MENTAL HEALTH CARE IN INDIA-

OLD ASPIRATIONS……RENEWED HOPE

Report of the Technical Committee on Mental Health

Constituted by the National Human Rights Commission

to evaluate mental health services in India

Pratima Murthy

Sudhir Kumar

Nimesh Desai

Balbir Kaur Teja

With inputs from:

Dr Sumit Kumar Gupta & Dr Pankaj Kumar, IHBAS, New Delhi

Dr Anil Sisodia, IMHH Agra

Dr Naveen Kumar, Dr Suresh Badamath, Dr Soundarya S & Mr Prem, NIMHANS

Mr JS Kochher, Dr Savita Bhakre, Mr Guljeet Singh, National Human Rights Commission

Special Rapporteurs

Mr Ajay Kumar Mr Anil Pradhan	Mr KS Challam Mr Damodar Sarangi	Ms S Jalaja Prof S Narayan

LIST OF ABBREVIATIONS

AAA	Aashray Adhikar Abhiyan
AIIMS	All India Institute of Medical Sciences
BIMHAS	Bihar State Institute of Mental health and Allied Sciences
CAG	Central Advisory Group
CBO	Community Based Organization
CIP	Central Institute of Psychiatry
CMHA	Central Mental Health Authority
CMHP	Community Mental Health Programme
DHS	Directorate of Health Services
DIMHANS	Dharwad Institute of Mental Health ad Neuro Sciences
DLSA	District Legal Services Authority
DME	Directorate of Medical Education
DMHP	District Mental Health Programme
DMO	District Medical Officer
DPN	Diploma in Psychiatric Nursing
DPM	Diploma in Psychological Medicine
GH	General Hospital
GHPU	General Hospital Psychiatry Unit
GMA	Gwalior Manasik Arogyashala
GMHC	Government Mental Health Centre
GO/GOVT	Government Organization
HHMH&R	Himachal Hospital of Mental Health and Rehabilitation
HMH	Hospital for Mental Health
IC	Inspection Committee
IEC	Information, Communication, Education
IHBAS	Institute of Human Behaviour and Allied Sciences
IMH	Institute of Mental Health
IMHH	Institute of Mental Health and Hospital
IPHB	Institute of Psychiatry and Human Behaviour
LGBRIMH	LG Bordoloi Regional Institute of Mental Health
MC	Medical College
MCI	Medical Council of India
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Act
MO	Medical Officer
NA	Not Available
NALSA	National Legal Services Authority
NCPCR	National Commission for Protection of Child Rights
NCRB	National Crime Records Bureau
NCW	National Commission for Women
NDPS	Narcotic Drugs and Psychotropic Substances Act
NHRC	National Human Rights Commission
NIMHANS	National Institute of Mental Health and Neuro Sciences
NMHP	National Mental Health Programme
NR	Not Recorded
NSSO	National Sample Survey Organization
NTA	National Trust Act
PG	Post Graduate
PGIMER	Post Graduate Institute of Medical Education and Research
PIL	Public Interest Litigation
PWD	Persons with Disabilities Act
PVT	Private
RCI	Rehabilitation Council of India
RINPAS	Ranchi Institute of Neuro-Psychiatry and Allied Sciences
RMH	Regional Mental Hospital
SIMH	State Institute of Mental Health
SMHA	State Mental Health Authority
TCMH	Technical Committee on Mental Health
UG	Under Graduate
UT	Union Territory
WHO	World Health Organization

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Foreword (by NHRC)

Volume 1

NATIONAL SCENARIO

1. INTRODUCTION

Mental health problems affect all societies. Mental illnesses are significant contributors to the burden of disease. They lead to loss of quality of life, economic loss and social dysfunction, as well as cause misery to both the sufferers and their families. In some low income countries, the treatment gap for mental disorders can be higher than even 90%[1].

There are several reasons why the treatment of mental disorders has not kept in pace with the treatment for physical disorders. The major reasons include among other things, a poor understanding about mental disorders; a dichotomy between physical and mental health conditions; stigma associated with mental disorders; inability of persons with mental disorders to stake a claim for treatment and support for their condition as well as lack of support for the disability that such conditions can cause.

Understanding mental disorders

Mental disorders arise from a complex interplay between individuals and the environments in which they live. Mental disorders influence thought, feeling and behaviour. Such disorders usually occur as an interaction between biological predisposition (heredity, temperament) and environment (stress, lack of support, lack of resources, infections, trauma). Many mental disorders affect people in their early adulthood, a time when persons are optimally productive.

Severe mental disorders

Psychotic disorders like schizophrenia, other psychoses or bipolar mood disorder can impair a person's judgment and ability to carry out their day to day activities during the acute phase. Once appropriately treated, persons suffering from such disorders may either entirely recover, or have residual disability, for which they may need varying degrees of support. Just like in the case of diabetes and heart diseases, such mental disorders too may have a chronic relapsing course. Persons who suffer from such disorders need comprehensive care and support, which includes not just medical management, but appropriate individual and family counseling, as

[1] World Health Organization. Mental Health Atlas 2014. WHO 2015.ISBN 978 92 4 156501.

well as a range of support systems including rehabilitation, social support, welfare measures, crisis intervention and legal support when necessary. Treatment consists not just of acute treatment, but appropriate rehabilitative measures to improve quality of life, productivity and return to as complete a life as possible with adequate support. Care givers of persons with mental disorders also undergo tremendous hardships, financial, emotional as well as social and need adequate support. Care giver support is crucial in India, where care is still largely provided by families.

Common mental disorders

Depression, anxiety and other common mental disorders are increasing all over the world and produce significant distress and disability. Factors that increase vulnerability to common mental disorders include poverty, insecurity, social change or changing lifestyles, illiteracy, gender, familial risk and physical illness[2].

Substance abuse and addiction

The abuse of alcohol and other drugs is associated with significant physical, behavioural, emotional and memory problems. In many countries, substance use disorders have become a serious public health problem[3]. While substance use disorders were considered in the past to be largely an adult male problem, substance use problems have now extended in many countries to children and adolescents, women and the elderly, and result in both individual and societal harm.

[2] Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bulletin of the World Health Organization 2003, 81 (8):609-615.

[3] World Health Organization. WHO's role, mandate and activities to counter the world drug problem: A public health perspective

The interface between psychological distress, mental and physical illness

A diagnosis of mental disorder is generally based on a cluster of symptoms and duration (these diagnoses are based on standard classificatory systems like the World Health Organization International Classification of Diseases-ICD or the American Psychiatric Association Diagnostic and Statistical Manual-DSM).

Psychological distress

There are many persons in the community who may be suffering from significant psychological distress, including anxiety, restlessness, nervousness, sadness, easy fatigue and worthlessness.

Psychological distress and physical illness

Studies suggest that such conditions of significant psychological distress are associated with higher age adjusted death rates for each of the three leading causes of death (heart disease, cancer/malignant tumors, and assaults/ accidents/unintentional poisonings) compared to those without serious psychological distress.

The role of mental illness and psychological distress as a risk factor for physical illness is increasingly being recognized.[4] The relationship between psychological distress and physical illness is bidirectional.

Suicides

It is estimated that every 40 seconds, there is one completed suicide globally and many more attempted suicides[5]. An estimated 804 000 suicide deaths occurred worldwide in 2012, representing an annual global age-standardized suicide rate of 11.4 per 100 000 population.
In India, during 2012, 1,35,445 persons are reported to have lost their lives due to suicide.[6] There has been an increase of 22.7% of reported suicides compared to the previous decade.

[4] Murthy P, Bharath S, Narayanan G, Soundarya S. Integrating mental health care and non-communicable disorders. Background document to the Gulbenkian NIMHANS Symposium on Integrating mental health care and non-communicable disorders, NIMHANS, Bangalore, November 2015.
[5] World Health Organization. Preventing suicide: a global imperative. WHO 2014. ISBN 978 92 4 156477 9
[6] National Crime Record Bureau. Suicides in India 2014. www.ncrb.nic.in/CD-ADSI-2012/suicides-11.pdf

Table 1. National Crime Record Bureau- Suicides in India

States with Higher Percentage Share of Suicides during 2012 to 2014

Sl. No.	Year					
	2012		2013		2014	
1	Tamil Nadu	(14.0%)	Maharashtra	(12.3%)	Maharashtra	(12.4%)
2	Maharashtra	(13.4%)	Tamil Nadu	(12.3%)	Tamil Nadu	(12.2%)
3	Andhra Pradesh	(11.8%)	Andhra Pradesh	(10.8%)	West Bengal	(10.9%)
4	Karnataka	(10.6%)	West Bengal	(9.7%)	Karnataka	(8.3%)
5	Madhya Pradesh	(8.1%)	Karnataka	(8.4%)	Telangana	(7.3%)

Among Union Territories, Delhi reports the highest number of suicides annually, followed by Puducherry (for 2012). Family problems and ill-health are the most commonly cited reasons for suicide. The problem of suicides among farmers has raised serious questions in recent times.[7]

It is a myth that people who talk about suicide do not mean to do it. People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option[8].

Risk factors for suicide can broadly be classified as health and societal (easy means to suicide, lack of prompt health care, sensationalization and stigma); community and relationship factors (war, stresses of acculturation, discrimination, isolation, abuse, violence and interpersonal conflict); individual factors including past suicidal attempt, family history of suicide, mental disorder, alcohol and drug abuse, financial loss and chronic physical problems[9].

Many of the risk factors for suicide are potentially preventable.

[7] Indian Express. India's suicide problem. www.images.indianexpress.com/2015/07/farmer2.jpg
[8] WHO 2014 ibid
[9] WHO 2014 *op cit*

Prevalence of Mental Disorders in India

Mental disorders are associated with tremendous distress both for the sufferer and the carer and can produce significant disability especially when not treated in a timely manner. Studies examining the prevalence and patterns of mental disorders in the last few decades from different parts of the country have generally yielded very variable figures- this is because of differences in the sampling, the populations studied, differences in definition of disorder and the 'case-ness' (whether there are enough symptoms for a valid diagnosis). Attempts have been made to study and synthesize these findings in a meaningful manner, in order to serve as an information system in order to plan services. The table below presents an illustrative example of studies that have attempted to estimate the problem based on the 2001 census.

The first meta-analysis formed part of the burden of disease in India report commissioned by the National Commission on Macroeconomics and Heath in 2005. This Report considered a prevalence of 65/1000 based on two earlier meta-analytical (systematic review of original studies) studies[10]. Other publications refer to special populations like children and the elderly, or problems in special settings like prisons.

[10] Gururaj G, Girish N, Isaac MK. Mental, neurological and substance use disorders: strategies towards a systems approach. NCMH Background Papers-Burden of disease in India. Ministry of Health and Family Welfare, New Delhi.

Table 2. Prevalence of Mental Disorders in India

	Prevalence/1000		Percentage		
	Gururaj et al 2005[11]	Badamath & Srinivasaraju 2010[12]	Gururaj et al 2005	Badamath & Srinivasaraju 2010	Others/ Comments
Any mental disorder	65	190-200	6.5%	20%	An earlier meta-analysis by Reddy and Chandrashekar[13] revealed a prevalence of 58.2/1000 (5.8%)
Schizophrenia	3	5-10	0.3%	1%	
Mood disorders	16	15-30	0.3%	1%	Data from Pondicherry revealed a lifetime prevalence of 9% and 12 month prevalence of 4.5% of major depressive episode[14]
Common mental disorder	20	20-30	2%	3%	
Alcohol use	60		0.6%		Among adult men, nearly one third drink alcohol as per the NFHS 3[15]
Alcohol dependence	10	30-40	0.1%	4%	
Cannabis use	8	5-10	0.8%	1%	
Opioid use	2	1-3	0.2%	0.3%	
Mental Retardation	1	5-6	0.1%	0.6%	
Children and adolescents- mental disorders	43	110-120	4.3%	12%	A recent meta-analysis suggests a community prevalence of 6.46% of mental health morbidity among children[16]
Geriatric mental disorders	3	25-30	0.3%	3%	
Dementia	2	2-5	0.2%	0.5%	

[11] Gururaj et al ibid. The figures were derived based on meta-analysis carried out by Reddy and Chandrashekar and Ganguly

[12] Badamath S and Srinivasaraju R. Indian psychiatric epidemiological studies: learning from the past. Indian J Psychiatry 2010;52:S95-103.

[13] Reddy VM, Chandrashekar CR. Prevalence of mental and behavioural disorders in India: a meta-analysis. Indian J Psychiatry, 1998, 40 (2): 149-57.

[14] Bromet E, Andrade LH, Hwang I et al. Cross-national epidemiology of DSM-IV major depressive episode. BMC Medicine 2011, 9:90.

[15] National Family Household Survey-3. Tuberculosis and lifestyle. 2005-06.www. rchiips.org/nfhs/NFHS.../PPT/NFHS-3%20TB%20and%20Lifestyle.ppt.

[16] Malhotra S and Patra BN. Prevalence of child and adolescent psychiatric disorders in India: a systematic review and meta-analysis

The Macroeconomic Report (2005) calculated the numbers of persons with mental illness in 2001 as 67 million, increasing to 70 million in 2005, projected to be 76 million in 2010 and to 81 million by 2015.

An official document of the Ministry of Health Government of India, in 2002, provided approximate numbers of persons suffering from mental disorders across the States of India (Table 3). This has been calculated at 6 % (major and minor mental disorders). The National Mental Survey[17] has been initiated to provide a direct estimate of mental disorders in the country. It is presently underway and the National Institute of Mental Health and Neuro Sciences is co-ordinating this activity. A pilot study carried out in the Kolar District of Karnataka in 2014 suggests a crude prevalence of 6.6% for the entire population and 7.5% among adults.

[17] National Mental Health Survey. Findings from the pilot study carried out in Kolar. National Institute of Mental Health and Neuro Sciences, Bangalore.

Table 3. Mental Health Case Load in India (2002)

ICD-10 Code F10 -F99

S. No.	State	Population @	Density/Sq. Km. $	Estimated Case Load # Mental Disorders	
				Major	Minor
	1	**2**	**3**	**4**	**5**
1	Andhra Pradesh	75727541	275	757275	3766375
2	Arunachal Pradesh	1091117	13	10911	54555
3	Assam	26638407	340	266384	1331720
4	Bihar	82878796	880	828787	4143935
5	Chhattishgarh	20795956	154	207959	1049795
6	Goa	1343998	363	13439	77195
7	Gujarat	50596992	258	505969	2529845
8	Haryana	21082989	477	210829	1054145
9	Himachal Pradesh	6077248	109	60772	303860
10	Jharkhand	26909428	338	269094	1345470
11	Jammu & Kashmir	10069917	99	100699	503495
12	Karnatka	52733958	275	527339	2636695
13	Kerala	31838619	819	318386	1591930
14	Madhya Pradesh	60388118	196	603881	3019405
15	Maharashtra	96752247	314	967522	4837610
16	Manipur	2388634	107	23886	119430
17	Meghalya	2306069	103	23060	115300
18	Mizoram	891058	93	8910	44550
19	Nagaland	1988636	120	19886	99430
20	Odisha	36706920	236	367069	1835345
21	Punjab	24289296	482	242892	1114460
22	Rajsthan	56473122	165	564731	2823655
23	Sikkim	540493	78	5404	27020
24	Tamil Nadu	62110839	478	621108	3105540
25	Tripura	3191168	304	31911	159555
26	Uttarakhand	8479562	159	84795	423975
27	Uttat pradesh	166052859	689	1660528	8302640
28	West Bengal	80221171	904	802211	4011055
29	A & N islands	356265	43	3562	18810
30	Chandigarh	900914	7903	9009	45045
31	Daman & Diu, Dadra & Nagar Haveli	158059, 220451	1411, 449	3785	18925
32	Delhi	13782976	9294	137829	689145
33	Lakshdweep	60595	1894	605	3025
34	Puducherry	973829	2029	9738	48690
	Total			**10270165**	**51251625**

Notes

@ The population figures haven been taken from the Census of India-2001 as published in Provisional Population Totals (Registar General Census Commissioner, India).

$ Population density per sqare Kilometre together with geographical terrain is a useful input in planning deployment of mental health resources.

 # Case-load in respect to major mental disorders has been calculated at the rate of 1% of the population and that of minor mental disorders at the rate of 5 % of population .

Information related to infrastructure is available in Chapter IV

Source: National Survey of Mental Health Resources carried out by the Directorate General of Health Services, Minisitry of Health and Family Welfare, Government of India, during May and July 2002 and published in Mental Health An Indian Perspective 1946-2003 DteGHS/MOHFW/GOI.

Mental health problems along a developmental continuum

At each developmental stage[18], there can be varying problems that affect thinking, feeling and behaviour.

Mental disorders among children and adolescents

Among children and adolescents, studies from high-income countries suggest that more than a quarter may meet lifetime criteria for a mental disorder. A recent review of studies (meta-analysis) carried out in India among the child population suggested that 6.5 % of the community samples and 23.3% of school samples reported mental health morbidity. [19] Given that 41% of India's 1.2 billion population is below 18 years of age[20], this translates to 3,17,83,200 children and adolescents with mental health morbidity. Substance use among children and adolescents is increasingly being recognized and causes attributed apart from biological vulnerability include poverty, illiteracy, lack of a caring family, peer influence and stress[21].

Intellectual subnormality (or mental retardation) is **NOT** a mental disorder, but can be associated with mental problems. It is characterized by sub-normal intellectual functioning, and deficits in the area of communication, self-care, social skills and variable capacity for independent living. According to the NSS 58th round (2002)[22], the number of persons with mental retardation is 94/100000. There are many preventable causes for intellectual subnormality, including birth trauma, maternal infections, thyroid deficiency and so on.

[18] Murthy P et al, ibid
[19] Malhotra S, Patra BN. ibid
[20] Census of India. www.censusindia.gov.in/Census_And_You/age_structure_and_marital_status.aspx
[21] National Commission for Protection of Child Rights (NCPCR). Assessment of pattern, profile and correlates of substance use among children in India 2013. www.ncpcr.gov.in/view_file.php?fid=17.
[22] National Sample Survey Organisation. Disabled persons in India. NSS 58th round. www.mospi.nic.in/rept%20_%20pubn/485_final.pdf

The elderly and mental illness

Mental illness in the elderly can begin anew, or continue from adulthood. Brain degeneration, metabolic problems, infection as well as hereditary predisposition are biological factors responsible for mental disorders in the elderly. In addition, physical illness as well as psychosocial factors like isolation, financial difficulties and poverty, lack of support and poor access to treatment can also lead to increased mental morbidity among the elderly. With increasing life expectancy in India, the elderly population is likely to grow. Migration of children to other parts of the country or abroad has left many elderly without immediate help and support. Cases of elderly neglect and maltreatment are not uncommon[23]. A study from rural Lucknow[24] estimates that nearly one in four older adults has one or more mental disorders. Mood disorders were the commonest, followed by mild cognitive impairment, followed by mental disorders due to substance abuse and dementia. Substance use is an important and increasingly recognized problem among older adults.[25]

Gender and Mental Disorders

Gender is a critical determinant of mental health and mental illness[26]. Gender differences have been reported in the age of onset of symptoms, clinical features, frequency of psychotic symptoms, course, social adjustment, and long-term outcome of severe mental disorder. Social factors and gender specific factors determine the prevalence and course of mental disorders in female sufferers. Women outnumber men as far as completed suicides are concerned in India, compared to other parts of the world[27]. Social factors like abandonment by marital families, homelessness, vulnerability to sexual abuse, domestic violence and stigma has major implications for causation, treatment seeking and outcome of mental disorders among women.

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[23] Helpage India. Elderly abuse in India. Country Report for the WHO. Soneja S (Ed) http://www.who.int/ageing/projects/elder_abuse/alc_ea_ind.pdf

[24] Tiwari SC, Srivastava G, Tripathi RK, Pandey NM, Agarwal GG, Pandey S, Tiwari S. Prevalence of psychiatric morbidity amongst the community dwelling rural older adults in northern India. Indian J Med Res 138, October 2013, pp 504-514

[25] Nadkarni A, Murthy P, Chrome I, Rao R. Alcohol use and alcohol-use disorders among older adults in India: a literature review. Aging & Mental Health 2013, 17(8):979-91.

[26] Malhotra S and Shah R. Women and mental health in India: an overview. Indian J Psychiatry 2015; 57(Suppl 2:S205-S211)

[27] Rao V. Suicidology: The Indian context. In: Agarwal SP, editor.Mental Health: An Indian Perspective 1946-2003. New Delhi: Directorate General of Health Services/Ministry of Health and Family Welfare Nirman Bhawan; 2004. pp. 279–84.

Apart from stigma, the dearth of appropriate government community-based services, and a lack of awareness about disability and available services among family members and persons with disabilities make those with psychosocial or intellectual disabilities especially vulnerable to institutionalization[28].

Women partners of men who use substances have high amounts of psychological distress and the needs of women as carers are often neglected.[29] The abuse of drugs and alcohol among women is also growing and needs attention.

Mental disorders in other special populations

It is well known that there is a higher prevalence of mental disorders in settings like prisons and other restrictive settings. In a study carried out by NIMHANS[30], 79.6% of the 5200 prisoners systematically interviewed in the Central Prison, Bangalore, showed evidence of mental illness or substance use morbidity. In a small study carried out among 50 residents of a destitute home[31], 42 (84%) were found to be suffering from a psychiatric disorder.

Homeless mentally ill

It is estimated that 1 % of the population in India is homeless[32]. A significant percentage of the homeless are likely to have mental health problems.

The Banyan, an NGO based in Tamil Nadu, has been rescuing destitute women for the last 16 years. They have rescued more than 1500 women from the streets, provided them shelter and rehabilitation and empowered them to move on. They run the Adaikalam Project (that rescues destitute women), provide urban and rural mental health services, have a community living

[28] Human Rights Watch. Treated worse than animals. Abuses against girls with psychosocial or intellectual disabilities in institutions in India. www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual.

[29] UNODC. Women and drug use in India. Women, substance and high-risk assessment study. Murthy P (Ed). www. http://www.unodc.org/documents/southasia/reports/UNODC_Book_Women_and_Drug_Use_in_India_2008.pdf

[30] Badamath S, Murthy P, Parthasarathy R, Naveen Kumar C, Madhusudan S. Mental health and substance abuse problems in prison: local lessons for national action. NIMHANS and KSLSA. NIMHANS Publication No 98.ISBN 81-86430-00-8.

[31] Nayak RB, Patil S, Patil N, Chate SS, Koparde VA. Psychiatric morbidity among inmates of center for destitute: a cross-sectional study. J Sci Soc 2015; 42:92-4.

[32] Mander H. Living Rough Surviving City Streets. A Study of Homeless Populations in Delhi, Chennai, Patna and Madurai - For the Planning Commission of India. www.planningcommission.nic.in/reports/sereport/ser/ser_rough.pdf.].

project and through the Banyan Academy of Leadership in Mental Health (BALM) offer networking and stakeholder development in the sector through education and training.

The Institute of Human Behaviour and Allied Science (IHBAS), along with the Aashray Adhikar Abhiyan (AAA) and the National Commission for Women)[33] carried out a situation analysis of Homeless Women in Delhi. The study found a large number of migrants among the homeless women. They had high levels of psychological distress. Homeless mentally ill women did not receive any treatment. The findings highlighted the need for making treatment and rehabilitation services available to this vulnerable population.

IHBAS, along with the AAA and the Delhi Legal Services Authority launched a joint initiative for the treatment of the severely mentally ill homeless[34] using a multidisciplinary approach which included social support, legal sanction and medical management. The project demonstrated that health services could be taken beyond formal institutional health care systems to the street for people who could not access these systems.

The response to mental disorders

Two broad streams of responses can be discerned among the following with respect to development of responses to address the problems of mental illness.

1. The National Mental Health Programme and its evolution over subsequent decades.
2. Attempts to improve institutional care and expand mental health care outside mental institutions.
3. Other initiatives which show potential for replication and adoption at a national level.
4. Current status

[33] IHBAS, AAA and NCW. Situation analysis of Homeless Women in Delhi with special reference to mental health and psychosocial aspects. Study Report for NCW 2008A

[34] IHBAS, AAA and DLSA. Treatment of homeless persons with severe mental illness. Making a difference. Desai NG, Kaur P, Menon A, Shivalkar R, Kumar P, Kumar S, Yadav A (Eds) Report of Pilot Phase (2009-2010).

Although mental health care began mostly in institutional settings, and it would be historically accurate to have discussed institutional care before community care, since community care has been highlighted both internationally and nationally as the most desirable, most accessible, affordable and least restrictive form of mental health care, the order of discussion is reversed. However, it must be emphasized that this does not undermine the importance of specialized mental health institutions in service delivery, training, research and policy formulations, especially among those which have traditionally been planned as therapeutic institutions offering holistic care (an example is the Mysore Government Mental Hospital that later became NIMHANS) or those that began as custodial centres but have been completely transformed to a specialized institute providing quality care, engaging with the community and promoting mental health services for vulnerable sections like the homeless mentally ill (an example is IHBAS)

Development and expansion of the DMHP

1985- Bellary model

1996-97 in four districts – one district each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu

1997-98 –states of Arunachal Pradesh, Haryana, Himachal Pradesh, Punjab, Madhya Pradesh, Maharashtra and Uttar Pradesh.

1998-99- expanded to one district each in the States of Kerala, West Bengal, Gujarat and Goa and the union territory of Daman & Diu

1999-2000 – expanded to Mizoram, Manipur, Delhi and union territory of Chandigarh

2000-2001- Tripura and Sikkim

By 2002 – Covered 27 districts

2002-2007 (10th Plan)- Extended to 100 districts

In 11th plan, implemented in 123 districts

Currently, coverage is in less than one-third of the districts in the country

Community Mental Health Care and the National Mental Health Programme

In 1982, India was one of the first countries in the developing world to formulate a National Mental Health Programme (NMHP). Local experiences of organizing mental health care through the existing primary/peripheral health care structure in Raipur Rani[35] and Sakalwara[36] provided the

[35] Wig NN, Murthy SR, Harding TW. A model for rural psychiatric services- Raipur Rani Experience. Indian J Psychiatry 1981;23:275-90

background to develop the NMHP. The NMHP was launched in 1982, one of the first in the low income countries of the world that advocated integration of mental health into primary health care, a theme that has re-emerged in the global context[37].

There have been several reviews of the NMHP and community mental health initiatives in India[38,39,40,41].

The main objectives of the NMHP were to:

- Ensure the availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population
- To encourage the application of mental health knowledge in general health care and social development
- To promote community participation in mental health service development and stimulate efforts towards self-help in the community.

Decentralization of the programme was to occur through the District Mental Health Programme. A model DMHP was initiated by NIMHANS and popularly known as the Bellary District Mental Health model in 1985.

In 1996, a budgetary provision of 270 million was made under the 8th 5 year plan to initiate the DMHP, in order to provide community based mental health services in the country at the Primary Health Centre with the help of trained medical officers and referrals to the psychiatrist

[36] Chandrashekar CR, Issac MK, Kapur RL, Parthasarathy R. Management of priority mental disorders in the community. Indian J Psychiatry 1981;23:174-8

[37] Isaac M. Introduction. In Community Mental Health in India. Sidana A et al (Eds).Jaypee Publications 2012

[38] Murthy RS. Mental health initiatives in India (1947-2010). National Medical Journal of India 2011;24 (2): 98-107.

[39] Isaac M. National Mental Health Programme: Time for reappraisal. In Kulhara P et al "Themes and Issues in Contemporary Indian Psychiatry" New Delhi, Indian Psychiatric Society, 2011.

[40] Van Ginneken N, Jain S, Patel V, Berridge V. The development of mental health services within primary care in India: learning from oral history. Int J Ment Health Syst. 2014; 8: 30

[41] Goel DS. Why mental health services in low- and middle-income countries are under-resourced, underperforming: an Indian perspective.Natl Med J India. 2011 Mar-Apr; 24(2):94-7.

for severe mental disorders. The DMHP thus became a centrally funded programme under the NMHP. It was launched in 4 districts in the 9th 5 year plan, it was expanded to 27 districts.

The DMHP was restrategised in the 10th 5 year plan (2002) to include school mental health programmes, suicide prevention, and development of IEC materials, with a financial outlay of Rs 1.9 billion.

In the 11th 5 year plan (2007), the DMHP was re-invigorated with a financial outlay of Rs 10 billion. It was expanded to 123 districts. In this plan, a scheme to expand manpower was devised. Through this, under Scheme A, it was proposed to establish 11 Centres of Excellence in the field of mental health by upgrading/strengthening existing mental hospitals/institutes. There was provision to increase human resources (add 44 psychiatrists, 176 clinical psychologists, 176 psychiatric social workers and 220 psychiatric nurses annually through this scheme). Under Scheme B, it was proposed to strengthen 30 departments of psychiatry, psychology, psychiatric social work and psychiatric nursing with an addition of 60 psychiatrists, 240 clinical psychologists, 240 psychiatric social workers and 600 psychiatric nurses. The Schemes were to augment mental health human resources by 1756 additional professionals each year. In addition, psychiatric departments of medical colleges/general hospital were to be upgraded and state run mental hospitals to be upgraded. It was proposed to integrate the NMHP with the NRHM and to add further components to the DMHP (life skills training, counseling in schools and colleges, workplace stress management and suicide prevention services). Research, IEC, NGO and public-private partnerships and monitoring/implementation/evaluation were other areas given impetus.

However, across the successive plans, central funding consistently reduced at least by half because of under-spending and this led to the NMHP losing credibility with the Planning Commission.[42] There has been both appreciation and criticism of the DMHPs. Where they have been successful, there has been positive impact in terms of the progressive thinking and aims.

A survey of 20 of the 123 DMHP sites by the Indian Council of Marketing Research in 2009[43] attributed partial success of the DMHP in terms of decentralization from mental hospitals and

[42] Van Ginnekin et al, ibid

[43] Indian Council of Marketing Research. Evaluation of District Mental health Programme - Final Report, 2009, Report submitted to Ministry of Health and Family Welfare, Government of India, New Delhi, 2009

medical colleges at least to the district if not the primary health care level and partial integration with general health care. Only 25% of DMHPs had regular inflow of medication, and a similar number received counseling services. Awareness of mental illness was higher in the DMHP implemented districts compared to control districts where DMHP was not implemented. Problems in staff recruitment and training, poor retention and inadequate focus on IEC were attributed to administrative delays.

Apart from the above review, there have been other reviews and critiques of the DMHP as well[44], [45]including a report from NIMHANS in 2003, a paper based on oral narratives and the observations of the Mental Health Policy Group[46]. The Mental Health Policy Group, set up to provide recommendations for the 12th five year plan, through its various regional reviews concluded that mental health services were not integrated in most places and services, if any, were provided only at the District Hospital.

Critique of the DMHP

The drawbacks of the DMHP in its various avatars from the time of inception as highlighted by different experts/researchers are summarized below:

- Inadequate and inconsistent leadership at central, state and district levels
- Political neglect
- Inaccessible funding
- Improper implementation (including poor training, motivation and retention of staff)
- Top-down approach
- Overburdened PHC doctors
- Over-medicalisation and lack of counseling and other psychosocial interventions
- Lack of networking with tertiary care centres
- Lack of technical support and hand holding of the DMHP teams

[44] Patel V, Copeland J. The great push for mental health: why it matters in India. Indian J Med Res 2011 134 (4):407-409.

[45] Jadhav, S, Jain,S. Pills that swallow policy: clinical ethnography of a Community Mental Health Program in northern India. Transcultural Psychiatry, 2009; 46:60-85.

