quantity and quality of food, variability in the menu, timeliness of food serving, availability of vegetarian and non-vegetarian diets, the way the food was prepared and served. A majority expressed overall satisfaction with the food related issues. Those who rated the food as poor or very poor were mainly the respondents from BMH Murshidabad (46% dissatisfied), RMH Pune and IMHH Agra (28%), RMH Thane (24 %) and MHC Kozhikode (20%).

Figure 11. Satisfaction with facilities for personal hygiene and basic comfort (%)

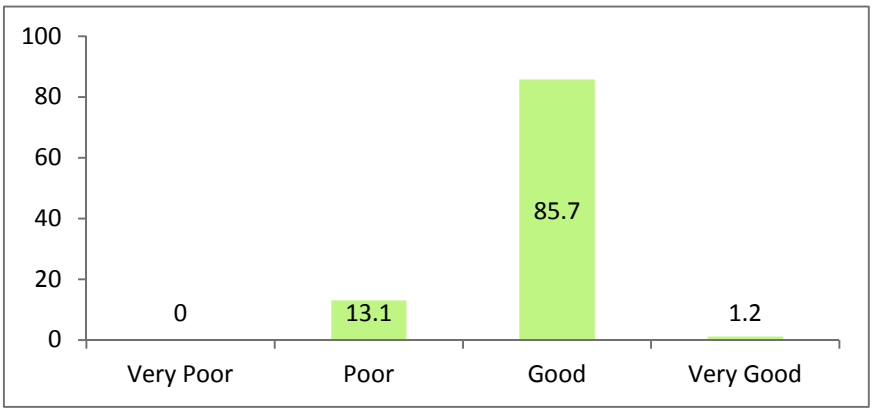


Questions related to personal hygiene and comfort included respect for privacy while bathing, using the toilet and changing clothes, provision of sanitary napkins and information on their use, provision of basic toiletry articles like soap, face powder, provision of bindis, permission to wear own clothes, provision of a choice of clothes, provision of inner garments, winter clothing and footwear.

A majority (82.8%) were satisfied with the basic comforts and attention to personal hygiene.

The ratings of poor and very poor were mainly from respondents in BMH Murshidabad (80% dissatisfied), RMH Thane (28%), MH Bareilly and MHC Kozhikode (20%), RMH Pune (16%) and RINPAS (12%).

Figure 12. Sleeping and Resting Facilities (%)

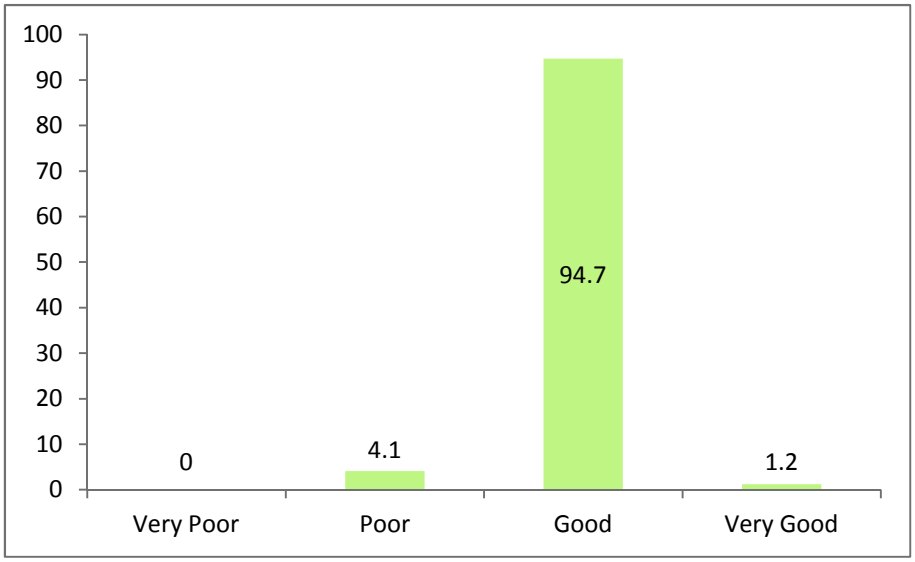


Questions asked included availability of bedding, availability of fans and heaters, silent environment at night, facilities to sit during the day, freedom from pests and help for emergencies at night.

Most respondents were satisfied with the sleeping and resting facilities.

However **dissatisfaction** with the sleeping arrangements was expressed by the respondents from BMH Murshidabad (32%), CPH Kolkata (28%), IMHH Agra (28%), RMH Thane (24%), MHC Kozhikode (24%) and RMH Pune (20%).

Figure 13. Satisfaction with attention to medical problems (%)

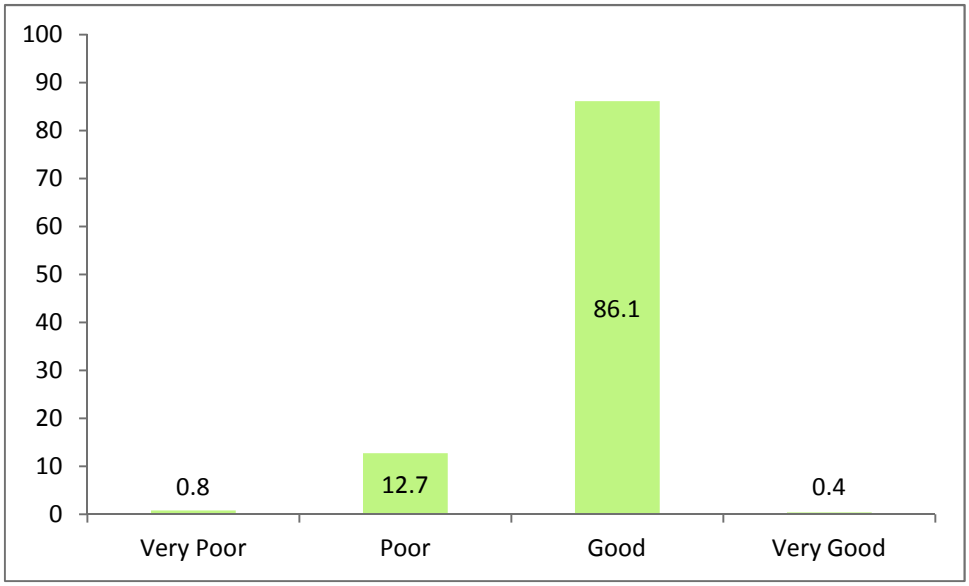


Questions pertained to whether the staff was helpful to the patient in taking the medicines, whether the patient had been explained about the medication and side effects, whether there was a female attendant when the patient was being examined by a male doctor and whether medical care was promptly provided during an emergency.

A majority of respondents was satisfied with the attention provided to medical problems.

Dissatisfaction was expressed by respondents from RINPAS (16%), RMH Pune (16%) and MHC Kozhikode (12%).

Figure 14.Satisfaction with quality of care and responses towards feelings/ needs (%)



Questions included the patient's perception on whether she was addressed with respect, whether the staff spent adequate time and listened to her, whether the staff showed concern towards her and maintained confidentiality, whether she was given access to making and receiving phone calls and letters.

A majority expressed satisfaction in this area.

Dissatisfaction with the quality of care and sensitivity was reported by respondents from RINPAS (28%), MHC Kozhikode (24%), BMH Murshidabad, RMH Pune, MH Bareilly (20%) and CPH Kolkata (16%).

Table XIII. Areas of Dissatisfaction*- A summary

Areas	**Basic facilities**		**Food related areas**		**Personal hygiene related areas**		**Sleeping & resting related areas**		**Medication and treatment related areas**		**Emotional needs related areas**	
	N	%	N	%	N	%	N	%	N	%	N	%
RMH Pune	3	**12**	7	**28**	4	**16**	5	**20**	4	**16**	5	**20**
MHC Kozhikode	2	8	5	**20**	5	**20**	6	**24**	3	**12**	6	**24**
RMH Thane	2	8	6	**24**	7	**28**	6	**24**	1	4	1	4
IPHB Goa	0	0	1	4	0	0	1	4	0	0	1	4
Calcutta Pavlov Hospital Kolkata	6	**24**	2	8	2	8	7	**28**	2	8	4	**16**
BMH Murshidabad	10	**40**	11	**46**	20	**80**	8	**32**	2	8	2	**20**

RINPAS Ranchi	2	8	0	0	3	**12**	0	0	4	**16**	7	**28**
IMHH Agra	1	4	7	**28**	1	4	7	**28**	1	4	1	4
MH Bareilly	0	0	2	8	5	**20**	0	0	0	0	5	**20**
IMH Amritsar	0	0	1	4	0	0	1	4	0	0	0	0

*Areas where 10% or more respondents indicated dissatisfaction are highlighted.

The maximum dissatisfaction was expressed by the women inpatients at BMH Murshidabad on practically all dimensions except medication and treatment, particularly in the facilities to ensure personal hygiene, basic amenities and food. About one in five patients in RMH Pune also expressed dissatisfaction in most of the areas. In RMH Thane, although one in five expressed dissatisfaction over the food, personal hygiene and sleeping arrangements, very few were dissatisfied with the medication and treatment facilities and attention to their emotional needs. Patients from Kozhikode also expressed dissatisfaction on multiple areas.

However, it must be underscored that a majority of the respondents across the hospitals expressed satisfaction with the facilities and services.

Detailed respondent feedback on the different dimensions from the individual hospitals is presented under the individual sections.

II.B. SUMMARY OF INTERVIEWS WITH CARE GIVERS ACROSS THE 10 INSTITUTIONS

1. Patients in the Closed Wards – Caregiver Perspectives

As the patients were in the closed wards, caregivers of this group were difficult to find for the interview. Ten caregivers were interviewed across the 10 hospitals.

Table: Caregivers' background information (n=10)

Age in years of the caregivers- Mean (SD)		48.2 (7.7)	
Variable		**N**	**%**
Gender	Male	7	70
	Female	3	30
Relationship to the patient	Parent	6	60
	Husband	2	20
	Daughter/Son	1	10
	Other relative	1	10
Duration of care giving (in years)	0-5 years	8	80
	> 5 years	2	20
Duration of hospitalization of the patient	0-6months	8	80
	> 1 year	2	20
Are you aware about the nature of your ward's illness/disorder?	YES	6	60
	NO	4	40
Have you ever discussed her illness with other family members?	YES	6	60
	NO	4	40
Are there any reasons that prevent you from taking her back home? **	YES	3	30
	NO	4	40
	CAN'T SAY	3	30
Do you think food inside the hospital is adequate?	YES	7	70
	NO	1	10
	CAN'T SAY	2	20
Do you think your ward's self-care is maintained inside the hospital?	YES	5	50
	NO	1	10
	CAN'T SAY	4	40
Do you think cleanliness is maintained inside the hospital?	YES	7	70
	NO	1	10
	CAN'T SAY	2	20
Do you think the doctors are not clear about the condition of the patient and the	YES	3	30
	NO	5	50

treatment she should receive?	CAN'T SAY	2	20
Do you think that general health care inside this hospital is good?	YES	4	40
	NO	4	40
	CAN'T SAY	2 ()	2
Does your patient get regular medication inside the hospital?	YES	8 (80)	
	NO	00	
	CAN'T SAY	2 (20)	
Is the psychiatric care inside the hospital good?	YES	8 (80)	
	NO	1 (10)	
	CAN'T SAY	1 (10)	
Is the nursing care inside the hospital good?	YES	6 (60)	
	NO	2 (20)	
	CAN'T SAY	2 (20)	

** Reasons for the care givers expressing difficulty in taking the patient home were explored.

Although the number of care giver respondents was few and these were care givers whose wards had been admitted for a relatively shorter time, their responses nevertheless were truly insightful of the kinds of problems that relatives of persons with serious mental illness face.

Box 7.

Reasons that prevent care givers from taking their ward back home

10. ***Financial Problems***: This is particularly true for poor families. They are unable to pay the charges for the patient's care on a long term basis. They express inability to bring the patients for follow-up. Travelling long distances is another problem. Under these circumstances, families find a huge sense of relief when their ward stays inside the mental hospital. Their basic needs are more or less taken care. Their safety is also more or less ensured. Over a period of time, however, the sense of relief may give way to indifference, the attachment would come down and this could lead to neglect and abandonment.

A father of a patient says, ***"In my family, I have seven children and I am the only source of earning. If I take my daughter to my house then it would be very difficult to bring her for regular follow-up and buy her medicines. So I have decided to put her in the hospital."***

Another patient's family member said, ***"We are from a very poor family, for every meal we have to go out and earn. If we take our child (the patient) home, then someone has***

to stay at home and take care of her. If there is no one at home, she would not take her medicines and start showing problems again, give trouble to us and the neighbours as well. So we thought keeping her in the hospital would be better."

11. ***Inadequate family support***: If a person is mentally ill in the family, parents are the usual primary care givers. Once they become old and physically weak, other members of the family (brothers, sisters in law and their children) may not take care of the patient and may want to get rid of the responsibility of her. Patient's mother says, **"*Agar yeh*(patient) *ghar mein rahegi toh mera beta aur bahu har din ladte hai, aur bahu keheti hai ke 'agar yeh pagal* (the patient) *iss ghar mein rahegi toh main aur mere bachhe ghar chodke chale jayenge, kya pata kab yeh pagal mere bachchon ko mar daale,' issiliye maine meri beti ko yaha admit kar diya hai." [***If she stays at home, then my son and daughter-in-law would fight daily; my daughter-in-law would say 'if this lunatic stays in my house, then my children and I will go away; who is to tell when this lunatic will kill my children'**]**

12. **Social stigma:** Social stigma is another reason for patients getting neglected by the families/societies. This is a well-known phenomenon throughout the world. Stigma plays an important role, particularly in the absence of support. A patient's family member says, ***"We put our daughter in the hospital because it shouldn't affect our remaining children's future. If our society/community came to know that we have a mentally ill person in our family, then they will break all relationships with us. It will become problematic for my other daughters to get married. So I wanted to keep her (the ill daughter) in the hospital at least till her sisters are married."***

13. ***Unsupportive Neighbourhood***: Most often in urban societies, neighbours are disconnected from each other. If one family has a mentally ill person, there is little co-operation from the neighbours. A mother of a patient says, ***"If our child make noise or tries to talk to their children or family members, they show their intolerance. They come to our doorstep and start shouting at us saying, 'Don't send your mental child outside your house. If she hurts or hits our children then we will file a case against your family'."***

14. **Lack of space**: In metro cities (like Mumbai and Pune), entire families often live in very small houses (1 or 2 room). In this background, it becomes very difficult to manage a person who is actively mentally ill. A couple of care givers say, ***"When relatives or friends come home, that time it's very difficult to manage her (the ill person). She won't sit inside, she comes out and start talking to them. If they say something that she does not like, she gets panicky and excited. It becomes very hard to calm her down."*** Another family member says, ***"Some of our relatives intentionally come home and disturb her. They provoke her. They ask, "How are you now? Is everything ok with you? Has your mental problem got cured or are still mentally ill?"***