[46] Mental Health Policy Group. XIIth Plan District Mental Health Programme. Prepared by Policy Group.29th June 2012

- Lack of integration with other treatments and interventions in the community
- Non-existence of linkages with other sectors (social welfare, employment etc)
- Poor family and community engagement
- Lack of sufficiently motivated staff and attrition due to the lure of the private sector
- System weaknesses (lack of indicators, lack of scope for corrective action, lack of accountability
- Major bureaucratic hurdles in fund flow and management
- Low rates of mental illness recognition (20-40%) by PHC doctors
- Training manuals too complex and inadequate coverage of stress and positive mental health
- Lack of engagement of the private sector

At the end, still a good thing

Despite all these drawbacks the benefits of the DMHP were realized and one recommendation of the ICMR research report was "*that implementation of DMHP has resulted in availability of basic mental health services at district / sub-district level. As such it is recommended to expand this programme to other districts of the country".* The general perception is that where the DMHP has been effectively run, there have been rich dividends. However, the progress is slow, and the positive changes eclipsed by the numerous systemic and administrative problems. Various experts have observed that the programme has ensured wider availability of essential psychotropic medication. The DMHP is now accepted as a relative low-cost, high-yield public health intervention which is doable, as shown in states such as Kerala and Gujarat"[47].

Mental Health Policy Group Recommendations

The recommendations of the Mental Health Policy Group included:

- Proper training and handholding by centres of excellence and expert institutions and groups
- Have a client-centred approach with psychosocial counseling in a befriending environment that supports and promotes a state of overall well-being

[47] Goel DS, Agarwal S.P, Ichhpujani RL et al. Mental Health 2003: The Indian scene. In Agarwaal S.P, Goel D.S, Ichhpujani R.L, et al (eds); Mental Health- An Indian perspective (1946-2003). New Delhi: Elsevier.

- Engage users and caregivers in the process of recovery
- Ensure the availability of appropriate medication
- To delineate the roles of team members, provide adequate training and ensure greater co-ordination between team members as well as other health/welfare teams
- To develop a continuum of services that include rehabilitation, long-term care etc
- To focus on the needs of vulnerable groups like women, children, elderly, homeless, migrants, persons living in strife prone areas
- Develop clear protocols of intervention at each location
- To build a clear monitoring and evaluation plan with scope for midcourse correction
- To constitute a Technical advisory team.

National Mental Health Policy for India

The first National Mental Health Policy for India document was released in October 2014. The document titled New Pathways, New Hope recommends a strategic, integrated and holistic policy to mental health. The vision of the policy is 'to promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and de-segregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span, within a rights-based framework. The fundamental values and principles representing the ethos of the policy are listed as Equity, Justice, Integrated Care, Evidence-based Care, Quality, Participatory and Rights-based approaches, proper Governance and Effective Delivery, Value-based Training and Teaching Programmes and a Holistic Approach to mental health. The Goals are to reduce distress, disability, exclusion, morbidity and premature mortality associated with mental health problems across the life span; enhance understanding of mental health; to strengthen leadership in the mental health sector at the national, state and district levels. Objectives listed include provision of universal access to mental health care; increase access to and utilization of comprehensive mental health services by persons with mental health problems; increase access to mental health services by vulnerable groups; reduce prevalence and risk factors associated with mental health problems; reduce risk of suicide and attempted suicide; ensure respect for rights and protection from harm of persons with mental health problems, reduce stigma, enhance availability and equitable distribution of skilled human resources for mental health;

progressively increase finance allocation and improve utilization for mental health promotion and care; identify social, biological and psychological determinants of mental health problems and provide appropriate interventions. The policy document also emphasizes cross cutting issues such as stigma, poverty, vulnerable groups including the homeless, persons in custodial institutions, orphans, children, elderly, internally displaced persons, persons affected by emergencies and disasters and other marginalized populations. It recommends adequate provision of funds, support to families, inter-sectoral co-ordination, research, monitoring and evaluation, and building research capacity. The document emphasizes mental health promotion, universal access to mental health services and community participation for mental health and development.

There is a mention of an action plan 365, but this is neither available in the public domain nor was available on request.

Ministry initiatives to restrategise the DMHPs

Through a series of regional workshops, the Ministry itself brought together various stakeholders to disseminate the revised guidelines of the NMHP between 2011-2012. Revisions were discussed based on the various problems encountered.

Problems identified	Responses
1. Multiplicity of administrative bodies 2. Shortage of manpower 3. Problems of fund flow 4. Poor communication between different levels 5. Sluggish response from states for NMHP schemes 6. Lack of standardization for training, schemes 7. Poor staff pay scales 8. Inadequate understanding of roles and responsibilities among staff 9. Insufficient funds for drugs and travel	1. Issue of revised guidelines 2. States to submit UCs and SOEs promptly 3. Nodal officer to co-ordinate between various administrative bodies and intimate programme division at centre of unresolved issues 4. All general health professionals to be trained for mental health care because of mental health human resource shortage 5. Training of trainers at Centres of Excellence 6. Share IEC materials with each other 7. Full time additional director for mental health 8. Develop a data base for DMHP 9. Clear guidelines for IEC and training with separate budgets 10. Separate travel budgets 11. Nodal officer to use internet facility to monitor

10. Delay in submission of UCs, SOEs 11. Lack of monitoring mechanisms 12. Lack of coordination between NMHPs and SMHAs	distant districts

While the Policy Group recommended the appointment of community mental health care workers, it has not been resolved if the NCD counselors (appointed under the NCD Programme) could address similar tasks.

Institutional Care of the Mentally Ill

Institutional care of the mentally ill, which was the mainstay for treatment has been extensively reviewed elsewhere.[48,49,50,51]

Living conditions in the old mental hospitals came under scrutiny repeatedly, particularly with reference to their custodial and restrictive nature, more like jails than therapeutic facilities, and common occurrence of human rights violations.

Concerns from Without, from Within

There were several reports on the specific problems in the mental health care, including the Bengal Enquiry in 1818, Investigation into the state of 'native lunatics' in West Bengal[+] (1840) and the reports of Dr Edwin Mapother of 1938* and Moore Taylor in 1940[#](reviewed in the NHRC reports of 1998 and 2008[52,53]. Issues raised from these early reports are all too familiar.

[48] Sharma S, Varma LP. History of mental hospitals in Indian subcontinent. Indian J Psychiatry.1984;26: 295–300.
[49] National Human Rights Commission. Quality Assurance in Mental Health. Channabasavanna SM, Isaac M, Chandrashekar CR, Varghese M, Murthy P, Rao K, Reddamma K, Sekar K, Shetty S, Murali T (Eds) NHRC 1998, New Delhi
[50] Sharma S. Psychiatry, colonialism and Indian civilization: A historical appraisal. Indian J Psychiatry.2006; 48:109–12.
[51] DGHS, MOHFW, Govt of India. Mental Health-An Indian Perspective 1946-2003. Agarwal SP (Ed).Elsevier 2004. ISBN 81-8147-195-4 (PB)
[52] NHRC ibid
[53] National Human Rights Commission. Mental Health Care and Human Rights. Nagaraja DN, Murthy P (Eds) NHRC 2008, New Delhi

They can be summarized as follows:

- Very poor living conditions in the asylums[+] *
- Rudeness of Staff[+]
- Inadequate diet[+]
- Need for humane care and handling of unmanageable patients[+]
- Avoidance of unnecessary coercion[+]
- Need for occupational avenues and rehabilitation[+]*[#]
- Need to reduce duration of admission*
- Need to increase voluntary admissions* (concerns regarding corruption once legal scrutiny was reduced)
- Need for visiting committees*
- Adequate beds and specialized services*
- Psychiatric services in government hospitals*
- Improvement in undergraduate training in psychiatry*[#]
- Advanced training for teachers and researchers*
- Need for well-trained staff particularly nurses and social workers*[#]
- Organised occupation for patients*/need for a systematic plan of work and diversional therapy[#]
- Need for qualified psychiatrists to lead mental hospitals[#]
- Post-graduate training courses with emphasis on prevention[#]
- Mental hospitals to be teaching institutions and attached to medical colleges[#]
- Need for a mental health services, with adequate pay and service conditions for staff[#]
- Special homes for persons with mental illness having physical problems (current day co-morbidity) [#]
- More outdoor clinics[#]
- Greater integration of psychiatry with other medical specialties[#]

It is worth recalling the advice of Moore Taylor to the Government in 1940: " *This is a suitable time for Government to take stock, overhaul resources and rechart the course for the next 30 years*". He also suggested that goodwill needed to be created about mental hospitals by letting the community know that the services people needed would be easily obtainable and that people would be glad they had come to take what the institute had to offer.

Similar concerns echoed from within.

Prior to independence, the Bhore Committee[54] in 1946 had expressed concerns about serious deficiencies in mental health care in India. It emphasized the need to develop trained manpower and was instrumental in the setting up of the All India Institute of Mental Health. The Committee, with a large number of experienced international advisers, stressed on the need for universal health care and the need to address social determinants of disease. The Mudaliar Committee in 1962[55] envisaged the development of psychiatric units in all district hospitals in the next ten years.

Over three decades beginning in the 1960's, medical superintendents periodically met to discuss ways of improving living conditions and facilities in the hospital, need for comprehensive care including emergency and outpatient services, need for specialized services for children and elderly, alcohol and drug problems, criminals with mental illness and the need for training of the staff and proper role delineation. They argued for a bigger role of the hospitals in teaching and training. They spoke about the need for expansion of general hospital psychiatry units and development of psychiatric facilities in the community. They emphasized the need for undergraduate and post graduate training and refresher training in undergraduate and postgraduate psychiatry and other mental health disciplines.

Nothing really happened.

It has never been adequately discussed as to why these recommendations were not heeded. Low priority for mental health care in India, lack of support from the Centre and State, low autonomy and decision making power invested with the medical superintendents appear to be some of the reasons underlying the inertia.

This is also true of the early days of the NMHP. Though it was formulated in 1982 and the demonstration district programme in Bellary was initiated in 1985, it was not until 1996 that the DMHP was formally initiated and expanded to a small number of districts. Again, it would be useful to do some soul-searching on whether it was the programme itself that was the

[54] Bhore Committee Report. 1946. www.nhp.gov.in/bhore-committee-1946_pg
[55] Health Survey and Planning Committee (Mudaliar Committee) Report. 1962. http://www.nhp.gov.in/mudaliar-committee-1962_pg

problem or whether the problems were more systemic in nature. There certainly has been some change since then and it is important to examine the causes and directions of such change.

Winds of Change

The role of the judiciary has been reviewed in two earlier publications of the NHRC.[56,57] Only a summary is provided here.

Three decades of judicial activism

The early PILs seeking intervention of the Supreme Court heralded three decades of judicial activism[58].

One of the earliest cases of public interest litigation was reported as that of Hussainara Khatoon (I) v. State of Bihar[59,60]. This highlighted the plight of undertrial prisoners in Bihar. Many of them had been in jail for longer periods than the maximum permissible sentences for the offences for which they had been charged. Another PIL (Veena Sethi vs State of Bihar in 1982) dealt with prisoners who had recovered from mental illness but continued to languish in jail.

Another PIL which continues to produce dividends for mental health care is the Dr Upendra Baxi Vs State of UP and Ors. This pertained to the inhuman treatment of 'inmates' of a protection home in Agra and their right to live a life of dignity enshrined in Article 21 of the Constitution. By 1991 (order dated 29-4-1991), the Supreme Court had dealt with and dismissed the petition after directing the District Judge from Agra to monitor the Home. However, as the Home continued to malfunction, the Supreme Court handed over the monitoring of the home to the National Human Rights Commission, which had statutory powers

[56] NHRC 2008 ibid
[57] National Human Rights Commission. Care and treatment in mental health institutions. NHRC 2012. New Delhi.
[58] Murthy P and D Nagaraja. Judicial interventions and NHRC initiatives in mental health care. In Mental Health Care and Human Rights, NHRC 2008, New Delhi.
[59] (1980) 1 SCC 81;

[60] Upendra Baxi, 'The Supreme Court under trial: Undertrials and the Supreme Court', (1980) Supreme Court Cases (Journal section), at p. 35

under Protection of Human Rights Act, 1993. The current effort at directing the states to submit affidavits regarding their mental health care situation stems from this case, which is still active.

A set of PILs by BR Kapoor & others vs Union of India (1983) regarding the Shahdara Mental Hospital led to the formation of the Institute of Human Behaviour and Allied Sciences, IHBAS.

In a public interest litigation (Sheila Barse & Ors Vs the Union of India and Ors 1986) before the Supreme Court, Sheila Barse questioned the practice of keeping children with physical and mental retardation and abandoned children in jails 'for safe custody'. The judgment read, '*We were extremely pained and anguished that these children should be kept in jail instead of being properly looked after, given adequate medical treatment and imparted training in various skills which would make them independent and self-reliant'.*

In 1993 (Sheila Barse Vs Union of India and others), the Apex Court observed that the admission of mentally ill persons to jails was illegal and unconstitutional. The Court called upon the State of West Bengal to furnish the list of all persons with mental illness detained in the jails. Dissatisfied with the response, the Apex Court appointed a committee to carry out a detailed evaluation of this population and formulate guidelines for the care of the 'non-criminal lunatics' languishing in jails (Unlocking the Padlock, RS Murthy and A Dhanda). This report highlighted the problems in jails- lack of human resources, lack of supervision of care, absence of mental health professionals and adequate treatment services. This led to a direction from the Supreme Court that detention of non-criminal mentally ill in prisons was in contravention to Articles 21 and 22 of the Constitution. One of the outcomes of this initiative was a growth in the number of NGOs working in West Bengal with the mentally ill.

Supreme Court – Some observations with respect to Mental Health Care (pre-2000)

'*Right to a speedy trial, a fundamental right, is implied in the guarantee of life and personal liberty enshrined in Article 21 of the Constitution*' (with respect to criminally mentally ill)- Hussainara Khatoon Vs home Secretary Bihar 1983

Shahdara Mental Hospital in Delhi to be modeled on the lines of NIMHANS – BR Kapoor & others Vs Union of India and others 1983

'*Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized stereotyped and bureaucratic approach to mental health issues'* – Chandan Kumar Bhanik Vs State of West Bengal (1988)

Admission of non-criminal mentally ill persons to jails is illegal and unconstitutional. Speedy psychiatric help must be available in jails. A mental health team must be available in mental hospitals. (Sheela Barse Vs Union of India and others (1993)

The mentally ill have a Right to food, water, personal hygiene, sanitation, recreation which is an extension of the right to life as in Article 21. Quality norms and standards in mental health are non-negotiable. Treatment, teaching, training and research must be integrated to produce the desired results. Obligation of the State in providing undiluted care and attention to mentally ill persons is fundamental to the recognition of their human rights and is irreversible (Rakesh Chandra Narayan Vs State of Bihar 1986)

Initiatives of the National Human Rights Commission

The contribution of the NHRC to mental health care policy development, service delivery and oversight in the last three decades have been highlighted in earlier publications.[61,62,63]

Following the Rakesh Chandra Narayan Vs State of Bihar case, the Apex Court gave the responsibility of monitoring the mental hospitals at Agra, Ranchi and Gwalior to the NHRC from 11.11.1997.

[61] NHRC 1998 ibid
[62] NHRC 2008 ibid
[63] NHRC 2012 ibid

Monitoring of Mental Hospitals at Agra, Ranchi and Gwalior

Under Section 12 of the Protection of Human Rights Act, the NHRC is mandated to visit any jail or other institution under the control of the State Government where persons are detained or lodged for purposes of treatment, reformation or protection. The NHRC has followed 'a totally open, transparent and participatory style of monitoring the pace and progress of activities in the mental hospitals it was initially assigned keeping the human rights dimension uppermost'. It has used monitoring as 'a tool of correction and promotion of human rights of the mentally ill persons'.

Quality Assurance in Mental Health

The NHRC proactively took up the Quality Assurance in Mental Health initiative in 1997, where in collaboration with NIMHANS, a detailed evaluation of the status of mental health in the country was undertaken. This included obtaining information on a pre-designed proforma from 37 mental hospitals throughout the country, personal visits to 33 mental hospitals, visits to 7 private psychiatric institutions and proforma information from 27 General Hospital Psychiatric Units.

The review of mental hospitals revealed that physical infrastructure and living arrangements were inadequate in most hospitals. Patients' rights with respect to privacy and dignity were grossly violated. Hospitals did not have adequate number of professional staff. Medical management was the mainstay of intervention, with psychosocial treatments almost absent. Policy makers, professionals and users were not aware of human rights related issues. Overall, mental health care in the mental hospitals was custodial rather than therapeutic.

Recommendations made in that review included immediate abolition of cells, downsizing of very large mental hospitals to improve administration, conversion of closed to open wards, greater focus on voluntary admissions, streamlining of admission and discharge procedures, upgradation of investigation facilities, regular training of staff, adequate living and dining

facilities for patients, adequate diet, choice of clothing (not uniforms), developing recreational, occupational and rehabilitation facilities, including day care.

Advisory Groups

Many of the mental hospitals received visits from the NHRC Special Rapporteurs to monitor change.

Central Advisory Group

The NHRC constituted a Central Advisory Group to guide strategy for mental health. The CAG included Secretaries of Health, Social Justice and Empowerment, Senior advocates of the Supreme Court. A sub-committee headed by a member of the Commission with representation from the Ministries of Social Justice and Empowerment and Women and Child Development to advise on steps to be taken for rehabilitation.

Core group on mental health

In 2003-04, the Commission constituted a core group on mental health.

The NHRC has dialogued with the Medical Council of India to increase the number of seats in psychiatry to augment human resources. During 2007-2008, a series of recommendations were made by the core group. This included the need to address the basic needs of persons with mental illness, ensure their access to disability benefits, among other recommendations.

Operation Oasis- Partnering with SEVAC and other initiatives

In 2003-04, 300 mentally ill prisoners were identified and treated in the jails. Persons in 'vagrant homes' were also screened and a significant number found to have mental illness.

The NHRC prepared a video documentary highlighting various needs for comprehensive care of persons with mental illness in hospitals.

For the rehabilitation of persons with mental illness, the NHRC assisted the launching of the project Maitri, by Action Aid.

Review of Mental Health Care

In 2008, the NHRC, in collaboration with NIMHANS carried out a review of mental health care. A decade after the Quality Assurance initiative, an attempt was made to assess the changes in functioning of the government mental hospitals in the country through a questionnaire assessment, review of the Central Government's intermediate report on mental hospitals, as well as review of the reports of the Special Rapporteurs.

The 2008 review showed positive changes (reduction in court admissions, improved structural facilities and living conditions, improved diet, improved facilities for recreation and rehabilitation, greater collaboration with NGOs, greater frequency of community level activities and improved budgetary allocation. However there continued to be area of poor progress (inadequate staff, many newly created posts vacant, psychosocial interventions still inadequate, many hospitals still having closed ward structures and lack of postgraduate training. Hospitals which were monitored by the Special Rapporteurs showed greater improvements in their amenities than those that were not being monitored.

Enhancement of human resources in mental health

During 2008-2009, the NHRC dialogued with the Medical Council of India and the Ministry of Health and Family Welfare to address the human resource shortage. The MCI was asked to relax its standards from the 1:1 (Professor student ratio) to 1:2 to increase the number of specialists in Psychiatry. The MCI incorporated this recommendation in its amendment in the Post-Graduate Medical Association Regulation 2000 under Clause 12 (1), (2) and (3). As per this amendment, the ratio of PG teachers to students would be 1:2 for professors and associate professors. The MBBS curriculum has also been revised by the MCI as per NHRC recommendation and teaching hours of psychiatry have been enhanced from 20 to 40 hours and questions in psychiatry have been made compulsory in the theory paper of medicine. Clinical posting in psychiatry has been increased from 2 weeks to 4 weeks. Internal assessment in psychiatry has been made mandatory for the final examination. 15 days of posting during

internship is mandatory. The MCI has also taken other steps to ensure that MBBS doctors are trained on various psychiatric issues.

The NHRC when approached, has facilitated the approval of post-graduate courses in psychiatry, psychology, psychiatric social work, psychiatric nursing at the IMHH Agra by interacting with the Agra University,

Regional Meetings

The NHRC, in collaboration with the National Law School of India Bangalore and NIMHANS, organized a National Conference on Mental Health and Human Rights during 2008-2009. Thereafter, five regional review meetings on mental health were held during 2009-2011 and the recommendations were shared with all the stakeholders. Significant recommendations included the need to delegate powers to the heads of institutions and a need to ensure availability of medicines to the patients.

Other initiatives

Other initiatives of the NHRC have included:

Monitoring of mentally ill persons languishing in prison

- On 7.2.2000, the Commission sent a letter to the Chief Ministers of the state to direct senior prison officers to inspect prisons regularly to ensure that mentally ill are not kept untreated in prisons. This led to a considerable decrease of mentally ill persons languishing in various jails.
- In 2004-2005, the NHRC intervened in the case of 72 year old Charanjeet Singh who was detained in jail for nearly 20 years as his mental condition did not permit him to stand on trial. The NHRC moved a CWP No 1278/04 before the High Court of Delhi to squash his trial. Following this, the Commission prepared a set of guidelines for the protection of rights persons with mental illness in jails and on the basis of this, the Delhi High Court quashed the charge-sheet against Charnjeet Singh

- In the case of Anil Kumar Burman, who had been languishing in the Tezpur Mental Hospital for 33 years, the Commission ordered for his immediate release and payment of monetary relief of Rs 3 lakhs by the State Government.

Monitoring of mentally ill kept in chains

- In 2000-2001, a Committee was constituted to examine the plight of mentally ill persons kept in chains at the Sultan Alayudeen Dargah of Goripalyam near Madurai. Based on the report of the Committee, the NHRC directed the Government of Tamil Nadu to implement the recommendations and send a compliance report.
- In 2001-2002, the NHRC directed the Chief Secretaries/Administrators of all the States/Union Territories to certify that no mentally ill patients are chained/kept in captivity.

Formulating guidelines on reporting deaths in mental hospitals

In 2003-2004, the NHRC formulated guidelines on reporting deaths that occurred in mental hospitals.

The Erwadi Tragedy and further interventions

The concerns raised in the 1998 Quality Assurance Report of the NHRC/NIMHANS really saw the light of day only following the 2001 Erwadi tragedy, where 26 mentally ill persons who were chained in a dargah tragically died in a fire accident. The Supreme Court took suo moto notice of the incident and issued notices to the Union of India and the State of Tamil Nadu (Writ petition (Civil) No. 334 of 2001). The Apex Court directed the Union Government to conduct a survey on an all-India basis to identify registered and unregistered facilities and check if the NHRC recommendations had been followed. PILs were filed by Saarthak[64], a Delhi-based NGO on calling for a ban on direct ECTs; by ACMI, an advocacy organization for families of mentally ill persons calling for the representation of carers in decisions regarding the mentally ill.

[64] http://www.wbhealth.gov.in/mental/Acts_Rules/Judgements.pdf

The Amicas Curae appointed by the Court provided the information that the MHA1987 is not at all implemented by the concerned authorities and there is failure on the part of Central / State Govts. to implement the 1987 MHA. The Court additionally ordered that the Chief Secretary co-ordinate the implementation of the MHA. The Court directed at this time that a mental hospital was to be set up in each state/UT. The Court also directed that 2 members of the legal aid board visit the mental hospitals. Explanation of rights to patients and formulation of the board of visitors were other directives from the Court. It was also directed that a scheme of rehabilitation be envisaged.

In its affidavit the Government requested the Supreme Court to review its directions regarding setting up of new mental hospitals as such a step was counter to the current scientific thinking. It mentioned uniform rules for public and private sector institutions and the development of norms for NGOs. The Government had set up committees to review norms for NGOs as well as for the care of the homeless mentally ill. The corrective ways planned by the Government to tide over the major shortage of trained manpower were to reduce the duration of hospitalization, involve families in patient care, develop community care and have the training of mental health professionals.

In response to the PIL to look at the quality of care in the mental hospitals, the Government pointed out in the affidavit that sufficient amount was earmarked for the aforesaid purposes, but states had not utilized the same for the benefit of these hospitals and the welfare of the inmates.

Thus, both the Dr Upendra Baxi and the Erwadi PILs have continued to be landmarks in mental health care in India and continue to influence judicial interventions to improve mental health services in India.

Mentally ill in religious centres

In 2012, the NHRC's attention was drawn by an NGO SEVAC to mentally ill persons languishing at the Chamatkari Hanumanji temple in the Chindwara district of Madhya Pradesh. Both belief in the curative powers of the deity and helplessness on account of lack of access to services led people to be brought here and more than often, dumped here. The NHRC carried out a pilot project with the NGO concerned to bring about awareness about mental illness and make treatment available near the temple. A team from NIMHANS visited the temple and based on their suggestions, the district authorities were asked to create a proper treatment facility for such persons. At a meeting organized by the NHRC, the Union Health Ministry, the Government of Madhya Pradesh and the NGO it was decided that the State Government would post a psychiatrist in the district to visit the civil hospital at Sausar, provide free medicines to the clinic, train the doctors in the nearby hospital to treat persons with mental illness, include the medicines in the State list of essential drugs. The State was to monitor the sanitary and health conditions of persons staying on the temple premises. The 108 ambulance service was extended to Chindwara. The Union Health Ministry was to include Chindwara under the DMHP and establish a psychiatric clinic at Sausar under the NRHM.
This is a potential example of a GO/NGO collaboration.

It would not be wrong to say that the role of governance in mental health has become a mandate that is being fulfilled more by the Courts rather than by Governments.

Public Health Based Approaches

Desai[65] stresses that attention should be paid to social issues such as poverty, homelessness, violence, urbanization, homeless populations, refugees, disaster affected populations, as also the health issues of the affluent classes, in order to evolve a truly public health model for the treatment of mental illness.

[65] Desai NG. Public mental health: An evolving imperative. Indian J Psychiatry 2006;48:135-7.

Urban Mental Health Needs

A research evaluation using multiple research methods carried out to study urban mental health care in 2002 in Delhi, Chennai and Lucknow [66] indicated the uneven availability of mental health services and human resource deficits (especially non-medical mental health professionals) and huge treatment gaps in mental health care (82% to 96%). This study found that the average service load in the specialist mental health services is largely carried by the Govt. sector (half to two thirds), followed by the private sector (one third to half), with only a small portion by the NGO sector. The average mental health service load in the primary care general health services is largely carried by the private sector, with significant contribution from the non-formal service providers. Barriers to service access include lack of awareness, stigma, financial difficulties, distance, negligence of service providers and lack of support. Lack of hygiene and long waits in government hospitals were cited as barriers in key informant interviews.

The role of legislation

Mental health legislation has an important role to play in the protection of human rights. Legislation must strike a fine balance between the individual's rights to liberty and dignity, and society's need for protection.[67]

The various provisions under the law for mental health have been summarized in the NHRC 2008 publication.[68] Major legislations have been the Mental Health Act (1987), Rehabilitation Council of India Act (RCI 1992), the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 (PWD 1995), the Juvenile Justice (Care and Protection of Children) Act (JJA 2015), National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act (NTA 1999), Protection of Women from Domestic Violence Act (DMV 2005). The Narcotic Drugs and Psychotropic Substances Act (NDPS 1985) is a legislation that largely addresses prosecution for the possession, supply and

[66] Desai NG, Tiwari SC, Nambi S, Shah B, Singh RA, Kumar D et al. Urban mental health services in India: how complete or incomplete. Indian J Psychiatry 2004, 46(3)194-212

[67] Pathare S. Beyond ECT: Priorities in mental health care in India. Issues in Medical Ethics, [11;1] January - March 2003

[68] Badamath S and Nagaraja D.Mental health legislation: an Indian perspective. In Mental Health and Human Rights. Nagaraja D and Murthy P (Eds), NHRC 2008.

manufacture of narcotics and psychotropic substances but has a provision for addicted persons to be diverted to treatment.

With an increasing recognition that health care including mental health care is a universal right, there is an expectation that the legal framework will now focus its attention to improving access to mental health care in community settings.

UNCRPD

India ratified the UN Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007. The Convention has been in force since May 2008. In order to be compliant with the Convention, the Right to Persons with Disabilities Bill 2014 was introduced to replace the PWD Act of 1995. This seeks to confer several rights and entitlements to disabled persons, guardianship for persons with mental illness and other issues to fulfill India's obligations under the international treaty. The Bill has been introduced in the Rajya Sabha in 2015.

Mental Health Care Bill

The Mental Health Care Bill was introduced in the Rajya Sabha on Nov 20, 2013. Salient features of the Bill include Rights of Persons with mental illness (to access good quality mental health care and treatment from services run and funded by government. protection from inhuman and degrading treatment, free legal services, access to medical records and right to complain; Advance directives (living wills by persons with mental disorders regarding their future treatment); Responsibilities of Central and State Mental Health Authorities; Registration of mental health establishments; Mental Health Review Commission and Board; De-criminalization of suicide; abolition of direct ECTs.

Legal Aid

The National Legal Services Authority (NALSA) has a provision for legal services to the mentally ill persons and persons with mental disabilities in its scheme launched in 2010, to provide legal

services to a neglected group of citizens namely mentally ill persons and mentally retarded persons including those who suffer from autism and cerebral palsy

A free Legal Aid Clinic, an innovative and a novel service was launched in collaboration with the Karnataka State Legal Services Authority on January 15, 2011 at NIMHANS.[69] Such initiatives have now been launched in other states.

[69] Math SB, Naveen KC, Harish T. Legal aid in hospital: an innovative approach. Indian J Med Res 137, March 2013, pp 440-441

1981 continuing

In the context of the Dr Upendra Baxi Vs State of Uttar Pradesh and Others, the Supreme Court has continued to issue appropriate directions from time to time to ensure that the provisions enshrined in Article 21 of the Constitution are meaningfully made available to persons with mental illness. Apart from the focus on the protection home in Agra and the involvement of the NHRC in supervising the mental hospitals at Agra, Ranchi and Gwalior, the Supreme Court had further directed the NHRC to monitor the mental health institutions/system in the country and had advised that it could be approached again, if directions were needed in the matter.

On the basis of this order, the NHRC again approached the Supreme Court seeking directions to deal with and overcome the deficiencies in the mental health care system in the country still persisting despite its interventions (CRLMP No of 2013 in Writ Petition (Crl) No 1900 of 1981.

The Union Ministry of Health had expressed its limitations in further improvement of mental health care in the country, stating that Health was a State subject. This appears to be a fallacy as mental illness and deficiency appear as a subject in the Concurrent List of the Constitution of India[70]. It also indicated that it had made financial outlays and made greater financial resources available for mental health care and it was up to State Governments to utilize these opportunities.

The Supreme Court's more recent interventions have thus focused on monitoring the implementation of the National Mental Health Programme/District Mental Health Programme directly with the States/UTs across the country, through this writ petition and other PILs.

[70] Constitution of India, Concurrent list. **List-III** (Seventh Schedule). Item 16.

Affidavits on the status of mental health services in each state

Following the regional meetings held by NHRC in 2009-2011, a set of questionnaires were prepared by NIMHANS on assessing at a state level the problem and responses to mental problems and the resources available in the state. This included a consolidated state level questionnaire, a questionnaire for psychiatric institutions in the state (both government and private), a questionnaire for medical college departments of psychiatry and general hospital psychiatry units, a questionnaire for NGOs and a questionnaire for the District Mental Health Programme. The questionnaires were suitably modified by the NHRC and made available to the Supreme Court.

The Supreme Court directed the States to file the responses to these questionnaires in the form of an affidavit in 2014/2015. Mr Harish Salve was appointed as Amicas Curae to facilitate this process. The State Counsels were asked to facilitate this process.

Technical Committee on Mental Health

In order to 'appraise the Hon'ble Supreme Court regarding the deficiencies prevailing in the area of mental health care in the country and with the objective to seek suitable directions for the concerned State Governments for taking suitable remedial action', the NHRC had filed a petition before the Supreme Court (CRLMP No 8032/2013) in WP (Crl) No 1900 of 1981. Dr Upendra Baxi Vs State of UP and Others and National Human Rights Commission. This sought the Apex Court to obtain detailed responses based on the questionnaire prepared by the NHRC. In order to examine the information received from the states in the form of sworn affidavits, in its order dated 23 March 2015, the NHRC constituted a Technical Committee on Mental Health with the following as Members: Dr Pratima Murthy, Professor of Psychiatry, NIMHANS, Dr Sudhir Kumar, Director and Professor of Psychiatry, IMHH Agra, Dr Nimesh Desai, Director and Professor of Psychiatry, IHBAS and Dr Balbir Kaur Teja, Consultant, National Human Rights Commission.

The Terms of Reference of the Technical Committee were the following:

a) To examine the state of mental health care infrastructure in all the States/UTs on the basis of information provided by them in response to the NHRC questionnaire and identify the gaps/shortcomings in the same if any
b) To give specific and actionable suggestions about improvement in the mental health care infrastructure in the States/UTs so that the gaps and inadequacies which have been brought out are covered/taken care of
c) To guide the Commission and the Supreme Court about the status of Implementation of the National Mental Health Programme and the District Mental Health Programme in different States and Union Territories

Two additional terms of reference were added later.

In a subsequent order (Order dated 9/4/2015 CRLMP No 8032 and 5325/2014, CRLMP No 9354/2014 in Writ Petition (Criminal) No 1900/1981), the Supreme Court directed that the Committee constituted by the NHRC should verify all the data given by the State/UT and forward the report to the Court.

Special Rapporteurs

In November 2014, the NHRC had also identified Special Rapporteurs to verify the facts as stated in the State Affidavits in response to the Union Ministry of Health and Family Welfare's stated helplessness in improving mental health care at the state level. The Rapporteurs were asked to:

1. Ensure that the questionnaire was filled and submitted by the States to the NHRC
2. Interact with the State Health Secretary/Nominee to discuss mental health care in the state including resources/gaps/challenges/innovations/way ahead
3. Interact with at least one psychiatric institution in the government sector and one in the private sector to understand issues related to functioning/resources available/resource utilization/improvement/deterioration over the last decade with respect to infrastructure, amenities and facilities, financial/administrative issues, diet, investigations and treatment, staffing and training, supportive services, recreation and

rehabilitation, other areas (community programmes, disability benefits, mental health extension care in prisons and other detention settings.

4. Interact with some users/families to understand the benefits of the service/accessibility and affordability with an emphasis on medication, psychosocial care, emergency care, disability benefits, rehabilitation and other needs.
5. Visit a General Hospital Dept of Psychiatry and evaluate its ability to handle emergencies, investigations, medication, psychosocial interventions and the training level of staff
6. Visit a DMHP site
7. Interact with an NGO representative

The Special Rapporteurs included Shri Ajay Kumar, Shri Anil Pradhan, Dr KS Challam, Dr Damodar Sarangi, Smt S Jalaja and Shri S Narayan.

Inspection of Mental Hospitals

In an order dated 09.04.2015 and 21.04.2015 (WP (Crl) No 1900/1981 and Criminal Miscellaneous Petition No 8032 of 2013 – Dr Upendra Baxi Vs State of Uttar Pradesh and others, the Supreme Court called on the Secretary, Ministry of Home Affairs and Secretary, Ministry of Health and Family Welfare as respondents to carry out a physical verification of the actual state of affairs existing in different mental health institutions across the states. The Secretary in turn constituted a joint Inspection Committee (hereinafter referred to as the Inspection Committee or IC) was constituted under the chairmanship of the Joint Secretary, Ministry of Health and Family Welfare, and included two eminent psychiatrists from the State, the State Health Secretary, the SMHA, a representative of the State Human Rights Commission and State Legal Services Authority.

A checklist/proforma was prepared by the Ministry of Health and Family Welfare, Government of India for the verification of the mental health institutes (Annexure 1) and sent out ahead of physical verification visits by the Inspection Committee.

Expanded mandate of the Technical Committee

The Technical Committee on Mental Health (TCMH) were given two additional mandates- to incorporate the report of the Special Rapporteurs as well as the detailed reports of the Inspection Committee.

3. METHODOLOGY AND SOURCES

Meeting at the NHRC

The Technical Committee Members attended meetings at the NHRC New Delhi on 16 and 17 April 2015, 1 and 2 May 2015, 25 and 26 May 2015, 30 and 21 July 2015, September 2 and 3 2015. The three Psychiatrist members of the team each undertook the responsibility of compiling state reports with the help of faculty and staff from their respective institutions. The NHRC member in the TC undertook the responsibility of summarizing the reports of the Special Rapporteurs.

The meetings were also attended by Shri JS Kochher, Joint Secretary, Training and Research, NHRC, Dr Savita Bhakre, Joint Director, Research, NHRC and Mr Guljeet Singh, Research Assistant, NHRC.

The TC carried out the following activities both face to face and via email:

1. Scrutiny of the affidavits submitted by the State Governments
2. Identification of prominent lacunae in the information provided
3. Communication to the NHRC and the Counsel regarding these lacunae and request for information
4. Direct communication with a few state representatives for supplementary information
5. Request for information from some of the Central Institutions that had not figured in the State Report

6. Tabulation of the Questionnaires [State level questionnaire, Appendix 1. Information pertaining to current structure and functioning of psychiatric hospitals (Government and Private); Appendix 2. General Hospital Unit/District hospital and Medical College Departments; Appendix 3. Information pertaining to NGOs; Appendix 4. Information pertaining to the DMHP]
7. Consolidation of the Questionnaire information
8. Review of developments in mental health care in India and WHO recommendations in the last 3 decades
9. Review of the initiatives of the NHRC
10. Review of the directives of the Supreme Court in the last 3 decades
11. Preparation of the State Level Reports
12. Preparation and Review of the Consolidated Report

Organization of the Report

The Report is organized in two volumes.

Volume 1 presents the consolidated report of all the States/UT and affords a comparison and changing trends. It also provides the overall summary and recommendations of the Technical Committee.

Volume 2 contains the individual reports of the States/UTs based largely on the affidavits submitted to the Hon'ble Supreme Court. It also contains Special Rapporteur comments and the observations of the Inspection Committee where relevant.

There may be some discrepancy in figures between Volume 1 and Volume 2. This is because some of the figures may have been updated in Volume 1, if received or collated later.

4. REPORT ON THE STATUS OF MENTAL HEALTH CARE

In this section, the consolidated findings of the state level questionnaires, which are logically the summary statements of the 4 appendix questionnaires is first reported.

State Level Information

In the State Government Reports, reports of the Central Psychiatric Institution reports were invariably missing. The Technical Committee had to specifically request for reports from NIMHANS, Bangalore, PGI, Chandigarh, AIIMS, New Delhi, LGBRIMH, Tezpur.

Table 4. Completeness of Information in the Affidavit

State	Completeness	Areas Inadequate	State	Completeness	Areas Inadequate
Andaman and Nicobar	Deficient	Lack of information data on treatment seeking as well as details of psychiatric services available	Lakshadweep	Mostly Complete	Limited Services
Andhra Pradesh	Deficient	Information from GHPUs, medical colleges, NGOs not available; No adequate information on service utilization	Madhya Pradesh	Partially complete	Problem assessment, DMHP
Arunachal Pradesh	Partially Complete	Information from District hospital, DMHP	Maharashtra	Partially complete	Problem assessment, DMHP
Assam	Partially Complete	Details outside of the mental institute (GHPUs, MC not provided. DMHP details not provided	Manipur	Partially complete	Medical College and not all the General Hospitals
Bihar	Partially Complete	Information from Medical Colleges, District hospitals, DMHP details	Meghalaya	Mostly complete	
Chandigarh	Mostly Complete		Mizoram	Deficient	Hardly any details provided
Chattisgarh	Partially Complete	Data from Medical Colleges and DMHP	Nagaland	Partially complete	General and District Hospital, community services, DMHP

Dadra and Nager Haveli	Partially Complete	Limited facilities	Odisha	Deficient	No information on the DMHP
Daman and Diu	Deficient	Details are inadequate- Unclear if facilities are limited	Puducherry	Partially complete	Inadequate for medical college departments and DMHP details
Delhi	Mostly Complete		Punjab	Partially complete	Information on psychiatric institutions deficient; information from MCs and GHs not complete. No figures from DMHP
Goa	Partially complete	Variation in figs of affidavit submitted on 6/8/2015 and 13/10/2015. Several areas of information not available	Rajasthan	Partially complete	No information on GH, community facilities, private facilities, NGOs
Gujarat	Mostly Complete		Sikkim	Mostly Complete	
Haryana	Deficient	Deficient in many areas	Tamil Nadu	Partially complete	Summary of human resource development facilities inadequate, data on patients from MCs, GH, Dt hospitals
Himachal Pradesh	Partially Complete	Says report awaited in many places	Telengana	Deficient	Information on GH was not provided initially, inadequate consolidation of overall state information
Jammu and Kashmir	Deficient	Information provided mostly for Jammu region	Tripura	Deficient	In all areas
Jharkhand	Deficient	Very little information apart from one single psychiatric facility	Uttarakhand	Partially complete	No information from medical colleges, district hospitals and DMHP
Karnataka	Deficient	No information on private psychiatric facilities, Govt Medical College Depts, NGOs; Information on DMHP inadequate	Uttar Pradesh	Partially complete	Information on patients seen at MCs, GHs, DHs. Better information of DMHPs

Kerala	Partially complete	No information on private psychiatric facilities. Partial information on medical college depts., GHPUs, and Dt hospitals	West Bengal	Partially complete	Information on private psychiatric facilities and Medical College depts. Deficient, no information on NGOs, no information on DMHPs

The TCMH initially rated the completeness of the information as Complete/Partially Complete/Deficient. However, even in the states initially rated as complete, there were deficiencies. Therefore, the ratings were re-categorised as Mostly Complete, Partially Complete/Deficient. Deficiency of information is startling for some states/UT. A case in point is Daman and Diu. Being a small UT, where hardly any information has been provided with respect to mental health care.

In some states, the state level information did not consolidate the information provided in the annexures. Thus the number of patients seen does not total the number seen in government institutions and medical college departments. Where available, an attempt has been made to add the numbers to provide a more comprehensive picture. It is evident that such information has not been adequately collated in many states.

The dictum that has been followed is that what has not been documented has not been done.

It is evident that many states do not readily have the information on parameters related to mental health. The idea of having a detailed questionnaire on the problem and response to mental health was to stimulate the states to start thinking of mental health services, so that they could have a blueprint on which to plan the development of comprehensive care.

This has succeeded to some extent.

In states where the information has been mostly complete, a concerted effort has been made to obtain such information. This is to be commended.

For the data provided, some states have calculated numbers with mental illness based on epidemiological data (prevalence)/ others have summed up the numbers seen in psychiatric

care. It is important to keep the two distinct. If no figures are provided for prevalence, we could generate prevalence estimates based on standard sources for severe mental disorders, common mental disorders, and substance use disorders, as well as for women, children and elderly.

While it is recognised that this data may not exist, the idea is raise the state's consciousness that unless such data gathering is systematised (made part of a systematic recording), we will not be able to effectively plan services].

For some states, the Mental Health Survey may throw up figures in the future.

In states where the information is deficient, it is a matter of concern that no effort has been made to collect and collate the data. One can assume that the priority to mental health is low. But if a directive from the Apex Court in the country and a sworn affidavit can still not shake off the lethargy and swing the system into action, one wonders what else can.

As earlier mentioned, in the initial State Government Reports, the Central Institution reports were invariably missing. The Technical Committee had to specifically request for reports from NIMHANS, Bangalore, PGIMER, Chandigarh, and, LGBRIMH, Tezpur. While there are differences in the funding mechanisms and mandates of these centres, as far as mental health care is concerned, these centres do contribute in a significant part to the health care delivery in the state. Hence, it is important that future State Reports should take cognizance of including the contribution of these centres to mental health care in the state.

Basic Information

Based on various reviews, the prevalence of mental illness was calculated at 7%. Some states have calculated much lower prevalence and others a much higher prevalence. It is important to have an idea of the prevalence and numbers required to treat in order to plan services appropriately.

Table 5 . Basic information about the state and approximate estimates of mental illness

Name of State	Area in KM^2	Population	Population male	Population female	No of persons with mental illness in the state noted in affidavit	Source of information quoted in the affidavit	Approximate No of persons with mental illness in the state (calculated at 7% of the population)	No of new cases registered in Outpatient	% with mental Illness registered during the year in psychiatric services (of the 7%)
Andaman and Nicobar	8249	379944	202330	177614	30000	7.9% of the population as per affidavit	26596	NR	0.73%
Andhra Pradesh	160205	49300000	24730000	24600000	NR		3451000	4728 (18672)	0.14% (0.54%)
Arunachal Pradesh	83743	1382611	720227	662379	852*	Patients seen at one centre	96783	704	0.73%
Assam	78438	31205576	15939443	15266133	Not specified		2184390	18494	0.85%
Bihar	94163	104099452	54278157	49821295	15901499	20% of the population (IJP 2010, S-95-S103	7286962	7794	0.12%
Chandigarh	114	1109377	NR	NR (M:F 818)	NR		77656	23735	30.6%
Chattisgarh	135194	25540196	12827915	12712281	1787814	Calculated at 7% of the population	1787814	17204	0.96%
Dadra and Nagar Haveli	491	343709	193760	149949	3000-5000		24060	3600	15%
Daman and Diu	112	243247	150301	92946	700*	Outpatient data	17027	25	0.15%
Delhi	1483	16787000	8987326	7800615	10046 (MI) 16338 (MR)	Calculated as per census	1175090	139655	11.9%
Goa	3702	1458545	739140	719405	3241*	This represents persons in treatment (incomplete)	102098	3713	3.64%
Gujarat	196204	60383628	31482282	28901346	2800000	Mental Health Mission Report 2003 (Calculated at 4.64%)	4226854	17085*	0.4%
Haryana	44000	25351462	13494734	11856728	722825	Calculated at 2.85% of population	1774602	142109#	8%
Himachal Pradesh	55673	6864602	3481873	3382729	NR		480522	4835	1%
Jammu and Kashmir	222236	12541302	6640662	5900640	877891	Calculated at 7%	877891*	29378	3.35%
Jharkhand	79716	32966238	16931688	16034550	863715	Calculated at	2307637	13114	0.57%

						2.62% of population			
Karnataka	191791	61095297	30966657	30128640	85533330	Calculated at 14% of population	4276671	6718^	0.16%
Kerala	38863	33406061	16027412	17378649	NR		2338424	6980	0.3%
Lakshadweep	32	64473	33123	31350	197		4513	0	4.4%
Maharashtra	118809	112374333	58243056	54131277	6500000	Calculated as per epidemiologic figures	7866203	251113	3.19%
Madhya Pradesh	308000	72597565	37612920	34984645	15608477 #	21.5% of the population as per affidavit	5081830	10000	0.2%
Manipur	22327	2721756	1369764	1351992	24051*	Treatment seeking data from RIMS, DMHP IMPHAL WEST, EAST & JNIMS	190523	9650	5.07%
Meghalaya	22429	2966889	1491832	1475057	178013	6% as per affidavit	207682	2701	1.3%
Mizoram	21081	1091014	552339	538675	4619*	Treatment seeking data from Kulikawn & civil hospital , AIZWAL	76371	NR	6.05%
Nagaland	16579	1980602	NR	NR	NR		138642	294	0.2%
Odisha	155707	41974218	21221136	20762082	42837*	Affidavit-	2938195	17000	0.58%
Puducherry	492	1244464	610485	633979	121549 **	Medical Records Department	87113	5214	5.99%
Punjab	50362	27704236	14634819	13069417	NR		1939297	119611	6.17%
Rajasthan	342239	68548437	35550997	32997440	250880*	0.37% as per affidavit	4798390	79427	1.66%
Sikkim	7096	610755	323070	287507	NR		42753	3752	8.78%
Tamil Nadu	130060	72147030	36137975	36009055	NR		50502921	1038953	2.06%
Telengana	114840	35193978	17704078	17489900	1800000	Minisurvey at Shankarpally	2463579	7994	0.32%
Tripura	NR 10486	NR 3673917	NR 1874376	NR 1799541	NR	NR	190528	NR	
Uttarakhand	53483	10116752	5154178	4962574	607005	6% as per affidavit	7081773	13622	0.19%
Uttar Pradesh	240928	199800000	104600000	95000000	19000000 #	9.5% (citing country wide surveys)	13986000	63113	0.45%
West Bengal	88752	91347736	46927389	44420347	5480864	6% as per affidavit	54808642	31036	0.06%

The asterisks indicate that counting of cases at one or more centres, or only treatment seeking data have been provided as estimates of mental illness, which is grossly under-representative of the problem.

Calculating the prevalence of mental illness among the population at about 7%, the current population likely to have a diagnosable mental illness is 80486483 (7% of 1149521188). There are likely to be a lot more people with psychological distress who need counseling and support.

Tabulation

Arunachal Pradesh provides a figure of 852 as the number of patients with mental illness. This clearly refers only to the patients seen at one centre. This is not complete information even on patient treatment seeking. Apart from this there are 2 district hospitals providing psychiatric care, where figures are not mentioned, although this number may not be huge.

For Dadra Nagar Haveli, a very rough figure of 20/day was mentioned as new cases. While this was used to calculate the persons seeking treatment, it is quite surprising that outpatient data could not be collated from the general hospitals.

For Lakshadweep, although their new OPD registration across facilities is tabulated as 0, the figure of 197 (mentioned in the affidavit as the number seeking treatment) has been used.

Some of the states have not consolidated the figures. For example, Andhra Pradesh has provided annual figures for the GHMC Vishakapatnam, no figures for the District hospitals and monthly figures for the DMHP. The report from Andhra says that the DMHP was running between 2005-2008 and seeing about 13944 cases across 7 DMHPs at S Kota, Saluru, Bhogapuram, Bobili, Cepurupalli and Vizianagarm (extrapolated from monthly data). **The DMHP was stopped in 2008.**

Chandigarh appears to have the highest percentage of registrations relative to numbers of mentally ill during the year. 70.6% of this is accounted for by PGIMER, Chandigarh which also caters to nearby States apart from population within the UT.

In regions where the mental health burden has been reasonably calculated (e.g. Delhi), relatively better assumptions can be made. For e.g. calculating that 8.34 lakh population has mental illness and that the number of persons registered for treatment is 1.4 lakhs, there are 12% who have been registered during the last year. The resources for mental health care are much more in Delhi (including private institutions and NGOs) compared to many other states. In Delhi, psychiatric care is stated to be available within about 5 kms for any person.

Based on meta-analytical studies, Delhi calculates that 3.15 lakh children are likely to be suffering from mental illness. Based on the estimates derived from the Ashray Adhikar Abhiyan, there are 26666 homeless mentally ill persons in Delhi alone.

Goa's figures are only from the government psychiatric hospitals.

In Gujarat, the affidavit mentions that 28,00000 persons suffer from mental illness (calculated at 4.64% prevalence). According to the state report, 372398 persons have sought treatment in various government hospitals, which is under 4%. If the prevalence is calculated at 7% the percentages of new registrations will be even lower, and less than 1% of the persons with mental illness will actually have registered for treatment in government settings. The problem in Gujarat, as has been pointed out elsewhere, is that the patients seen in the private psychiatric hospitals, medical college departments and DMHP have not been accounted.

In Karnataka, according to the information gathered from the affidavit, 592996 persons are seen annually across the 2 psychiatric institutes, 32 Dt Hospitals/Medical Colleges and DMHPs. The information does not include persons seen in private psychiatric institutions, of which there is a large number. Calculating at a 7% prevalence of mental illness, annual new registrations are only 1.6%.

Jammu and Kashmir: The NHRC Special Rapporteur's report states that 80,000 persons visited various mental health professionals in 2005-2006. For Jammu and Kashmir- Various studies cited by the NHRC Special Rapporteur suggest that psychiatric morbidity in Jammu and Kashmir is higher than the national average suggested by meta-analysis. Ladakh, which has a huge administrative area has no mental health resources at all.

Kerala has provided detailed information on the government psychiatric hospitals, but no information on private psychiatric hospitals, medical college departments (29), district hospitals (18), NGOs outside of Thrissur.

Jharkand-the affidavit only provides the information from RINPAS, and is therefore extremely under-representative of the facilities in the state.

In Maharashtra, although several institution reports are included, information from many of the prominent medical college hospitals has not been collated.

In Mizoram, there is no mention of the OPD registrations. The total number of persons with mental illness calculated from the hospitals (4619) is considered here.

The State of Tamil Nadu has a comprehensive set of information. Apart from the single state mental hospital, an attempt has been made to obtain information from most medical college departments and many of the district hospitals. However, details of private psychiatric facilities are inadequate. Details of the DMHP are not collated adequately in the affidavit, despite the state having had an external review of the DMHP programme in 2013.

For Telengana, no information on patients seen was provided in the first affidavit. Later, in response to a letter from the NHRC, information was provided from the Govt General Hospital, Nizamabad, MGM Hospital, Warrangal, Dt Hospital Khammam, Sangareddy and Nalgonda.

The State of Tripura has not even mentioned basic demographic information based on the Census 2011 information. Census data indicates that Tripura has a population of 36,73,917.

Table 6. Resources Available and Service Utilization as per Affidavit

Name of State	No of inpatient beds in Psychiatric hospitals	No of inpatient beds in GHPUs/ Medical Colleges	No of inpatient beds in Private Sector	No of patients seen in emergency settings	No of new cases registered in Outpatient	No of follow-up seen in Outpatient	No of IP admissions	No seen in DMHP (New and Old cases)	DMHP follow-up
Andaman and Nicobar	0	0	0	NR	NR	NR	NR	NR	NR
Andhra Pradesh	300	NR	NR	1123	4728	47832	3058	0 -not functional	NR
Arunachal Pradesh	10	NR	NR	NR	704	631	NR	NR	NR
Assam	336	NR	NR	NR	18494	81213	1825	NR	NR
Bihar	265	NR	NR	94	7794	19506	504	NR	NR
Chandigarh	24	59	24	2181	23735	92123	913	5986	Nearly half on regular treatment
Chattisgarh	100	NR	21	111	17204	1200	117+484	NR	NR
Dadra and Nager Haveli	0	10	0	NR	3600	NR	NR	NR	NR
Daman and Diu	10	0	0	NR	25	NR	NR	Discontinued	
Delhi	270	375	170	21742	139655	601556	5761	27993	26.9%

Goa	190	10	0	364	636		2120	5205	NR
Gujarat	683	340	280	377	17085*	129045*	NR	NR	NR
Haryana	40	86	NA	370#	142109#	83622#	57#	37777	NR
Himachal Pradesh	62	31	30	179	4835	20431	1292	488	NR
Jammu and Kashmir	220	NA	NA	4-5 daily	29378	59299	NR	NR	NR
Jharkhand*	580	NA	NA	NA	13114	80563	2458	2966**	NR
Karnataka	894	NA	NA	369^	6718^	94542^	8356^	NR	NR
Kerala	1332	216	NA	5295	6980	97321	NR	NR	NR
Lakshadweep	0	0	0	NR	NR	NR	0	NR	NR
Maharashtra	5695	410	NR	22402	251113	1080264	4513	NR	NR
Madhya Pradesh	350	300	NR	2500	10000	NR	NR	NR	NR
Manipur	10	30	NR	1460	9650	6825	509	5884	4737
Meghalaya	150	NR	80	469	2701	31280	1415	530	266
Mizoram	NR	NR	NR	NR	NR	NR	NR	468	408
Nagaland	25	NR	NR	92	294	718	NR	NR	NR
Odisha	120	40	NR	NR	17000	NR	NR	NR	NR
Puducherry	38	10	NR	750	5214	50561	NR	NR	NR
Punjab	330	NR	88	781	119611	116005	NR	NR	NR
Rajasthan	395	143	0	NR	79427	95484	NR	~23000	NR
Sikkim	0	20	0	72	3752	NR	187	1659+	NR
Tamil Nadu	1800	645	NR			1038953 (new and followup)			
Telengana	NR	NR	NR	NR	NR	NR	NR	NR	NR
Tripura	50	30	NR	NR	NR	NR	271	NR	NR
Uttarakhand	30	NR	NR	324	13662	11972	267	NR	NR
Uttar Pradesh	331	408	838	697	63113	135655	3609	51024$	~50%
West Bengal	750	238	NA	51	31036	117959	NR	NR	NR

Bihar-Numbers are mentioned only for BIMHAS and AMMMMCH.

Chandigarh- Mentions inpatient beds in GH and private facilities. Substance use disorders predominate admissions. In the outpatient, depression and anxiety disorders most common. However, it appears that the psychiatry beds in the PGIMER are not included here. The follow-up rates are impressive.

There are very few beds in the private sector (hospitals and nursing homes) with a bed strength of only 24 according to the affidavit and these cater primarily to addiction related disorders.

Chattisgarh- figures provided only for State Mental Hospital, Bilaspur, Pragya Hospital (Pvt), LBRK, CIMS, JNMC for others. OP new cases seen include government and private hospital data. The majority of

registrations are for alcohol and drug abuse disorders, followed by anxiety and depression and schizophrenia and bipolar mood disorder. The CIMS records seeing 130 children with psychiatric illnesses.

Delhi- IP admissions include numbers from psychiatric hospitals and government teaching hospitals (5761). (There are no beds apart from this in any Government Facility). Among the OPD registrations, about 13% (17972) are being seen at the GHPU/District hospitals. While 88.8% of all emergency cases are seen at IHBAS, The AIIMS Dept of Psychiatry sees most of (6.2% of total) the emergency cases in the government general hospital sector (1350). The Army Base Hospital reports getting 1-2 cases/day. About 184 cases have been reported to have been seen in emergency setting in the non-teaching GHPU/Dt hospitals.

Gujarat- The number of OPD registrations are provided only for the Government Psychiatric Hospitals (17085). This is likely to represent only 5% of the OPD data as per the WHO-AIMS 2006 report. Thus OPD attendance at all the facilities is likely to be 20 times this figure.

In the District hospital Northern Goa, all the 573 annual admissions in the previous year were for addiction treatment. Government Sector services inadequate for the size and population of the state.

Haryana- # The affidavit records 137390 new patient registrations across 12 district hospitals. It needs to be clarified if this number represents only mental health related registrations. The emergency registration information has only been provided for the District Hospitals. Follow up information appears to have been provided only for a few institutions. It is absurd that only 57 admissions have been recorded in Haryana. Across 3 DMHPs of Hissar, Gurgaon and Kurukshetra, there appear to have been 37,777 old and new registrations (figures provided from 2 centres for 7 months and one for one month extrapolated to one year.

In Himachal Pradesh, the number of patients seen in the 2 DMHPs is very low.

Jammu and Kashmir- It is mentioned that there is a variable load, with 2-3 new patients per day.

In Jharkand, low figures of 241 per month are mentioned across the 4 DMHPs of Daltonganj, Dhumka, Gumla and Jamshedpur.

^Karnataka- No of admissions mentioned for government psychiatric institutions only.

In Manipur, though the numbers recorded across the 5 DMHP districts is small, there appears to be at least a sincere attempt to document the cases.

Mizoram has mentioned DMHP figures for 1 month, which has been extrapolated to one year.

The DMHP figure provided in the Rajasthan DMHP report is an approximation.

In Sikkim, although there are 4 DMHP districts, the numbers recorded are very low, and may perhaps be from only one district.

The state of Uttar Pradesh has meticulously recorded the DMHP statistics, across the six districts of Faizabad, Kanpur, Sitapur, Rai Bareilly, Etawah and Banda. Although the data are for one month only, nevertheless, their number of persons who are on regular treatment is really encouraging (more than 50%)

Emergency admission data has been recorded by a very few states.

Comment

In summary, **a large problem appears to be with proper documentation of the service utilization.** Where it is properly documented, there is significant utilization of outpatient services (e.g. Chandigarh, Delhi).

Number of new registrations and number of patients in follow-up would have helped determine the number accessing services in the government sector. However, the follow-up numbers indicate the footfalls (total number of follow-ups) and not the persons maintaining follow-up. Hence treatment gaps cannot be accurately calculated. Nevertheless, it appears that in most states, the treatment gap is huge, and only a small percent of persons are being seen in treatment.

Ratio of inpatient beds to the population

Since the figures from the private sector and medical colleges are grossly inadequate, it is still not possible to calculate the total number of inpatient beds to population. Nevertheless to provide a beginning, the ratios are calculated. The figures will need to be revised once the information has been updated.

Table 7: Ratio of inpatient beds/100,000 population across states based on submitted affidavits (State level information)

Name of State	Population (Census 2011)	Total Number of inpatient beds as per affidavit	Inpatient beds /100000
Andaman and Nicobar	379944	0	0
Andhra Pradesh	49300000	300	0.6
Arunachal Pradesh	1382611	10	0.72
Assam	31205576	527	1.7
Bihar	104099452	265	0.25
Chandigarh	1109377	107	9.65
Chattisgarh	25540196	121	0.47
Dadra and Nager Haveli	343709	10	2.9
Daman and Diu	243247	10	4.11
Delhi	16787000	815	4.85
Goa	1458545	200	13.7
Gujarat	60383628	1303	2.16
Haryana	25351462	126	0.5
Himachal Pradesh	6864602	123	1.79
Jammu and Kashmir	12541302	220	1.75
Jharkhand*	32966238	1243	3.80
Karnataka	61095297	1250	2.04
Kerala	33406061	1714	5.2
Lakshadweep	64473	0	0
Maharashtra	112374333	8170	7.27
Madhya Pradesh	72597565	650	0.9
Manipur	2721756	40	1.47
Meghalaya	2966889	230	7.75
Mizoram	1091014	NR	
Nagaland	1980602	25	1.26
Odisha	41974218	160	0.38
Puducherry	1244464	85	6.83
Punjab	27704236	501	1.81
Rajasthan	68548437	538	0.78
Sikkim	610755	20	3.27
Tamil Nadu	72147030	2445	3.39
Telengana	35193978	675	1.92
Tripura	NR-3673917	80	0.23
Uttarakhand	10116752	142	1.40
Uttar Pradesh	199800000	1577	0.8
West Bengal	91347736	988	1.08
Total as per affidavit		24670	2.15

For Maharashtra, the state questionnaire affidavit totals 6105 beds. However, tabulation of all the private facilities yields a total of 8170 beds. **Information from private facilities as well as complete information from medical colleges, general hospitals and district hospitals is not provided from most states**.

The figures have not been provided for Mizoram and Telengana . Andaman and Nicobar and Lakshadweep record no psychiatric beds.

The number of beds as per the affidavits/IC report totals 24670. In 1998, the bed strength of 37 hospitals is mentioned in the NHRC report as 18024[71]. A report from the DGHS, Ministry of Health and Family Welfare, Govt. of India from the National Survey of Mental Health Resources calculates 20893 beds in the government sector and 5096 beds in the private sector (totaling 25989). If there is a meticulous count including the private facilities and medical colleges in all the states, the current count of 24670 is likely to be higher.

Counting is important to effectively plan services. In some states, individual responses have been bound together and no attempt has been made to incorporate the information into a meaningful state level response.

Ratio of inpatient beds to the population

The WHO Atlas 2014 provides a comparison of inpatients beds per 100,000 population across high and low income countries across the world. The present audit places our situation well below even the low-income countries.

Table 8. Relative status of bed to population ratio

	Beds/100000 population (N=141)
Global	6.5
Low-income countries	1.6
Lower-middle income countries	4.0
Upper-middle income countries	14.4
High-income countries	41.8
India as per affidavit	**2.15**

Thus, as per the affidavits, the beds in India are well below the global averages and far below the averages for high-income countries. However, if the beds in the medical colleges, district hospitals and private sector are correctly counted in each state, the ratios at the state and national level may actually improve.

With this level of information, Chandigarh, Goa, Maharashtra, Meghalaya and Puducherry are the only states which have ratios matching or better than the global ratios of beds to population.

[71] NHRC Report 1998, ibid

Deficits in Recording

The deficits in recording of beds in the private sector and in medical colleges/general hospitals/district hospitals are apparent when a comparison is made with the DGHS Mental Health Resource Report in 2002. The mapping of mental health resources was undertaken at the behest of the Hon'ble Supreme Supreme Court Order dated 12 April 2002.