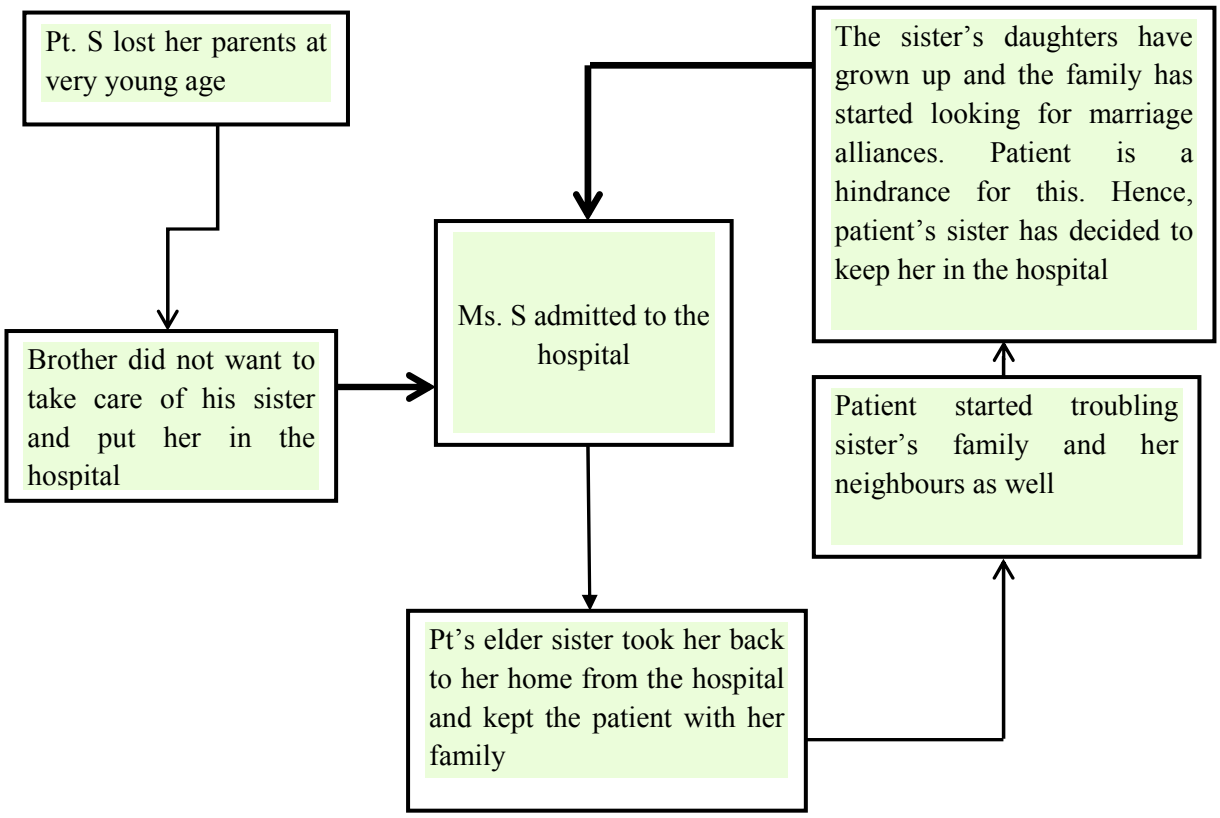
15. **Parent's old age**: Ageing parents are often unable to look after the mentally ill woman at home. If the patient gets violent, it becomes very difficult for the old parents to manage her. This is particularly true when there are the only care-givers in the family. A father of a patient says, ***"In my house there is only myself and my old and physically ill wife. I go for work and my wife alone can't take care of my ill daughter. She doesn't listen to us; she doesn't take tablets and gets ill again. She has sometimes tried to harm my wife. Once when I was not at home, she has hit my wife. So I don't want to take any risk, because for me, my wife is everything. Let my daughter stay here so that we all can all live peacefully."***

16. **Safety issues**: Families perceive that a mentally ill unmarried woman in the family is very unsafe. '**Anybody can abuse her with both through their words as well as physically. She may not be able to judge who is good and what could be the other person's intention**'. A few caregivers said, ***"The main cause for admitting our daughter in hospital is that when she gets ill, she just runs away from the house. Though we try to keep an eye on her, it is not possible to guard her all the time. If she goes out of the house, anything might happen; so we don't want take any chances. She is very much safe inside the hospital."***

"Institutionalisation"- The Story of Ms. S

Specific examples help us to understand how the process of institutionalisation occurs due to a complex interplay of various factors.

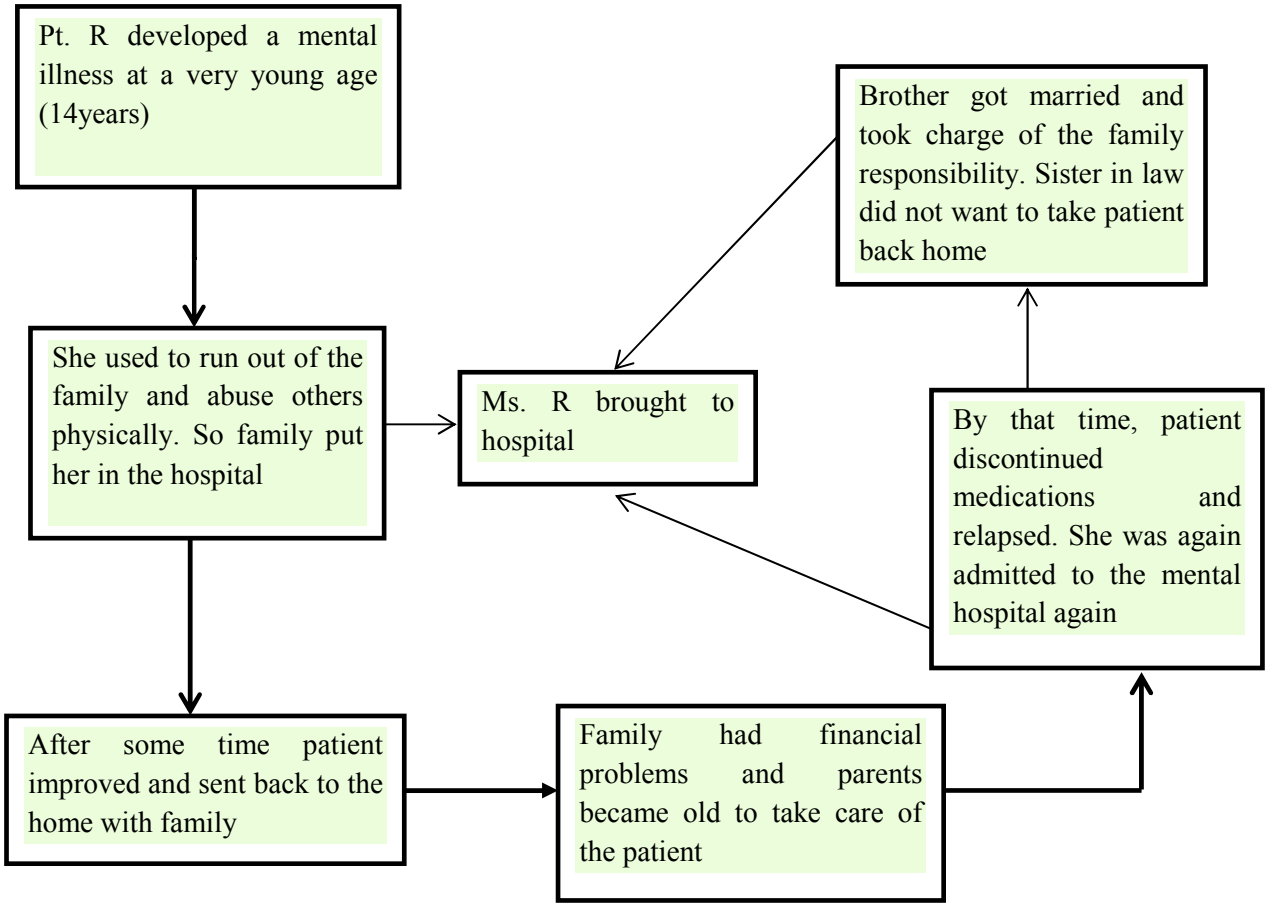
Figure 15. Reasons that keep Ms. S in the psychiatric hospital



Ms. S's brother doesn't want to take care of her after discharge. Although her sister is willing to take care of her, her brother-in-law is not allowing her to take Ms S back home.

Ms. S's sister says, "I am very much willing to take care of my ill sister, but my family and husband are not allowing me to take her back. I had taken my sister home for a festival, but during her stay in the home, she creates lots of problems; i.e. doesn't take the medicines, screams, hurts other family members verbally, make bad signs and whistles at neighbours' young children; which causes me to face many problems. Neighbours come to our doorstep and shout at me and say, 'Why are you keeping this mentally ill person at home? If you are not able to manage her, send her to the mental hospital or we will lodge a complaint.' Moreover, I have 2 young daughters whose wedding has to happen. If I keep my sister at home it is difficult to get a groom for them. Therefore, much as I don't want to, I am forced to keep my sister in the hospital.

Figure 16. Reasons that keep R in the Psychiatric Hospital



Ms. R used to create a lot of problems for her family. She used to run out of the house often. Patient's parents were old and hence transferred the responsibility of her care onto her brother. After his wedding, he and his wife were not willing to keep Ms. R in the house thinking she might harm them or their children. Her mother was helpless as she had to obey son's decisions.

R's mother said, "Till my husband was alive, we use to take care of our ill daughter; though she used to be problematic at home, we could manage her. But after my husband's death, my son and his family is not willing to take my daughter back home. My old age and physical health problems are not allowing me to look after her. I am helpless."

These are just two stories. There are many more stories that resonate with similar themes.

II. Patients in the Outpatient and Family Ward – Caregiver Perspectives

Twenty-one caregivers who accompanied patients in the outpatient or stayed with them in the family ward settings across the ten hospitals were also interviewed.

Table: Outpatient and Family ward caregivers- background characteristics (N=21)

Age in years of the caregiver -Mean (SD)		46.1 (1.3)	
Variable		N	%
Gender	Males	6	28.6
	Females	15	71.4
Relationship to the patient	Parent	15	71.4
	Husband	4	19
	Son/Daughter	2	9.5
Duration of care giving (in years)	0-5 years	10	47.6
	6-10 years	1	4.8
	> 10 years	10	47.6
Frequency of your visits to the Hospital	Monthly	5	23.8
	Quarterly	2	9.5
	Yearly	14	66.7
Whether you discussed the illness of the patient with other family members?	YES	16	76.2
	NO	3	14.3
	NA*	2	9.5
Are you aware about the nature of your ward's illness/disorder?	YES	6	28.6
	NO	14	66.7
	NA*	1	4.8
Do you think the doctors are not clear about the condition of the patient and the treatment she should receive?	YES	3	14.3
	NO	16	76.2
	NA*	2	9.5
Do you think that general health care is good inside this hospital?	YES	7	33.3
	NO	5	23.8
	NA*	9	42.9
Does your patient get adequate amounts of medication inside the hospital?	YES	22	100
	NO	0	0

*NA-not applicable. In cases of outpatient caregivers

Outpatient and family ward caregivers interviewed in this study had been providing care for much longer than the caregivers of inpatients who were interviewed. The outpatient and family ward caregivers appeared to have relatively better understanding of the patient's illness, more likely to have discussed the patient's illness with family members and appeared to have relatively more confidence in the treatment that was being provided.

II.C. SUMMARY OF INTERVIEWS WITH SERVICE PROVIDERS / ADMINISTRATORS ACROSS THE 10 INSTITUTIONS

About 100 service providers were interviewed across the 10 institutions**.** These included the director of the institution, medical superintendent, nursing superintendent, consultant psychiatrists, clinical psychologist, psychiatric social worker, social worker, psychiatric nurse or general nurse, attendant, NGO representative as available.

The over-arching themes that emerged through these interviews included the following:

1. Reasons for long-stay include being shunned by the family (husbands remarry), lack of half-way homes and rehabilitation facilities.
2. Unmarried women are seen as a hurdle for other family members who are 'ready for marriage.
3. Sometimes there are cases of litigation, property, custody issues. Sometimes relatives get a legal notice issued against the hospital if they are pressurised to get the patient discharged.
4. Sometimes, when patients are discharged to unwilling families, the families dump them again, and such patients may become homeless and add to the pool of wandering mentally ill.
5. Stigma is rampant. One issue is, 'girls who have gone out of the homes' are not fit to come back to the families.
6. The woman cannot be discharged to a relative unless the relative's bona-fide is established.
7. When there is judicial intervention, the issues become more complex.
8. There is a need to review laws and policies
9. If death occurs following a shift to a half way home, the hospital service provider is not free of liability
10. Need to ban the concept of custodial care and insist that family members should stay with the patients.
11. Family wards should be started, but in some hospitals, this has not worked, e.g. Bareilly.
12. Issues in India are different from the western world where women are generally better educated, employed, independent, and the social security systems are strong.
13. Instead of becoming places of treatment and rehabilitation, mental hospitals have become dumping grounds for all sections of society.
14. Greater involvement and accountability of the social justice, law, health, women and child welfare departments.
15. State must give greater priority for mental health
16. Staff shortages, non-availability of ECT services, inadequate health care (a gynaecologist, physician and surgeon should be available for general health care) should be addressed.
17. There should be greater autonomy in running the hospitals
18. Penalties mentioned in the MHA 1987 for errant families must be increased.
19. Mental hospital must have a legal cell
20. In some of the premises of the hospitals, state governments are using the land for other purposes- to build multi-speciality hospitals, legislator's home etc. This must be prevented and the land used for rehabilitation of persons with mental illnesses.

SECTION 3

Questionnaire-based self-reports from psychiatric institutions

INTRODUCTION

43 institutions returned the filled out questionnaires pertaining to treatment details of the women seen at the respective hospitals. The remaining institutions for which information was not sought include the Midpu MH in Arunachal Pradesh and the State Mental Hospital, Bilaspur in Chhattisgarh, Mankundu in West Bengal and RIMS Haryana.

Table II. Self-filled Questionnaires received from Institutions

SI. No	STATE	INSTITUTE
1	Andhra Pradesh	Govt. Hospital for Mental Care (GHMC), Vishakhapatnam
2	Assam	Lokpriya Gopinath Bordoloi Regional Institute Mental Health (LGBRIMH), Tezpur, Assam
3	Bihar	Bihar State Institute of Mental Health and Allied Sciences (BIMHAS), Bhojpur, Bihar
4	Delhi	Institute of Human Behaviour & Allied Sciences(IHBAS), Delhi
5	Goa	Institute of Psychiatry and Human Behaviour (IPHB), Goa
6	Gujarat	Hospital for Mental Health (HMH), Bhuj
7		Hospital for Mental Health (HMH), Ahmedabad
8		Hospital for Mental Health (HMH), Vadodara
9		Hospital for Mental Health (HMH), Jamnagar
10	Himachal Pradesh	Himachal Hospital of Mental Health and Rehabilitation (HHMHR), Shimla
11	Jammu & Kashmir	Govt. Psychiatric Diseases Hospital (GPDH), Srinagar
12		Psychiatric Diseases Hospital (PDH), Jammu
13	Jharkhand	Central Institute of Psychiatry (CIP), Kanke, Ranchi
14		Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Ranchi
15	Karnataka	Dharwad Institute of Mental Health and Neurosciences (DIMHANS), Dharwad
16		National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore
17	Kerala	Govt. Mental Health Centre (MHC), Thrissur*
18		Mental Health Centre (MHC), Thiruvananthapuram
19		Mental Health Centre (MHC), Kozhikode
20	Madhya Pradesh	Mental Hospital (MH), Indore
21		Gwalior Mansik Arogyashala (GMA), Gwalior
22	Maharashtra	Regional Mental Hospital (RMH), Ratnagiri
23		Regional Mental Hospital (RMH), Nagpur
24		Regional Mental Hospital (RMH), Yerwada, Pune
25		Regional Mental Hospital (RMH), Thane
26	Meghalaya	Meghalaya Institute of Mental Health and Neurological Science (MIMHANS), Shillong
27	Nagaland	State Mental Hospital Institute (SMHI), Kohima, Nagaland
28	Orissa	Mental Health Institute (MHI), SCB Medical College Hospital, Cuttack
29	Punjab	Institute of Mental Health (IMH) (Govt. Mental Hospital) Amritsar
30	Rajasthan	Psychiatric Center (PC), Jodhpur
31		Mental Health Centre (MHC), Jaipur**
32	Tamil Nadu	Institute of Mental Health (IMH), Chennai
33	Telangana	Govt. Hospital for Mental Care (GHMC), Erragadda, Hyderabad***
34	Tripura	Modern Psychiatric Hospital (MPH), Tripura

35	Uttar Pradesh	Mental Hospital (MH), Bareilly
36		Mental Hospital (MH), Varanasi
37		Institute of Mental Health and Hospital (IMHH), Agra
38	Uttarakhand	State Mental Health Institute (SMHI), Dehradun
39	West Bengal	Institute of Mental Care IMC), Purulia
40		Institute of Psychiatry (IOP), Kolkata
41		Pavlov Mental Hospital (CPMH), Kolkata
42		Lumbini Park Mental Hospital (LPMH), Kolkata
43		Berhampur Mental Hospital (BMH), Murshidabad

*Thrissur - (page no.3 & from serial no.5h to 8e not received;); ** Jaipur- Not in prescribed format and incomplete details; **GHMC Hyderabad- (from Serial No. 3b to 9h not received).

Institutional perception on adequacy of Staff

The questionnaire contained a question on the overall perception of staff adequacy and specifically the perception of the adequacy of female staff.

Table III. Institutional perception of adequacy of staff

Overall staff as well as female staff adequate	Overall staff as well as female staff inadequate	Overall staff adequate, but female staff inadequate
GHMC Hyderabad	MH Bareilly	MPH Tripura
IMH Amritsar	SMHI Dehradun	
MHC Thiruvananthapuram	GMA Gwalior	
HMH Ahmedabad	RMH Nagpur	
BIMHAS Bihar	RINPAS Ranchi	
IMC Purulia	CIP Ranchi	
IMH Chennai	HMH Vadodara	
IMHH Agra	HHMH Shimla	
IOP Kolkata	GHMC Vishakapatnam	
IPHB Goa	HMH Jamnagar	
PC Jaipur	LGBRIMH Tezpur	
MH Indore	LPMH West Bengal	
MIMHANS Shillong	BMH Murshidabad	
IHBAS Delhi	IMH Cuttack	
DIMHANS Dharwad	SMHI Nagaland	
NIMHANS Bangalore	Calcutta Pavlov Hospital	
RMH Thane	GMHC Thrissur	
	MH Varanasi	
	MHC Kozhikode	
	PDH Jammu	

Seventeen institutions (39.5%) perceived that overall staff and female staff were adequate. Twenty-three institutions (53.5%) perceived that both the overall staff and the female staff were inadequate. One institution (Modern Psychiatric Hospital, Tripura) perceived that the overall staff was adequate, but the female staff was inadequate. No response was recorded by HMH Bhuj and GPHD Srinagar.

Table IV. Details of women treated across the mental health institutions in the previous year

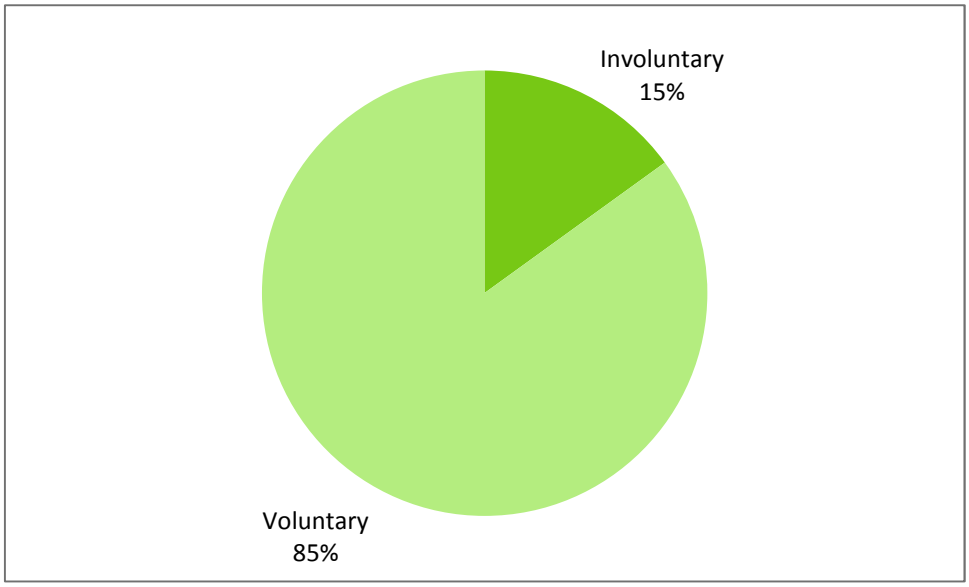
	Median	Range
Number of new OP registrations of women in the past one year	1907.5	74-43885
Number of follow-ups of women patients in the past year	14360	100-79517
Number of women admitted during the past year	563	16-6541
Average number of inpatient female beds	155	8-992
Average number of open ward female beds	47.8	2-278
Average number of closed ward female beds	147.4	0-1000

There is a wide variability in the number of women seen across the institutions and the availability of beds. In general, across the institutions, there are more closed ward beds compared to open ward beds.

Details of admissions and discharges during the previous year

The median number of voluntary admissions (97.0) actually exceeds the number of involuntary admissions (40.0) in the previous year. This is a very encouraging trend.

Fig 1. Involuntary and voluntary admissions of women during the last year



However, in 16 hospitals, the number of involuntary admissions still outnumbers the voluntary admissions as far as women are concerned.

Table V. Institutions where involuntary admissions still exceed voluntary admissions

Institution	Involuntary admissions of women during the last year	Voluntary admissions of women during the last year
RMH Nagpur	221	11
RMH Yerwada, Pune	568	216
RMH Thane	954	31
HMH Vadodara	543	33
HMH Bhuj	88	26
MHC Kozhikode	179	49
MH Bareilly	181	10
GPHD Srinagar	122	6
IHBAS, Delhi	722	39
IPHB Goa	351	92
LGBRIMH, Tezpur	400	47
Behrampore MH, Murshidabad	212	-

Table VI. Self-report by institutions on adequacy of living spaces and facilities (N=43)*

	Reported as Adequate (N)	Percentage	Reported as inadequate by
Cooking area	35	81.4	Calcutta PH (CPH) and Lumbini Park (LPMH) in West Bengal, MHC Thiruvananthapuram, MHC Kozhikode, MHC Thrissur, PDH Jammu and BIMHAS in Bihar
Dining area	29	67.4	IPHB Goa, BIMHAS Bihar, MHI Cuttack, RMH Pune, GHMC Visakhapatnam, HMH Bhuj, GPDH Srinagar, MHC Thrissur, MHC Kozhikode, MHC Thiruvananthapuram, IMC Purulia, LPMH Kolkata, CPH Kolkata, BMH Murshidabad,
Space for washing and drying clothes	27	62.8	RMH Pune, IPHB Goa, CPH Kolkata, BIMHAS Bihar, HMH Bhuj, MHC Thrissur, MHC Kozhikode, RMH Ratnagiri, RMH Nagpur, MH Varanasi, BMH, Murshidabad, SMHI Dehradun, LPMH Kolkata
Outdoor activities	18	41.9	IPHB Goa, GHMC Visakhapatnam, IHBAS Delhi, HMH Bhuj, HHMH Shimla, PDH Jammu, GPDH Srinagar, MHC Thrissur, MHC Kozhikode, MHC Thiruvananthapuram, MIMHANS Shillong, PC Jodhpur, CPH Kolkata, BMH Murshidabad, MH, Bareilly, BIMHAS Bihar, NIMHANS Bangalore, MHI Cuttack, MPH Tripura, MH Varanasi, SMHI Dehradun, IMC Purulia, IOP Kolkata, LPMH Kolkata
Facilities for physical exercise and yoga	27	62.8	CPH Kolkata, IMHH Agra, MH Bareilly, GHMC Visakhapatnam, BIMHAS Bihar, IHBAS Delhi, HMH Vadodara, HMH Jamnagar, HHMH Shimla, PDH Jammu, GPDH Srinagar, MHC Thrissur, MHC Kozhikode, MHC Thiruvananthapuram, MIMHANS Shillong, SMHI Kohima, MPH Tripura, IOP Kolkata, LPMH Kolkata
Music	29	67.4	CPH Kolkata, HMH Bhuj, HHMH Shimla, MPH Tripura, LPMH Kolkata, GHMC Visakhapatnam, MHC Kozhikode, BIMHAS Bihar, PDH Jammu, GPDH Srinagar, MH Varanasi, SMHI Dehradun, BMH Murshidabad, HMH Bhuj, MHI Cuttack, MH

			Varanasi, IMC Purulia
Cultural activities	25	58.1	CPH Kolkata, BMH Murshidabad, GHM, Visakhapatnam, MHC Kozhikode, HHMH Shimla, NIMHANS Bangalore, PC Jodhpur, LPMH Kolkata, MH Bareilly, BIMHAS Bihar, HMH Bhuj, PDH Jammu, GPDH Srinagar, MIMHANS Shillong, MPH Tripura, MH Varanasi, SMHI Dehradun
TV with cable	26	60.5	RMH Pune, CPH Kolkata, GHMC Visakhapatanam, RMH Nagpur, LPMH Kolkata, IPHB Goa, BIMHAS Bihar, MHC Kozhikode, PDH Jammu, GPDH Srinagar, GMA Gwalior, PC Jodhpur, MPH Tripura, MH Varanasi
Library facilities	18	41.9	**INADEQUATE IN MOST PLACES** Reported **as adequate** by RMH Thane, RINPAS Ranchi, IMH Agra, LGBRIMH Tezpur, HMH Vadodara, HMH Ahmedabad, PDH Jammu, CIP Ranchi, DIMHANS Dharwad, NIMHANS Bangalore, MHC Thiruvananthapuram, MH Indore, GMA Gwalior, RMH Ratnagiri, IMH Chennai, IOP Kolkata
Facilities for spiritual activities	17	39.5	**INADEQUATE IN MOST PLACES** Reported **as adequate** by RMH Thane, IPHB Goa, RINPAS Ranchi, IMHH, Agra, IMH Amritsar, LGBRIMH Tezpur, HMH Ahmedabad, HMH Vadodara, PDH Jammu, CIP Ranchi, DIMHANS Dharwad, NIMHANS Bangalore, MH Indore, GMA Gwalior, RMH Ratnagiri, SMHI Kohima, IMH Chennai, MPH Tripura
Visitor's rooms	32	74.4	CPH Kolkata, MH Bareilly, IHBAS Delhi, MHC Thrissur, MHC Kozhikode, IPHB Goa, BIMHAS Bihar, HMH Bhuj, GPDH Srinagar, SMHI Kohima, MHI Cuttack, SMHI Dehradun, LPMH Kolkata
Access to phones	26	60.5	RMH Pune, RMH Thane, MH Bareilly, GHMC Visakhapatnam, BIMHAS Bihar, PDH Jammu, GPDH Srinagar, MHC Kozhidode, MHC Thiruvananthapuram, RMH Nagpur, MH Ratnagiri, MIMHANS Shillong, SMHI Kohima, MH Varanasi
Allowed to send/receive letters	31	72.1	RMH Thane, BMH Murshidabad, BIMHAS Bihar, HMH Bhuj, MHC Kozhikode, MHC Thiruvananthapuram, RMH Ratnagiri, RMH Nagpur, MIMHANS Shillong, MHI Cuttack

*Inadequate information from GHMC Hyderabad and PC Jaipur.

In general, majority of the institutions in West Bengal, Kerala and Maharashtra, the GHMC in Andhra, HMH Bhuj in Gujarat, MH Bareilly, BIMHAS, Bihar, MH Varanasi and SMHI Dehradun report inadequacies in several aspects of the living spaces and facilities.

Table VII. Self-report by institutions on patient clothing, toiletries and care*

	Reported as YES (N)	Percentage	Comment
Allowed to wear their own clothes	33	76.7	**Reported as NO** in RMH Pune, RMH Thane, LGBRIMH Tezpur, HMH Vadodara, RMH Ratnagiri, RMH Nagpur, IMH Chennai LPMH Kolkata
Clothes provided by hospital (if required)	42	97.7	**Reported as NOT PROVIDED** in RMH Nagpur
Hospital clothes are uniforms	24	55.8	**Reported as being uniforms** by RMH Pune, RMH Thane, IPHB Goa, CPH Kolkata, IMHH Agra, MH Bareilly, GHMC Visakhapatanam, RIMH Tezpur, BIMHAS Bihar, IHBAS Delhi, HMH Vadodara, HMH Jamnagar, HHMH Shimla, PDH Jammu, GPDH Srinagar, CIP Ranchi, DIMHANS Dharwad, MH Indore, GMA Gwalior, RMH Ratnagiri, RMH Nagpur, IMH Chennai, MPH Tripura, MH Varanasi, SMHI Dehradun, IMC Purulia
Winter wear provided	38	88.4	**Not provided** in the hospitals in Kerala, Andhra and Goa (Do not need winter wear)
Footwear provided	37	86.0	**Not provided** by RMH Pune, GHMC Visakhapatnam, DIMHANS Dharwad, RMH Ratnagiri, MPH Tripura, IOP Kolkata
Toiletries provided	34	79.1	**Not provided in** MH Varanasi, Calcutta Pavlov hospital, IOP Kolkata, PDH Srinagar, GHMC Vishakapatnam and BIMHAS, Bihar (Not specified by MH Bareilly and GHMC Hyderabad)
Sanitary napkins provided	42	97.7	**Not provided** in MH Varanasi
Compulsory short hair	7	16.3	**Compulsory** in HMH Bhuj, MHC Thiruvananthapuram, MH Indore, RMH Ratnagiri, HMH Vadodara, MH Tripura
Lockers provided	28	65.1	**Not provided** by CPH Kolkata, IMHH Agra, IMH Amritsar, HMH Bhuj, GPDH Srinagar, GMA Gwalior, RMH Ratnagiri, RMH Nagpur, MIMHANS Shillong, SMHI Kohima, MHI Cuttack, MH Varanasi, LPMH Kolkata

*Inadequate information from GHMC Hyderabad and PC Jaipur.

Uniforms still exist in many hospitals, despite several attempts in the past to discontinue this practice and make available a range of clothing for women admitted to mental health institutions. No footwear is provided in a few of the hospitals. Only MH Varanasi reports

not providing sanitary napkins. Compulsory tonsuring of the hair is still practiced in the hospitals at Indore, Bhuj, Thiruvananthapuram, Ratnagiri, Vadodara and Tripura. Basic toiletries are not provided by a few hospitals (MH Varanasi, IOP Kolkata, PDH Srinagar, GHMC Vishakapatnam and BIMHAS Bihar).

Table VIII. Self-report by institutions on treatment and research related issues*

	Reported as YES (N)	Percentage	Self-reported as NOT occurring/NOT present
Informed consent taken before providing treatment	38	88.4	RMH Pune, RMH Thane CPH Kolkata, HMH Bhuj, BMH Murshidabad
Free medication provided for women below the poverty line (BPL)	40	93.0	MH Bareilly Not entered by MHC Kozhikode
Psychotherapy provided routinely	35	81.4	MH Bareilly, HMH Bhuj, HHMH Shimla, RMH Ratnagiri, MH Varanasi, SMHI Dehradun, IMC Purulia
Group therapy activities	28	65.1	IPHB Goa, GHMC Visakhapatnam, HHMH Shimla, MHC Thrissur, MHC Kozhikode, MH Bareilly, BIMHAS Bihar, HMH Bhuj, MIMHANS Shillong, MH Varanasi, SMHI Dehradun, CPH Kolkata, BMH Murshidabad, IMC Purulia, LPMH Kolkata
Confidentiality maintained always	40	93.0	HMH Bhuj
Day care centre present	20	46.5	RMH Pune, IPHB Goa, BMH Murshidabad, RINPAS Ranchi, MH Bareilly, IMH Amritsar, BIMHAS Bihar, HMH Bhuj, HHMH Shimla, CIP Ranchi, MHC Kozhikode, GMA Gwalior, MIMHANS Shillong, SMHI Kohima, PC Jodhpur, MPH Tripura, MH Varanasi, SMHI Dehradun, IMCPurulia, LPMH Kolkata
Informed consent taken prior to inclusion in research	32	74.4	SMHI Dehradun, CPH Kolkata, BMH Murshidabad, MH Bareilly, MH Varanasi. Mentioned as not relevant by MHC Kozhikode

*Inadequate information from GHMC Hyderabad and PC Jaipur.