Table 9. Number of Beds- Comparison between 2002 and 2015

Name of State	Existing Beds DGHS REPORT 2002			Existing beds (Compiled from State Affidavits 2015			
	Govt Sect Psy	Pvt Sector Psy	Total	Govt Sect Psy	Pvt Sector Psy	Medical College/ GH/DH	
Andaman and Nicobar	10	-		0	0	0	**0**
Andhra Pradesh	1020*	210*	**1230**	300	NR	NR	**300**
Arunachal Pradesh	10	-	**10**	10	0	0	**10**
Assam	500	-	**500**	336	NR	191	**527**
Bihar	-	-	**-**	265	NR	NR	**265**
Chandigarh	57	-	**57**	0	24	59	**107**
Chattisgarh	10	3	**13**	100	21	NR	**121**
Dadra and Nager Haveli[+]				0	0	10	**10**
Daman and Diu	10	-	**10**	NR	NR	10	**10**
Delhi	329	113	**442**	270	375	170	**815**
Goa	210	-	**210**	190	0	10	**200**
Gujarat	853	326	**1179**	683	280	340	**1303**
Haryana	89	98	**187**	40	NR	86	**126**
Himachal Pradesh	14	3	**17**	62	30	31	**123**
Jammu and Kashmir	120	-	**120**	220	0	0	**220**
Jharkhand*	1173	145	**1318**	1243	NR	NR	**1243**
Karnataka	1341	1113	**2454**	894	NR	356	**1250**
Kerala	1937	1539	**3476**	1342	NR	372	**1714**
Lakshadweep	-	-	**-**	0	0	0	**0**
Maharashtra	6073	652	**6725**	5695	2065	410	**8170**
Madhya Pradesh	NR	NR	**NR**	359	NR	15	**650**
Manipur	10	-	**10**	10	NR	30	**40**
Meghalaya	70	-	**70**	150	80	NR	**230**
Mizoram	14	-	**14**	0	NR	NR	**NR**
Nagaland	25	-	**25**	25	0	0	**25**
Odisha	118	-	**118**	120	NR	40	**160**
Puducherry	44	20	**64**	0	0	85	**85**
Punjab	580	267	**847**	330	88	83	**501**
Rajasthan	627	110	**737**	395	0	143	**538**
Sikkim	20	12	**32**	0	0	20	**20**
Tamil Nadu	1800	NR		1800	NR	645	**2445**
Telengana*				600	NR	75	**675**
Tripura	16	-	**16**	50	0	30	**80**
Uttarakhand	NR	NR	**NR**	30	NR	112	**142**

Uttar Pradesh	1750	275	**2025**	1577	NR	NR	**1577**
West Bengal	1471	210	**1681**	750	NR	238	**988**

*Andhra Pradesh before bifurcation; + combined with Daman and Diu in 2002 table

The purpose of the above table is to afford a comparison with an earlier government assessment of mental health resources. While in the 2002 assessment, the beds were categorized as government and private, in the affidavit questionnaire, they are classified as government psychiatric facilities, private psychiatric facilities and medical colleges/general hospitals/district hospitals. Gujarat, for example, is one state which has cumulative figures for government and private beds. The ratio of beds to population for Gujarat is only 2.16, still below the global average.

Most states have not counted beds in the private sector/medical college/GH/DH. Some states have done only a partial count, resulting in a lower number of beds reflected in the affidavit. This is particularly true of **Karnataka, Kerala, Haryana, Jharkand, Punjab, Rajasthan, Uttar Pradesh and West Bengal. Gujarat's** count is also incomplete. Among the smaller states, **Mizoram** has not provided the information and **Sikkim** has not specified the beds in the private sector. **Until this information is provided, accurate calculation of bed ratios to the general population will not be possible.**

Many states show a reduction in the number of beds in the government psychiatric hospitals (From 18830 to 17846), a 5% reduction. As per the current count, medical college/ GHPU beds are 3323, which seems an under-estimate. The private sector beds, which were 5096 in 2002 reach a number of only 2963 presently, which is a gross under-estimate, as more than 19 states have not mentioned the number of beds in the private sector. The reduction in the government psychiatric beds can be explained by downsizing of some of the government psychiatric facilities and closure of some facilities (e.g. Mankundu in West Bengal). This is however, only marginally compensated by adequate increase in facilities in the government medical colleges and general hospital psychiatry units. Considering the increase in population between 2002 and 2015, the bed increase is insignificant, as per the figures presently available.

What is also evident is the **complete lack of change in the availability of beds** in the Union Territories of **Lakshadweep, Daman and Diu, Dadra Nager Haveli** and **no change** in the state of

Nagaland. The affidavit for **Andaman and Nicobar mentions no beds**, although the DGHS figure in 2002 indicates 10 beds.

States which have made a sincere effort to collect the information show an attempt to improve inpatient beds in response to growing populations needing inpatient care. However, with increasing populations, these states are also generally well below the average beds in high-income countries.

Figure 1. States which show an increase in beds as per 2015 affidavit in comparison with 2002 DGHS Report

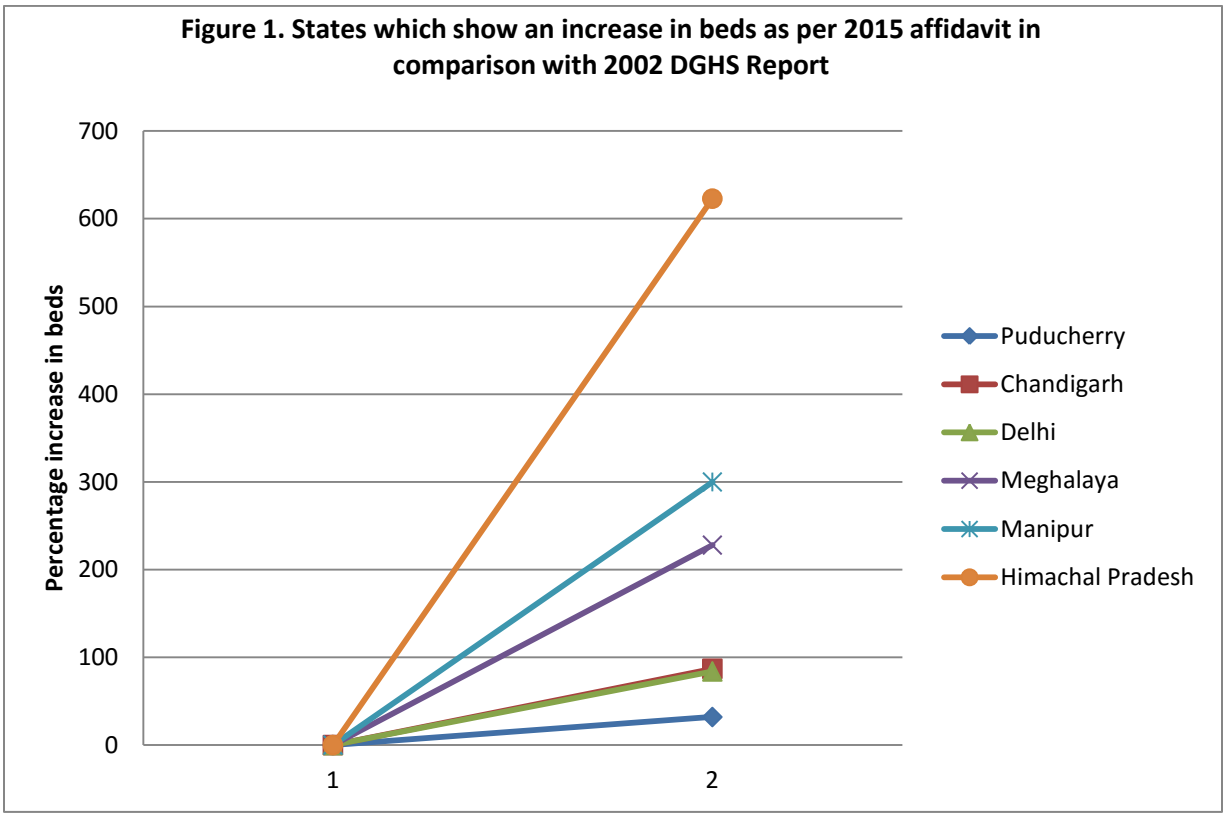


Table 10. Psychiatric Services

Name of State	No of Govt Psychiatric Institutions	No of Pvt Psychiatric Institutions	No of Medical Colleges with Dept of Psychiatry	No of Districts	No of general/district hospitals providing psychiatric care	No of districts covered by DMHP	No of NGOs providing mental health care
Andaman and Nicobar	0	0	1*	3	1	0	1
Andhra Pradesh	1	NR	25 (10 Govt, 15 Pvt)	13	1	7	0
Arunachal Pradesh	1	0	0	19	2	2	3
Assam*	0	0	6	27	12	5	11
Bihar	1	0	10 (7 Govt+3 Pvt)	38	66	11	4
Chandigarh	0	2	1	1	2	1	2
Chattisgarh	1	2	6 (1 Govt,5 Pvt)	27	16	9	1
Dadra and Nager Haveli	0	0	0	1	1	0	0
Daman and Diu	0	NR	0	2	1	0	NR
Delhi	1	22	8	11	13	5	14
Goa	1	NR	1	2	2	2	3
Gujarat	4	64	19	29	14	8	8
Haryana	1	0	NA	21	11	3	1
Himachal Pradesh	1	3	3	12	12	2	13
Jammu and Kashmir	2	0	4	Jammu 10 Kashmir 10 Ladakh 2	4	6	3
Jharkhand	1	NR	3	24	4	4	2
Karnataka	2	82	47	30	30	12	14
Kerala	3	NR	29	14	18	7	14
Lakshadweep	0	0	0	1	0	0	0
Maharashtra	4	103	15	36	23	12	14
Madhya Pradesh	2	NR	14	51	21	5	4
Manipur	1	NR	2	9	10	6	69
Meghalaya	1	1	0	7	4	1	1
Mizoram	0	0	0	8	4	4	10
Nagaland	1	0	0	11	1	1	0
Odisha	1	NR	1	30	NR	13	NR
Puducherry	0	0	9	4	2	2	0
Punjab	1	7	41	22	14	3	8
Rajasthan	2	0	10	33	7	1	NR
Sikkim	0	0	1	4	3	4	0
Tamil Nadu	1	80	42	32	27	25	121
Telengana	1	NR	11	10	NR	12	0
Tripura	1	NIL	NR	NR 8	NIL	NR	NR

Uttarakhand	1	NIL	4	13	0	5	3
Uttar Pradesh	3	NR	28	75	16	14	4-5 IN EACH DISTRICTS
West Bengal	5	35	16	18 Revenue Districts (26 Health Districts)	13	13	4

*Andaman and Nicobar- provision in new Medical College/ Assam affidavit has not included LGBRIMH, Tezpur in the count of government hospitals, but has included the number of inpatient beds for the institute.

Most states/UTs have a government psychiatric facility, with the exception of Andaman and Nicobar, Lakshadweep and Sikkim. Puducherry does not have a psychiatric hospital but delivers substantial psychiatric care through its general hospitals. A relatively higher private sector presence is recorded in Maharashtra, Gujarat, Tamil Nadu, Karnataka and Delhi. With the exception of Delhi, documentation of specific details from this sector is **grossly insufficient**.

Table 11. Outpatient and Emergency Services

Name of State	Outpatient Annual New Registrations as per affidavit					Outpatient Annual Follow-ups as per affidavit				
	Govt Psychiatric facilities	Private Psychiatric facilities	Medical College/GH	DMHP	TOTAL	Govt Psychiatric facilities	Private Psychiatric facilities	Medical College/GH	DMHP	TOTAL
Andaman and Nicobar	0	0	NR	0	**NR**	0	0	NR	0	**0**
Andhra Pradesh	4728	NR	NR	13944	**18672**	47832	NR	NR	NR	**47832**
Arunachal Pradesh	40	0	664	NR	**704**	NR	NR	631	NR	**631**
Assam*	18494	NR	15051	NR	**33545**	81213	NR	NR	NR	**81213**
Bihar	5382	NR	2392	NR	**7774**	19506	NR	NR	NR	**19506**
Chandigarh	0	1076	22659	1648	**25383**	0	4630	87493	4338	**96461**
Chattisgarh	2267	867	14070		**17204**	1200	NR	NR	NR	**1200**
Dadra and Nager Haveli	0	0	NR	0	**NR**	0	0	NR	0	**NR**
Daman and Diu	0	0	NR	0	**NR**	0	0	NR	0	**NR**
Delhi	33939	15808	89908	2294	**141949**	204131	51133	346392	25699	**627355**
Goa	3713	0	8407	1964	**14084**	41730	0	6534	1948	**50212**
Gujarat	17085	NR	NR	NR	**17085**	129045	NR	NR	NR	**129045**
Haryana	4719	NR	137390	NR	**142109**	8946	NR	74676	NR	**83622**
Himachal Pradesh	260	3192	2393	206	**5041**	718	16410	5293	251	**226722**
Jammu and	19837	0	9641	NR	**29478**	48506	0	9793	NR	**58299**

Kashmir										
Jharkhand	28498	NR	NR	NR	**28498**	129179	NR	NR	NR	**129179**
Karnataka	6718	NR	62677	300	**69695**	94542	NR	79068	10032	**183642**
Kerala	6980	NR	NR	NR	**6980**	97321	NR	NR	NR	**97321**
Lakshadweep	0	0	NR	0	**NR**	0	0	NR	0	**0**
Maharashtra	6718	137000	107395	NR	**251113**	94542	800000	185722	NR	**1080264**
Madhya Pradesh	10351	NR	3474	83	**13908**	58541	NR	4130	241	**62912**
Manipur		NR	9650	454	**10104**	NR	NR	6825	5430	**12255**
Meghalaya	970	1731	114	530	**3345**	10569	20711	NR	375	**31655**
Mizoram	0	0	NR	468	**468**	0	0	NR	408	**408**
Nagaland	294	0	0		**294**	718	0	0		**718**
Odisha	10846	NR	7880	516	**19242**	NR	NR	7861	7114	**14975**
Puducherry		NR	18538	NR	**18538**	NR	NR	99496	NR	**99496**
Punjab	12506	17252	89853	NR	**119611**	27071	6602	82332	NR	**116005**
Rajasthan	79427	0	NR	NR	**79427**	95484	0	0	NR	**95484**
Sikkim	0	0	3752	NR	**3752**	0	0	NR	NR	**0**
Tamil Nadu	10559	NR	86644	38790	**135993**	136223	NR	508240	43027	**687490**
Telengana	8990	NR	6887	NR	**15877**	126880	22060	NR	NR	**148940**
Tripura	738	0		NR	**738**	3019	0	NR	NR	**3019**
Uttarakhand	13662	NR	12337	NR	**25999**	11972	NR	NR	NR	**11972**
Uttar Pradesh	63113	NR	NR	8136	**71249**	135655	NR	NR	34296	**169951**
West Bengal	64237	NR	125557	10314	**200108**	260522	NR	383019	11472	**655013**
Total	**435071**	**175916**	**837333**	**79647**	**1527967**	**1865065**	**919556**	**1887505**	**144631**	**5022797**

As earlier mentioned, much of the information with respect to medical colleges/GH/DH as well as the private sector details is not mentioned in the state affidavits. Therefore, the totals are incomplete.

From the information available, medical colleges/GH in the states/UTs of Assam, Chandigarh, Chattisgarh, Delhi, Haryana, Karnataka, Maharashtra, Puducherry, Punjab, Tamil Nadu and West Bengal cater to a large outpatient clientele, and if this properly documented, the numbers are likely to be even higher.

Table 12. Emergencies and Inpatient admissions

Name of State	Annual Emergencies as per affidavit					Annual Admissions as per affidavit			
	Govt Psych Hospitals	Pvt Psych Hospitals	Medical College/GH	DMHP	TOTAL	Govt Psych Hospitals	Pvt Psych Hospitals	Medical College/GH	TOTAL
Andaman and Nicobar	NR	NR	NR	NR	**0**	NR	NR	NR	**0**
Andhra Pradesh	1123	NR	NR	NR	**1123**	2626	NR	NR	**2626**
Arunachal Pradesh	NR	NR	NR	NR	**0**	NR	NR	NR	**NR**
Assam*	NR	NR	NR	NR	**0**	1825	NR	2575	**4400**
Bihar	94	NR	NR	NR	**94**	111	NR	399	**510**
Chandigarh	0	15	2166		**2181**	0	267	643	**910**
Chattisgarh	77	34	NR	NR	**111**	117	NR	481	**598**
Dadra and Nager Haveli	0	0	0	0	**0**	0	0	NR	**NR**
Daman and Diu	NR	NR	NR	NR	**0**	0	NR	0	**NR**
Delhi	19312	896	1534	NR	**21742**	1923	2728	1110	**5761**
Goa	377	0	447	0	**824**	1547	0	573	**2120**
Gujarat	NR	NR	NR	NR	**0**	4322	NR	NR	**4322**
Haryana	NR	NR	NR	NR	**0**	57	NR	NR	**57**
Himachal Pradesh	173	6	0	NR	**179**	114	796	388	**1298**
Jammu and Kashmir	980	0	NR	NR	**980**	14035	0	NR	**14035**
Jharkhand	NR	NR	NR	NR	**0**	6624	NR	NR	**6624**
Karnataka	369	NR	6025	NR	**6394**	8356	NR	2961	**11317**
Kerala	5295	NR	NR	NR	**5295**	7507	NR	NR	**7507**
Lakshadweep	0	0	0	0	**0**	0	0	0	**0**
Maharashtra	369	13000	9033	NR	**22402**	2639	20683	1874	**25196**
Madhya Pradesh	NR	NR	NR	NR	**0**	NR	NR	14	**14**
Manipur	NR	NR	1460	NR	**1460**	NR	NR	509	**509**
Meghalaya	469	NR	NR	NR	**469**	1051	364	82	**1497**
Mizoram	0	0	NR	NR	**0**	0	0		**0**
Nagaland	92	0	0	NR	**92**		0	0	**0**
Odisha	1095	NR	39	NR	**1134**	3071	NR	616	**3687**
Puducherry	0	0	768	NR	**768**	0	0	57818	**57818**
Punjab	NR	151	630	NR	**781**	106	1194	NR	**1300**
Rajasthan	NR	NR	NR	NR	**0**	4353	0	NR	**4353**
Sikkim	0	0	72	NR	**72**	0	0	187	**187**
Tamil Nadu	NR	NR	17634	NR	**17634**	3544	NR	9407	**12951**

Telengana	NR	NR	1064	NR	**1064**	4134	NR	490	**4624**
Tripura	NR	NR		NR	**0**	308	0	271	**579**
Uttarakhand	324	NR	NR	NR	**324**	267	NR	173	**440**
Uttar Pradesh	697	NR	NR	NR	**697**	3609	NR	NR	**3609**
West Bengal	NR	NR	10929	NR	**10929**	794	NR	7459	**8253**
Total	**30846**	**14102**	**51801**	**0**	**96749**	**65533**	**26032**	**88030**	**179595**

Details of psychiatric emergencies seen are also poorly documented. High numbers are documented from Karnataka, Maharashtra, Tamil Nadu and West Bengal Medical Colleges/GH. Relatively higher numbers of admissions are recorded in government psychiatric facilities in Gujarat, Jharkand, Jammu and Kashmir, Karnataka, Rajasthan and Telengana. This may be either due to the cost factor of admission or inadequate recording of the non-government facilities. In Maharashtra, maximum of the admissions occur in the private sector.

The Example of Maharashtra

Although Maharashtra has not compiled all the information collected into the consolidated state proforma, an attempt has been made by the Technical Committee to examine the provision of psychiatric services across different sectors in this state. Although this is **still incomplete**, it nevertheless reflects some trends. It is important that other states similarly map resource utilization across different areas and see how the government sector can be optimally resourced.

Table 13. Mental Health Statistics for Maharashtra

	Psychiatric Hospitals Govt (5)	**Psychiatric Hospitals Pvt (103)**	**Medical Colleges (18)**
No of beds	5695	2065	410
No of admissions per year	6577	20683	1874
No of outpatient registrations	9336	137000	107395
No of follow-ups	150157	678729	185722

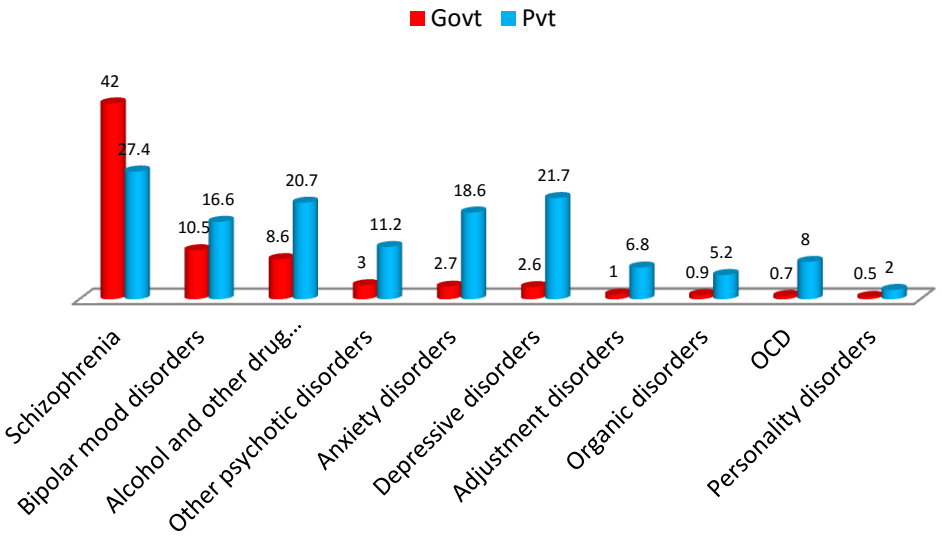
There is a very large private sector. The average beds/facility in private and medical college facilities is 20-22 beds in contrast to government psychiatric facilities in the state which average

more than 1100 beds. Outpatient registrations in the government, private and medical college sectors average 1867, 1330 and 5966 respectively. Averages for follow-up are much higher in the government (30031 patients per centre) compared to medical colleges (10317) and private psychiatric facilities (6589). Cost and free medications may be important determinants of follow-up.

Rank order of cases seen in different types of facilities in Maharashtra

Information about the different diagnostic categories seen in the outpatient were analysed. Institutions which did not provide this figure in numbers were not included for this analysis. Diagnostic break-up was considered for a total of 83510 patients seen in the government institutions and 60505 seen in the private institutions. In the government institutions, schizophrenia is the commonest diagnosis, followed by bipolar mood disorder and alcohol and other drug abuse. In the private sector, schizophrenia, alcohol and drug abuse, depressive disorders, anxiety disorders and bipolar mood disorders are the common disorders diagnosed.

Figure 2. Pattern of outpatient registrations across government and private psychiatric institutions in Maharashtra (figs in %)



Many of the forms returned by medical colleges and GHPUs do not contain this information. Obtaining such information for medical college departments of psychiatry and district hospitals would help greatly to see which sectors are catering to which kind of patients, and require

strengthening. Such information is also vital for the District Mental Health Programme, if all kinds of mental illness are to be provided treatment at the primary health care level.

Table 14. Suicide and Homelessness

Name of State	Annual number of suicides in the state as per affidavit	Annual suicide rate/100000 as per NCRB	Number of homeless mentally ill as per affidavit
Andaman and Nicobar	NR	28.8	NR
Andhra Pradesh	NR	16.9*	NR
Arunachal Pradesh	NR	18.0	NR
Assam	NR	11.3	238
Bihar	NR	1.1	NR
Chandigarh	NR	6.0	NR
Chattisgarh	NR	21.7	NR
Dadra and Nager Haveli	NR	21.4	NR
Daman and Diu	NR	9.8	NR
Delhi	2059	10.4	26666 (Figs from Ashray Adhikar Abhiyan)
Goa	NR	17.4	NR
Gujarat	NR	11.8	NR
Haryana	NR	12.6	NR
Himachal Pradesh	NR	8.0	NR
Jammu and Kashmir	NR	2.5	NR
Jharkhand	NR	4.5	NR
Karnataka	NR	18.5	NR
Kerala	NR	24.6	NR
Lakshadweep	NR	3.9	NR
Madhya Pradesh	NR	12.6	NR
Manipur	NR	1.5	NR
Maharashtra	16622	14.3	NR
Meghalaya	NR	5.1	NR
Mizoram	NR	9.2	NR
Nagaland	NR	1.6	NR
Odisha	NR	12.6	NR
Puducherry	497	35.6	0
Punjab	NR	3.4	NR
Rajasthan	NR	6.9	NR
Sikkim	NR	29.3	NR
Tamil Nadu	NR	24.3	NR
Telengana	NR		NR
Tripura	NR	25.9	NR
Uttarakhand	NR	3.6	NR
Uttar Pradesh	NR	2.5	NR
West Bengal	NR	14.3	NR

*Figures for Andhra Pradesh for undivided Andhra

Suicides

On an average, more than one lakh persons commit suicides every year in the country (during the decadal period 2003-2013.[72] The highest rates of suicides during 2013 according to the NCRB are reported from Puducherry, followed by Sikkim, Andaman and Nicobar, Tripura and Kerala. In terms of the numbers of suicides in different states during 2013, Maharashtra reported the highest number of suicides, followed by Tamil Nadu, Andhra Pradesh, West Bengal and Karnataka. Among UTs, Delhi recorded the highest number of suicides followed by Puducherry. Suicides occur due to a variety of reasons which include socio-economic causes including family problems and illness. Among illnesses, mental illness and other prolonged illnesses constitute the major causes of suicide across all age groups.

Means adopted for committing suicide include consumption of poison, drowning and immolation. Poisoning and hanging were the commonest methods of suicide in 2013. However, NCRB observations indicate a decreasing trend in the older methods and an increase in other methods of suicide like self-inflicted injuries, hanging, shooting etc across the recent years (2011-2013). An analysis of suicides in 53 mega-cities shows an increasing trend between 2009 to 2013 (from 13503 in 2009 to 21313 in 2013).

Sadly, the recording of suicides is practically negligible in the affidavits. Surveillance of suicide rates, causes of suicide, patterns of suicide are extremely important in the effective prevention of suicides. Only Delhi, Maharashtra and Puducherry have provided data on the annual suicides in their states.

Homeless Mentally Ill

Only 2 UTs, Puducherry and Delhi and the State of Assam have provided any information on the homeless mentally ill. As mentioned earlier, it is well known that rates of mental illness among the homeless are very high.

The Banyan, an NGO in Chennai has been having a notable service for the homeless mentally ill since 1993. The Ashray Adhikar Abhiyaan (AAA), along with IHBAS and DLSA, started a service for persons with serious mental illness who are homeless in and around Delhi since 2008[73]. The joint outreach model consists of identifying the homeless person with mental illness, treatment engagement with the local community, pharmacological treatment, and when necessary, magistrate certification for involuntary

[72] National Crime Records Bureau. Suicides in India. www.ncrb.nic.in/adsi2013/suicides%202013.pdf

[73] Treatment of homeless people with server mental illess. Joint initiative of IHBAS, AAA and DLSA. Report of a Pilot Phase 2008-2010. www.slideshare.net/nitin_das/smi-report-final-24-10

treatment. Attempts at rehabilitation are also attempted. Of an evaluation of 49 patients seen in the program at the end of the year, 16 were in regular follow-up, 6 in irregular follow-up in the community, 3 were at follow-up at IHBAS and 24 were lost to follow-up.

A mobile court has been set up for issuing treatment and reception orders outside the Jama Masjid in Delhi with the help of DLSA and NGOs.

There is active collaboration in Delhi between the Health and Social Welfare Departments for regular review of Mental Health Services in various shelter homes, women homes and Juvenile Homes.

Rehabilitation

Rehabilitation facilities in the country, particularly in the government sector are extremely scarce.

Table 15. Rehabilitation Services, helplines and mental health intervention in special settings

Name of State	Half way homes/Rehabilitation	Helplines	Mental health interventions in other facilities	Mental health interventions in prisons
Andaman and Nicobar	Nil	Nil	Nil	Nil
Andhra Pradesh	Nil	Nil	Nil	Nil
Arunachal Pradesh	2 half way homes (20 capacity each) 3 Long stay homes (both have NGO participation)	Nil	Nil	Nil
Assam	NR	NR	NR	NR
Bihar	Nil under government 1 longstay rehabilitation facility (NGO Dishayein)	Nil	1 counselor in each of the 19 children's homes and 8 open shelter 1 counselor in 3 out of 11 observation homes. 1 counselor each in 16 of 17 destitute home for women.	8 Central Jails; 32 district jails; 16 subjails- No mental health intervention
Chandigarh	2 day care rehab (Govt)/1 halfwayhome (20)	1 suicide helpline (ASHA)	3 shelter homes/2 women's protection homes (2 trained counselors)/3 old age homes (no trained counselors)	1 Jail (no trained counselors)
Chattisgarh	1 longstay rehab for female patients(50 bed capacity)	Nil	3 shelter homes, 8 observation homes, 3 special homes 37 childrens homes, 3 destitute women homes, 21 old age homes (no trained counselors)	5 central jails, 10 district jails no information on whether counselors trained in mental health available Psychiatrist visits jail thrice a month
Dadra and Nager Haveli	Nil	Nil	Nil	Nil
Daman and Diu	0	Nil	1 women destitute protection home, 2 old age home, no trained counselors	Nil

Delhi	0 1outdoor day care centre at IHBAS	Suicide Helpline by NGOs- Sanjivini, Sumaitri and Snehi Pre-exam helpline for students –Disha run by Snehi Hopeline-Pre and post exam helpline run by Snehi	5 shelter homes, 1 protection home for destitute women,2 old age homes- No trained counselors (Mental Health Services available through NGO funded by Delhi Government)	2 central jails and district jails. No trained counselors (Jail Hospital has Psychiatrists)
Goa	Nil	1097 for women, 2252525 for suicide prevention	2 Counselors in Apna Ghar for juvenile children	3 jails, Psychiatrist posted once a month
Gujarat	4 rehabilitation facilities	Aadhaar Helpline for mental health in Ahmedabad and Vadodara. Saath suicide prevention at Ahmedabad	23 special homes/10 trained counselors; 14 protection homes for destitute women/7 trained counselors; 10 old age homes/ no info on trained counselors	4+22- no information on whether trained counselors are available
Haryana	40 (de-addiction cum rehabilitation) not for persons with mental illness	Nil	Only 7 Old age homes mentioned (1 Govt, 6 NGO)/No trained counselors	19 (No trained counselors)
Himachal Pradesh	1 longstay facility with the participation of the Red Cross Society in Kangra	NGO child helpline 1098	22 Children Homes, 1 Shelter home run by NGO, 2 in children home at Hamirpur and Una, 1 protection home, No trained counselors	12 jails, no counselors
Jammu and Kashmir	Nil	Nil	1 Protection home for destitute women/1 Old age home/no trained counselors	1 Central Jail, 7 district jails/no trained counselors
Jharkhand	2	Umang-Suicide	Details of number of institutions NA MH care provided in the probation and observation homes, Ranchi.	MH care provided in the Central Jail, Ranchi, Gumla, Daltonganj, Chaibasa
Karnataka	2 longstay 13 daycare 2 halfway homes	104 Arogyavani 24*7 100 lines	43 shelter homes/29 trained counselors; 18 trained counselors; 27 old age homes/54 trained counselors	102 central/district jails Position of psychiatrist in Central Prison and Belgaum vacant
Kerala	8 longstay facilities (6 Asha Bhavans under social justice departments, 1 outdoor facility in one institution	1056 –DISHA 1098-Child Helpline	24 shelter/observational homes for children, 20 destitute homes for women, 14 old age homes- no trained counselors	3 Central Jails and 11 district jails, no trained counselors
Lakshadweep	Nil	Nil	Nil	Nil
Madhya Pradesh	1 rehab facility; No outdoor rehabilitation; Plan to establish 2 government run half-way homes; No NGO participation;	Helpline for disabled at NGO Arushi 1090-police helpline related to violence against women 1098 run by Min of	21 shelter/observational homes- 4 trained counselors; 31 protection homes for women-no trained counselors; 67 old age homes –all run by NGOs	11 central jails and 33 district jails- No trained counselors

	No longstay facility	Women and Child Welfare for Children and 1091 for family counseling		
Manipur	Nil	Nil	11 Protection and Rehabilitation Homes run by Social Welfare Dept 2 shelter homes, 4 observation homes, 11 special homes and 19 children's homes – no counselors; 18 protection homes for destitute women- no counselors; 36 old age homes- no counselors	2 central jails; district jails and subjail not functioning- no counselors
Meghalaya	1 government rehabilitation facility; 3 outdoor rehab facility; no halfway home	Nil	20 children home run by Government, 64 run by NGOs, 24 shelter homes- no counselors. No homes for destitute women, no old age homes	4 district jails- no counselors
Mizoram	Nil	NR	NR	NR
Nagaland	Nil	Nil	NR	4 jails, no counselors
Odisha	Nil in Government. 6 longstay rehabilitation being run by NGOs	Nil	6 protection homes for destitute women run by NGOs, nothing else recorded- no counselors	5 central jails and 2 district jails- no counselors
Puducherry	Nil in government	Helpline for suicide, addiction, domestic violence, adolescent mental health problems	44 shelter/observational/ special childrens homes; 11 homes for destitute women/6 old age homes- no counselors mentioned in any	4 jails- no counselors
Punjab	17 rehab/residential facilities, nil daycare, nil half way homes, nil longstay	104- Medical Helpline	15 shelter/observation/special homes – no counselors; 1 protection home for destitute women-no counselors;Old age homes- NR	NR
Rajasthan	Nil	222216 Helpline in Jalore district	Nil shelter/observation/special/ children's homes according to affidavit; Nil home for destitute women/Nil old age homes	36 jails-no trained counselors
Sikkim	Nil	STNM Department of Psychiatry helpline (18003453225)	1 shelter/observational home-No counselor; 1 old age home-no counselor; No home for destitute women	2 Jails- weekly visit by psychiatrist
Tamil Nadu	NR	104 TN Health System Project in collaboration with NGO SNEHA Suicide Prevention Helpline 044-24640050/24640060	NR	NR
Telengana	Nil in government 6 longstay rehabilitation facilities run with the help of NGOs	Nil	NR except 1 old age home in Bansilalpet in Secunderabad and Aaramgarh Home for destitute, Shivaramapally – Erragada Hospital providing counseling services	Central Prison Chanchalguda, Hyderabad- Erragada Hospital providing counseling Rest Not Recorded
Uttarakhand	Nil rehabilitaton facility; 1 outdoor rehab facility;1 government halfway home planned at Haridwar in PPP	Nil	13 shelter/observation/special/childrens home- no counselors;1 protection home for destitute women-no counselors; 2 old age homes-no	1 Central Jail, 7 district jail, sub-district jail – 2, Open Jail-1 No counselors

	model; no longstay rehabilitation facility		counselors	
Uttar Pradesh	NR	NR	NR	NR
West Bengal	Nil	NR	14 government run observational homes-no counselors; 3 NGO run observational homes-no counselors; 25 NGO run shelter homes-no counselors; 6 government run special homes-no counselors; 16 government run children's homes-no counselors; 2 NGO run children's homes- no counselors. 1 government run home for destitute women and 36 short stay homes- no counselors. 6 central correctional homes and 12 district correctional homes- 3 clinical psychologists posted to the central correctional homes	NR

In Punjab, most of the rehabilitation facilities are for substance use. IHBAS in Delhi has a day care facility.