As with the facilities, inadequacies in treatment are mostly apparent in many of the mental health care institutions in West Bengal, Maharashtra, Uttar Pradesh (MH Bareilly and MH Varanasi), BIMHANS in Bihar, HMH Bhuj in Gujarat, SMHI Dehradun, and IPHB Goa.

Table IX. Self-report by institutions on addressing special needs *

	Reported as YES (N)	Percentage	Comment
Separate wards for pregnant women	12	27.9	**Not available in most hospitals.** Reported as being available in RMH Pune, RINPAS Ranchi, IMHH Agra,

			HMH Ahmedabad, MH Indore, RMH Ratnagiri, SMHI Kohima, MHI Cuttack, PC Jodhpur, IMH Chennai MPH Tripura, IOP Kolkata
Separate wards for mother with babies	13	30.2	**Not available in most hospitals.** Reported as being available in RMH Pune, RINPAS Ranchi, IMHH Agra, IHBAS Delhi, HMH Bhuj, HMH Ahmedabad, NIMHANS Bangalore, MH Indore, SMHI Kohima, MHI Cuttack, IOP Kolkata, LPMH Kolkata
Separate wards for elderly women	14	32.6	**Not available in most hospitals**. Reported as being available in RMH Pune, RMH Thane, RINPAS Ranchi, IMHH Agra, IMH Amritsar, HMH Ahmedabad, HMH Vadodara, NIMHANS Bangalore, RMH Nagpur, SMHI Kohima, MHI Cuttack, IMH Chennai, IOP Kolkata
Separate wards for women with substance use disorders	11	25.6	**Not available in most hospitals.** Reported as being available in IMHH Agra, IMH Amritsar, HMH Ahmedabad, NIMHANS Bangalore, MHC Kozhikode, MH Indore, SMHI Kohima, MHI Cuttack, IOP Kolkata
Separate wards for women with physical disabilities	13	25.6	**Not available in** RMH Pune, RMH Thane, RINPAS Ranchi, IMHH Agra, IMH Amritsar, LGBRIMH Tezpur, HMH Ahmedabad, MH Indore, MHC Kozhikode, RMH Ratnagiri, SMHI Kohima, IOP Kolkata
Separate wards for long-stay patients	22	51.2	**Not available in** IPHB Goa, BMH, Murshidabad, MH Bareilly, LGBRIMH Tezpur, BIMHAS Bihar, HMH Bhuj, HMH Jamnagar, HHMH Shimla, PDH Jammu, CIP Ranchi, NIMHANS Bangalore, GMA Gwalior, MIMHANS Shillong, MHI Cuttack, PC Jodhpur, MPH Tripura, MH Varanasi, SMHI Dehradun, LPMH Kolkata

*Inadequate information from GHMC Hyderabad and PC Jaipur.

Most of the hospitals do not have separate wards or facilities for women with special needs. Special services for substance use disorders, a growing problem among women are only present in 10 hospitals. Facilities for pregnant women and women with babies and the elderly, as well as facilities for women with physical problems or disabilities are present in only a few of the hospitals.

Table X. Self-report by institutions on record maintenance and procedural issues*

	Reported as YES (N)	Percentage	Reported as NOT being followed
Case records maintained in standard format	40	93.0	CPH, Kolkata
Disability certificates issued	29	67.4	RMH Thane, MIMHANS Shillong, MH Bareilly, LGBRIMH Tezpur, RMH Nagpur, SMHI Kohima, MH Varanasi, IMC Purulia, LPMH Kolkata
Admission / discharge procedures as per MHA 1987	40	93.0	*
Drug register maintained	43	100.0	
ECT register maintained	34	79.1	MHB Murshidabad, HMH Jamnagar, HHMH Shimla, IMC Purulia
Incident register maintained	34	79.1	MH Bareilly, GHMC Vishakhapatnam, BIMHAS Bihar, HMH Bhuj, HMH, Jamnagar, MIMHANS Shillong, SMHI Kohima

*Inadequate information from GHMC Hyderabad and PC Jaipur.

Most institutions maintain case records and follow the admission/discharge procedures under the Mental Health Act of 1987.

Critical incidents

In the previous year (April 2014 to March 2015), the median number of deaths among women in-patients across the hospitals is 5.04. Maximum number of deaths is recorded in the RMH, Yerawada (35), MHI Cuttack (14) and RMH Nagpur (10). Three suicides in the last year have been reported in each of the following institutions- GMA Gwalior and MHC Thiruvananthapuram and one from PC, Jaipur. Three medical terminations of pregnancy were reportedly carried out in the previous year at IHBAS, Delhi and one each at MHC Thiruvananthapuram and HMH Ahmedabad. Nineteen incidents of violence/assault were reported from IHBAS (which has a standard operating procedure for reporting and responding to incidents), 4 instances were reported from RMH Nagpur and one each from DIMHANS Dharwad and Calcutta Pavlov Hospital.

Legal Issues

The highest number of legal issues pertaining to property, finances/custody/divorce were reported from MHC Kozhikode (60 cases during the last year). Legal issues were reported from MHC Thrissur (14 cases), GPDH Srinagar (7 cases), HMH Ahmedabad (5 cases), GMA Gwalior (2 cases), MH Bareilly, IMH Chennai, MHI Cuttack and MH Thiruvananthapuram (one each).

Free legal aid is provided in 30 institutions (69.8%). It is not available in SMHI Dehradun, BIMHAS, Bihar, HMH Bhuj, BMH Murshidabad, MH Varanasi, SMHI Kohima and RMH Thane. The information on the availability of free legal aid is not recorded by Calcutta Pavlov Hospital, GHMC Hyderabad, IMH Amritsar and MH Bareilly.

Issues related to discharge

Median number of discharges across the hospitals during the previous year is 378, indicating that many of the women are being discharged in most of the hospitals.

Very few women are discharged to either government or NGO residential facilities. In the previous year, the median number of women placed into government facilities was 3.5 (range 0-40) and to NGO facilities was 5 (range 0-20). This is not surprising, because only 23 of the 43 institutions (53.5%) report active collaboration with non-governmental organizations for rehabilitation and after-care. Hospitals that report no active NGO engagement include RMH Ratnagiri, HMH Bhuj, SMHI Kohima, MH Varanasi, MPH Agartala, MH Indore, BIMHAS Bihar, GHMC Vishakapatnam, Lumbini Park Mental Hospital, Kolkata, IPHB Goa, IMH Purulia, SMHI Dehradun, RMH Nagpur and GPHD Srinagar. Information on active collaboration with NGOs for rehabilitation is not provided by GHMC Hyderabad, IMH Amritsar and MH Bareilly.

This also suggests that a significant number of women are being discharged to their families. The accompanying table shows the hospitals with the highest numbers of women inpatients staying more than 5 years.

Table XI. Institutions having the highest number of long-stay women patients

Institution	Stay 6 months-1 year	Stay 1 year-5 years	Stay more than 5 years
Regional Mental Hospital, Thane, Maharashtra.	450 more than 6 months		
Regional Mental Hospital, Yerwada, Pune, Maharashtra	71	150	230
Calcutta Pavlov Hospital, West Bengal	63	36	205
Berhampore Mental Hospital , Murshidabad, West Bengal	120	105	90
Regional Mental Hospital Nagpur, Maharashtra	24	69	80
Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Jharkhand	19	55	67
Institute of Mental Health (Govt. Mental Hospital) Amritsar, Punjab	6	37	67
Institute of Mental Health, Chennai , Tamil Nadu	22	40	57
Gwalior Mansik Arogyashala, Gwalior, Madhya Pradesh	18	26	48
Mental Hospital Indore, Madhya Pradesh	5	10	41

RMH Thane has provided figures of 807 staying between 6 months to 1 year; 1482 between 1 to 5 years and 3197 staying more than 3197 (but these figures appear to represent both genders).

Thus, while voluntary admissions are increasing in many institutions and many women patients do get discharged from the hospital, some of the institutions continue to have a large number of involuntary admissions. Post-discharge placements are very small in number. It appears that women patients following recovery or improvement are either discharged to their families or continue to remain in the hospital. This appears particularly true of involuntary admissions.

Some insights into the long-stay patients

The long-stay lists from the hospitals are very insightful.

RINPAS

RINPAS has provided detailed information on 141 long-stay women patients, between the ages of 15 to 81 years. These women are mostly from Bihar or Jharkhand. Among the long stay patients, there are 2 women from Kerala, 3 from West Bengal and 1 from Nepal.

Box 5. Stories from RINPAS

31 year old Ms. S has been at RINPAS since 11 years. She was previously living with her mother and grandmother. Her mother died, her father remarried and abandoned the patient.

58 year old Ms. B from Hazaribagh has been in the hospital since 18 years. Her parents died and her brother refused to look after her. Her husband who is an advocate in the Supreme Court sent a lawyer's notice that he could not be forced to take her as he had not admitted her.

Ms. JB was admitted by her family member as a voluntary admission 29 years ago. She was diagnosed as suffering from mental retardation with psychosis. She is now 59 years old. Several letters were sent to her family and she was subsequently taken home by a hospital escort. Her family got her re-admitted almost immediately and abandoned her. At present she has no living family members.

Circumstances of admission

A majority of the women (90) were brought for admission by the police. Family members brought 41 (29%) for admission. They were all admitted as free patients. While 40 (28.6%) of them were admitted as voluntary patients, most of them (71%) were admitted as certified patients.

Eighty two women (59%) were brought to the hospital as 'unknown'.

Diagnosis

The most common diagnosis was schizophrenia (71), followed by Psychosis not otherwise specified (33) and Bipolar mood disorder (7). Six patients were diagnosed as having mental retardation along with psychosis. Five had an additional diagnosis of epilepsy.

Physical illness

A few women had diabetes (6), thyroid dysfunction (2), hypertension or cerebrovascular disease (7), and one each had Hepatitis B, HIV and filariasis.

Tracing attempts

The hospital has recorded the attempts to contact the family among those who provided addresses (more than 89 patients). However, in most cases, the address has not been correct.

Future?

Forty three of the women at RINPAS for more than five years are still young (between 23 to 50 years of age. They have no families to go back to. Are they destined to spend their entire lifetime within the institution or do they have any hope of an alternative and better future?

Summary of the long-stay patients across the different hospitals

Information on long-stay patients (greater than 6 months) was provided by GMA Gwalior, RMH Thane, IMH Amritsar, DIMHANS Dharwad, MHC Thrissur, MHC Thiruvananthapuram and MH Bareilly. The remarkable features of the long-stay patients and the striking differences across the institutions are summarised below.

Table XII. Summary of long-stay patients in the mental hospitals

	Age Range (at admission) and background	**Details of admission and status at admission**	**Diagnosis**	**Visit by family/ Current status/ Attempts to discharge/ Rehabilitate**
GMA Gwalior Information on 92 patients	14-63 years 22 married 20 unmarried 34 marital status unknown 23 illiterate 7 primary education 24 high school education 4 graduates 1 postgraduate	29 brought by police as unknown Mostly free, involuntary	Schizophrenia 65 Psychosis2 MR with psychosis 25 MR with epilepsy 2 Bipolar mood disorder 10	43 participate regularly or intermittently in ward activities In 32 cases, families not willing to have the patient back at home For the rest, the addresses are incorrect or unknown
RMH Thane Information on 267 long-stay	15-76 years Mainly from Thane, Mumbai& surrounding areas, a few from Nashik, Nagpur, Raigarh	162 brought by family (father, brother, mother, sister, other relatives; less often by husband Paying 114 Voluntary 35	Schizophrenia 158 Psychosis 7 MR with psychosis 50 Epilepsy with psychosis 23 Bipolar mood disorder 7 Hypertension/Heart disease 18 Thyroid problems 2 Diabetes 4 CA Breast 1	In 66 cases, family is in touch. However, in most cases, family has been informed about discharge, but does not come to get the patient discharged
IMH Amritsar Information on 52 long-stay		Free 24 Paying 11 Involuntary 33	Schizophrenia 35 Psychosis 8 MR with psychosis	

		Rest Voluntary 15 brought by family 11 by police 4 by Nari Nikethan	4 Epilepsy with psychosis 1 Bipolar mood disorder 1	
DIMHANS Dharwad Information on 18 long-stay	30-73 years No addresses for many	All free involuntary admissions	Schizophrenia 8 Psychosis 2 MR with epilepsy/psychosis 6 Dementia 1	No addresses available 15 False addresses 3
MHC Thrissur Information on 76 long-stay	21-83 years Residents of Kerala 34 Not known 15 Tamil Nadu 9 West Bengal 3 Andhra 2 Bihar 2 Maharashtra 2 Karnataka 2 Nepal 1 Tripura 1 UP 1 Rajasthan 1	All free admissions 9 voluntary rest involuntary	Schizophrenia 17 Psychosis 34 Bipolar mood disorder 7 Physical health problems include Hypertension/heart disease 1 Asthma 2 Hbs Ag+ 1 Diabetes 1	Only 7 patients visited by their families after admission. Address not traced 26 Relatives not able to take care 3 Relatives not interested 3 No relatives 7 Awaiting tracing of family 27 Patient not willing to go to family 1 Awaiting inter-state transfer 4 Being shifted to Asha Bhavan 1
MHC Thiruvananthapuram Information on 50 women	20-70 years Out of state Andhra 3 Tamil Nadu 4 Bhopal 1 Orissa 3 Maharashtra 1 Kanpur 1	Voluntary 2 Under trial 2 Certified Rest	Not documented	Attempts to send home underway 21 Attempts for inter-state transfer 13 Transfer to Asha Bhavan 1 Transfer to NGOs (Snehashram, Kanakulam) 2
MH Bareilly Information on 48 long-stay	15-63 years In 23, address not known	23 brought by police 25 brought by relatives Voluntary 26 Rest involuntary Free 22 Paying 26	Schizophrenia 10 Bipolar mood disorder 11 Psychosis 7 MR with psychosis 18 Major Depression 1 Diabetes 2 Seizures 2 Cardiomyopathy 1	No address available 22 Letters sent to families 24 cases, but no family member has come

Case illustrations

In the MHC Thrissur, there is one patient from Tripura. The family in Tripura has been contacted but cannot come to take the patient back due to financial constraints. The hospital has been in touch with the Tripura police who have been unwilling to arrange an escort.

The MHC Thrissur has been attempting to send 2 patients from Karnataka back to the state. The photo and details of one patient has been sent to the Director General of Police and the Legal Services Authority as well as the Health Secretary, Karnataka to facilitate state

transfer. The second patient is from Hiriyur in Karnataka. Attempts are being made to transfer her to the local relief and rehabilitation centre with the help of the Kerala Legal Services Authority.

Medical problems are common among long-stay patients. DIMHANS, Dharwad, documents the case of a 60 year old lady, Ms S, who was brought from Sirsi. Her antecedents were unknown. She was diagnosed as dementia. She had a fracture neck of femur and had to be referred to the Karnataka Institute of Medical Sciences for treatment.

Although the Mental Health Act 1987 vests the responsibility of patient care upon the families, even in families that can seemingly afford to care for the patient, things are not so easy in reality. This is illustrated by the case of a 37 year old woman who was admitted at NIMHANS Bangalore in 2012. She was found wandering near the railway station and was abusive and assaultive to the public. She was brought by the social worker from the Nirashrithara Parihara Kendra (Beggars' Home) and admitted under a reception order. She was diagnosed and treated for Schizophrenia and had partial improvement of her symptoms. The treating team contacted the patient's mother in Haryana through a Delhi-based NGO. The patient's father, a bureaucrat had died some years back. Her family, including 2 siblings seemed well-off, but were all indifferent to the requests to contact the treating team/make arrangements for the continued care of the patient. The patient was keen to go home or at least back to her permanent place of residence. Attempts to transfer her to the State Institute of Mental Health Haryana, through the intervention of the State Human Rights Commission, were made. A letter to the SHRC was forwarded to the Deputy Commissioner of Police Haryana, to file a report in the matter. The hospital also wrote to the National Commission for Women to see if it was possible to pursue justice for the woman by making the family more accountable for her care. However it was informed that no complaint could be registered as it was non-mandate. The process to send her back to Haryana is still ongoing. The case illustrates the difficulties that arise when families that can afford to provide for their relative with mental illness refuse to support or engage in decision making for the patient's longer-term welfare.

Such situations are often worse when economic issues such as property and finances are involved. They are also complicated by social issues, particularly stigma and desertion by spouse.

Summary of the analysis of the questionnaire responses from the mental health care institutions

The following is a summary of the major observations from the reports submitted by the 43 psychiatric institutions:

1. A majority of the institutions (61.5%) feels that the overall staff, as well as the female staff, is inadequate.

2. Overall in these institutions, the average number of closed wards are almost three times the number of open wards.
3. However, it is heartening to see that the number of voluntary admissions of women during the previous year has exceeded involuntary admissions.
4. However, in 16 institutions, involuntary admissions exceed voluntary. This is particularly evident in most of the institutions in Maharashtra, Gujarat (Bhuj and Vadodara), West Bengal (Murshidabad has exclusively involuntary patients), MH Bareilly, IHBAS, Delhi, LGBRIMH Tezpur, IPHB Goa and GPDH Srinagar.
5. Approximately two-thirds of hospitals report that their spaces for cooking, dining, washing, drying clothes, entertainment (music, TV) are adequate. However, relatively fewer have library facilities, cultural and outdoor activities. Just about a third has facilities to address the spiritual needs of patients.
6. Most hospitals state that they allow women to wear their own clothes. Clothes are provided by the hospitals in most (except RMH Nagpur).However, in more than half, the clothes provided by the hospitals are 'uniform-like'. Except where there is no perceived need for winter clothing, appropriate clothes are provided.
7. Footwear is provided in most hospitals.
8. Toiletries are said to be provided in nearly 80%.
9. Except for MH Varanasi, all other hospitals report providing sanitary napkins.
10. A small number of hospitals still do compulsory hair tonsuring (HMH Bhuj, MHC Thiruvananthapuram, MH Indore, HMH Ratnagiri, HMH Vadodara, **IMH Amritsar** and PC Jaipur.
11. About two-thirds report that they provide lockers for patients.
12. Most hospitals indicate that they take informed consent prior to treatment.
13. Most hospitals indicate that they provide free medicines for women below the poverty line.
14. Group interventions are reported to being carried out in about a third of the hospitals.
15. Day care is present in less than half the institutions.
16. One-fifth to one-third of the institutions have special wards for women with special needs (pregnant women, women with babies, women with substance use disorders, elderly women and women with physical disorders).
17. Record maintenance, including case records and registers is reported to be satisfactory in most hospitals.
18. While disability certification has become a norm in many hospitals, around one-third still do not carry out disability certification.
19. Some critical incidents include death (more in hospitals with very high number of long-stay). There are occasional incidents of medical termination of pregnancy and incidents of violence and assault.
20. Legal issues related to property, finance, custody, divorce etc. are reported in a few hospitals. This is striking in Kozhikode, where 60 such cases are reported in the last year.
21. More than two-thirds of the institutions report that they provide free legal-aid.
22. Many women are actively discharged from the hospitals, most probably back to their families.

23. Considering the number of long-stay patients in some hospitals, the placement of destitute women in either government or NGO rehabilitation centres in extremely low. Many of the long-stay patients are still young women and have the right to a good quality of life, livelihood and family life. It is important to protect these rights.
24. Some long-stay patients are from different states. This is particularly striking in the hospitals of Kerala. Procedures to have such women return to their families living in distant states or to rehabilitation facilities in their state of origin are tedious and attempts are not always successful.
25. In general, majority of the institutions in West Bengal, Kerala and Maharashtra, the GHMC in Andhra, HMH Bhuj and HMH Vadodara in Gujarat, MH Bareilly and MH Indore, BIMHAS, Bihar, MH Varanasi, IPHB Goa, GHMC Hyderabad, SMHI Kohima, MIMHANS Shillong, IMH Amritsar and SMHI Dehradun report inadequacies in several aspects of the living spaces, facilities and functioning.

DISCUSSION

DISCUSSION

The present study *Addressing concerns of women admitted to psychiatric institutions in India-an in-depth Study* attempted to understand from various vantage points the issues concerning women with severe mental disorders requiring institutional care. It focused not only on the conditions of their care within the psychiatric institutions of the country, but expanded its mandate to examine the circumstances of these admissions, gender-related issues in care and most importantly, the outcome of admission to psychiatric institutions.

The treatment and psycho-social needs of women with mental illness in India has so far only been the subject of symposia or a few articles in psychiatric journals and popular media. To date, no gender-based audit of mental illness has occurred in the country.

Mental hospitals have been the focus of attention for the last two decades and the intervention of the National Human Rights Commission led to several positive changes in many of them, particularly those that were regularly monitored.

The Human Rights Watch Report 2014 in a provocative title, '*Treated worse than animals*' focused on instances of abuse against women and girls with psychosocial or intellectual disabilities in institutions in India (both mental hospitals and other institutions viz. homes for destitute women, remand homes, beggars' homes etc.).

The present study adopted a comprehensive approach focused on studying concerns of women with mental illness in psychiatric institutions in the country. Three main activities were carried out in the study.

Activity 1 consisted of visits by a joint team that included a research team and faculty members from NIMHANS as well as a Member from the NCW. They conducted on-site visits, interacted with administrators and service providers, women patients, carers when available and carried out inspections of the hospital facilities.

Activity 2 consisted of consolidating the responses of the interviews with women patients from all the institutions visited.

Activity 3 consisted of analysis of the questionnaires answered to by the psychiatric institutions. This questionnaire, prepared by NIMHANS, had been sent by the NCW to these institutions and the filled questionnaires were received from 43 institutions.

During the on-site visit, the team has interviewed 245 patients, about 100 service providers, and 31 care-givers across 10 psychiatric institutions from different regions of the country. The interviews with the service providers focused on the diagnostic conditions of the admitted women, their treatment needs, extent of family engagement, family attitudes to the patient, treatment as well as psycho-social needs of women with severe mental illness, living conditions and facilities in the hospital, discharge related issues, including difficulties in discharge. Interviews with administrators focused on issues of infrastructure within the hospital, living conditions, family involvement, concerns regarding the homeless mentally ill,

budgetary provisions, legal issues, existing support from the government and expected support to improve facilities for better care for women with mental health concerns.

The interviews with patients consisted of questions related to their satisfaction with basic facilities, food and dining services, sleeping and resting facilities, facilities for personal hygiene and comfort, emotional support, medication and treatment, social engagement, meeting of ethical and spiritual needs and issues of coercion and abuse.

Interviews with carers focused on their reasons for hospitalisation of their ward, regularity of visits, interaction with treating staff including doctors, knowledge of the illness and treatment, satisfaction with the treatment provided, plans for rehabilitation and difficulties they faced regarding discharge.

Although this work was primarily focused on gender-specific issues, there is no doubt that many of the issues are pertinent to anyone admitted for institutional care of mental illness-man or woman. Another important aspect is that gender-issues within hospitals cannot be divorced from the larger socio-economic milieu and gender inequities that operate in society.

As mentioned earlier, the interventions of the Apex Court and the monitoring of mental health institutions by the NHRC has already led to improvements in institutional care. The focus of these interventions was largely on improving the glaring deficiencies in basic infrastructure and functions (dilapidated buildings, overcrowding, food, toilets, beds, overcrowding, regular medicines, recreation and rehabilitation).

A striking observation in this study is the high level of satisfaction that women expressed overall across hospital on most of the areas they were asked about, including food, personal hygiene, sleeping and resting facilities. Even with respect to whether their emotional and social needs were met, most rated this as good. This is quite at variance to the documentation in the Human Rights Watch Report.

An immediate response that this high rate of satisfaction evokes is that the women may be providing these as socially desirable responses or because of fear or intimidation. On a closer examination, it appears that they are indeed reasonably satisfied. Support for this premise comes from the findings of the study of satisfaction of needs in the Central Prison, Bangalore (discussed earlier in this report) where women were more likely to express satisfaction with existing facilities as compared to men, and more willing to put up with delays and hardships. Also given that many of these women come from difficult socio-economic and deprived backgrounds, having basic needs like food, water and shelter taken care of is possibly a source of satisfaction for them.

That this is a genuine feedback is further supported by the fact that in some institutions, there was a higher level of dissatisfaction with basic amenities like safe drinking water, facilities to sleep, rest, wash and dry clothes. Women admitted to the Berhampur Mental Hospital in Murshidabad and the MH Bareilly gave higher dissatisfaction ratings on these areas, whereas respondents from IMHH Agra, RINPAS and Amritsar were significantly more satisfied with the services. Another point that supports the finding that the respondents are fairly discerning

comes from the feedback, that though they have no complaints about the amount of food, the frequency of serving food and the politeness with which the staff serve the food, there are complaints about the quality of food from some of the hospitals, and nearly a ubiquitous complaint that non-vegetarian food is not served. Concerns about pests in the wards, including mosquitoes, are expressed across all hospitals.

Lack of privacy is evident both from patient responses as well as team visits. It is an affront to personal dignity to deny privacy to women while bathing, using the toilet and changing their clothes. Undergarments are not provided in many of the hospitals. While sanitary pads are generally provided, they are not always regularly provided and even if they are, patients are not told how to dispose them. The result is that they are sometimes pushed out of the window or thrown erratically.

While there is general satisfaction with the basic facilities, and this is testimony to the fact that some of the facilities having improved through concerted action, there are still many areas of relative dissatisfaction across many of the hospitals. These include inadequate facilities to rest during the day, lack of spaces to wash and dry clothes and lack of lockers in most hospitals to keep personal possessions.

It is surprising, that despite the recommendations of the NHRC, many hospitals still have made uniforms mandatory and give little choice to the woman on what clothes she would like to wear. While toiletries are generally provided, basic cosmetics like kum-kum, powder and mirrors to address their personal appearance are not provided in many of the hospitals. Poignantly, when one of the faculties visiting the hospital at Murshidabad showed a woman her face in a mirror, she was not able to identify herself.

A majority of patients across institutions are invariably satisfied with the medication and treatment, across most hospitals, as well as with emergency care. However, two-thirds or more respondents said that they have not been explained the rationale for medications and their side-effects. Many service providers feel they are not able to provide optimal care for medical co-morbidities, especially for older women.

While the focus has been on improving infrastructure, caloric content of food, and other basic facilities, issues of personhood and rights have not been in focus. This is reflected in the fact that majority of the women respondents across hospitals state that they are not involved in decisions related to their health care. While most women say they have not been treated against their will, many say that informed consent has not been taken prior to initiating treatment. Half or more respondents across the hospitals say confidentiality is not maintained by the treating team. Ironically, although many hospital administrators say that the rights of patients are displayed in the hospitals, almost all the women are unanimous in their feedback that they have not been explained their rights.

Access to recreation and rehabilitation is still very inadequate. In some hospitals like RINPAS, these facilities have been actively strengthened, but in many others, patients have very little to do and over time, get de-skilled and unable to do any kind of productive work once they are outside the hospital.

Across all hospitals, most women say they are not discriminated on account of their religion. However, adequate attention is not paid to ensuring that they have spaces to pray and meet their religious/spiritual needs.

Overall, a lot of positive changes have occurred in the hospitals at Agra and Ranchi. This can be attributed to the regular monitoring by different agencies, in particular, the NHRC. The hospital at Amritsar is very well maintained, despite some infrastructure deficits, and patients there appear happy and well looked after.

The state of affairs in the hospitals of West Bengal, Maharashtra and Kerala, visited as part of the NCW study, is a great concern. These hospitals are in need of immediate attention to many aspects of functioning and care.

Advantages of greater autonomy

Results show Agra and Ranchi hospitals have done relatively better on most of the dimensions. An important factor that may have contributed to this positive aspect is the active monitoring by the judiciary and the Human Rights Commission. Since the past 20-odd years, various developments have occurred in these hospitals under close monitoring. These hospitals are supposed to send periodic reports to the Commission about their activities. Local management committees have been formed with a notable autonomy in running the institutions. Greater autonomy leads to quicker fixing of problems and deficiencies and better and timely implementation of new developmental ideas. Most importantly, this autonomy reduces 'red-tapism' (and consequently inadvertent delay in implementation of even day-to-day issues). An example to illustrate this issue: Director of one of the institutes reports that even if 'woollen blankets' are to be purchased for patients, the file needs to be put up and it has to reach the 'Directorate of Health Services' and from there, the 'Health Secretariat'. It takes months and years (sometimes) for the file to come back with the sanction. Ultimately, the very purpose gets defeated. Agra is an example of how an institute can progress if there is autonomy. The day-to-day issues can be handled immediately and smoothly and there also is scope of development.

Trainees- young blood, new ideas

Once development starts occurring in terms of human resources, post-graduate courses in mental health etc., new ideas gets infused and ultimately leads to improvement in the living conditions for women patients.

"WANT TO GO HOME": THE ECHOING THEME

While the service providers and the visiting team members obsess about infrastructure and functioning and adequate levels of care for the women, the women's pre-occupation is not with the existing facilities but with concerns about going home to their families. As evidenced in many of the hospitals, where the patients are voluntary and seen in the outpatient, many patients live or go back to their families. However, there are many others, who are admitted in the hospital, and forgotten by their families. The accompanying excerpt from the Hindustan Times[63] in 2010 is a chilling reminder of the reality of mental illness

Are families inevitably so cruel? Interviews with the care givers and service providers reveal different kinds of family situations leading to abandonment.

Abandonment by the family can be classified into three kinds from the descriptions available:

1. **Helpless abandonment**- this appears to occur in a majority of families. Poverty, lack of support, inability to meet the cost of medications, inability to travel long distances of care, elderly care givers, stigma, lack of support, sub-optimal living conditions, unsafe neighbourhoods, stigma of mental illness.
2. **Care-less abandonment**- when the primary care-givers, particularly parents, get old, infirm and unable to care, other relatives, including sibs are not willing to shoulder the responsibility of care.
3. **Wilful abandonment**- Deliberate 'dumping' of the woman into the hospital with ulterior motives including usurping property, child custody and re-marrying.

Families dump mentally ill in tiger reserve

Salil Mekaad, Hindustan Times, New Delhi Updated: Jun 03, 2010 01:01 IS

Some families have found a shocking way of getting rid of their mentally challenged members.

They pay truckers to dump them on a forlorn stretch of road running through Karnataka's Bandipur National Park, a tiger reserve 220 km southwest of Bangalore.

The hapless victims, many of whom can't even utter their own names coherently, hail mostly from West Bengal, Orissa, Maharashtra, Uttar Pradesh, Tamil Nadu and Kerala.

Left to the mercy of the elements, many have either been killed by wild animals or sexually abused by truckers. Lacking basic survival skills, some of them have even set alight forest fires.

Apart from families, police in neighbouring states of Tamil Nadu and Kerala are also alleged to have paid truckers to get rid of mentally ill people whom they have apprehended off the streets, NGOs working in the region said.

Of the 57 currently being treated at the Karunalaya hospital, 32 are women, six of them pregnant and five HIV positive.

Checkpoints along the stretch have done little to curb the menace. Police attribute it to their inability to understand what the victims are saying. Sometimes the truckers are known to drug the victim with opium, making it impossible to question him or her.

Besides, policemen normally check the papers of vehicles and what they are carrying, not the cabin or passengers in it.

(Partially excerpted)

There is a need for sustained community action to prevent abandonment and encourage families to continue to support and care for their wards with mental illness. Being responsive to the needs of families who might otherwise helplessly abandon their wards and garnering support may lead to fewer instances of abandonment. Strategies include subsidised and free treatment as close to the community as possible, incentives like free transportation, patient and family friendly insurance schemes, disability pension etc. may help in this regard. Innovative incentivisation of families who continue to care for their wards with mental illness may encourage more families to do so. Respite care for patients when families are under duress is another way of supporting families.