Innovations in rehabilitation and community care

Mobile Mental Health Service (MMHU) by IHBAS in New Delhi provides pre-hospitalization services for home-bound and homeless mentally ill. In the 12th plan sanctioned for IHBAS, there is a line item for outreach services to be provided for homeless mentally ill under the overall plan outlay for the institution.

Writ Petition (WPC 6698/2007) Pratibha Chopra Vs Union of India has ensured that several long-stay homes for recovered mentally ill persons are in final stages of being materialized. The order in this Writ Petition had directives to start mental health services across various agencies with the predominant focus on having minimum accessible mental health services to the various categories of vulnerable populations.

NIMHANS has very well established rehabilitation services with modernized facilities, good NGO networking, day care and community rehabilitation has been initiated at Sakalwara Centre.

In Karnataka, apart from NIMHANS, the Asha Kirana scheme is planned for rehabilitation in several districts. Kerala has initiated Asha Bhavans under the Ministry of Social Justice and Empowerment.

An Insurance scheme is under consideration by State Government and Pension Scheme for persons disabled by mental illness is already in place.

Helplines

14 states report having Helplines. Some of these are general helplines. It is not clear whether the staff operating the helplines have any training in provide counseling for mental health conditions. Seven states report have dedicated suicide prevention helplines. Delhi reports having pre-exam helplines, run by NGOs. Madhya Pradesh reports having helplines for disabled persons, persons facing domestic violence and a helpline for family counseling (run by an NGO, police and the Department of Women and Child Welfare respectively).

Mental health services in other corrective/institutional facilities

This is glaringly lacking.

There are no trained counselors in residential homes for children, women and elderly. Very few jails have mental health interventions.

We do not seem to have learned adequately from the Erwadi incident. Health care in general and mental health care in particular in institutional settings like old age homes, women's destitute homes, children's homes etc. is very very poor. An illustrative case is the incident of over 28 deaths from gastro-enteritis in the Bangalore Beggars' home, including in dormitory 2 which housed persons with mental illness. Such homes have disproportionately higher rates of intellectual disability, psychosocial disability and mental disorders. There are simply no resources available for mental health care. As the Human Rights Watch Report quotes[74], "Every NGO run home should have a qualified and trained counselor….at the moment they have counselors but not all are well-qualified. They need counselors so children open up".

Mental Health Human Resources as per affidavits

At the time of India's Independence, there were 100 psychiatrists in the country. In 2002, the National Survey of Mental Health Resources carried out by the Directorate General of Health Services, Government of India revealed that there were 2219 psychiatrists across the different states. Calculating for 1 psychiatrist per 100000 population, the deficit of psychiatrists was estimated at 7477 at that time.

[74] Human Rights Watch 2014 ibid.

Table 16. Human Resources as per affidavits

Name of State	No of Psychiatrists as per DGHS Report 2002	No of Psychiatrists as per NHRC publication 2008	Ratio Govt: Private (2008)	Number of Psychiatrists as per State Affidavit 2015				
				Psychiatrists in Government Service	Psychiatrists in Private Medical Colleges/ facilities	Psychiatrists in Private Practice	TOTAL PSYCHIATRISTS	Ratio of Psychiatrists per 100000 population
Andaman and Nicobar	**1**	2		2	NR	0	**2**	**0.52**
Andhra Pradesh*	**180**	250	1:5.2	14	12	NR	**26**	**0.05***
Arunachal Pradesh	**1**	**		5	0	0	**5**	**0.4**
Assam	**29**	20	1:0.7	47	0	NR	**47**	**0.15***
Bihar	**28**	125	1:5.3	28	NR	3	**31**	**0.03***
Chandigarh	**31**	34	1:1.6	40	0	3	**43**	**3.9**
Chattisgarh	**15**			11	NR	NR	**11**	**0.04***
Dadra and Nager Haveli*	**1**	0	0	1	0	NR	**1**	**0.3***
Daman and Diu*		0	0	1	NR	NR	**1**	**0.4***
Delhi	**155**	175	1:2.8	134	1	61	**196**	**1.17**
Goa	**26**	46	1:14	20	0	NR	**20**	**1.4**
Gujarat	**97**	125	1:7.5	52	17	200	**269**	**0.45**
Haryana	**39**	46	1:3.2	12	NR	NR	**12**	**0.04***
Himachal Pradesh	**8**	10	1:0.1	7	0	5	**12**	**0.17**
Jammu and Kashmir	**4**	12	1:1.4	15	NR	NR	**15**	**0.12***
Jharkhand	**50**	44	1:1.3	18	NR	NR	**18**	**0.05**
Karnataka	**198**	350	1:1.5	87	NR	170	**257**	**0.42***
Kerala	**238**	150	1:4.9	71	42	**NR**	**113**	**0.34**
Lakshadweep	**0**		0	0	0	0	**0**	**0**
Madhya Pradesh	**12**	125	1:2.0	210	NR	NR	**210**	**0.23**
Manipur	**6**			37	NR	25	**62**	**2.23**
Maharashtra	**486**	475	1:9.6	15	NR	NR	**15**	**
Meghalaya	**5**	**		6	NR	NR	**6**	**0.2***
Mizoram	**4**	**		6	0	0	**6**	**0.6**
Nagaland	**5**	**		6	NR	NR	**6**	**0.30**
Odisha	**19**	20	1:1.7	25	NR	NR	**25**	**0.06***
Puducherry	**15**	8	All govt	15	33	NR	**48**	**3.86***
Punjab	**89**	108	1:3.9	31	NR	NR	**31**	**0.1***
Rajasthan	**75**	60	1:2.5	55	16	NR	**71**	**0.1***

Sikkim	**2**	3	All govt	6	5	NR	**11**	**1.8***
Tamil Nadu	**262**	375	1:3.8	169	69	NR	**238**	**0.3***
Telengana				64	NR	NR	**64**	**0.2***
Tripura	**9**	**		4	3	NR	**7**	**0.2***
Uttarakhand	**6**	4	1:0.3	5	7	NR	**12**	**0.1**
Uttar Pradesh	**115**	250	1:3.3	30	NR	NR	**30**	**
West Bengal	**83**	225	1:5.1	117	14	NR	**131**	**0.14***
All of North-East		26	1:0.4					
Total	**2219**	2800		1366	219	467	2052	*

*All India ratio not calculated because psychiatrists in private sector not completely captured.

It is intuitive that the number of psychiatrists should have increased in the last 13 years. However, as with the beds, **the figures for the state-wise distribution of psychiatrists is incomplete as many states have not at all mentioned in the affidavits the number of psychiatrists working in the private sector, or have provided incomplete data.** No attempt has been made to calculate the ratios for Maharashtra and Uttar Pradesh, because the present figures are far below the 2002, indicating an improper count.

Mental Health Human Resource Development

Medical graduates can obtain post-graduate qualification in psychiatry by doing either an MD in Psychiatry, a Diploma in Psychological Medicine (DPM) or DNB in Psychiatry. Some centres like NIMHANS have discontinued the DPM course and converted the seats to MD recently.

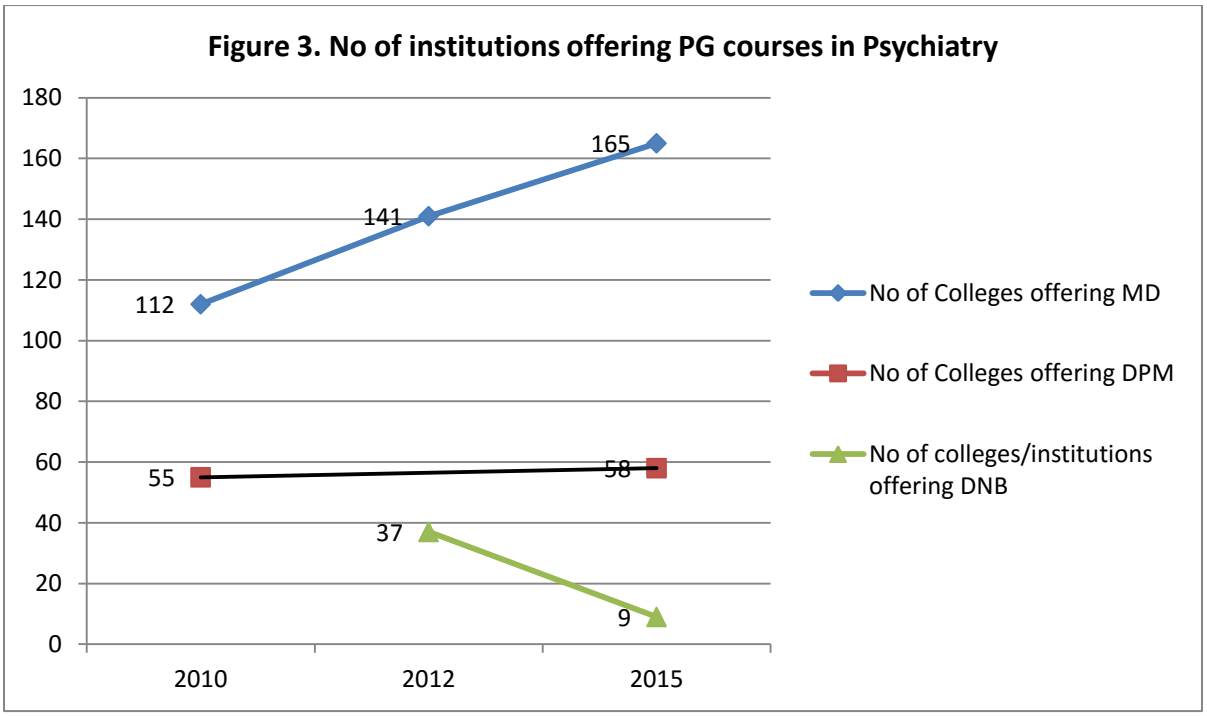
Post Graduate Training in Psychiatry

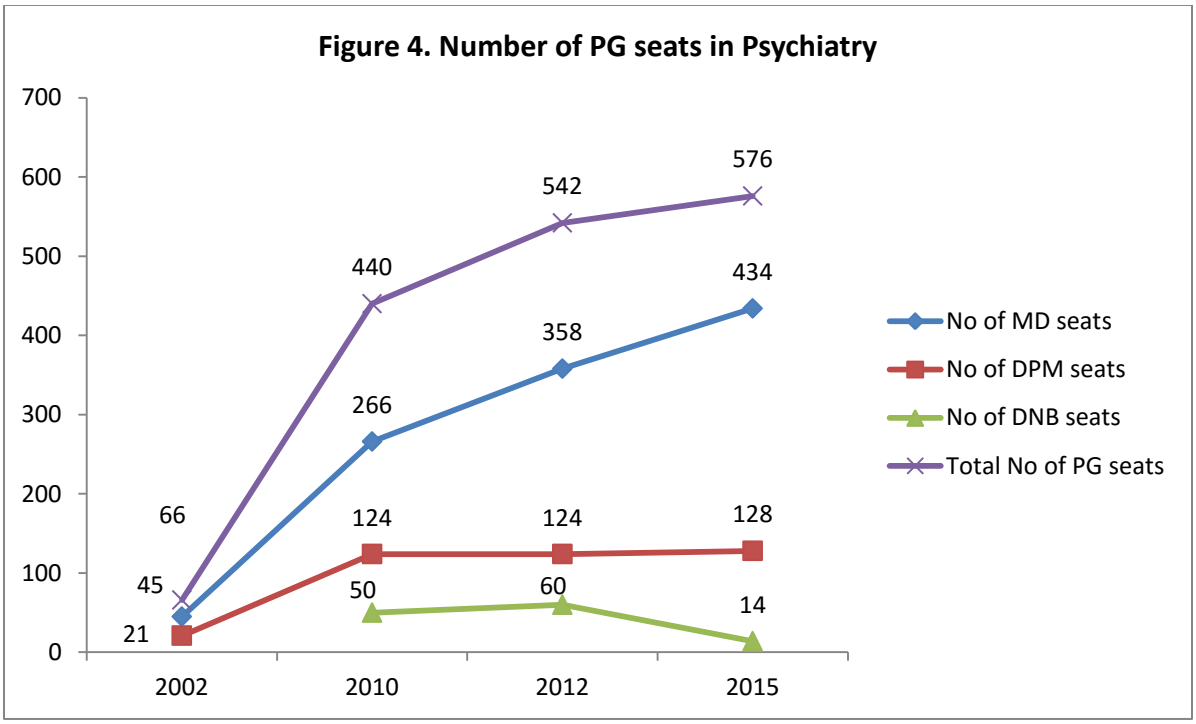
There has been a steady increase in the number of institutions offering post-graduation – MD in psychiatry. However, to date only 165 colleges of a total of 412 medical colleges (40%) in the country have a PG course in psychiatry. The institutions offering DNB have come down drastically, as the colleges which have started MD programmes have discontinued the DNB. Net-Net, there has been only a marginal increase in the total number of PG seats in the recent years.

This report mentions that 45 MD psychiatrists and 21 DPM were being trained annually in 2002[75]. The document on post-graduate training guidelines in Psychiatry[76] tracked the Medical Council of India and the Diplomate of the National Board (National Board of Examinations) between 2010 and 2012. Presently, in 2015, according to the MCI website, there are 165 institutions which offer a total of 434

[75] DGHS Report ibid.
[76] Indian Psychiatric Society. Guidelines

seats in MD psychiatry each year. Adding to this the DPM seats (128) and the few NBE seats (14), this **totals to 576 PG seats annually in 2015**.





Compared to a total of 66 seats in 2002 (source- DGHS 2002), there has been a huge increase in the total number of PG seats. However, this is far below the seats offered in many of the other medical and surgical specialties. Lack of beds and PG teachers are rate limiting steps. Although through the intervention of the NHRC, the MCI has made its regulations flexible (to relax the 1:1 –one professor to one student to 1:2 (one Professor: 2 students) for a 10 year term. This was recommended in 2008-2009. However, without any substantial change in the availability of positions in government facilities, the new graduates are likely to work in the private sector or go abroad to further their prospects.

Table 17. Places offering PG training

Name of State	Medical Colleges with Dept of Psychiatry	No of Centres offering Post Graduate training in Psychiatry	No of Centres offering Post Graduate training in Clincial Psychology	No of Centres offering Post Graduate training in PSW	No of Centres offering Post Graduate training in Nursing	No of Medical Colleges with UG training	In service training/other training
Andaman and Nicobar	In new medical college (according to MCI website, ANNIMS under University of Pondicherry) - not mentioned in affidavit	0	0	0	0	0	2 trained at AIIMS
Andhra Pradesh	9	NR *As per MCI 11 colleges, 27 MD seats* *7 colleges 9 DPM seats*	NR	NR	NR	25	
Arunachal Pradesh	0	0	0	0	0	0	6 MOs on drug addiction 2 MOs on mental health
Assam	6	12 MD, 6 DNB at LGBRIMH, Tezpur 4 DPM in medical colleges *As per MCI, 4 colleges 11 MD seats* *2 colleges 4 DPM seats*	8 MPhil in LGBRIMH	6 MPhil in LGBRIMH	10 MSc Psy Nursing and 30 DPN in LGBRIMH	6 medical colleges -30 hour lecture classes, 2 weeks clinical posting	NMHP training of medical officers(192 MOs) and nurses(272)
Bihar	10 (7 Govt and 3 Pvt)	MD-3 seats *As per MCI, Darbhanga Medical College,*	NR	NR	NR	30 hours lecture and 2 weeks clinical posting	HIV/IDU for trainers of OST MH orientation for one medical

		Katihar Medical College and Patna Medical College recognised				*As per MCI 13 medical colleges*	officer from all districts
Chandigarh	1	MD-16 seats (GMCH, PGIMER)	MPhil-8 seats (PGIMER)	MPhil-8 seats (PGIMER)	MSc-4 seats BSc- 85 Basic Diploma-10 (PGIMER)	25 hours lecture and 2 weeks clinical posting	10 month caregiver training by GMCH
Chattisgarh	6 (5 Govt and 1 Pvt)	DNB-2 (Pragnya) No MD seats	MPhil-15 (Pvt)	MPhil-15 (Pvt)	Basic Diploma-10	NR	HIV/IDU training in OST
Dadra and Nager Haveli	0	0	0	0	0	0	None
Daman and Diu	0						
Delhi	8	MD-22 (IHBAS, AIIMS, MAMC, LHMC, RML) DNB-5 (Sir Ganga Ram Hospital,Base hospital, VIMHANS	PhD-3 (AIIMS) MPhil-17 (IHBAS)	0	0	10 hours theory, 2 weeks clinical posting	Training of GPs, medical and paramedical staff from Delhi Health Services and MCs and Central Armed Police (IHBAS)
Goa	1	MD-2 DPM 2 (IPHB under GMC)	0	0	0	NR	105 MOs from DHS trained at IPHB
Gujarat	19	MD-23 DPM-11	PhD-3 MPhil-12	0	PhD-0 MSc-15 Basic Diploma- 20	NR	2 week training for Medical Officers 10 day training for nurses 7 day training for health workers 4 day training for school teachers
Haryana	NR	MD-4 (PGIMS, Rohtak) DPM-2 (PGIMS, Rohtak)	0	0	0	NR As per MCI, 8 medical colleges	Nil
Himachal Pradesh	3	MD-3 (IGMC)	0	0	0	20 hours of theory, 2 week UG posting and 2 weeks internship posting at IGMC Shimla, Dr RPGMC, Tanda	230 **in-service training for Govt medical officers** training course in mental health offered in psychiatric Nursing
Jammu and Kashmir	4	MD-3 seats (GMC Srinagar)	MPhil -4 (GMC)	0	0	*4 medical Colleges as per MCI* NR	4 medical officers trained under DMHP
Jharkhand (information for RINPAS only)	3	MD-1 seat DPM-1 seat *As per MCI 10 MD-9 at CIP and*	PhD -4 MPhil -12	PhD-4 MPhil-12	DPN-6	*3 medical colleges as per MCI* Medical	

		1 at RINPAS *As per MCI 18 DPM in CIP and 1 in RINPAS*				students posted to RINPAS according to affidavit	
Karnataka	47	MD-73 DPM-21 DNB-6 *As per MCI, there are 63 MD seats across 18 colleges and 21 DPM seats across 8 colleges.* The MCI list does not include the 22 MD seats at NIMHANS	PhD-4 (NIMHANS) MPhil-29 (NIMHANS, Manipal)	PhD-4 (NIMHANS) MPhil-29 (NIMHANS, Manipal)	PhD-1 MSc-8 (NIMHANS, Bangalore Nursing College) BSc-20 (NIMHANS, DIMHANS) DPN-20	26 hours theory, 2 weeks UG posting and 2 weeks internship. For examination, 25 mark allocation planned as in dermatology	2283 medical officers (3 days) and 8086 paramedical staff trained (1 day)
Kerala	14 of a total of 29 medical colleges (50%)	MD -29 DPM- 11 DNB Psychiatry – 4 *As per the MCI, there are 31 MD seats across 15 medical colleges and 11 DPM seats across 5 medical colleges*	NR	NR	PhD-1 MSc -153 DPN-15		Medical officers in the DMHP are being trained for 3 days (so far 2283 trained). Other paramedical staff receive 1 day training (so far 8086 are trained)
Lakshadweep	0	0	0	0	0	0	0
Maharashtra	15 medical colleges As per the MCI, 48 medical colleges	MD-6 DPM-4 *As per the MCI, there are 52 seats across 20 colleges(7 govt) And 20 DPM seats across 11 colleges*	NR	NR	NR	All medical colleges have 15 days of training	MO trained in 3 day programme (120); Paramedical staff 1 day training (50)
Madhya Pradesh	5 medical colleges and AIIMS Bhopal MCI lists a total of 14 medical colleges	MD-9 SEATS across 5 medical colleges	0	0	0	All medical colleges have 25 hours of theory, 2 weeks of UG posting and 2 weeks of internship	NR
Manipur	2	MD-3 (RIMS, Imphal)	MPhil-7 (RIMS)	0	0	NR	350 MOs have received training; 362 others have received training
Meghalaya	NIL	0	0	Mphil - 5 (Sanker, Mawlai)	0	0	NR
Mizoram	NIL	0	NR	PhD and MPhil	NR	0	15-20 MOs are trained for 3 days

				available in Mizoram University- no details provided			
Nagaland	NIL	0	0	0	0	0	NR
Odisha	NR MCI lists a total of 8 medical colleges	MD-5 SEATS (Kalinga Institute of Medical Sciences and SCB Medical college, Cuttack)	0	0	0	25 hours of theory, 2 weeks of UG posting and 2 weeks of internship	400 staff of DMHP trained in the previous year.
Puducherry	9 medical colleges	9 As per MCI 7 MD seats across 4 medical colleges 1 DPM seat	12 (Pondicherry University)		PhD-2 (JIPMER) MSc-5 (JIPMER, MTIPGHS)	Report no UG training in psychiatry	BSc Nursing 3rd year mandatory training. Affidavit of 19 Jan 2015 says there is no inservice training
Punjab	41(all medical colleges)	MD-11 (GMC Amritsar, Faridkot, Patiala; Dayanand Medical College, Ludhiana) DNB-9	0	0	MSc-5	NR	*2 day training for MOs; nearly 258 trained till date*
Rajasthan	10 medical colleges have Depts of Psychiatry As per MCI 13 medical colleges	MD-24(across 8 medical colleges- SNMC Jodhpur, GMCH usaipur, GMC Kota, JNMC Ajmer, MGMCH Jaipur, NIMSR Jaipur, RNTMC Udaipur, SPMC Bikaner, SMSMC Jaipur	0	0	MSc-26 (UCN, Jaipur, GCN Jaipur, GCN Bikaner, IMTNE, AMTI Sikar	NR	Nil
Sikkim	1	MD-2 (Sikkim Manipal) *As per MCI, 3 seats*	0	0	0	Nil	MOs receive 3 day training
Tamil Nadu	42 As per MCI 46 medical colleges	MD-43 seats DPM-14 seats DNB-3 seats *As per MCI MD seats- 47 across 16 colleges* *DPM-17 across 6 colleges*	MPhil-20 (Pvt Sector)	NR	MSc-3 BSc-311 DPN-20 (not mentioned where)	30 hours of theory, 2 weeks posting	1253 MOs trained under DMHP 2741 paramedicals
Telengana	11 *As per MCI 20 medical colleges*	MD-6 seats DPM-2 seats *As per MCI 21 MD seats across 9 colleges* *DPM-6 seats*	0	0	0	Theory 30 hours UG posting 4 months Internship 2 weeks	Nil

		across 5 colleges					
Tripura	NR *As per MCI 2 medical colleges (AGMC and BRAMTC)*	MD-1 (Agartala Medical College)	0	0	Mentions that the Modern Psychiatric Hospital, Narsingarh is functioning as training centre for BSc Nursing	Interns posted to psychiatry dept. Duration not mentioned	NR
Uttarakhand	4	0 presently 2 MD seats proposed at SGRR medical college, Dehradun- pending with MCI	0	0	0	21 lectures, 2 week UG posting; 2 week internship posting	HIV/IDU training for OST; 14 MOs and 4 govt nurses underwent inservice training
Uttar Pradesh	28 *As per MCI there are 36 medical colleges*	MD-25 (KGMU Lucknow and IMHH Agra) DNB PSYCHIATRY- 4 DPM-1 (As per MCI,24 MD seats across 12 medical colleges)	MPHIL-14 (KGMU and IMHH)	0	0	NR	HIV/IDU training in OST. KGMU has training courses for govt nurses
West Bengal	16	MD-16 DPM-10 (IPGMER, Kolkata) As per the MCI, MD seats-18 across 8 medical colleges	8- MPHIL CLINICAL PSYCHOLOGY	16- MPHIL PSW	MSC NURSING -7 BSC NURSING – 291 DPN – 10		Medical officers in the DMHP are being trained for 3 days (so far 520 trained), 1932 nursing staff received 1 day training

Jharkand affidavit information on post-graduate seats is incomplete and does not match with the MCI website. The affidavit mentions only the information for RINPAS. The CIP at Ranchi offers 9 MD and 18 DPM seats, which does not find any mention in the filled questionnaire.

In Karnataka, MD seats are mentioned as 73. The MCI website mentions 63 MD seats across 18 colleges. This does not include NIMHANS, which now offers 31 annual MD seats (which include 8 domiciled to Karnataka). Thus, Karnataka ought to have 94 annual MD seats.

In Kerala, the affidavit mentions that only 14 of the 29 medical colleges haves a department of psychiatry. This is at variance with the MCI mandate that every medical college should have a department of psychiatry.

In Madhya Pradesh, only 5 of the 14 medical colleges have a department of Psychiatry.

In Maharashtra, only 15 of the 48 medical colleges have a Dept of Psychiatry as per their affidavit. The affidavit lists only 6 MD and 4 DPM seats whereas the MCI lists 52 MD and 20 DPM seats.

In Puducherry, although the medical colleges have departments of psychiatry, the affidavit states that there is no undergraduate training in psychiatry, which is really surprising.

Punjab has 41 medical colleges but does not list the training in psychiatry for undergraduates.

Rajasthan has started MD programmes in many private medical colleges.

Tamil Nadu has no substantive courses for training psychiatric social workers.

For Telengana, the affidavit lists departments of psychiatry being present in 11 medical colleges. While the affidavit mentions only 6 MD and 2 DPM seats, the MCI website records 21 MD seats and 6 DPM seats. Telengana has no training for any of the other mental health care disciplines. Telengana records a UG posting of 4 months, which is more than in any other state.

Uttar Pradesh has Departments of Psychiatry in 28 of the 36 medical colleges.

Superspecialty courses in Child Psychiatry (DM) are offered at NIMHANS and PGIMER. Superspecialty courses in addiction are offered at NIMHANS, PGIMER and AIIMS.

Undergraduate teaching

In 2011, the MCI had stipulated the following for the UG MBBS curriculum[77]:

- Teaching hours to be increased from 20 to 40 hours
- Posting to increase from 2 to 4 weeks
- 20 marks in the medicine theory paper for a compulsory question in psychiatry
- Internal assessment in Psychiatry mandatory for the final examination
- Compulsory psychiatry posting during internship

[77] Kallivayalil RA. The importance of psychiatry in undergraduate medical education in India. Indian J Psychiatry 2012; 54 (3):208-216.

- Integrated teaching of psychiatry, especially in community medicine.

Chandigarh- Focused training for nurses with a large number for BSc Nursing. UG training is 25 hours of theory and 2 week posting in both UG and internship. No qualifying exam that includes competency evaluation in psychiatry. However, since attendance is not mandatory, students do not come

UG training- Delhi – No skill testing; only a single question in medicine theory examination

Jammu and Kashmir-The Special Rapporteur's Report mentions that manpower is significantly short. . *Instances of selected candidates not being provided joining letters are worth highlighting for the State administration's introspection.*

For human resource augmentation, the same report mentions a proposal for a Centre of Excellence to facilitate human resource development for mental health care.

The state of Maharashtra, though it has provided a lot of information on psychiatric facilities, has not provided the figures for number of psychiatrists in the private sector. **Thus, it would be inappropriate to calculate the overall psychiatrist population ratio without getting the accurate figures. These figures are obtainable, and necessary**.

Finally….the Count (Human Resources)

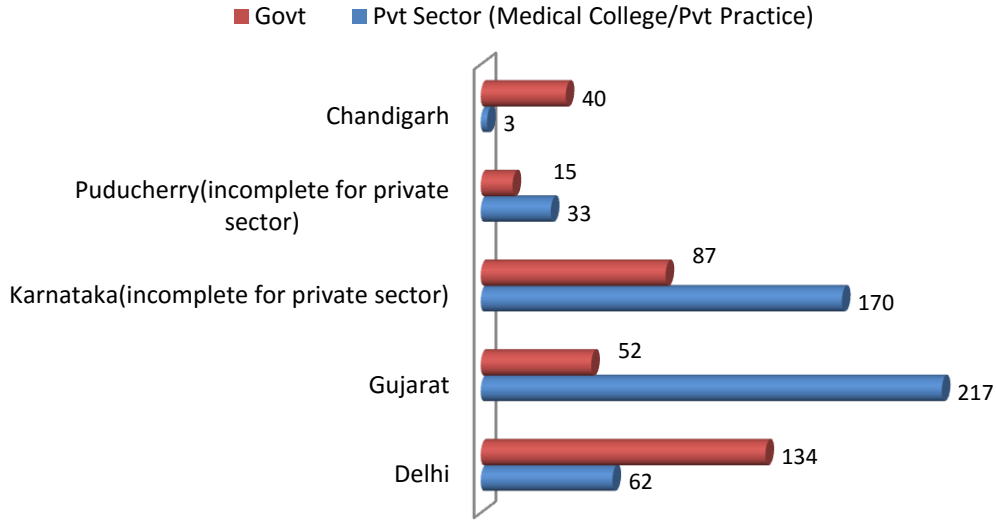
The NHRC Report in 2008[78] indicated a count of 2800 (quoting Doctors in India 2007). We know since 2010 from the figures of the Medical Council of India and the NBE that 440 annual PGs in Psychiatry (presented in the earlier figure) were added each year between 2008-2011, 542 annually between 2012 to 2014, and 576 in 2015. This should add up to a further 3420 psychiatrists (**making the count upward of 6220 psychiatrists in 2015).**

Where have all the psychiatrists gone? A proper count should provide a clearer answer.

In the accompanying figure, an illustration is provided regarding the distribution of psychiatrists in the government and private sector:

[78] Kishore Kumar and Murthy P. Realizing the objectives of the national mental health programme: a look at states and innovations. In Mental Health and Human Rights. ibid

Figure 5. Psychiatrists in government and private sectors (illustrative for 4 States/UTs)



In Gujarat and Karnataka, and perhaps in many other states once a proper counting is done, the private sector far exceeds the government sector. In places like Puducherry, where the only psychiatrists in 2008 were all in government service, the private sector is increasing. It is only in the UTs of Delhi and Chandigarh that a substantial number of psychiatrists are in the government sector.

The DGHS report (2002) suggests a ratio of 0.3 psychiatrists per 100,000 population and a desirable ratio of 1 psychiatrist per 100,000. Chandigarh, Delhi, Manipur, Puducherry and Sikkim have managed to achieve this ratio. Many of the other states, which have not mentioned figures in the non-government sector and medical colleges are likely to show improved ratios if they count right.

However, despite appropriate counting, there remains a deficit in psychiatrists. Gujarat stands out in terms of mental health care human resource development. The state of Gujarat has a total of 269 psychiatrists, of whom about one fifth are in the government sector. The state has a relatively higher number of trained nurses in the government sector and has some trained counselors as well. However, as illustrated from the affidavit report of Gujarat, although their ratios of psychiatrist per 100,000 population has increased from 0.19 in 2002 to 0.45 in 2015, this is still very low, and systematic plans to improve it further need to be undertaken.

Another point of concern is that the change in the number of psychiatrists in the government sector is lower compared to that in the private sector.

Other mental health professionals

For these categories of mental health professionals, the totals calculated from the affidavits are mentioned, as there are not many of them in the private sector. Delhi is an exception, where there are more clinical psychologists working in the private sector (56) compared to the government sector (16). This trend is also true for nurses trained in mental health (22 in private sector). Delhi has 4 trained counselors in the government sector. Apart from the medical college and teaching institutions, there is no sanctioned post of psychiatric social worker or clinical psychologist in any district hospital. Very few states have trained counselors.

Table 18. Status of other mental health professionals across states

Name of State	No of Psychologists as per DGHS Report 2002	No of Psychologists as per State Affidavit 2015	No of Psychiatric Social Workers per DGHS Report 2002	No of Psychiatric Social Workers as per State Affidavit 2015	No of trained Mental Health Nurses as per DGHS Report 2002	No of trained Mental Health Nurses as per State Affidavit 2015
Andaman and Nicobar	**0**	0	0	1	**0**	0
Andhra Pradesh[#]	**8**	3	3	1	**0**	0
Arunachal Pradesh	**0**	1	0	1	**0**	6
Assam	**5**	3	1	20	**1**	2
Bihar	**13**	2	NR	2	**NR**	0
Chandigarh	**14**	18	10	5	**1**	6
Chattisgarh	**1**	1	2	2	**0**	0
Dadra and Nager Haveli*	**0**	1		1	**4**	8
Daman and Diu*	**0**	0	1	1		1
Delhi	**43**	72	13	19	**172**	24
Goa	**2**	5	3	2	**2**	60
Gujarat	**12**	11	12	15	**0**	399
Haryana	**2**	0	0	1	**1**	NR
Himachal Pradesh	**2**	13	0	14	**0**	47
Jammu and Kashmir	**1**	8	1	2	**0**	0
Jharkhand	**15**	9	10	14	**NR**	10
Karnataka	**69**	57	56	56	**175**	49
Kerala	**42**	22	40	19	**14**	233
Lakshadweep	**0**	0	0	0	**0**	0

Madhya Pradesh	**0**	1	0	75	**1**	156
Manipur	**1**	13	2	15	**0**	135
Maharashtra	**33**	12	44	14	**117**	17
Meghalaya	**0**	4	0	5	**2**	26
Mizoram	**1**	8	1	4	**2**	4
Nagaland	**0**	1	0	0	**1**	4
Odisha	**5**	8	1	1	**0**	4
Puducherry	**1**	11	13	12	**20**	22
Punjab	**18**	12	21	24	**10**	12
Rajasthan	**12**	8	4	6	**0**	0
Sikkim	**0**	1	0	0	**0**	0
Tamil Nadu	**7**	29	21	74	**0**	13988*
Telengana		6		7		80
Tripura	**0**	1	0	0	**0**	9
Uttarakhand	**0**	3	0	8	**0**	12
Uttar Pradesh	**20**	15	35	25	**0**	0
West Bengal	**28**	37	0	8	**4400***	231
Total						

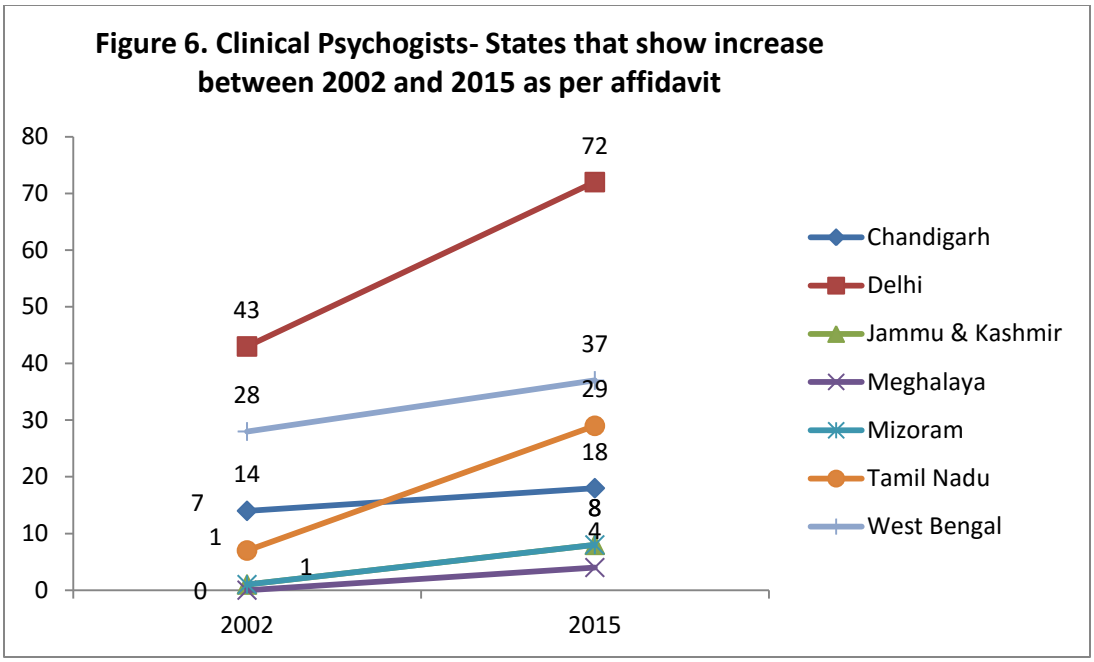
[#] Undivided Andhra; *West Bengal in 2002 and Tamil Nadu in 2015 have mentioned a very large number of nurses. It appears that these are not qualified mental health nurses, but that general nurses have been sensitized about mental health related issues.

The low rates of mental health professionals demonstrated way back in 2002[79] leading to huge treatment gaps persist in many places.

Clinical Psychologists

The figures mentioned in the affidavits of Jharkand, Karnataka, Kerala, Maharashtra, Punjab, Rajasthan and Uttar Pradesh need to be verified by the respective states. Seven states record an increase in the number of clinical psychologists, but except for Delhi, the increases are not substantial. Andaman and Nicobar, Daman and Diu, Haryana and Lakshadweep do not record a single clinical psychologist in the state. States like Chattisgarh and Madhya Pradesh record one each.

[79] Indian Council for Medical Research (ICMR) and IHBAS. Situational Analysis of Urban Mental Health in India. Shah B, Desai NG (Publishers). ICMR-WHO Urban Mental Health Project 2002-2004.



Meeting ratios

The DGHS document of 2002 aspired to have 1.5 psychologists per 100,000 population. Chandigarh has met this aspiration and Meghalaya is close to this.

Table 19. Clinical Psychologists according to affidavit in 2015

State/UT	2002	2015	Population	Ratio of CP/100000 population
Chandigarh	14	18	1109377	1.62
Delhi	43	72	16787000	0.43
Jammu & Kashmir	1	8	12541302	0.06
Meghalaya	0	4	2966889	0.13
Mizoram	1	8	1091014	0.73
Tamil Nadu	7	29	72147030	0.04
West Bengal	28	37	91347736	0.04

Psychiatric Social Workers

Chandigarh and the states of Karnataka, Kerala, Maharashtra, Punjab and Uttar Pradesh need to check the figures provided in the affidavit for the numbers of psychiatric social workers. Their numbers are static in Odisha, Puducherry, Chattisgarh, Daman and Diu, Goa, Haryana and

Nagaland. Lakshadweep, Nagaland, Sikkim and Tripura do not even now document a single psychiatric social worker.

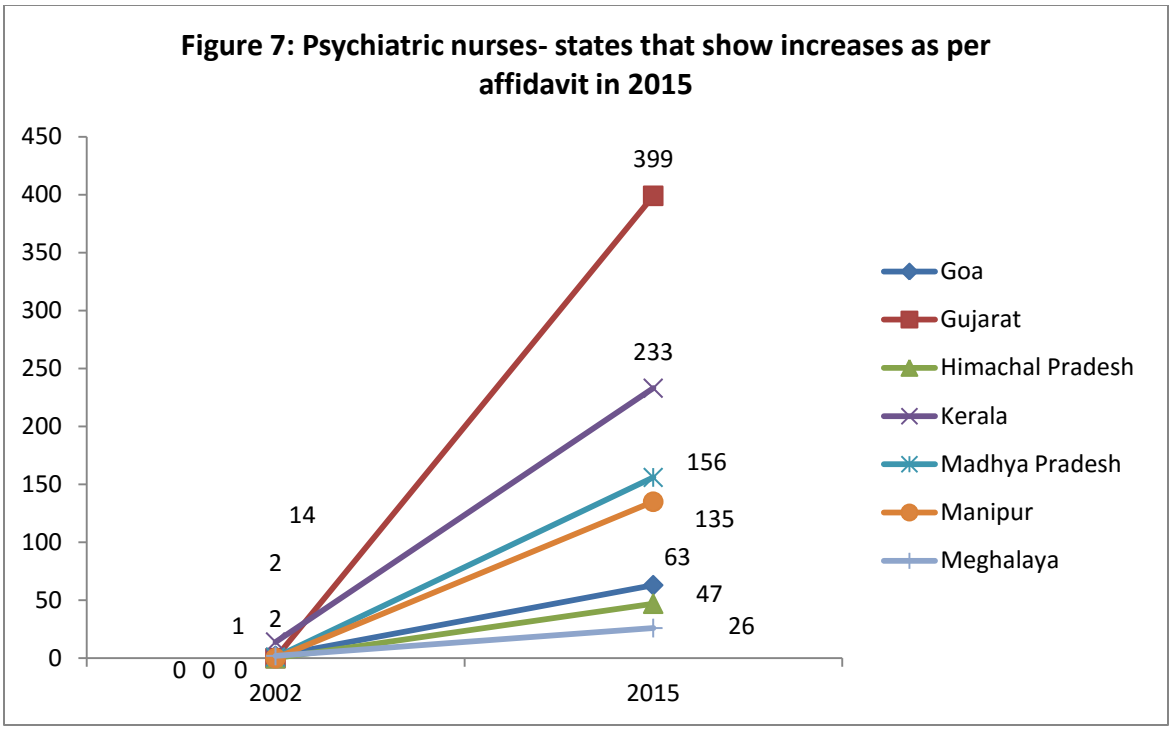
Table 20. Psychiatric Social Workers according to affidavit in 2015

State/UT	2002	2015	Ratio of PSW/100000 population
Assam	1	20	0.06
Delhi	13	19	0.11
Gujarat	12	15	0.02
Himachal Pradesh	0	14	0.20
Madhya Pradesh	0	75	0.10
Manipur	2	15	0.6
Meghalaya	0	5	0.2
Mizoram	1	4	0.4
Punjab	21	24	0.1
Tamil Nadu	21	74	0.1
West Bengal	0	8	0.01

Significant increases in psychiatric social workers are evident in Madhya Pradesh, Tamil Nadu, Assam and Himachal Pradesh. Himachal Pradesh has been making a concerted effort to train its medical officers, psychologists and psychiatric social workers in the management of addiction and the latter for management of mental health problems by organizing their deputation to NIMHANS for training. However, the ratios are well below the aspired ratios of 2 PSWs per 100000 population.

Psychiatric Nursing

States which have significantly increased their mental health human resource in psychiatric nursing include Goa, Gujarat, Himachal Pradesh, Kerala, Meghalaya, Madhya Pradesh and Manipur. Dadra and Nager Haveli have doubled the number of psychiatric trained nurses. Chandigarh, and Jharkand have increased the number of psychiatric nurses marginally.



Governance

There are still several states where there is variability in the governance mechanisms to oversee the mental health services.

This section looked at nodal authority identified to oversee mental health services and its composition, existence of a State Mental Health Plan, existence of Rules under the Mental Health Act 1987, oversight mechanisms for policy and programmes, evidence of high level commitment, inter-sectoral co-ordination and attempts to integrate mental health care with general health care.

Table 21.Governance

Name of State	Identified nodal authority	State Mental Health Plan	State Mental Health Rules present	Oversight of mental health policy and plans	Attempts to integrate MH into GHC/NCD programme	Examples of high level commitment to mental health care	Any examples of inter-sectoral co-ordination for mental health care
Andaman and Nicobar	NR	NO	NR	NR	NO	NO	NO
Andhra Pradesh	DME	NO	NR	NR	NR	NR	NR
Arunachal Pradesh	YES- ME/Health/SW/ SMHA/DLSA	NR	NR	NR	NR	NR	NR
Assam	DME/DHS/SMHA/ASL SA/DSW	NR	NR	State support for mental health programme since 2011	NR	NR	NR
Bihar	YES-ME/Health/SW/ SMHA/DLSA	NR	NR	NR	NR	NR	NR
Chandigarh	YES-Health	NO	NR	NR	NR	NR	NR
Chattisgarh	YES-ME/Health/Social Welfare/SMHA/DLSA	NR	NR	NR	NR	NR	NR
Dadra and Nager Haveli	NR	NO	NR	NR	NR	NR	NR
Daman and Diu	NR	NR	NR	NR	NR	NR	NR
Delhi	Health and Family Welfare/Social Welfare/SMHA/DLSA	Draft Delhi Mental Health Plan has also been prepared by SMHA, Delhi which is now in the process of final stages of deliberations with the Policymakers under Dept of Health.	YES	Dedicated nodal officer of the rank of Special Secretary for mental health SMHA active role in mental health awareness Active collaboration of IHBAS with NGOs, User and carer organizations, DLSA	NR	Facilitated by Depts of Psychiatry in medical colleges and multi-specialty private hospitals. Also by locating DMHP in GH/dispensary	Improved budget for govt psychiatric hospital (IHBAS). Time to time loans by State Govt to rescue the DMHP
Goa	Dr Prashant Natekar, designation not	NO	NR	NO	NO	NO	NO

	mentioned						
Gujarat	ME/Health/Social Welfare/SMHA/DLSA	NO	YES	NR	Taluka Mental Health Programme initiated with Rs 5 Lakh PA grant-in-aid to hospitals from 13 taluks for OPD upgrading/IEC/ medications support	NR	Suicide prevention programme initiated at all medical colleges in Ahmedabad
Haryana	Medical and Health Dept/SMHA	NO	NO	NO	NO	NO	NO
Himachal Pradesh	Director Medical Education and Research Director Health Services HP Director Social Welfare	NO	NO	No specific programme or policy	NO	NO	NO
Jammu and Kashmir	SMHA non functional according to SR Report	NR	NR	NO	NO	NO	NO
Jharkhand	ME/Medical and Health/SMHA/ JHALSA	NR	NR	NR	NR	NR	NR
Karnataka	State Mental Health Authority	Yes, 2003	2008	NR	Happening as a pilot in Kolar district through a NIMHANS – GOK initiative.	NR	Tirthahalli Mental HealthProject Basic Needs project to empower persons with mental disorders and their families. Siddalghatta community mental health project (RFS) The Karuna Trust initiative for mental health training in 25 PHCs. The preliminary experience suggested very low levels of identification.
Kerala	Kerala State Mental Health Authority	Yes	2012	Kerala State Mental Health Authority	Partial integration of mental health care into general health care.	NR	NR

Lakshadweep	NR	NR	NR	NR	NR	NR	NR
Maharashtra	Additional Director, Mental Health, Directorate of Health Services	NO	NO	NR	NO	NR	NO
Madhya Pradesh	Medical education/ State Medical and Health Department/ Social Welfare Department/ State Mental Authority	NO	NO	NR	NO	NR	NO
Manipur	Medical Education/ SMHA	NR	NR	NR	NR	NR	NR
Meghalaya	State Mental Health Authority	NR	NR	NR	NR	NR	NR
Mizoram	Medical Education / State Medical and Health Department/ Social Welfare Department/ State Mental Health Authority	NR	NR	NR	NR	NR	NR
Nagaland	State Medical & Health Department	NR	NR	NR	NR	NR	NR
Odisha	Additional Director, Mental Health, Directorate of Health Services	NO	NO	NR	NO	NR	NO
Puducherry	Director of Medical Education b. Director, State Medical and Health Department c. Director, Social Welfare Department d. Programme Officer, Social Welfare Department e. Programme Officer, State Mental Health Authority f. Member Secretary, District Legal Services Authority	NR	NR	NR	NR	NR	NR
Punjab	Dr Sukhwinder Kaur (State Programme Officer)	NO	NO	NR	NR	NR	NR
Rajasthan	Dr Pradeep Sharma	NO	NR	NO	No	NR	NR
Sikkim	Medical Education: Dr JK Topagay, additional Director State Mental Health Authority: Dr PM Pradhan, Director	NO	NR	NO	NO	NO	NO

Tamil Nadu	State Mental health authority, Dy Director of Medical Education (H and D), Chennai; Additional Director of Medical and Rural Health Services, Chennail, District legal Services Authority, Commissioner for welfare of Differently abled	NO	NO	NR	NO	NO	NO
Telengana	Additional Director, Mental Health	NO	NO	NO	NO	NO	NO
Tripura	NR	NR	NR	NR	NR	NR	NR
Uttarakhand	1. Medical Education – Dr. R.P. Bhatt 2. State Medical and Health Department – Dr. Suman Arya, 3. Social Welfare Department Mr. Vishnu Singh Dhanik, 4. SMHA – Dr. J.S. Bisht, 5. District Legal Services Authority – District Judge in all districts.	NR	NR	NR	NR	NR	NR
Uttar Pradesh	1. Medical Education – Dr. V.N. Tripathi (Director General Medical Education), 2. State Medical and Health Department – Dr. Renu Jalolte, 3. Social Welfare Department – Dr. Surendra Vikram, 4. SMHA – Dr. S.C. Tiwari, 5. District Legal Services Authority – Shri Tej Pratap Tiwari.	NR	NR	NR	NR	NR	NR
West Bengal	Director of Medical Education, Director of Health Services (Mental Health), Commissioner Disability and JD Health Services (State Mental Health Authority)	NO	NR	NR	NR	NO	NO

Nodal Authority

The following do not even mention a nodal authority for mental health- Andaman and Nicobar, Dadra and Nager Haveli, Daman and Diu, Lakshadweep and Tripura.

States which report nodal authorities in health, legal and social sectors include Arunachal Pradesh, Assam, Bihar, Chattisgarh, Delhi, Gujarat, Himachal Pradesh, Jharkand, MP, Mizoram, Puducherry, Tamil Nadu, Uttarakhand, Uttar Pradesh and West Bengal.

State Mental Health Plan

Delhi reports having a draft mental health plan awaiting approval and Karnataka reports having a mental health plan, made in 2003. Apart from these two, none of the other States has a mental health plan.

State Mental Health Rules

Only Delhi, Karnataka, Kerala and Gujarat report having framed/adopted the Mental Health Rules. Most have the states do not record this (although the DGHS Report of 2002 says that Goa, Manipur, Assam, Chandigarh, Delhi, Gujarat, MP, Mizoram, Tamil Nadu had framed the Rules**)- possibly a clear case of done…..and forgotten!**

Oversight of mental health policy and plans

When there are no policies and plans, there is little question of oversight of the same. The lack of high level commitment to mental health care is quite evident from the lack of responses to this question.

Integration of mental health

There are hardly any examples of attempts to integrate mental health into general health care or NCDs and examples of inter-sectoral co-ordination for mental health care. It was in 1982, more than three decades ago that a plan was made to integrate mental health into general health care.

Delhi, Gujarat, Karnataka and Kerala are the exceptions to the above, and report some examples of state initiatives to address mental health issues. Kerala mentions a partial integration of mental health into general health care.

Innovations

Every State/UT was asked to mention innovations and what they included as innovations are mentioned in the table below.

Table 22. Innovations in Mental Health Care, Budgetary Provisions and Pending Proposals

Name of State	Innovations	Separate budget for mental health in state	Percentage of health budget allocated for mental health care	Pending proposals
Andaman and Nicobar	None	No	No specific allocation	*As per affidavit submitted before Hon'ble Supreme Court on 8th October, 2014 by Resident Commissioner of ANI, the UT plans to initiate DMHP and PIP (project Implementation Plan) has been submitted for 2014-17, but approval from National Programme Coordination Committee , MOHFW, GOI is awaited.* *The ROP (Record of Proceedings) of MOHFW, GOI shows no funds approved for 2015-16 against a proposal of 5.09 by the UT.* *(Source: NRHM website)*
Andhra Pradesh	None	NR	Nil	Nil
Arunachal Pradesh	None	NR	Nil	Plan to establish two half-way homes of 20 residents in each
Assam	None	Grants enhanced from 18 crore in 2012-13 to 64 crore in 2013-14 to 66 crore in 2014-15	Nil	New hospital under construction
Bihar	None	BIMHAS-2.09 crores	Nil	Positions for 11 new DMHPs sanctioned and recruitment to be completed soon State proposes DMHP in remaining districts in next five years beginning 2015-2016
Chandigarh	Home based care for mentally ill and Crisis intervention services-GMCH	No	NR	Plans for a designated psychiatric hospital
Chattisgarh	None	SMH Bilaspur-separate budget	Nil	Nil
Dadra and Nager Haveli	None	No	Nil	Nil
Daman and	None	No	Nil	Nil

Diu				
Delhi	Mobile Court Mental Health Outreach Programme for Homeless Mobile Mental Health Service	GOI finances Dept of Psychiatry at AIIMS and other hospitals, and 3 out of 5 DMHP. It is supporting IHBAS as COE	State Govt finances IHBAS and state run medical colleges and hospitals. The state has taken over 2 DMHPS MC finances a medical college with a Dept of Psychiatry	Network of Long Stay Homes and Half way Homes (LSH/HWH) is being planned for the State of Delhi. 7 of such LSH/HWH are to be started soon. 5 LSH/HWH are planned to be under administrative control of Department of Social Welfare. The buildings have been constructed and administrative and monitoring mechanism for such rehabilitation homes is under deliberation. 2 LSH/HWH are planned to be constructed at IHBAS for which approval o f Layout plan is MCD and DDA is in process. DMHP in all districts in a phased manner
Goa	None	NR	NR	NR
Gujarat	Dava and Dua Taluka Mental Health Community Based initiatives Psychological first aid	NR	NR	8 NGOs have been selected to continue support and upscale community based mental health activities (AWAG, TRU, VJT, BCC, Ashadeep, BAIF, BPA
Haryana	NR	For the SIMH, 2.5 crores	NR	Plan to expand DMHP to 5 more districts In service training planned for medical officers in 2015
Himachal Pradesh	NR	NR	NR	DMHP data suggests that the approach may not be useful in difficult terrains with sparse populations and other approaches are needed
Jammu and Kashmir	None	NR	NR	State Mental Health Authority needs to get activated
Jharkhand	None	NR	NR	Plan to expand DMHP to 2 more districts-Hazaribagh & Deogarh in next 5 years Plan to upgrade RINPAS Plan for two 50 bed halfway home underway at RINPAS
Karnataka	One major driving force in Karnataka to develop psychiatric services was the proactive role taken by the High Court of Karnataka which asked for a plan of action in its order of 18 July 2002. 104 Arogyavani 108 Toll free ambulance 1056 Toll free control room 09449000739- ambulance to shift persons with mental illness from home to hospital (only in Bangalore)	DMHP (Central functions) Rs 9 crores (12 DMHPs) Remaining DMHPs being funded by State Rs 50 lakhs to SMHA under NRHM (2008-09 and 2009-10)	Not specified	Nil

	Manasadhara day care Super Tuesday psychiatry clinics Manochintana mental health awareness programmes on FM Radio; Regular DD programmes on mental health awareness Intersectoral initiatives (Basic Trust, Karuna) Community Projects (Thirthahalli and Siddalghatta). Radio and TV programmes (Hello Gelayare) and mass education (Drs CR Chandrashekar, Ashok Pai and Sridhar) Evaluation of mental health and substance use problems in prisons (NIMHANS/KSLSA) Free legal aid cell first started at NIMHANS Mental Health Awareness Programmes under the KLSA (spearheaded by Justice Kumar) Centre for well-being started at NIMHANS			
Kerala	7districts (Ernakulam, Kasargod, Kozhikode, Malappuram, Palakkad, Pathanamthitta and Kottayam) have initiated community mental health program under NHRM. This community mental health program is similar to DMHP, however it is not comprehensive. Hence, partial implementation of mental health services. The state has successfully diverted the general physical health budget from NHRM to community mental health' for the first time in the history of INDIA'	NR except for DMHP grants to Trivandrum, Thrissur, Idukki, Wayanad and Kannur (two for 2008-09 and others for 2012-2013) Comment that there is a Separate budget, somewhat adequate	Not specified	Nil
Lakshadweep	None	No	No	1 post of psychiatrist at Rajiv Gandhi Hospital at Agatti Island proposes under the PPP mode
Maharashtra	Nil	Regional Mental Hospital and 4 DMHPs Poor fund utilization at MIMH. 13 state medical college departments funds ranging from17,00,000 till 35,00,000/- from the	No separate budget, but some financial resources available annually	Nil

		state. Used for infrastructure development (no significant human resource development)		
Madhya Pradesh	Nil	Two mental hospitals receive grants from State through DME and received one time grant from Union Govt in 2005-06.Mainly used for infrastructure development. DMHP funds poorly utilized	No separate budget, but some financial resources available annually	Nil
Manipur	NR	NR	NR	NR
Meghalaya	Nil	MIMHANS Plan (Amount in Rs. 19050000, Non Plan Rs. 20450000)	NR	Nil
Mizoram	NR	NR	NR	Nil
Nagaland	Nil	State Mental Health Institute Kohima : Non plan funds [(Amount in Rs. 1,58,54,100.00 (Salary Head)]	NR	Nil
Odisha	Nil	NR	NR	NR
Puducherry	Nil	The IGGGH receives financial support from the state budget and NRHM funds (for DMHP).	No. But, according to the affidavit submitted by the Health Secretary, the necessary funds have been allocated for maintenance and improvement of the physical infrastructure and there are no administrative or financial constraints in delivery of mental health care services.	NR
Punjab	Nil	NR	NR	NR
Rajasthan	NR	NR	NR	'State is striving for 2 NIMHANS like institutions'
Sikkim	Nil	Govt Dept of Psychiatry supported by State	NR	There is a stringent act called "Sikkim Anti-Drug act, 2006" aimed to control drug use
Tamil Nadu	Separate budget, somewhat adequate	The comment is that the Psychiatric Institute and Medical Colleges are adequately funded	NR	Nil
Telengana	NR	NR	NR	Nil
TRIPURA	None	No	Nil	Nil
Uttarakhand	State Mental Health Institute,	No	NR	1 Proposal of SGRR Medical

	Plan Funds of amount Rs. 71,45,000.00			College at Dehradun, Name of Authority with home pending – MCI, No. Of Seats requested – 2, Current Status of Proposal – Pending at MCI,
Uttar Pradesh		Mental Hospital, Varanasi 3131205 (P)/61192470 (NP) IMH Agra 150000000 Mental Hospital Bareilly-55000000	NR	Nil
West Bengal	Nil	NR	NR	NR

Home- based care, crisis intervention, mobile units, novel community based interventions, awareness programmes on radio and tv, day care centres are some of the notable interventions that have occurred. But these are reported only from 5 or 6 states.

It is very well known that health spending within the country itself is low. Within health, unless carefully allocated and regularly monitored, funding for mental health tends to get eclipsed, or mental health services often get forgotten. A typical example is the sanctioning of a single grant-in-aid by government to build de-addiction facilities. A review of this a few years later showed that most of these facilities had been used for other activities, or simply as godowns for storage.

Many of the states have no pending plans. Jammu and Kashmir still has to activate its mental health authority. Pending plans are largely limited to DMHP expansion. Delhi plans to establish as set of longstay homes. Gujarat plans to scale up NGO supported community activities.

INFORMATION ON PSYCHIATRIC INSTITUTIONS

The questionnaire (Appendix 1) circulated to the states applied to specialized psychiatric institutions. However, many gaps were found in the affidavit replies. Since the Inspection Committee visited most of the government psychiatric institutions (and responses from private institutions was extremely limited), this section has consolidated the reports of individual hospitals collated by the Inspection Committee.

As mentioned earlier, each of psychiatric institutions was visited by a committee comprising the Joint Secretary, Ministry of Health and Family Welfare, Government of India, Secretary Health of the State Government, secretary of the State Mental Health Authority, State Legal Services Authority, State Human Rights Commission, and a prominent psychiatrist.

The IC visited 3 Central Institutions and 41 state institutions. In the list below, institutions in Arunachal Pradesh, Chattisgarh and Haryana were NOT visited by the IC, but have been included as they are state institutions (information from Section 2 for these institutions).