Such action may also be useful for 'care-less' families, if their burden is reduced and the mentally ill person is productive and symptom free.

There need to be strictures to prevent families from wilful abandonment including legal action against such families.

Alternatives to the family

Families are shrinking, migrating, undergoing a great deal of stress, and often stretched financially, emotionally and socially. That is the writing on the wall. Therefore, much as patients would like to return to families and much as we should try and support family care, it is pragmatic to think of alternative to family care. This requires engagement of various stakeholders in the community.

Lastly, the larger issues merit consideration as these are to be addressed on a long term and sustained basis. In India, community based long-term rehabilitation centres are almost non-existent, especially in the government sector. These include a range of facilities for women patients with psychiatric disorders including half-way homes, day-care centres and long-stay facilities. This is a big immediate need and must be addressed on a priority basis. Once such facilities operate, they can serve as a great source of respite to families and could help in reintegrating patients back to the families. Care should be taken to see that these facilities do not become more 'dumping' grounds, as otherwise, they would just replace the hitherto unsatisfactory mental hospitals. Active rehabilitation efforts should be integral to these facilities. Only then, women patients can be successfully reintegrated back into their societies.

Experiences of rehabilitation

Some of the experiences of rehabilitation have been documented in the report of the Technical Committee on Mental Health constituted by the NHRC in 2015[64].

Many states are in the process of conceptualizing and testing various kinds of rehabilitation efforts. The HMH Ahmadabad, through a series of efforts, which include making medication available free of cost, making admissions short, having open ward facilities, family carer

[64]National Human Rights Commission. Report of the Technical Committee on Mental Health 2015.Unpublished.

groups, outreach activities, staff trained in rehabilitation, strengthened vocational training and rehabilitation and NGO collaboration, has successfully reduced its long-stay patients.

The Incense Project, funded by the Tata Trust, has attempted to rehabilitate long-stay patients, including women at Tezpur and Yerwada. Of the 669 long-stay patients identified at Yeravada Hospital at Pune, 200 (30%) were enrolled in the project. At LGBRIMH, Tezpur, 37 long-stay were identified (median duration of 18 years in hospital) and placed in community facilities. This group had evidently high levels of disability in personal, social and occupational domains. Needs perceived for this group of persons included:

- Treatment needs including management of symptoms
- Physical health needs (medical illness, visual and auditory impairment etc., chronic use of tobacco)
- Independent living skills training
- Social needs
- Recreational needs
- Engagement in meaningful activity
- Building up of self-confidence and self-esteem
- Citizenship needs (lack of citizenship identity like an Aadhar card)
- Safety and shelter needs once discharged
- Financial need (disability allowance, job opportunity)

The attempts at Pune including setting up a transit Devrai ward, developing sheltered housing with an NGO called Meher and supported housing called the Unnati Nivas in 2012.

At Tezpur, the interventions for the homeless led to the reunion of some of the homeless persons with their families. This has also been the experience of agencies like the Banyan in Tamil Nadu. Involvement with an NGO, Atmika was helpful for the rehabilitation of the homeless in Tezpur. In the Incense programme, 93 of 167 persons engaged with individual job placements were working regularly.

In terms of financial management, activities including addressing systemic barriers for patients and their families to open and operate bank accounts, financial literacy, and financial protection. This included opening of 'Jan Dhan' accounts in local banks, post office accounts as well as investment in the National Pension Scheme. Patients below the poverty line were also linked to available government funded insurance schemes like the Rashtriya Swasth Bima Yojana (RSBY) to facilitate treatment of physical health problems.

In Pune, nearly 40% of the long-stay patients could be helped by these efforts at the end of 18 months.

At Tezpur,[65] towards the middle of 2014, following a court order from the High Court of the state of Assam in response to a public interest litigation, patients were moved enmasse to an NGO managed rehabilitation centre. During the period of last two years (2014 to 2015) 45

[65] Information provided on request from LGBRIMH on request.

long-stay patients were placed in the three NGOs designated by Govt. of Assam for care of destitute and homeless mentally ill. Of them, 31 were doing satisfactorily at follow-up (carried out by the psychiatric social workers of LGBRIMH) and 9 had died (those over 70 years of age from physical causes). Many expressed a desire to come back to the hospital. Main challenges in the care of the persons in placement included the NGO's inability to manage physical health problems, lack of regular psychiatric medication, lack of trained staff, lack of ambulance support and financial constraints faced in caring for homeless and destitute patients.

The Banyan in Chennai has extensive experience in providing rehabilitation for homeless mentally ill women for some decades now.

In Pune, the Kimaya products prepared by the patients have become an entrepreneurial success. Such marketing options for products made by patients have been successful in many places. The products produced by the rehabilitation section of NIMHANS, from candles and bakery items to leather goods like cervical collars have are marketable commodities.

As demonstrated by the experiences of Gujarat, if placement is done early, and there is active community collaboration, it may be possible for many patients to move out from the restrictive settings of the hospital to a better location, provided, of course, that no violations occur in such centres and the patient is able to lead a good quality of life. However, for long-stay highly dependent patients, facilities for assisted living need to be developed.

The experience of Tezpur cautions that the rehabilitation process must be carefully planned, be a collaborative effort, involve a gradual transition from hospital to community based facilities, and be carefully monitored as outcomes may be variable.

Similar rehabilitation measures are being carried out in Thane, by Tarasha, a Tata Institute of Social Sciences (TISS) initiated project that appears to have been successful in rehabilitating a few women with jobs and skills.

RECOMMENDATIONS FROM THE NCW/NIMHANS STUDY AND ACTION PLAN

RECOMMENDATIONS EMERGING FROM THE NCW/NIMHANS STUDY

The recommendations emerging from the different phases of the NCW project include the following:

I. Institutional

1. It is necessary to specifically focus on gender related issues while planning/improving mental health services in both residential and community settings.
2. The rights of women with mental illness must be protected in institutional, community as well as family settings.
3. Within psychiatric institutions, gender-sensitive aspects in need of urgent attention include facilities to improve personal hygiene (provision of toiletries and personal effects, provision of undergarments, regular supply of sanitary napkins and instruction on their proper disposal), reduction of overcrowding, focus on dignity (ensuring privacy during bathing, changing, using the toilet; banning compulsory tonsuring and uniforms), improving comfort (better arrangements for resting, warm clothing and heaters in winter, fans and coolers in summer)
4. Focus is specifically required on the rights and personhood of women- making them aware of their rights on an individual basis, involving them in decisions about their health, educating them about the illness and planned treatment, informed consent prior to treatment, informed consent for any other interventions or arrangements made in their interest.
5. Adequate facilities for recreation, leisure time activities, and spiritual needs must be available.
6. There is a need to address human resource deficiencies; ensure adequate gender ratio of staff at all levels.
7. A regular audit of satisfaction with the facilities and treatment must be carried out (once a year).
8. Long-stay must be discouraged by increasing family and open wards and voluntary admissions, improving the awareness of families regarding mental illness and sensitising the judiciary.
9. Even for patients admitted involuntarily, the hospitals must establish contact with families, document their identities at the time of admission.
10. There is a need to examine and develop standard procedures for homeless out-of-state women so that they may be transferred to facilities closer to their own places of origin if they so desire.
11. The issues of long-stay need consistent attention (Homeless & abandoned-minimizing stay, establishing identity, skilling /re-skilling, graded placement).
12. Mid way homes for women now have recovered but need a place to stay and get training to start their life on their own.

II. Support and Monitoring

1. The NCW/SCW need to be part of the monitoring committees of hospitals to specifically address women's issues
2. A routine legal aid need assessment must be carried out for each women who is admitted involuntarily or is not discharged within 3 months of hospitalisation. Such a facility may be set up by the State Legal Services Authority and emergent issues discussed with the hospital committee as well as other monitoring committees.
3. The SCW can set/oversee a Women's Support Service in each of the hospitals to holistically address women's issues both in treatment settings and in the community and ensure access to benefits, support for child care, etc. This should involve scrutiny of the annual audit of women's satisfaction and suggestions for improvement in facilities and would involve engagement with the hospital staff, social service agencies and NGOs on a regular basis.

III. Help and empower families

Families caring for persons with chronic mental illness must be empowered and supported through measures such as:

1. Accessible and free/subsidized treatment.
2. Access to incentives like disability benefit, travel benefit etc.
3. Awareness about these benefits and how to access them
4. Women-centric information regarding importance of early help-seeking for psychological distress and support
5. Women's mental health Help lines [Organizational aspects could be led by the NCW and engage MoSJE, Women and Child Welfare etc.]
6. In cases where the family is the source of neglect and abuse, a proactive role of NCW/SCW for rescue and rehabilitation
7. To create a Mental Health Cell to monitor human rights violation in women with mental illness. To have a corpus fund to fulfil these objectives

IV. Community –level responses

With the challenges posed by shrinking families, as well as families that have lost the capacity to care, the need to set up community level facilities is a social reality. Towards this there is an urgent need to set up:

1. Women's respite/half-way home facilities/rehabilitation including treatment for addiction related problems
2. Shelters for women with mental health needs
3. Day care facilities
4. Linking with vocational centres to ensure equal opportunities for women with mental health issues
5. Linking with self-help groups, employment schemes, other social benefit schemes

V. Evaluation of care and monitoring in other settings

Violation is known to occur in many settings where women with mental health issues are located. Thus, steps to evaluate the extent of mental health disorders, the capacity of staff to detect and assist women with such problems, to develop networks for remediation and rehabilitation must occur in the following settings:

1. Social Service Facilities
2. Beggars' homes
3. Juvenile homes for adolescent girls
4. Prisons
5. Homes for children with mental retardation
6. Elderly homes for women
7. NGOs and private residential facilities
8. Any other location of institutional care for women.

VI. Liaison and networking

1. There needs to be effective inter-sectoral liaison between the various sectors involved in the care and rehabilitation of women with mental health needs –health, social justice and empowerment, women and child welfare, rehabilitation, housing, judiciary, law, police, home affairs, education, labour, law and others
2. Similarly, the NCW needs to liaise with other commissions (like NHRC, Disability Commission, Child Commissions), other Governmental agencies and NGO's to proactively set standards of care to address women's mental health needs.
3. National Commission for Women should have a representative in all the committees and policy making bodies related to health and mental health
4. Sexual Harassment Committee needs to be formed in all mental hospital and custodial care settings.

VII. Legal recommendations

Legal provisions to ensure adequate standards of care and prevent any form of abuse are extremely important. They may include the following:

1. All psychiatric institutions in the country including privately managed institutions must be registered under State Mental Health Authority.
2. Annual social/gender audit of each psychiatric institution in the country may be undertaken by an independent agency duly recognized and empanelled by Ministry of Health & Family Welfare, GoI.
3. Any women leaving the mental health institution after being declared fit may be provided financial support to facilitate her re-integration into society in a manner as may be prescribed.
4. Provision for child care, day care facilities must be available for women with mental illness with living children up to the age of 18 years. The provision for child up to the

age of 6 years to stay in the institution along with a relative, or guardian may be permitted to ensure that the child and mother are not separated. Adequate financial provisions need to be made for ensuring the same

5. Provision for after care visits by psychiatric social workers should be ensured for fit patients discharged by psychiatric institution.
6. Every application made for intake of allegedly mentally ill person must be accompanied by medical certificates from two medical practitioners ratified by government psychiatrist within 15 days of issuance of the order. Any contravention of the Act will impose the penalty clause of the proposed Bill (Mental Health Care Bill).
7. No child born to a woman with mental illness should be declared free for adoption without the consent of the mother and a proper assessment of her mental state and ability to provide care.
8. Abused/violated women with mental illness and their rights in the absence of legal capacity, with relation to hysterectomy, termination or birth of child from rape encounters etc. should be ensured.
9. The provision for visiting system for external supervision of the psychiatric institutions especially for women patients may be incorporated.

ACTION PLAN

The following tangible steps are therefore suggested as an outcome of the NCW-NIMHANS study:

1. Adoption of 10 psychiatric institutions by the NCW to handhold, monitor and assist in improving facilities for the women. This will include regular visits to the hospitals, plan of action on the needed changes with timelines, dialoguing with the relevant state and central machinery and having time-bound and measurable targets. In addition to the areas outlined earlier, the possibility of making available adequate sanitary pads and their easy disposal needs to be explored. Of the 10 institutions visited, as IMHH Agra and RINPAS are already under NHRC monitoring, IMH Chennai and MH Varanasi may be added to the other 8 institutions for collaboration (RMH, Yerwada, RMH Thane, IPHB Goa, IMH Kozhikode, BMH, Murshidabad, Pavlov Hospital, MH Bareilly and IMH Amritsar.
2. Many of the hospitals have large areas of land which are now being used by State Governments for several other purposes, including setting up of multi-specialty hospitals. The NCW must write to the Centre and State to prevent any misuse of such land and use it instead to develop rehabilitation facilities for persons with mental health needs.
3. The NCW can be engaged in improving awareness regarding mental illness and its treatment, direct the setting up of help-lines to address the mental health needs of women, given that suicide, depression, and anxiety are all growing problems among women.
4. Hospitals must be encouraged and supported to develop facilities for women with special needs- pregnant women with mental illness, those with infants and young children, elderly, women with mental and physical disabilities, substance use etc.
5. A plan for rehabilitation is critical. There is as yet, no critical assessment of existing rehabilitation models in order to recommend one or more models. The NCW can invite agencies which have implemented such rehabilitation models, to provide an evaluation of how well the models worked, what challenges they posed and how such challenges can be overcome. The output of such an initiative would be a white paper recommending effective models of rehabilitation which could then be replicated in other settings.
6. Long-stay women in the various hospitals should be helped to establish their identity (Aadhar card, birth certificate, bank account etc.) many of which are necessary to avail any benefits.
7. In the existing hospitals where the NCW will collaborate, specific plans for rehabilitation need to be addressed. One potential area for rehabilitation is the complex at Varanasi. On a pilot basis, and in a careful planned, collaborative engagement with patients, a pilot may be carried out at the MH Varanasi to examine the feasibility of rehabilitation in that setting.

8. The NCW can explore whether the 'NIRBHAYA' and 'SWAADHAR' funds can be used for improving the living conditions of women with mental illness in institutional settings
9. The incentives for families including free or subsidised treatments, travel concessions, disability assessment and pension, access to insurance schemes must first be ensured as being in place and then widely publicised.
10. The NCW can have a national consultation to disseminate the findings of the report and engage a variety of stakeholders.
11. The various recommendations of the Technical Committee on Mental Health of the NHRC submitted to the Hon'ble Supreme Court encompasses not just care in institutional settings, but also community care and care in medical colleges and general hospitals. All these are of relevance to women with mental illness. The mechanism to realize these recommendations for women needs the proactive engagement of the NCW.
12. A cabinet portfolio for mental health in general and women's mental health in particular can mainstream women's mental health issues in a big way, and this move has already occurred in some countries. The NCW can strongly suggest this to the government.

IN CONCLUSION

This report has provided an opportunity to examine various issues involved in the care and support for women with severe mental disorders. While it highlights persisting lacunae in the facilities provided and administrative and bureaucratic hurdles, a greater focus of the report has been on understanding the feelings of the recipients of care, a shift in focus from a humanitarian to a personhood perspective, so that services for women with mental disorder can be gender-nuanced. Although improvements can well start in mental hospitals, there is also a need to turn the gaze to other institutions, communities and families. This report ends with a reminder that ensuring the rights of women with mental health issues involves numerous players including the women themselves; it needs contextualisation in larger socio-economic and cultural contexts and the narrative needs to incorporate not just stories of abuse and violation, but positive experiences of women who cope successfully with mental illness and lead fulfilling lives in a supportive and conducive environment.

Annexure I

National Commission for Women & National Institute of Mental Health and Neuro Sciences
Informed Consent Form for In-Depth Interviews with Patients

Title: "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An In-depth Analysis"

Information to the Patient:

This is a study commissioned by the National Commission for Women and undertaken by the National Institute of Mental Health & Neurosciences to assess the treatment conditions of women admitted in psychiatric institutions in India and to have an in-depth understanding of issues related to their admission and discharge. This study will help in gaining understanding of various clinical, social, cultural, familial, economic and legal factors likely to affect the lives of women with mental illnesses admitted to mental hospitals in India.

Your participation in the study will help us to understand your needs and concerns while availing treatment in mental hospital, reasons for your admission to the hospital, your experience in the ward, your satisfaction with quality care provided by treating team in the hospital, your expectations from the hospital staff and treating team, and also know any other concerns related to your illness. For this purpose I would be having an individual interview with you which would last about 60 to 90 minutes**.** The information revealed will be used to formulate recommendations to improve the care of women admitted in mental hospitals. During the in-depth interview, if you find any question uncomfortable you are free to refuse to answer the question.

If you have any specific concerns or complaints about your care, this will be directly communicated to the National Commission for Women for necessary action.

Undertaking by the Investigator:

Your participation in the study is voluntary; it does not carry monetary or material benefits thereupon. You have the right to refuse consent or withdraw the same during any part of the research without giving any reason. If you have any doubts about the study please feel free to ask and clarify the same by contacting any of the investigators mentioned below if you so desire (1) Dr. Pratima Murthy, Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995274(2) Dr. Naveen Kumar, Associate Professor, Department of Psychiatry, NIMHANS, Phone: 080-26965254 (3) Dr. Suresh Badamath, Additional Professor, Department of Psychiatry NIMHANS, Phone: 080-26965276 (4) Dr. Prabha S Chandra Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995272 (5) Dr. Srikala Bharath, Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995271(6) Dr. Poornima Bhola, Associate Professor, Department of Clinical Psychology NIMHANS, Phone:080-2699519(7) Dr. Vranda M.N, Assistant Professor Department of Psychiatric Social Work, NIMHANS, Phone: 080 26995236 and (8) Dr. Sailaxmi Gandhi, Associate Professor, Department of Nursing, NIMHANS, Phone: 080 3699532.

Consent:

I have been informed about the procedures of the study. I have understood that I have the right to refuse consent or to withdraw the same at any time during the research without adversely affecting my treatment. I am aware that the in-depth interview may be audio recorded. I am also aware that I will have to give the required time for the in-depth interview and this will not interfere with any benefits I might be eligible for.

I……, the undersigned, give my consent to be a participant for an in-depth interview of this research study titled "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An In-depth Analysis".

Signature of the participant (Name and address)

Signature of the Investigator (Name and address)

Place:

Date:

National Commission for Women & National Institute of Mental Health and Neuro Sciences
Addressing Concerns of Women Admitted to Psychiatric Institutions in India:
An In-depth Analysis

Individual Questionnaire

Instruction to interviewer:
Kindly carry out the interview in a place where there is no noise or interruption. Ideally, do it in the absence of any service providers, so that the respondent can speak frankly and without any fear. The questions you need to ask/information you need to provide are in italics.

Introduction:
This is a survey commissioned by the National Commission for Women and undertaken by the National Institute of Mental Health & Neurosciences to assess the existing conditions and treatment of women admitted in psychiatric institutions in India and to have an in-depth understanding of issues related to their admission and discharge.
Kindly provide your responses to the questions related to your experiences from admission to discharge. Your frank response for every item of the questionnaire is important. Your responses will be kept confidential.
We appreciate your kind cooperation and willingness to participate in this study.

Name: (optional) _____ Hospital ID No (from record)_____
Age: _____ Gender: _____
Education: _____ Education in Years:_____
Occupation (Before Admission):_____
Marital Status: _____ Religion: _____
Address: _____
Where did you live before you came into the hospital? _____ (own home, care home etc.)
With whom did you live? _____ *(*parents, husband, children, sheltered care etc.)
Which is the place you were staying in (Area) before you came to hospital? _____ *(*village, town, city)
Distance from hospital _____ (if they cannot give distance, ask for bus or train charge)
How long have you been in the hospital _____ *(*in days)
Duration of the illness: _____ Date of Admission_____
Diagnosis: _____ Medication: _____

Family Charting:

*Would you please share your admission experiences with us? (***Probe:** How did you come to the hospital? Who brought you and why? What can you tell us about your experience in the OPD/casualty)

Record Verbatim Responses (use separate sheets if required with proper identifiers):
The following are a set of questions relating to the facilities in the hospital. Please indicate your satisfaction with these and please provide additional comments wherever possible:

Area and question	YES	NO	Comments (If any)
Basic facilities - *The following questions are about your basic living facilities.*			
1. *Is the lighting in the ward adequate during the day?*			
2. Is the lighting in the ward adequate during the night?			
3. Do you get hot water for bathing?			
4. Is safe drinking water provided?			

5. *Are the bathrooms and toilets in the hospital adequate?*					
6. *Are the bathrooms and toilets cleanly maintained?*					
7. *Is there space for washing and drying your clothes?*					
8. *Is the ward cleaned regularly?*					
9. *Is linen changed regularly?*					
10. *Is there over-crowding in the ward?*					
11. *Are you allowed to go outside the ward regularly?*					
12. *Is there adequate space for you to walk outside the ward?*					
13. *Is there a locker facility to keep your personal belongings?*					
14. *Overall, what do you think about the basic facilities provided to you?*	**Very Poor**	**Poor**	**Good**	**Very Good**	

Kindly share with us anything else you want to about the basic facilities in the ward.

What do you think can be done to improve these facilities:

Food - ***The following questions relate to your food and diet.***	**YES**	**NO**	**COMMENT**
1. *Is the food provided to you adequate?*			
2. *Is there sufficient variety in the food provided daily? (*Is the menu changed regularly*)*			
3. *Is the quality of food served to you satisfactory?* (e.g. properly cleaned, properly cooked, tasty)			
4. *Are you satisfied with the frequency/timings of food served to you?*			
5. *Are you served special food on special occasions such as festivals?*			
6. *Are you served non-vegetarian meals if you request it?*			

7. Are the staff who serve you the food polite?					
8. Is there a separate dining area?					
9. Are facilities provided in the dining area (Table, chair etc.)?					
10. Are the utensils and dining room cleanly maintained?					
11. Overall, what do you think about the food provided and served to you?	**VERY POOR**	**POOR**	**GOOD**	**VERY GOOD**	

Kindly share with us anything else you would like to say about food and dining facilities available in the ward.

What do you think can be done to improve the food arrangements:

Personal hygiene – *The following questions relate to arrangements for personal hygiene and comfort.*	**YES**		**NO**		**COMMENT**
12. *Do you have some privacy (while bathing, using the toilet, changing clothes?)*					
13. *Are sanitary napkins provided regularly*?					
14. *Do the nursing staff/attendants provide information on proper disposal of sanitary napkins?*					
15. *If you do not have your own toilet articles, are basic toiletries provided?* (soap, comb, oil, etc.)					
16. Are you permitted to wear your own clothes if you have them?					
17. If you do not have your own clothes, are you given a choice of what to wear?					
18. Are you provided inner garments if you need them?					
19. *Is winter wear provided?* (Sweater, socks?)					
20. *Is footwear provided*?					
21. *Are basic cosmetics provided*? (powder, bindi)					
22. Overall, what do you think about the facilities available for your personal hygiene and basic comfort?	**Very Poor**	**Poor**	**Good**	**Very Good**	

Kindly share with us anything else you would like to about the facilities available for your personal hygiene/comfort in the ward.
***What do you think can be done to improve these facilities*:**

Sleeping and resting facilities. ***The following questions relate to sleeping and resting facilities in the ward/hospital***	**YES**	**NO**	**COMMENTS**
23. Is the ward quiet at night so you can sleep?			
24. Are you provided with a separate cot, mattress, pillow and blanket?			
25. Are fans provided and regularly used when it is hot?			
26. Are heaters provided and used when it is very cold?			
27. Do you have facilities to sit and rest during the day? (chairs, benches)			
28. Does the ward/hospital have bedbugs, cockroaches or mosquitoes?			
29. In the night, if you have had any serious physical or mental problem, is immediate help provided to you? (Example: breathing difficulty, stomach pain, restlessness)			

30. *Overall, what do you think about the facilities available for proper sleep and rest*	**Very poor**	**Poor**	**Good**	**Very Good**	

Kindly share with us anything else you would like to say related to the facilities for proper sleep and rest?

What do you think can be done to improve these facilities

Medication and treatment **The following questions relate to the medications you are being given.**	**YES**	**NO**	**COMMENTS**
31. Does the nursing staff help you in taking medications? (Example: reminding you when it is time for medicines and offering water)			

32. Have you been explained by the treating team why you are being given the medicines, what are the side effects that may occur?					
33. When you are being physically examined by a male doctor, has a female nurse/attendant been present always?					
34. When you have a problem (like a cold or fever, headache, menstrual problems) does someone immediately see you and attend to the problem?					
35. Overall, what do you think about the way medicines are given and your medical problems attended?	**Very poor**	**Poor**	**Good**	**Very Good**	
Kindly share with us anything else you would like to about the medical treatment provided? **What do you think can be done to improve the medical treatment?**					
Emotional Needs **The following questions relate to the way you are treated in the ward and the staff's responses to your feelings**					
36. Do the members of the treating team address you properly? (Are they respectful)					
37. Do they spend enough time and listen to you?					
38. Do they show adequate concern?					
39. When any of the doctors/counsellors/nurses speak to you, do they maintain confidentiality?					
40. Are you permitted to have your personal possessions along with you? (Ex; diary, family photos, religious articles).					
41. Do you have access to a phone in the ward?					
42. Are you permitted to receive phone calls, letters etc.)?					
43. Does the staff read your letters or listen to your phone conversations?					
44. If you wish to write a letter, does the staff provide you with the pen and paper?					
45. Overall, what do you think is the quality of care with respect to responding to your feelings and needs?	**Very poor**	**Poor**	**Good**	**Very Good**	

Kindly share with us anything else you would like to about the way in which the hospital staff treat you and respond to your feelings.

What do you think can be done to improve the way the staff treat you and respond to your feelings?

Coercion *The following questions relate to any possible bad experiences you may have had. Some of them are sensitive and may upset you. Please do not be afraid to reply. Please provide us further details if you would like to.* 46. Were you threatened / have fear because of hospital staff?	YES	**NO**	COMMENTS
Emotional Abuse: 47. Does the hospital staff hurt you by using bad words?			

Please share few emotional experiences (*if any & if you would like to*) **that made you feel bad to be in the hospital.**

(*Probe: Behaviour of the hospital staff with you or any other experiences*)

How much are you satisfied with the attention given to your emotional needs by treating team in the hospital:

What do you expect from health care providers during your stay in the hospital?

Social Needs - How much are you satisfied with:	**Very Poor**	**Poor**	**Good**	**Very Good**	**Comments**
48. Permissions to attend family functions and gatherings during your hospital stay?					
49. Group activities?					
50. Social interactions with other patients?					
51. Outdoor activities?					
52. Participation in sports/ games or cultural activities during your hospital stay?					
53. Provision of separate visiting room?					

Kindly share with us anything else you would like to related to social interactions during your stay in the hospital?

Kindly give a few suggestions to improve:

Religious Needs - How much are you satisfied with:		
54. Permission for religious activities?	**Yes/No**	**If yes, kindly share your experiences:**
55. Are you forced to practice other religious activities which you do not like?	**Yes/No**	**If yes, kindly share your experiences:**
Ethical Needs -Were are you satisfied with the following:		
56. As a patient, in the hospital, were you offered considerate and respectful care?	**Yes/No**	
57. Were you furnished with the name of the physician responsible for coordinating your care?	**Yes/No**	
58. Were you treated against your wish by the hospital?	**Yes/ No**	**If yes, kindly share your experiences:**
59. Were you informed of the medical consequences of acceptance or refusal of treatment?	**Yes/ No**	**If yes, kindly share your experiences:**
60. Are you allowed to read newspapers, magazines etc. according to your wish?	**Yes/No**	
61. Are you allowed to make health care decisions?	**Yes/No**	**If yes, kindly share your experiences:**
62. Was your hair cut without your consent?	**Yes/No**	
63. Were you permitted to represent legal matters in the court?	**Yes/No**	**If yes, kindly share your experiences:**
64. Were you restrained physically any time during hospitalization? If yes, give the details A) Were you informed about the need of restraint? B) Were you told about alternatives like chemical restraint or seclusion? C) Any staff nurse or Group 'D' official was with you while being restrained? D) If yes, female or male? E) Were you left unattended more than two hours? F) Did staff check the restraint frequently? G) Were the restraints padded? H) Were you restrained more than 24 hrs? I) Did you have any injuries?	**Yes/ No**	**Description wherever offered:**

J) Were you offered use of wash room? K) Did you receive due medication? L) Were physiological needs like water, food met? M) What was the manner of restraining (crossing leg and arm, restraining face to floor more than 3mts, etc.)? N) What was the material used for restraining (leather belts, rope etc.)? O) Describe the physical facilities of the room where restrained (lighting, toilet facilities, free from bad odour, etc.) P) Any other experiences related to restraining?		
65. Were your records made accessible to you? Are you allowed to see/access your medical records?	**Yes/No**	**Description wherever offered:**
66. Were you allowed to examine your hospital bill and receive an explanation of the charges, regardless of the source of payment of the bill? a. Do you pay hospital bill? b. Who is paying the bills? c. Do the hospital official/staffs explain about the hospital bills?	**Yes/No**	
67. Did you get the information about your rights in hospital during your admission?	**Yes/No**	
68. Have you ever felt that confidentiality is not maintained by the treating team during hospitalization?	**Yes/No**	
69. Did the treating team educate you and family members about the nature of illness, symptoms and the way to manage hallucinations and delusions, etc.	**Yes/No**	
70. Did any staff ask bribes or gifts from you?	**Yes/No**	
71. Have you felt any kind of discrimination by treating the team because of your religion or culture?	**Yes/No**	
72. Were your hobbies like drawing, painting, singing encouraged during hospital stay?	**Yes/No**	
73. Do you know where to complain if you are not satisfied with the admission procedure /care home, treatment, and attitude of the treatment team?	**Yes/No**	
74. Is informed consent taken for treatment procedures?	**Yes/No**	
75. Is informed consent taken for research?	**Yes/No**	
76. Is pre-test counselling done for HIV/other STI testing? *(To be asked only for the tested population)*	**Yes/No**	
Physical Abuse Were you ever beaten up by hospital personnel?	**Yes/No**	
77. Did any of the treatment team members make sexual advances towards you?	**Yes/No**	
What are your plans regarding discharge? (Probe: Will stay with whom, Job placement, medication supervision, etc.)		

Would you like to share anything else?

Visits by family members	YES/ NO	
Perception of support	YES/ NO	
Choice of where to return after discharge	YES/ NO	
Other post discharge plans	YES/ NO	

From Patient's perspective: Apart from medication whether you received any rehabilitation training

From Nursing/ Treating teams perspective: Why is the patient still in hospital?

Annexure2

National Commission for Women &National Institute of Mental Health and Neuro Sciences

Informed Consent Form for In-Depth Interviews of Caregivers (Family/Friend/NGO)

Title: "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An In-depth Analysis"

Information to Caregiver:

This is a study commissioned by the National Commission for Women and undertaken by the National Institute of Mental Health & Neurosciences to assess the treatment conditions of women admitted in psychiatric institutions in India and to have an in-depth understanding of issues related to their admission and discharge. This study will help in gaining understanding of various clinical, social, cultural, familial, economic and legal factors likely to affect the lives of women with mental illnesses admitted to mental hospitals in India.

Your participation in the study will help us to get a comprehensive understanding of the background and needs of women with mental illness admitted to mental hospitals. It also helps us to understand your needs and concerns as a caregiver, your satisfaction with quality care and services for your ward in the hospital, satisfaction with treatment, your understanding about her illness, your expectations from the hospital and also know your concerns, worries related to caring your family member with mental illness.

For this purpose I would be having an individual interview with you which would last for about 60 to 90 minutes**.** The information revealed will be used only for the purpose of formulating a report to improve the care of women admitted with mental illness. During the in-depth interview, if you find any question uncomfortable you are free to refuse to answer the question.