Table 23. List of Government Psychiatric Institutions in the Country

	Name of the Institution	State
1	Midpu MH, Pampampure*	Arunachal Pradesh
2	GMHC Vishakapatnam	Andhra
3	Lokopriya Gopinath Bordoloi Institute of Mental Health	Assam
4	Bihar State Institute of Mental Health, Bhojpur	Bihar
5	State MH Sendari, Bilaspur*	Chattisgarh
6	IHBAS	Delhi
7	IBHB, Panaji	Goa
8	HMH Bhuj	Gujarat
9	HMH Jamnagar	Gujarat
10	HMH Ahmedabad	Gujarat
11	HMH Baroda	Gujarat
12	RIMS*	Haryana
13	HMH Shimla	Himachal Pradesh
14	Psychiatric disease hospital, Jammu	Jammu and Kashmir
15	Govt Hospital for Psychiatric Diseases, Srinagar	Jammu and Kashmir
16	RINPAS, Ranchi	Jharkand
17	CIP, Ranchi	Jharkand
18	NIMHANS, Bangalore	Karnataka
19	DIMHANS, Dharwad	Karnataka
20	MHC Thiruvananthapuram	Kerala
21	GMHC Kozhikode	Kerala
22	GMHC Thrissur	Kerala
23	Gwalior Manasik Arogyashala,Gwalior	Madhya Pradesh
24	Mental Hospital,Indore	Madhya Pradesh
25	Regional Mental Hospital,Pune	Maharashtra

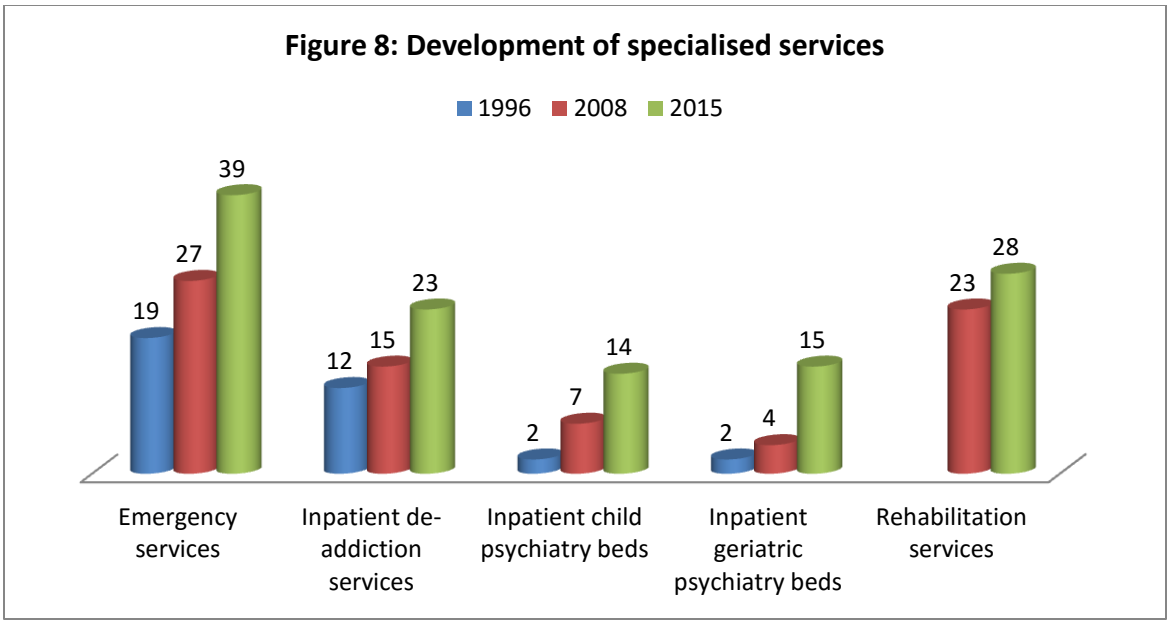
26	Regional Mental Hospital,Thane (W)	Maharashtra
27	Regional Mental Hospital, Ratnagiri	Maharashtra
28	Regional Mental Hospital, Nagpur	Maharashtra
29	Meghalaya Institute of Mental Health & Neurosciences,Shillong	Meghalaya
30	Mental Hospital,Kohima	Nagaland
31	Mental Health Institute, Cuttack	Odisha
32	Dr.Vijayasagar Punjab Mental Hospital,Amritsar	Punjab
33	Mental Hospital, Jaipur	Rajasthan
34	Mental Hospital, Jodhpur	Rajasthan
35	Institute of Mental Health,Chennai	Tamil Nadu
36	Institute of Mental Health, Hyderabad	Telangana
37	Modern Psychiatric Hospital, West Tripura	Tripura
38	Institute of Mental Health, Agra	Uttar Pradesh
39	Mental Hospital, Bareilly	Uttar Pradesh
40	Mental Hospital, Varanasi	Uttar Pradesh
41	State Mental Health Institute, Dehradun	Uttarakhand
42	Lumbini Park Mental Hospital, Kolkatta	West Bengal
43	Institute of Mental Care, Purulia	West Bengal
44	Mental Hospital, Berhampore	West Bengal
45	Calcutta Pavlov Hospital, Calcutta	West Bengal
46	Institute of Psychiatry, Calcutta	West Bengal
47	MH, Munkundu	West Bengal

***not visited by the IC**

Patient load and special services

Inpatient beds in the 47 hospitals totals 18307. A total of 473913 new registrations (annual) are seen across the hospitals (data for 45/47) and follow-ups number 2259300. A total of 79947 admissions have occurred across the institutions (no figures for MH Midpu Arunachal Pradesh and SMH Bilaspur, Chattisgarh).

Fourteen institutions (30%) have dedicated beds for children (12 exist and 2 are under construction at the IMH Agra and GHPD Srinagar), 15 institutions offer specialized inpatient services for the elderly (includes one under construction at the IMH Agra). De-addiction services are now offered at 22 hospitals (47%). Most offer direct emergency services. But only IHBAS, IPHB Goa and PDH Jammu actually specified the number of emergencies seen in the last year.



The hospitals in Maharashtra, West Bengal, Uttar Pradesh (apart from Agra), Arunachal Pradesh, Bihar, Chattisgarh, Nagaland and Tripura have not kept pace with the other states in developing these facilities within the psychiatric institutions. It can also be noted that though there are substantial changes since 1996, inpatient de-addiction services still do not exist in 50% of these hospitals, inpatient children wards do not exist in 68%, beds for the elderly with mental illness do not exist in 67% and rehabilitation facilities do not exist in 39%.

Mother-baby units have been initiated at NIMHANS and IHBAS.

The Inspection Committee Report for RINPAS notes that the vocational training workshops at RINPAS are quite impressive.

Facilities

Facilities in general have approved across all hospitals. Fans are reported as adequate in all hospitals except MH Kohima and VPMH Amritsar. Water supply problems are reported in HMH Shimla. At RINPAS, the Special Rapporteur noted that there were long queues at both the registration counter as well as at the medicine distribution counter. The OPD space was not clean and some cracks were found in the walls and floor.

With regard to other specific problems with the facilities, the IC has made specific observations and recommendations for the 44 institutions visited by them.

Overcrowding, inadequate facilities, persistent old practices in a few

Some of the large hospitals, particularly those in Maharashtra, some of the hospitals in Kerala and West Bengal, still continue to have issues related to overcrowding, inadequate facilities and care. A report by the Human Rights Watch[80] raises concerns of ongoing rights violations against women in some of the hospitals like forced institutionalization, crowding, inadequate sanitation, compulsory head shaving, forced treatment, exploitation and lack of access to proper care, treatment and rehabilitation.

Low bed utilization-the new problem

In contrast to the overcrowding continuing in a few hospitals, in many of the newer hospitals set up in the last decade, the bed utilization is extremely low. These are mentioned later. At HMH Jamnagar the Special Rapporteur noted that services require improvement and occupancy is only 50%.

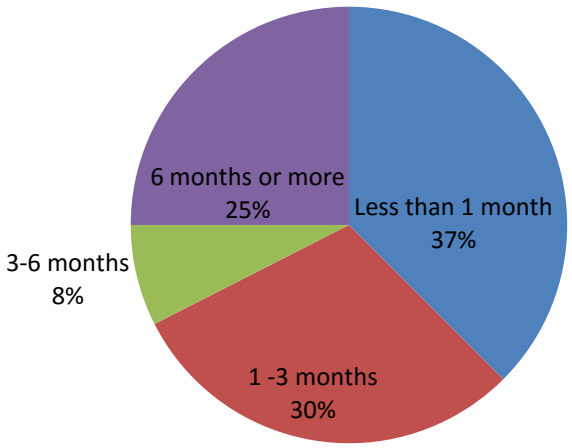
At DIMHANS in Karnataka, sanctioned bed strength is 375, but functional clinical beds are only 212. Reason for the same is not mentioned.

Duration of inpatient stay

Duration of hospital stay in the psychiatric hospitals has come down drastically, with about two –thirds (65%) having admission periods less than 3 months. This can largely be attributed to having more voluntary admissions, involvement and possibly early restoration to the family.

[80] Human Rights Watch.2014, ibid.

Figure 9: Average duration of inpatient stay in different psychiatric hospitals



Complaints, Rights and Oversights

Twenty-two of the institutions (47%) report one or more visits by the SHRC/NHRC in the last two years. Institutions that report no monitoring visits include the hospital at Midpu in Arunachal Pradesh, RMH Pune, RMH Ratnagiri, RMH Nagpur, Vidyasagar MH Amritsar, MH Jodhpur, Model MH Tripura, SMHI Dehradun, IMHH Agra, MH Bareilly, MH Varanasi, Lumbini Park Hospital and IMC Purulia in West Bengal. Twenty-one institutions report one or more visits by the State Mental Health Authority in the past two years.

Institutions that report no visits either from the SHRC/NHRC or the SMHA include the Midpu MH in Arunachal Pradesh, SMH Sendari in Chattisgarh, HMH Vadodara in Gujarat, RMH Pune, Ratnagiri and Nagpur in Maharashtra, MH Jodhpur, MH Bareilly and MH Varanasi.

IHBAS, NIMHANS, HMH Vadodara and IMH Hyderabad report receiving patient complaints regularly and responding to them. Incident records and reports are kept in IPHB Goa, NIMHANS, GMHC Thrissur, GMA Gwalior and RMH Nagpur.

IHBAS has developed a document for Policy and Procedure for Voicing of Complaints/Grievances by the Users and their Redressal-the IHBAS Quality Manual in 2012,

with a policy regarding grievance redressal, the procedures for complaining and procedures for handling the complaints. Complaints resolved range from diet, mosquitos, rude behaviour of attendants, to long queues in the pharmacy for senior citizens.

More than two-thirds of the hospitals (68%) report displaying rights of the patients.

Investigations

36 (77%) of the hospital report having laboratory facilities for basic investigations within the hospital. Hospitals in Nagaland, Jodhpur, the Lumbini Park Hospital report not having in-house facilities. This information is not provided by the hospitals in Arunachal Pradesh, Bihar and Haryana.

Treatment

Availability of psychotropic medications is reported as satisfactory by 36 (77%) of the hospitals. With other hospitals there appears to be occasional irregularity in the availability of medication, but this is not a serious problem (grading of B). Poor availability of medicines is reported only by the MH at Kohima. These details are not available for the hospitals of Agartala, Bihar, Haryana and Behrampore.

Thirty-three (70%) of the hospitals offer ECT services. The hospital in Bareilly is in the process of developing these services. The hospitals at Shimla, Thrissur, Meghalaya, Dehradun, Varnasi and all the hospitals in West Bengal except the IOP do not provide ECT treatments.

Among the institutions who have administered ECTs during the last year, there has been an anaesthetist available except in the hospital at Tripura. Where anaesthetist has not been available, no ECT treatments have been given in the hospitals at Jamnagar, Kozhikode and PDH Jammu.

Psychosocial counseling is available in most institutions (90%).

Recreational activities

Most institutions offer recreational activities for patients, with the exceptions of Midpu MH in Arunachal, State MH Sendari in Chattisgarh, MHI Cuttuck and a couple of hospitals that have not provided any information (Haryana and Bihar).

Medical Co-morbidity

High rates of medical co-morbidity are reported among the in-patient population from many hospitals, notably IHBAS, HMH Ahmedabad, GHPD Jammu, CIP Ranchi, GMHC Thiruvananthapuram and Koxhikode, RMH Pune, Ratnagiri and Nagupur, SCB Cuttuck, IMH Chennai and Calcutta Pavlov Hospital.

Deaths in the hospital

Across the 47 hospitals, 368 deaths have been reported during the last year. However, it may be noted that in most of the psychiatric hospitals, few deaths are recorded. This number is accounted for by a few of the hospitals, particularly Regional Mental Hospital, Pune, Thane and Nagpur, MHI Cuttuck, IMH Chennai, MH Behrampore, Calcutta Pavlov Hospital and GHME Kozhikode.

While deaths related to old age among the long-stay may be inevitable, it is important to consider deaths due to co-morbid physical illnesses, particularly nutritional and infectious causes as being potentially preventable, and investigating the cause of such deaths. This is particularly important in hospitals where the number of deaths is relatively high – the hospitals of Maharashtra, Punjab, Tamil Nadu, West Bengal and Kerala. Suicide as the cause of death in all these hospitals is negligible, thus indicating co-morbid physical illnesses or old age as possible underlying causes - a very similar pattern to asylum deaths in the nineteenth century.

Table 24: Annual deaths in different psychiatric institutions during the last year

Name of the Institution	State	No of deaths
Midpu MH, Pampampure	Arunachal Pradesh	NR
Lokopriya Gopinath Bordoloi Institute of Mental Health	Assam	4
GHMC Vishakapatnam	Andhra	1
Institute of Mental Health, Bhojpur	Bihar	0
State MH Sendari, Bilaspur	Chattisgarh	NR
IHBAS	New Delhi	6
IBHB, Panaji	Goa	4
HMH Bhuj	Gujarat	0
HMH Jamnagar	Gujarat	0
HMH Ahmedabad	Gujarat	7
HMH Baroda	Gujarat	3
HMH Shimla	Himachal Pradesh	1
Psychiatric disease hospital, Jammu	Jammu and Kashmir	0
Govt Hospital for Psychiatric Diseases, Srinagar	Jammu and Kashmir	0
RINPAS, Ranchi	Jharkand	7
CIP, Ranchi	Jharkand	5
NIMHANS, Bangalore	Karnataka	5
DIMHANS, Dharwad	Karnataka	1
MHC Thiruvananthapuram	Kerala	8
GMHC Kozhikode	Kerala	13
GMHC Thrissur	Kerala	7
Gwalior Manasik Arogyasala,Gwalior	Madhya Pradesh	9
Mental Hospital,Indore	Madhya Pradesh	3
Regional Mental Hospital,Pune	Maharashtra	72
Regional Mental Hospital,Thane (W)	Maharashtra	27
Regional Mental Hospital, Ratnagiri	Maharashtra	8
Regional Mental Hospital, Nagpur	Maharashtra	26
Meghalaya Institute of Mental Health & Neurosciences,Shillong	Meghalaya	0
Mental Hospital,Kohima	Nagaland	0
Mental Health Institute, Cuttack	Odisha	20
Dr.Vijayasagar Punjab Mental Hospital,Amritsar	Punjab	17
Mental Hospital, Jaipur	Rajasthan	6
Mental Hospital, Jodhpur	Rajasthan	6
Institute of Mental Health,Chennai	Tamil Nadu	30
Institute of Mental Health, Hyderabad	Telangana	2
Modern Psychiatric Hospital, West Tripura	Tripura	3
State Mental Health Institute, Dehradun	Uttarakhand	0

Institute of Mental Health, Agra	Uttar Pradesh	2
Mental Hospital, Bareilly	Uttar Pradesh	3
Mental Hospital, Varanasi	Uttar Pradesh	4
Lumbini Park Mental Hospital, Kolkata	West Bengal	8
Institute of Mental Care, Purulia	West Bengal	4
Mental Hospital, Berhampore	West Bengal	24
Calcutta Pavlov Hospital, Calcutta	West Bengal	22
Institute of Psychiatry, Calcutta	West Bengal	0

Longstay

The following is a listing of hospitals which report more than 25 longstay patients (greater than 1 year). In many of the hospitals, a significant number of the longstay patients are destitute (in IHBAS, RINPAS, CIP, NIMHANS, GMA, MH Indore, RMH Thane and Nagpur, IMH Chennai and Calcutta Pavlov Hospital. Duration of stay is also very long at SIMH, Haryana. In the other hospitals, despite not being destitute, a large number of longstay patients are still in hospitals.

Table 25: Longstay patients in the psychiatric hospitals

Hospital	No of patients with stay more than 1 year	No of patients with stay more than 5 years	No of patients who are destitute
IHBAS	18	30	48
IPHB Goa	117	56	19
HMH Ahmedabad	36	2	5
HMH Vadodara	15	31	0
RINPAS Ranchi	28	90	100
CIP Ranchi	12	60	60
NIMHANS	7	41	48
GHMC Kozhikode	169	196	13
GHMC Thiruvananthapuram	92	41	31
GHMC Thrissur	99	36	27
GMA Gwalior	84	34	85
MH Indore	17	45	58
RMH Pune	338	373	68

RMH Thane	235	389	161
RMH Ratnagiri	16	46	1
RMH Nagpur	111	170	236
VPMH Punjab	237	178	44
MH Jaipur	170	81	70
MH Jodhpur	26	8	11
IMH Chennai	733	551	100
MPH Tripura	32	4	32
IMH Agra	118	74	1
MH Bareilly	148	87	54
MH Varanasi	39	16	30
Lumbini Park West Bengal	83	52	50
MH Purulia WB	30	66	35
MH Behrampur WB	160	130	45
Calcutta Pavlov Hospital, WB	238	138	156

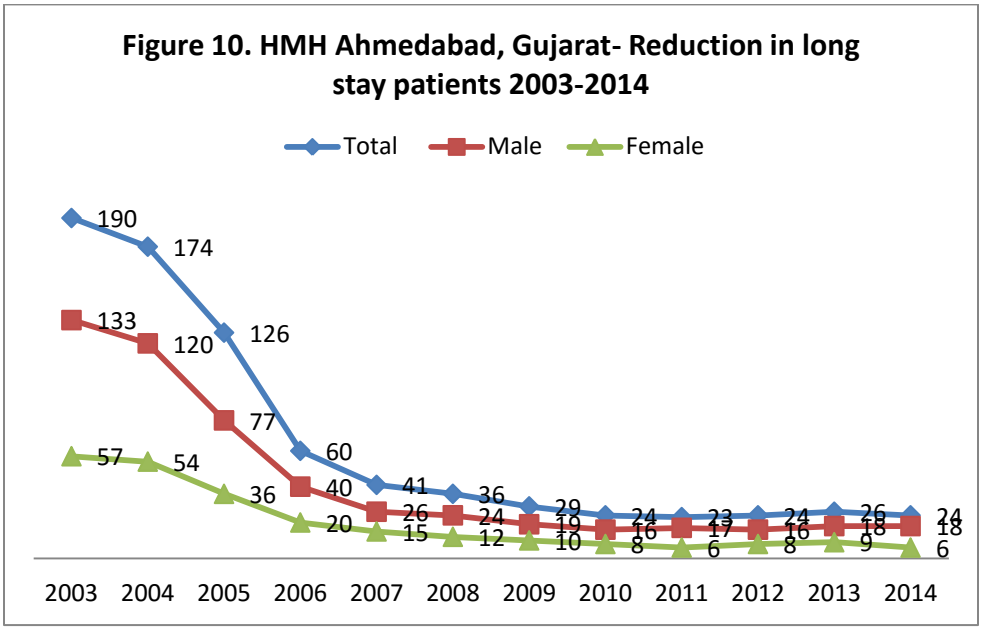
The issues with regard to longstay are many and complicated. **Addressing the issues of longstay should not become an exercise to 'get rid' of them because they occupy hospital beds.** The main reason to address longstay is the premise that persons have a right to the least restrictive treatment and that is likely to be available in the community. However, this premise may not always be correct. It is therefore important to know that whether a patient returns to a family that will provide care, or if placed in an institution or community setting, that their quality of life improves. There is a poignant example from the Central Prison, Bangalore, where a psychiatrist recalls an experience a few years back. A prisoner with mental illness who was on regular treatment was discharged from prison. A week later, she came back and begged to be allowed into the prison again. Within its walls, she was able to get shelter, food and medicines. Thus, it is important to make collaborative arrangements and network in the community before placements are made. Monitoring to ensure that the persons placed are comfortable and have a reasonable quality of life is also important.

Gujarat has had a successful experience of reducing the longstay. Reasons for longstay at the HMH Ahmedabad, were attributed to the following:

- Admission as a wandering person
- No co-operation from families
- Poverty and non-availability of services nearby
- Resistance to treatment and chronicity of illness
- No alternative arrangements available

An important point to be kept in mind that the longer a person with mental illness is untreated and the longer a person remains in hospital without any attempt at rehabilitation and re-integration, the chances of independent living are likely to diminish. Thus early intervention, and early rehabilitation, appropriate medication whenever necessary are all very important factors in reducing chronicity and disability.

Figure 10. HMH Ahmedabad, Gujarat- Reduction in long stay patients 2003-2014



HMH Ahmedabad has managed to reduce both their male and female longstay numbers. Over the last decade, the longstay patient population has reduced by nearly 88%. The steps taken by the hospital to reduce longstay included the following:

- Making essential drugs available from 2 weeks upto 2 months
- Emphasis on short stay
- Open ward facility with admission along with family members
- Family groups/Care giver groups to address families' challenges of managing patients at home

- IEC activities involving families
- Outreach services
- Hospital staff trained in rehabilitation
- Enhance vocational and occupational training involving relatives along with patients
- Strengthening of NGO linkages for rehabilitation

Tezpur and Pune- the INCENSE Project[81]

This project aimed at providing integrated community care for vulnerable persons with severe mental illness. NGOs Sangath and Parivartan worked with the psychiatric hospitals at Yervada and Tezpur. The project, funded by Tata Trusts, aimed to build a systemic framework for persons with serious disorders in three locations –those in psychiatric hospitals, homeless mentally ill persons and persons with mental illness living with families. 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). 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 intervention by a multi-disciplinary team focused on improving general health and well-being, providing access to work, livelihood promoting opportunities, meeting instrumental

[81] INCENSE Program 2011-2015. Project Report. Sangath, Parivartan, LGBRIMH, RMH, Yeravada, Pune. Supported by Tata Trusts.

aspects of citizenship (like identity proof, equitable pay for work, and access and inclusion in the financial sector. In Pune, because of significant disability, a recovery oriented as well as transit ward, the Devrai Ward was developed to develop more self-reliance and less dependent living. This is intended to provide an opportunity for patients to either move out to more independent living if they would like to and are able to; or live more independently in the sheltered environs.

For the homeless persons with severe mental illness, the project enabled the setting up of sheltered housing with NGO (Maher) involvement in Pune, leading to the development of a new supported community housing facility for women –'Unnati Niwas' in September 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 from agencies like the Banyan in Tamil Nadu. Involvement with an NGO, Atmika was helpful for the rehabilitation of the homeless in Tezpur.

For a group of patients with severe mental illness living with their families, efforts within the project included responding to the patient's treatment needs including medications, skill building, involvement in either home based income generation, collective employment or independent work.

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.

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.

Procurement of basic citizenship proof, which is often a gateway to several facilities, is very difficult for persons with mental illness to procure. One important initiative in the project was procuring Aadhar cards for patients.

In Pune, nearly 40% of the long-stay patients could be helped by these efforts at the end of 18 months.

The Tezpur Experience[82]

A few hospitals have been able to successfully develop community networks in order to place patients who do not need to remain in a restrictive institutional setting. One example is Tezpur. Right from 2001, the Department of Psychiatric Social Work began the process of trying to rehabilitate long-stay patients. However, in Tezpur, 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 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), 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.

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

[82] Information provided on request from LGBRIMH

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.

Outreach activities

Nearly 60% (27) of the institutions have one or other outreach activities. Active outreach activities are carried out by IHBAS, LGBRIMH Tezpur, RINPAS, CIP, NIMHANS and RMH Pune. The CIP carries out 7 outreach programmes- Extension Clinic in West Bokaro, Hazaribagh, Chandankiyari, Deepiksha for Child and Adolescent Services, Epilepsy and School Mental Health,School Mental Health Programmes at St Xavier's School, Hazaribagh and Holy Cross School, Bokaro.

Table 26. Involvement with the DMHP and NGOs

Name of the Institution	State	Involved with DMHP	NGO involvement
Midpu MH, Pampampure	Arunachal Pradesh	NR	NR
Lokopriya Gopinath Bordoloi Institute of Mental Health	Assam	Yes	7
GHMC Vishakapatnam	Andhra	No	2
Institute of Mental Health, Bhojpur	Bihar	No	No
State MH Sendari, Bilaspur	Chattisgarh	NR	NR
IHBAS	New Delhi	Yes	14
IBHB, Panaji	Goa	No	1
HMH Bhuj	Gujarat	Yes	4
HMH Jamnagar	Gujarat	Yes	6
HMH Ahmedabad	Gujarat	Yes	6
HMH Baroda	Gujarat	Yes	5
SIMH Rohtak	Haryana	No	No
HMH Shimla	Himachal Pradesh	No	2
Psychiatric disease hospital, Jammu	Jammu and Kashmir	Yes	1
Govt Hospital for Psychiatric Diseases, Srinagar	Jammu and Kashmir	Yes	1
RINPAS, Ranchi	Jharkand	Yes	2
CIP, Ranchi	Jharkand	Yes	2
NIMHANS, Bangalore	Karnataka	Yes	Many
DIMHANS, Dharwad	Karnataka	Yes	9
MHC Thiruvananthapuram	Kerala	Yes	17
GMHC Kozhikode	Kerala	Yes	8
GMHC Thrissur	Kerala	Yes	17

Gwalior Manasik Arogyasala,Gwalior	Madhya Pradesh	No	3
Mental Hospital,Indore	Madhya Pradesh	Yes	3
Regional Mental Hospital,Pune	Maharashtra	Yes	1
Regional Mental Hospital,Thane (W)	Maharashtra	Yes	2
Regional Mental Hospital, Ratnagiri	Maharashtra	No	1
Regional Mental Hospital, Nagpur	Maharashtra	Yes	1
Meghalaya Institute of Mental Health & Neurosciences,Shillong	Meghalaya	No	0
Mental Hospital,Kohima	Nagaland	No	0
Mental Health Institute, Cuttack	Odisha	Yes	3
Dr.Vijayasagar Punjab Mental Hospital,Amritsar	Punjab	Yes	1
Mental Hospital, Jaipur	Rajasthan	Yes	3
Mental Hospital, Jodhpur	Rajasthan	No	1
Institute of Mental Health,Chennai	Tamil Nadu	Yes	2
Institute of Mental Health, Hyderabad	Telangana	Yes	0
Modern Psychiatric Hospital, West Tripura	Tripura	Yes	0
State Mental Health Institute, Dehradun	Uttarakhand	No	0
Institute of Mental Health, Agra	Uttar Pradesh	NA	1
Mental Hospital, Bareilly	Uttar Pradesh	No	0
Mental Hospital, Varanasi	Uttar Pradesh	No	0
Lumbini Park Mental Hospital, Kolkatta	West Bengal	No	1
Institute of Mental Care, Purulia	West Bengal	No	0
Mental Hospital, Berhampore	West Bengal	No	1
Calcutta Pavlov Hospital, Calcutta	West Bengal	Yes	2
Institute of Psychiatry, Calcutta	West Bengal	No	0

More than half the hospitals (56.2%) are involved with some or other aspect of the DMHP. A fifth of the hospitals (21.7%) report no collaboration with NGOs. These include the IMH Bhojpur, MIMHANS, Meghalaya, MH Kohima, IMH Hyderabad, MPH Tripura, SMHI Dehradun, two of the hospitals of UP (Bareilly and Varanasi), IOP Psychiatry and IMC Purulia from West Bengal.

Human Resource adequacy and distribution

Inadequate human resources continue to be a problem in most institutions as well as in other settings. For some of the hospitals the response contains no information of the staffing details. Apart from medical officers, no other staff are mentioned, e.g. GMHC, Kozhikode. At the HMH Ahmedabad, faculty psychiatry, lecturer clinical psychology, lecturer psychiatric social work and

nursing positions have vacancies. Such vacancies are common across many hospitals. The RINPAS is autonomous but there is no rule for recruitment, service conditions etc. The large number of vacant teaching and non teaching sanctioned posts affects the working of the hospital. The mental hospital had no dietician; there is no Radiologist in the RINPAS.

Observations of the Special Rapporteur for RINPAS: There are 58 vacancies of a total of 76 posts (76% posts vacant) listed under Plan. Less than 50% of the posts in Psychiatry (14/29) are filled. There are several vacancies in Clinical psychology faculty (3) and nonfaculty (4) positions; PSW faculty (7) and non faculty (4); Faculty in Psychiatric Nursing (2). Under non plan, there is a further list of 599 positions, of which 344 are vacant (57%). Although the Checklist/Proforma mentions that a director is in place (Prof Amool Singh, Clinical Psychologist) and the Medical Superintendent is a psychiatrist, according to Appendix III provided by the institution, the posts of Director, Joint Director, Deputy Director and Medical Superintendent are all vacant. Of a total of 134 psychiatric nursing positions, 80 (59.7%) are vacant.

Even in better resourced institutions, it can become difficult to calculate inpatient staff resources when the institution is multidisciplinary. With institutions like NIMHANS, where there is a huge number of staff, it is difficult to discern how many of the staff is available to provide mental health care. For e.g., attendants are listed as 308, but it is not specified whether these are exclusively for psychiatry or for the whole hospital (which also has neurological and neurosurgical facilities). Similarly, nurses are listed as 393, but that is likely for the whole hospital. This does not indicate the staff available for mental health care. It is important to ascertain the ratios of staff available for mental health care separately, as inpatient facilities require adequate human resources particularly for crisis intervention and oversight of patients with suicidal risk or behavioural problems.

Medical Superintendent

In the past, it has been recommended that the medical superintendent should be a psychiatrist. This was to ensure that the person at the helm was aware of the needs of the patients with mental illness and would be more responsive to their needs. Further, in the event of medico-

legal problems, a psychiatrist as the medical superintendent would be better apply him/herself to the tasks required.

However, in 13 of the 47 hospitals (28%), the medical superintendent is not a psychiatrist. These include HMH Shimla (Himachal Pradesh), GHPD, Srinagar (Jammu and Kashmir), MHC Thiruvananthapuram and Thrissur (Kerala), RMH Ratnagiri (Maharashtra), MIMHANS (Meghalaya), SMHI Dehradun (Uttarakhand), MH Varanasi (Uttar Pradesh) and Lumbini Park MH, IMC Purulia, MH Behrampore and Calcutta Pavlov Hospital (West Bengal). The medical superintendent NIMHANS is also not a psychiatrist. In HMH Bhuj, there is no director or medical superintendent, but the person in charge is a class 1 psychiatrist. In the SIMH Haryana, a relatively newer psychiatric hospital, there is no post at all of Medical Superintendent.

Bhuj has 1 RMO position still vacant since December 2010.

The case of Goa

Enquiry by the Goa Human Rights Commission (Proceeding No 20/2012)

This enquiry was in response to media reports in a local newspaper 'Herald' under the caption: It's a mad scene at IPHB; 'IPHB lacks infrastructure to help calm tense nerves; 3) Plights of patients at IPHB unending even after cure. The Commission issued notices to the Chief Secretary, Govt of Goa, Secretary Health, Govt of Goa and the Dean, Goa Medical College. The Commission also visited the IPHB on 13/05/2013 to ascertain the factual position. The Commission noted the inordinate delay in filling up vacancies, the delay in creation of post of a full-time director, and the lack of basic infrastructure though the State Govt was making an effort to provide necessary basic infrastructure. The Committee made a set of 8 recommendations:

1. Filling up of post of director
2. Filling up of all vacant posts
3. Providing of all basic infrastructure for the 'inmates'
4. Establishing of a day-care centre
5. Shifting of fully recovered patients to a safe environment
6. Utilization of the large area available for recreational activities
7. Growing of trees in the campus to make it environment friendly

8. Sincere efforts to maintain cleanliness

Two year later, there is still no director. Many of the vacant posts appear, however, to have been filled. The IPHB is in the process of applying under the Scheme A of the Central Govt for support as a Centre of Excellence.

To overcome the human resource shortage, the IPHB has taken 6 Assistant Lecturers on contract.