Undertaking by the Investigator:
Your participation in the study is voluntary; it does not carry monetary or material benefits there upon. You have the right to refuse consent or withdraw the same during any part of the research without giving any reason. If you have any doubts about the study please feel free to ask and clarify the same by contacting any of the investigators mentioned below if you so desire (1) Dr. Pratima Murthy, Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995274 (2)Dr. Naveen Kumar, Associate Professor, Department of Psychiatry, NIMHANS, Phone: 080-26965254 (3) Dr. Suresh Badamath, Additional Professor, Department of Psychiatry NIMHANS, Phone: 080-26965276 (4) Dr. Prabha S Chandra, Professor , Department of Psychiatry, NIMHANS, Phone: 080-26995272 (5) Dr. Srikala Bharath, Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995271 (6) Dr. Poornima Bhola, Associate Professor, Department of Clinical Psychology NIMHANS, Phone: 080-2699519 (7) Dr. Vranda M.N, Assistant Professor Department of Psychiatric Social Work, NIMHANS, Phone: 080 26995236 and (8) Dr. Sailaxmi Gandhi, Associate Professor, Department of Nursing, NIMHANS, Phone: 080 3699532.

Consent:

I have been informed about the procedures of the study. I have understood that I have the right to refuse consent or to withdraw the same at any time during the research. I am aware that **the in-depth interview will be audio recorded** by giving my consent to participate in this study. I am also aware that I will have to give the required time for the in-depth interview and this will never interfere with any benefits I might be eligible for.

I……, the undersigned, give my consent to be a participant in an in-depth interview of this research study titled "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An In-depth Analysis".

Signature of the participant
(Name and address)

Signature of the Investigator
(Name and address)

Place:

Date:

Care Giver Feed-Back on the Care Arrangements

Care Giver of Patient:	Hospital Code:	Patient Code:
Name:	Age:	Gender: F /M
Relationship to Patient:		
Duration of Care:	Months:	
Duration of Institutionalization:	Months:	

Frequency of your visits to the Hospital: Weekly / Monthly / Quarterly / Bi annual / Annual

A. In the last 12 months have you

Taken patient out of hospital on permission	: Y / N
Requested for discharge of patient and take home	: Y / N
Placed patient in a Rehabilitation Centre / Half way Home	: Y / N
Brought patient for follow-up at the hospital	: Y/ N
Supervised medication of the patient	: Y/ N
Discussed the illness of the patient with doctors	: Y / N
Discussed the illness of the patients with other family members	: Y / N
Taken patient out to family functions	: Y / N
Made attempts to send patient to work / college	: Y / N

B. In your view point what are the aspects that make Ms.---------- (Patient) continue to be in the hospital

Nature of the condition	
Patient refusing medication / follow up	: Y / N
We, family not very clear about the illness / medication	: Y / N
Doctors not being clear about the condition / medication / follow-up	: Y / N
Patient not resuming house work / work / education / training	: Y / N
Family / society reasons where we cannot take her back	: Y / N

C. Opine whether the services of the hospital in the following areas are adequate or not

Food	: Y / N NS
Hygiene (menstruation, daily self-care)	: Y / N NS
Cleanliness	: Y / N NS
Safety	: Y / N NS
General Health Care	: Y / N NS
Social Activities / Entertainment	: Y / N NS
Medication	: Y / N NS
Care by the doctors	: Y / N NS
Care by nursing staff	: Y / N NS
Care by ward- assistants	: Y / N NS
Support / working with family by the treating team	: Y / N NS

D. Any other feed-back you would like to provide

Mention any initiatives which in your view, helped your relative's improvement

Mention any Initiatives which you consider which in your view delayed your relative's improvement.

Annexure 3

National Commission for Women & National Institute of Mental Health and Neuro Sciences

Informed Consent Form for In-Depth Interviews with Service Providers

Title: "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An In-depth Analysis"

Information to Service Provider:

This is a study commissioned by the National Commission for Women and undertaken by the National Institute of Mental Health & Neurosciences to assess the treatment conditions of women admitted in psychiatric institutions in India and to have an in-depth understanding of issues related to their admission and discharge. This study will help in gaining understanding of various clinical, social, cultural, familial, economic and legal factors likely to affect the lives of women with mental illnesses admitted to mental hospitals in India.

Your participation in the study will help us to understand circumstances of women admission to mental hospital, involvement of family caregivers during and after treatment, understand the involvement/lack of involvement of family member (if any), collect information on coercion/exploitation of women admitted to the institutions, and your difficulties as service provider in rehabilitating and re-integrating such women patients to their family and community.

For this purpose, I would be having an individual interview with you which would last for about 60 to 90 minutes**.** The information given by you will be kept confidential and your identity will not be revealed to anyone. The information revealed will be used only for the purpose of the research study.

Undertaking by the Investigator:

Your participation in the study is voluntary; it does not carry monetary or material benefits there upon. You have the right to refuse consent or withdraw the same during any part of the research without giving any reason. If you have any doubts about the study please feel free to ask and clarify the same by contacting any of the investigators mentioned below if you so desire (1) Dr. Pratima Murthy, Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995274(2)Dr. Naveen Kumar, Associate Professor, Department of Psychiatry, NIMHANS, Phone:080-26965254 (3)Dr. Suresh Badamath, Additional Professor, Department of Psychiatry NIMHANS, Phone: 080-26965276 (4) Dr. Prabha S Chandra , Professor , Department of Psychiatry, NIMHANS, Phone: 080-26995272 (5) Dr. Srikala Bharath, Professor, Department of Psychiatry, NIMHANS, Phone: 080-26995271(6)Dr. Poornima Bhola, Associate Professor, Department of Clinical Psychology NIMHANS, Phone:080-2699519(7)Dr. Vranda M.N, Assistant Professor Department of Psychiatric Social Work , NIMHANS, Phone: 080-26995236 and (8) Dr. Sailaxmi Gandhi, Associate Professor, Department of Nursing, NIMHANS, Phone: 080 3699532.

Consent:

I have been informed about the procedures of the study. I have understood that I have the right to refuse consent or to withdraw the same at any time during the interview. I am also aware that I will have to give the required time for the in-depth interview and this will never interfere with any benefits I might be eligible for.

I……, the undersigned, give my consent to be a participant in the in-depth interview of this research study titled "Addressing Concerns of Women Admitted to Psychiatric Institutions in India: An In-depth Analysis".

Signature of the participant (Name and address)

Signature of the Investigator (Name and address)

Place:

Date:

NATIONAL COMMISSION FOR WOMEN&NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE

QUESTIONNAIRE FOR THE SERVICE PROVIDERS AND ADMINISTRATORS (Doctors/Clinical Psychologists/ Psychiatric Social Workers/Nurses/Resident Medical Officers/Medical Superintendents/Directors Of Mental Health Institutions)

Name of Institution:

Name of person being interviewed:

Designation:

Age:

Total years of professional experience:

No of years of experience in current institution:

Instruction: Please carry out the semi-structured interview with different service providers in the Institution. The interview is ideally carried out in a quiet environment, with little interruption. Kindly record the responses verbatim, ask for examples whenever possible. Do not settle for just yes or no responses. Ask the respondent '*Can you tell me more about that*? Or *Can you give me an example*?' In each institution, please ensure that two persons each are interviewed from the following categories:

I. (Treating doctors)-Psychiatrists
II. Other mental health care professionals (Psychologist/Psychiatric Social Worker)
III. Nurse (Psychiatric Nurse or general nurse)
IV. Administrator (Director/MS/RMO/Nursing Suptd./Matron.

The responses may be handwritten and later transcribed. Please ensure that the Institution and Respondent ID are mentioned on the front page, and that the pages are numbered.

1. Perspectives from the treating doctors

b. Diagnosis and treatment of women with psychiatric disorders who are treated in the institute as inpatients
   I. What is the most common diagnosis? Roughly, what is the percentage?
   II. What are the other diagnostic categories?
   III. What is the average duration of inpatient stay in open wards?
   IV. What kinds of treatments are employed? Please describe
c. Involvement of family members in care
   I. What is the nature of their involvement? Please describe
   II. Do they get involved in care for all patients?
      1. If not, in what proportion of patients?
      2. Why is this?
d. Attitudes/Needs of the 'caregivers'
   I. What is the general attitude of the caregivers towards their ill family member?
   II. What are the needs of the caregivers in your opinion?
   III. What aspect of care giving is the most burdensome?
   IV. How are they coping with the burden? Please give examples
   V. How are they managing the financial resources?
e. What are the specific needs of women inpatients from your point of view?
   I. Are all of them being met? Please describe with a couple of examples
   II. If not, why do you think so?
   III. What are the suggestions to ensure that their needs are met?
f. Closed ward facility (for women) in the hospital
   I. What is the bed strength?
   II. What is the bed occupancy in the closed ward generally?
   III. What is the usual duration of in-patient stay inside the closed wards?
   IV. What are the criteria used in order to shift patient to the closed ward?
      1. Request from family members? If so, what rationale would they give?

2. Unmanageable in the open ward? (for e.g.: escaping tendencies)
3. Reception orders from the courts
4. Brought by the police?
5. Any other reasons?

V. Do patients get discharged from closed wards without any hassles?
1. If difficulties are encountered in the discharge processes, what are these? Could you please enumerate and describe?
2. In the past one-year, how many closed ward patients turned chronic (staying inside the hospital more or less continuously for more than a year)?

2. Perspectives from clinical psychologist

a. What kinds of treatments are employed? Please describe
b. What are the needs of women patients from your point of view?
i. Are all of them being met? Please describe with a couple of examples
ii. If not, why is it so?
iii. What are the suggestions to change this scenario?
c. Involvement of family members in care
i. What is the nature of their involvement? Please describe
ii. Do they get involved in care for all patients?
1. If not, in what proportion of patients?
2. Why is this?
d. Attitudes/Needs of the 'caregivers'
i. What is the general attitude of the caregivers towards their ill family member?
ii. What are the needs of the caregivers in your opinion?
iii. What aspect of care giving is the most burdensome?
iv. How are they coping with the burden? Please give examples
v. How are they managing the financial resources?

3. Perspectives from the psychiatric social worker/social worker

a. What kinds of treatments are employed? Please describe
b. What are the needs of women patients from your point of view?
I. Are all of them being met? Please describe with a couple of examples
II. If not, why do you think so?
III. What are the suggestions to change this scenario?
c. Involvement of family members in care
I. What is the nature of their involvement? Please describe
II. Do they get involved in care for all patients?
1. If not, in what proportion of patients?
2. Why is this?
d. Attitudes/Needs of the 'caregivers'
I. What is the general attitude of the caregivers towards their ill family member?
II. What are the needs of the caregivers in your opinion?
III. What aspect of care giving is the most burdensome?
IV. How are they coping with the burden? Please give examples
V. How are they managing the financial resources?
e. Are there any sufficient rehabilitation homes (Govt. / Private)?
i. Do you have long stay homes(Govt./Private)- Yes/No
ii. Do you have halfway homes (Govt./Private)- Yes/No
iii. Do you have private homes (Govt./Private)- Yes/No
iv. Do you have day care center (Govt./Private)- Yes/No

4. Perspectives from the Nurses

a. What are the needs of women patients from your point of view?
I. Are all of them being met? Please describe with a couple of examples
II. If not, why is it so?
III. What are the suggestions to change this scenario?
b. Involvement of family members in care
I. What is the nature of their involvement? Please describe
II. Do they get involved in care for all patients?

1. If not, in what proportion of patients?
2. Why is this?

c. Attitudes/Needs of the 'caregivers'
   I. What is the general attitude of the caregivers towards their ill family member?
   II. What are the needs of the caregivers in your opinion?
   III. What aspect of care giving is the most burdensome?
   IV. How are they coping with the burden? Please give examples
   V. How are they managing the financial resources?
   VI. Are educational programs conducted for care givers?

5. Perspectives from the Administrators (Resident Medical Officers/ Medical Superintendents/Directors of the mental health institutions)

a. Professional human resources
   I. Do you have enough human resources to cater to all women patients?
   II. What are the needs with regards to professional human resources?
   III. If the human resource is deficient, what do you think are the reasons? How do you think, these can be improved
b. Other hospital staff
   I. Do you have enough human resources to cater to all women patients?
   II. What are the needs with regards to them?
   III. If the human resource is deficient, what do you think are the reasons? How do you think, these can be improved
   IV. Do you have continuous professional education for the staff? For Whom? Frequency?
c. Infrastructural facilities
   I. Do you think, infrastructural facilities in your institute are adequate to cater to women patients particularly?
   II. What are the lacunae?
   III. What are the reasons for the same?
   IV. How can these be improved?
d. Treatment related issues
   I. Timely, continuous and adequate supply of medications?
   II. What are the administrative hurdles in this respect?
   III. Suggestions to overcome these problems
   IV. Liaising with other medical specialties
      1. How easy or difficult is this? Please describe. Give a couple of examples
      2. Shifting patients to other hospitals?
      3. Are immediate referral services available?
      a. What are the hurdles? Availability of ambulances?
      b. Personnel to shift patients immediately?
e. Family involvement
   I. To what extent are families involved in care?
   II. What are the difficulties you encounter when dealing with families?
   III. Are educational/support groups arranged for care givers?
   IV. What have been the positive experiences with families
f. Reintegration with families/communities
   I. Is the process easy?
   II. In cases of difficulties, what are the common reasons?
   III. What do you think is the involvement of family members in caring women patients?
   IV. Who are the family members that accompany them regularly?
   V. Any other lacunae that needs attention? What needs to be done to fill in this gap?
g. Homeless mentally ill
   i. In the past one-year, how many persons without homes were treated in your hospital?
   1. Where did they come from?
   2. How many of them were reintegrated to back with their families?
   a. What difficulties you had in doing so?
   b. How many such patients (proportion/percentage) have comeback for follow-up to the hospital?
   c. How many of such patients are doing well even after one year of follow-up?
   3. Where were all other women placed? Please describe

a. What difficulties you had in doing so?
b. How many such patients (proportion/percentage) have comeback for follow-up to the hospital?
c. How many of such patients are doing well even after one year of follow-up?
4. What proportion of them become chronic inpatients (staying for more than a year at a stretch) inside your hospital?
a. What were the reasons?
b. What are the resources to place such persons?
5. Why do you think women with mental illnesses become homeless?
a. What are the needs of such patient?
b. What is the solution to this problem?

h. Budget and finances to run the institute
I. Is the process smooth and continuous?
II. Are there any particular hurdles in getting finances from the government? Please describe. Give a couple of examples
III. What are the suggestions for improvement?

i. Formalities with the court
I. What are the processes that are followed in the institute in order to obtain reception orders?
1. Does it happen quickly? Please describe
2. What are the impediments? Please describe
3. Do the doctors/mental health professionals have to go to court for obtaining reception orders?
4. How is the cooperation from the police?
5. Do police personnel respond to your requests immediately?
a. How long would they take?
b. Reasons for delay

j. In cases of alleged sexual harassment of patients, what are the procedures that are followed?
I. How frequently do you encounter such situations?
II. Lodging a police complaint?
III. Arranging for forensic examination and collection of evidence?
IV. Do patients feel any sense of difficulty in completing these formalities?
V. Is there any delay? What are the reasons for the same?
VI. Do the police co-operate?
1. Regarding this issue, in your opinion, what are the lacunae in the system?
2. How do you think, these could be overcome?

k. What kind of support do you think the government should provide
I. Dept. of Health and Family Welfare
II. Dept. of Women and Child Development
III. Dept. of Social Justice and Empowerment
IV. Other sectors like law, justice, education, labour

Name of the interviewer: _____

Date of interview: _____

1. Details of women 'placed' in different locations in the last two years and information regarding their status.

2. Information regarding women's homes (Govt. sector) in the state- regarding the nos, staffing, whether staff trained in counselling.

3. Information regarding NGOs who take in women and details thereof
(If the hospital does not have the above bits of information, they can be asked to send it later)