Academic training

Twenty four (52%) of the psychiatric hospitals have academic activities, and this is an extremely encouraging trend, as it was earlier envisioned that these hospitals should contribute to the development of mental health human resources. However, in the states of Maharashtra, none of the hospitals record any initiation of academic activities. In Uttar Pradesh and West Bengal, some of the institutions offer academic training and some do not. The institutions in Arunachal Pradesh, Bihar, Chattisgarh, Himachal Pradesh and Tripura also do not offer any academic training.

The increase in academic training represents more than a doubling of institutions that were offering post-graduate training in 1996 (21%). However, only a few institutions, mostly the centrally run ones and a few others like IHBAS have made consistent efforts at increasing all mental health human resource. There is a great opportunity for these institutions to be training centres which must be capitalized.

NIMHANS runs a variety of courses in the mental health disciplines. In Psychiatry, apart from MD, 1 year post doctoral fellowships and DM in Child Psychiatry and Addiction are available. Similar courses have been started at the AIIMH and PGI Chandigarh.

Despite earlier recommendations, many of the institutions have still not started post-graduate training courses. GMHC Thrissur- Despite having an academic department, there are no PG courses. It is a matter of irony that many medical colleges, particularly in the private sector, which have been established much later, have started post-graduate courses in psychiatry and

allied disciplines although their older counterparts with better faculty strengths in the government sector have failed to do so.

Both the NHRC Special Rapporteurs and the IC made specific observations with respect to individual psychiatric hospitals and facilities within the state. A few of the salient observations are mentioned here. Further details are available in the individual State level reports at the end of this publication and in the report submitted by the Secretary, Health and Family Welfare, Govt of India to the Hon'ble Supreme Court on 1 July 2015. Only a brief summary is presented here:

Table 27. Overall Observations and Recommendations of the Inspection Committee

The IC made 9 observations and made 23 recommendations

Observations	Recommendations
1. Massive transformation in the mental health care institutions many of which are very old 2. Most have adequate physical infrastructure (though some dilapidated), adequate drugs, generally adequate hygiene and sanitation (with exceptions), adequate food 3. ECTs not being adequately used because of non-availability of anaesthetist 4. Shortage of qualified human resources especially in non-teaching institutions 5. The problem of longstay destitutes admitted through magistrates orders 6. Varying levels of recreation and vocational training across institutions 7. Calculated the bed strength of 43 institutions as 17842 with 11101 male and 6741 female beds (4 of the newer institutions not visited and hence not accounted for in this count) 8. Variation in oversight by SMHA, SHRC 9. Need for autonomous structure and greater operational flexibility for the institutions	1. Enhancing human resources 2. Starting academic training in all mental health specialties 3. Adequate anaesthetists for ECTs 4. Care provision for medical illnesses including non-communicable diseases like hypertension, diabetes cancer etc 5. Supportive neurological and neurosurgical facilities 6. Rehabilitation of long-stay 7. Specialised wards for children and elderly 8. Separate de-addiction wards 9. More open wards with engagement of families 10. Proper food preparation and distribution 11. Special efforts to reintegrate Reception Order patients back to their families with the intervention of the SHRC, SLSA and other departments 12. Setting up of half way homes under the aegis of the Social Work Department with links to the mental health institution 13. Need for alternative residential facilities 14. Hygiene and sanitation, modernization and regular repairs. Patients permitted

	to wear their own clothes 15. Development of facilities for vocational training and recreation 16. Segregation of wards for mentally ill prisoners 17. Proper maintenance and ideally computerization of patient records 18. Linkages of institutions and their outreach with DMHP 19. More prominent display of patient rights 20. OPD services for other medical requirements of patients 21. Co-ordination by a senior level officer from the State Health Department, and inter-agency co-ordination 22. Sensitization by the SLSA of the relevant officers in the Magistracy dealing with Reception Order and admission 23. Every institution to have a Rogi Kalyan Samithi to provide a forum for grievance redressal

The findings of the Inspection Committee were not new. Nevertheless, they reiterate the issues that have been a concern with respect to mental health care institutions for several decades. The inspection provided an opportunity for senior officials of the Centre and State to visit the hospitals and first hand obtain insights into the residential care of the mentally ill within institutions, the challenges and needs of the patients.

Newer Hospitals….the Same Old Concerns

Mental Hospital Midpu, Arunachal Pradesh

Very little information is available from the Appendix 1 of the affidavit submitted by the State Government regarding the Mental Hospital at Midpu. There are 10 inpatient beds. Only 40 registrations have been recorded in the previous year. No other information is available.

Special Rapporteur's observation: Sri Anil Pradhan (Special Rapporteur date of visit July 28th, 2015 – Mental Hospital, Midpu). The facility was completed in the year 2011. It consists of two separate blocks, one is the administrative block and other is indoor ward. The indoor block has rooms for male and female patient with a common kitchen. According to the Rapporteur's

report, this mental hospital at Midpu locality also suffers from erosion by river Pare which flows about hundred feet below the hillock on which this facility stands. The 10 bedded mental hospital attached to civil hospital, Naharlagun was dismantled to make way for a three hundred bedded General Hospital and Medical College, with Central Funds. Like in Mizoram, the doctor and nurses employed under NMHP and DMHP of Arunachal Pradesh were absorbed as regular govt. employees once the funds stopped from Govt. of India.

State Mental Hospital, Sendari, Bilaspur, Chattisgarh.

This hospital records 2267 outpatient registrations, 77 emergencies and 543 admissions during the last year. Appendix 1 of the State affidavit mentions that psychoeducation and counseling is provided to all patients who come to the hospital. It is a 100-bed facility with 60% occupancy. Average inpatient stay is 30 days. There are 30 closed ward beds, rest are open. This hospital has issued 45 disability certificates in the previous year. The hospital carried out one community outreach activity regularly. No other information has been provided.

Professor S. Narayan, Special Rapporteur visited the state between 29th June to 5th July, 2015. While visiting a Maharani Medical College and Hospital and District Hospital, he noted that there are few doctors in the hospital. Majority of population of Jagdalpur are tribals and they still use traditional herbs, plants, roots, fruits to treat themselves. There is no mental health society. According to his report, the incidence of mental health is on rise in the district specially among tribals because of naxalism.

Bihar Institute of Mental Health, Bhojpur

Set up nearly 10 years ago (101.61 acres of a total of 129.91 acres of the TB hospital was used for building this hospital and the rest of the area is allotted to the CRPF), BIMHAS appears to have all the problems faced by institutions witnessed during the first NHRC evaluation of psychiatric institutes- lack of staff, lack of financial powers to the director, lack of recreational and rehabilitation facilities, poor network for continued care, lack of vehicles to move patients for referral to other facilities, no scheme to start post-graduate training in a human resource starved state like Bihar.

The following are the observations of the Special Rapporteur Smt. S. Jalaja, upon visiting BIMHAS. OPD is being run with the help of Psychiatrists. No tracking of these cases in done. There is no data on how many patients recovered from illnesses. Indoor facilities are virtually non-existent with only 5-6 beds (capacity is 265 beds) being occupied by MH patients that too in the General Wards. The indoor patients are kept for about two weeks in PMCH; while in the other two hospitals it is seen that they are discharged in 5-6 days. In these circumstances it is not clear as to what kind of treatment is being given to the patients.

There appears to be not net-working with other institutions, especially custodial institutions. No NGOs have been associated with patient care, including counselling. The Medical Colleges are unable to take up community out-reach services in the absence of staff as well as funds. Rehabilitation of recovered patients is not taken up either. Thus there is acute shortage of human and material resources for providing psychiatric services through Medical Colleges in the State.

The IC which also visited BIMHAS found the facilities satisfactory, though the toilets needs improvement in cleanliness.

Their recommendations for the State of Bihar included:

- Increasing PG training to enhance human resources through enhanced seats in the medical colleges and short-term training in institutions like NIMHANS
- Separate De-addiction, forensic and children's facilities
- Upgradation of training including creation of Senior Resident posts, Clinical Psychologist and PSW post
- Helplines
- Ambulance services and vehicles
- Increased autonomy to the Director
- Training of master trainers
- Expansion of DMHP to cover all districts
- Co-ordination by SMHA, identification of a nodal officer in mental health within the State administration

The 'what 'to do is clear. The question is how to do it and who will do it in a time-bound manner.

SIMH (Rajya Mansik Swasthya Sansthan), Haryana

This institution was not visited by the IC. However, there are serious administrative problems in the RIMS with a lack of an independent director and medical superintendent. Despite the institution having been set up in 2009, human resources and services are sub-optimal. The Health Department of Haryana website has not been updated and does not even list this hospital. There are no teaching posts at the hospital. Inpatient utilization is very low. The hospital has no community networking, NGO involvement or training. The summary of the Special Rapporteur Smt Jalaja is as follows: It was, however, seen that there were hardly any indoor patients. The policy appears to restrict hospital admissions. But this should not mean that serious and difficult cases do not need admission, at least for brief periods. The institute is facing many problems. It was reported that no activity was taken up in the period 2010-14. *The impression one gets is that the institute is functioning at a sub-optimal level as* the facilities at the sprawling institute are not being put to use. The Institute is under the administrative control of the University of Health Sciences.

Himachal Pradesh

HHMH&R, Himachal Pradesh- Although a recently established mental health facility with 62 beds, the staffing is low and not multidisciplinary. This runs the risk of becoming a new age mental hospital with all the inherent problems.

The Inspection committee observed in its visit on 20.6.2015 that the space here is adequate, the number of patients receiving ECT has reduced because of early intervention, recreation and rehab are adequate, basic living facilities are adequate. The Committee has recommended that:

1. The hospital be raised to the level of a State level Mental Hospital. IT has recommended additional human resources including consultant psychiatrist (1), medical officer (1), male attendant (5), clinical psychologist (2), PSW (2) and occupational therapist (2).
2. It has recommended an increase in the bed strength to 100, provision of a dedicated ambulance.

3. That the State Government initiates the district mental health programme at all districts with support under the NHM in order to provide comprehensive services at the district level.
4. At the state level, services for de-addiction have improved with de-addiction centres running in all the 12 districts of the state.
5. For effective rehabilitation, adequate facilities through the Social Welfare Department.
6. Strengthening of vocational and rehabilitation facilities.

Achievements

NIMHANS has been recognized as a model institute by NHRC, SHRC and SMHA. It has been granted the status of an Institute of National Importance. The institute has introduced online screening for patients. It has initiated a residential rehabilitation facility at Sakalwara. NIMHANS has also expanded the staff for facilities like rehabilitation, strengthened liaison with general hospitals for NCD care, developed a Centre for Well-Being, established a museum on the history of NIMHANS which dates back to the Lunatic Asylum in the nineteenth century. The Tirthhalli project which has completed a decade has been focusing on providing psychiatric care for severe mental disorders in the community. A free legal aid service has been started. An inpatient facility for women with addiction, a separate emergency management unit are some of the other developments.

IHBAS has received NABH accreditation since 2012 and this has been renewed for a second time. The Special Rapporteur was highly appreciative of the steps taken by its Director to put in many innovative changes.

HMH Ahmedabad, as part of the NABH accreditation, has several committees functioning in the hospital to ensure quality of care including the following:

Quality improvement committee/Infection control committee/Safety committee/Medical Audit committee/Grievance redressal committee/Vishaka (sexual harassment prevention) committee/Drugs and Therapeutics committee/Death audit committee/Dava and Dua programme.

Kudos

NHRC Rapporteurs' comments (2010, 2012 and 2013) commend HMH Ahmedabad for implementing most of the recommendations of the Dr Channabasavanna Committee. They observed that the therapeutic and diagnostic facilities had been improved by improving the OPD services and psychological interventions; establishment of open ward had increased the proportion of voluntary patients; conditions in the closed wards have been improved; there had been notable progress in the development of occupational therapy facilities, starting day care centre and other measures for the rehabilitation of cured patients; community service programmes have been run on an appreciable scale; the Board of Visitors functions effectively, NGO involvement has been active, there is a lot of effort at capacity building and rehabilitation. The reports opine that HMH had the potential to be a good centre of education and research in the field of mental health.

Quality Rights

9 mental health institutions in the state of Gujarat have participated in the implementation of quality rights in mental health (Quality Rights Toolkit) developed by the WHO.

The State Govt provides financial support to 22 community based projects with NGOs and grant in aid institutes to promote community based management of mental illness. Community support groups have been identified as care givers for effective rehabilitation and resettlement of persons affected with mental illness. Efforts have been made to train traditional healers to serve as linkages with formal mental healthcare providers.

The DMHP in Gujarat has active NGO collaboration along with the nodal institute.

Under the DMHP, DH and civil hospitals are linked to the adjoining hospitals for mental health or Dept of Psychiatry of medical colleges, The programme is aimed at improving mental health service delivery, training and IEC in collaboration with local NGOs.

The State of Gujarat has supported a suicide prevention programme at all 6 Medical Colleges, with Surat as the nodal centre. The BJ Medical College has projects on Child Mental Health,

Adolescent Mental Health, IEC and Psychological first aid. Dava and Dua, a programme which aims at amalgamation of religious and modern psychiatric care at Miradatar Dargah, Mehsana works along with HMH Ahmedabad. A Helpline Aadhar for implementation of Section 23 of the MHA (with respect to wandering mentally ill) has been set up at Ahmedabad in collaboration with the HMH, Ahmedabad, Police Commissioner and Altruist, an NGO.

Psychiatric Diseases Hospital Srinagar- Arrangements in place for psychiatric care were very good and appropriate. Free medicines, hygienic facilities, modified ECTs and personalized care were all very encouraging. The NHRC suggested that there should be measures for continuing care/rehabilitation for those patients fit to be discharged but their families do not claim them/or they are destitute. A Legal aid clinic started in Psychiatric Diseases Hospital, Srinagar. The hospital provides services for mentally ill prisoners in the jails. At the time of the Swine Flu epidemic, all patients here were vaccinated.

NGO PRESENCE (Appendix 3)

Excluding Uttar Pradesh (which mentions 4-5 NGOs in each district), there are upwards of 325 NGOs working in the area of mental health and substance use across the states. This suggests a substantial increase in NGOs working in the area over the last two decades.

Only Delhi and Jharkand report having User-Carer Groups. Though not mentioned by Karnataka, AMEND, a carer group works out of Karnataka.

Table 29. NGO presence and areas of intervention

Name of State	NGOs	Areas of NGO intervention
Andaman and Nicobar	**NR in affidavit**	
Andhra Pradesh	**NR in affidavit**	
Arunachal Pradesh	Mother Homes, Lekhi Village, Naharlagun, Papumpare District Prayer Centres Harahappa Missionary of Charity	Advocacy, Awareness, Education both for Mental illness and Health Promotion Residential Care, Counselling, Medicines, Follow-up, Aftercare, Home based programme

Assam	11 NGOs in total NEVARD, Bongaigaon Help AID, Panikhaiti, Guwahati ASHADEEP, Guwahati NERM School and Mental Handicap Training Centre, Balipukhuri Missionary of Charity, Tezpur Human Welfare Society, Nizara, Sibsagar INCENSE Project	 Placement of homeless persons and treatment of mentally ill persons -do- -do- -do- -do- -do- Integrated care for severe mental disorders
Bihar	Dishayein at Aara (Bhojpur) under Ujjawala Scheme. Home of Mentally Retarded and Psychological sufferers, Moradpur, Patna Akansha Institute for Mentally handicapped, Gaya Mother Touch Foundation for Mentally Handicapped, Muzaffarpur Patliputra Parent Association of Mentally Handicapped, Danapur, Patna	Longstay rehabilitation
Chandigarh	Prayatan, Half Way Home, Sector 47D, Chandigarh	Social assistance and Rehabilitation (Day Care Centre for 13 clients). Maintains the only half-way home. Liaises with GMCH
Chattisgarh	**NR in affidavit**	
Dadra and Nager Haveli	**NR in affidavit**	
Daman and Diu	Nil	
Delhi	Sumaitri Voluntary Organization Sanjivini Society For Mental Health SAARTHAK MANAS ROSHINI SNEHI NAMI AANCHAL Action For Autism Ashray Adhikar Abhiyan MNGO IGSSS The Earth Saviours' Foundation	Suicide prevention and crisis intervention Crisis intervention, Rehabilitation, Community outreach programmes, Training in counselling skills Awareness and advocacy, training OPD services and community outreach Awareness, family support Positive MH, suicide prevention, training, Helplines Counseling, day and residential care, social assistance Special education for children with intell. Disabilities Rehabilitation and Special education Community outreach, shelter homes, training Residential care, rehab, legal and social assistance Awareness on mental illness, substance use Accommodation, counseling, medical care, rehab for elderly and destitutes
Goa	Sangath COOJ Mental Health Foundation, Bastora Sethu Centre, Povorim	Counseling and home based programmes. Research on developmental and behavioural problems in children and adolescents, common mental disorders, alcohol and drug use disorders; training in leadership in mental health; development of psychosocial interventions Awareness, education. Vocational training for persons with mental illness Advocacy, awareness, education, training for caregivers and professionals, training on sexuality for persons with special needs
Gujarat	AWAG, Ahmedabad TRU, Panchmahal	Domestic violence, school and adolescent mental health Tribal populations, traditional healers Street children

	VJT, Vadodara BCC, Vadodara Ashadeep, Junagadh, Porbunder BAIF, Dang, Bharuch, Surat BPA, Surendranagar, Kheda, Jamnagar, Navsari and Anand Manavjot, Bhuj Lok Seva Sarvaganik trust, Bhuj Navchetan trust Om foundation, Bhuj Jalaram Trust, Vadodara Tru, Vadodara Association of relatives of chronically ill mentally ill patients, Vadodhara Samvedhana Trust, Vadodhara Altruist, Vadodhara	Urban slum population, family members Rural, rehabilitation and day care Traditional healers, service delivery Rural, Disability, Community Based Rehabilitation
Haryana	Sambandh	Rehabilitation of patients from SIMH
Himachal Pradesh	Aastha Prem Ashram DCPU Red Cross Society CORD Chil line Helpline Uddan Sahyog Bal Shravan Viklang Kalyan Samiti Jagriti research and rehabilitation society for special children Savera research and rehabilitation centre Divya jyoti research and rehabilitation society Sakar Society for differently abled persons Gyan Shiksha Samiti Bhangrotu	Formal education, health education and checkups, living skills Child disability Counseling, rehabilitation, training for stakeholders Self help groups, IEC, MR appliances, AA -do- -do- Social assistance, home based services for special children -do-
Jammu and Kashmir	Mother Theresa's home for dying and destitutes Jeevan Dhara Choti Theresa Action Aid in Mental Health Medicine Sans Frontiers (5 NGOs listed by SR, though only 3 mentioned in affidavit)	Information not provided in affidavit but recorded by Special Rapporteur
Jharkhand	Sanjeevini Gram Trust Nav Bharat Jagriti Kendra Deepiksha Brothers of Charity	Help in identification and follow-up of DMHP patients -do- Mental Retardation
Karnataka	**Very Deficient in the Affidavit** Very little information is provided regarding NGOs in Karnataka. Karnataka is the first state which had a carer group (AMEND). There are several NGOS working in the area of mental health in the State including Basic Needs, Karuna Trust, Poirada,CCDC, AV Baliga Trust, Roots, Promise Foundation, RFS, MPA, Banjara Academy,Chittadama, Prasanna Counseling Centre, Narendra Foundation, VGKK	There are NGOs that work in the area of mental health, addiction, children with intellectual disabilities, elderly with dementia, mental health awareness and education, longstay facilities and support groups.
Kerala	**NR in affidavit** The NGO presence in Kerala which has not been documented. NGOs include Society for Mental Health, MHAT, Mariasadanam, Margadeepti.	

	Submission to the IC mentions 13 NGOs in Thrissur and 15 in Thiruvananthapuram and adjoining districts	
Lakshadweep	NONE	
Maharashtra	14 NGO's SAA Pune Centre for Advocacy in MH, Pune IPH Thane Anand Rehab Centre, Thane Shree Amritavahini Gram Vikas Mandal Ahmednagar Samaritans Mumbai Shraddha Rehab Centre, Mumbai Chaitanya MHC, Pune Kshitij MHC, Mumbai Miraj, Sangli, Raigadh, Bandra, Ratnagiri, Nagpur, Wardha, Satar and Latur	Some provide residential care for homeless mentally ill. Many are carrying out awareness activities.
Madhya Pradesh	Samarpan Mahila Vikas Kendra, Jabalpur Late Sri CK Sakpal Memorial Psychosocial rehab centre, Barwani The MH Policy Group website also lists Ashagram Trust in Bharwani, DIRH Bhopal,Arpan and Samarpan Indore, Asra Indore	Counseling, legal and social assistance, advocacy, awareness, health camps, ICTC linkages.
Manipur	Centre of Mental Hygiene, CHANGANGEI, Airport Road, Imphal, Manipur Integrated rehabilitative centre of addicts Ibomal Institute for Mentally retarded children Half way home for treated and controlled mentally ill persons Rehabilitation Centre for older persons suffering from dementia.	Counselling, Social Assistance, Residential Care, Rehabilitation, After Care, Home based programmes, Awareness Generation Activities, In the Field of Drugs abuse, Mental Retardation and Mental illness. In the previous year, the NGOs provided drug de-addiction services to 800 persons, services for mental retardation for 110; 75persons were placed in half-way homes and 10 elderly in rehabilitation homes for dementia.
Meghalaya	**NR in affidavit**	
Mizoram	Chhawndawlna In, Grace Society, Lunglei. Damna In, Zuangtui Rescue Centre, Kawmzawl Lunglei. Rescue Centre, Sihphir Social Guidance Agency, Aizawal Synod Rescue Home, Durtlang TNT Centre, Zuangtui TNT Centre, Kolasib TNT Centre, Harangchalkawl, Lunglei Volunteers for Community Health (VOLCOMH)	Majority of the NGOs work in the area of substance use and HIV. Activities include awareness on HIV/AIDS and drug abuse, parental, client and caregiver education, domestic violence education, suicide prevention, legal awareness programmes NGO VOLCOMH liaises with the Dept of Psychiatry, Civil Hospital. This NGO provides information on mental health legislation, nodal depts., various benefits and facilities provided by government and facilitates access of mentally ill persons and their families to such services
Nagaland	**NR in affidavit**	No details provided
Odisha	Nil	The affidavit mentions no NGOs
Puducherry	**NR in affidavit**	
Punjab	8 Pingalwada Society, Amritsar	No details provided Community mental health care
Rajasthan	TC Sidana charitable society	Rehabilitation
Sikkim	**NR in affidavit** However, there seem to be 2 NGOs working in mental health and 6 NGOs working in drug abuse control work	No details
Tamil Nadu	TN has many well-known NGOs , including The Banyan/BALM Chennai	Care, training and research in schizophrenia MH care for homeless, residential care, training,

		advocacy and research; lobbying for disability cards with MSW; night shelter in collaboration with city corporation, collaboration with Pudhu Vazhu Thittam, a state govt initiative also focusing on mental health treatment and prevention, engagement with Puzhal Central Jail from 2009, Transit care centre for homeless; long-term care through assisted housing/collaboration with IMH Chennai, Human Rights Cell, Vocational training, research projects with Grand Challenges Canada (NALAM- well-being approach using community based workers, exploring alternative living options to institutionalization); Ratan Tata Trust(alcohol use study); training and internships; involvement with mental health policy
		Suicide prevention
		Alcohol and drug de-addiction, training
	Soumanasya Hosp	Counseling, Rehabilitation
	Miracle Foundation	Counseling, legal and social assistance, residential care, rehabilitation, after care, home based programmes
	New Deepam Foundation	Counseling, social assistance, residential care, rehabilitation, aftercare
		All aspects except legal assistance and home based
	Recovery Home Foundation	Counseling, residential and aftercare
	Rathna Mental Health Center	-do-
	Asdharikum Annai Care Centre	All aspects
	Valli Care Foundation	All aspects except home based care
	Ashram Foundation	Counseling, residential care, rehabilitation, aftercare
	Dr Fernandez home for schizophrenia	All aspects except legal assistance and home based
	Sugam Foundation	Residential care, rehabilitation and aftercare
	United Home for adult mentally ill	Counseling, residential care, rehabilitation, home-based care
	Manasu	All except rehabilitation and home based care
	Putholi Health care Nursing Home	All except legal assistance and home based care
	Holistic rehabilitation centre	All aspects. Offer services to rural population. Have created grass root mental health volunteers at the village level to anchor mental health services. Organize mental health camps. With MANASA (District Mentally Disabled Welfare Agency), DMHP and Subitcham (Family Fellowship for Mentally Retarded and Mentally Ill), Mental Health Literacy Campaigns, Legal Assistance through Legal Aid Clinic, Disability certification, Counseling to juvenile home and vigilance home, social assistance under MGNREGS and income generation, short stay, half way and long term care homes, vocational rehabilitation and community based rehabilitation, research
	MS Chellamuthu Trust	
	Addiction treatment centres	Counseling, residential care, rehabilitation, aftercare
	St. Joseph's Mercy Home	-do- and legal and social assistance
	NALAM DRC	Counseling
	Moonshine DRC	All aspects
	Liberty Care Centre	All aspects
	Wisdom Hospital	All aspects
	Vidiyal Foundation	All aspects
	MS De-addiction cum Rehailitation Centre	
	Many other NGOs not listed	

	SNEHA Chennai SCARF Chennai TTK Foundation Navjeevan-YWCA Chennai AASHA Chennai Uduvam Karangal Chennai Oxford Charitable Trust Kanchipuram Subitcham Madurai Shantivanam Trust Trichy	
Telengana	**NR in affidavit**	
Tripura	**NR in affidavit**	
Uttarakhand	Rapheal Ryder Cheshire International Centre, Mohini Road Trans-Rispane Nadi, Dehradun Latika Rai Foundation Cheshire Homes Sragan Spastic Society	Day care centre Residential Care (for 81 persons with intellectual disability during previous year) Community based Rehabilitation (250 with intellectual disability in previous year) Disability pension for over 50 Home based programme for 50 severely disabled Teachers' training
Uttar Pradesh	4-5 per district as per affidavit	**No details mentioned**
West Bengal	**NR in affidavit** There are several NGOs in WB Turning Point Kolkata Paripurnata Kolkata Anjali Kolkata NIBS Kolkata Ishwar Sankalp Kolkata Sevak Kolkata Malipukur Samaj Unnayan Samiti, Howrah Antaragram 24 Parganas	

There has been a significant increase in the non- governmental organizations throughout the country. They have been involved in school mental health, college mental health (NIMHANS initially initiated programmes on life skills in schools and college teachers training programmes for counseling students, and such programmes are now being conducted in several states). There are organizations working with children with intellectual difficulties, children with mental health problems, destitute children with mental illness, stress and mental health counseling, suicide prevention, crisis intervention, elderly services including dementia services, alcohol and drug-deaddiction including camp approaches, community mental health care, training of anganwadi workers in recognition of mental disorders, using lay volunteers as partners in mental health care management, rehabilitation of persons with serious mental illnesses and

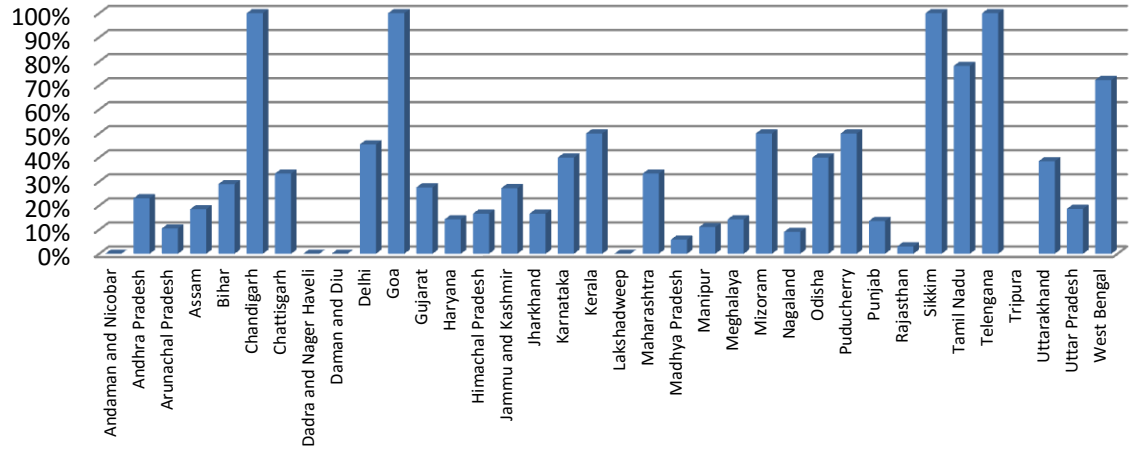
services for the homeless mentally ill. Some of these have been reviewed in detail in the publication of the NHRC in 2008[83]

However, the concern is, that just as in the case of the inequitable distribution of mental health professionals and services, the number and distribution of NGOs is also inequitable and some states do not even mention the existence of NGOs working in the area of mental health in their affidavits.

DISTRICT MENTAL HEALTH PROGRAMME (Appendix 4)

Section 4 of the Affidavit Questionnaire submitted by the states contained details of the DMHP in each state. Returns regarding the DMHP were almost entirely focused on budgets, utilization certificates and statements of expenditure. Very little information was provided by most states on the activities under the DMHP, its coverage and impact.

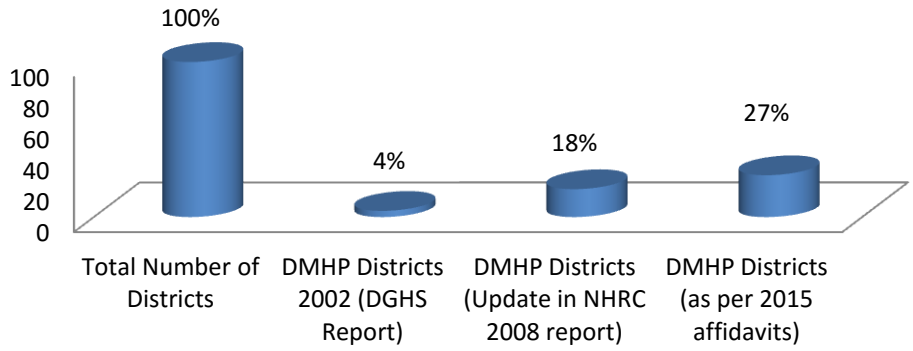
Figure 11. Percentage of districts covered by DMHP in each state



[83] Mental Health Care and Human Rights 2008, ibid.

DMHP Expansion

Figure 12. Expansion of DMHP districts between 2002 and 2015



Although the DMHP was envisaged more than 35 years ago, it was reformulated in 1996, and from a 4 % coverage of districts (25) in 2002 to 18% (124) by 2008 to 27% (189) presently.

Table 28. DMHP Expansion and Implementation Status

State/UT	**Total Number of Districts**	**DMHP Districts 2002 (No and sites)- 25 districts**	**DMHP Districts (Update in NHRC 2008 report)- 124 districts**	**DMHP Districts 2015 (As per information in State Affidavits 2015**	**Implementation Status**
Andaman & Nicobar	3	Nil	Nil	Nil	
Andhra Pradesh	13	1 (Vizianagaram)	2 (Cuddapah, Prakasham)	3	Not functioning in all (Guntur, Kurnool, Prakasham) –no funds
Arunachal Pradesh	15	1 (Naharlagun)	2 (Naharlagun, E Siang)	2	**No details provided**
Assam	27	2 (Nagaon & Goalpura)	6 (Nagaon, Goalpara, Darrang, Morigaon, Nalbari, Tinsukia)	6 6 additional districts proposed in 2015-16	2- Fully implemented (Nagaon & Goalpara)-Taken over by State Govt 3- Partially implemented (Morigaon, Nalbari, Tinsukia)-lack of funds No details of implementation
Bihar	38	Nil	Nil	1 In a presentation at the NHRC in 2015, the representative from	Plan to expand to 11 districts-(Muzaffarpur, Vaishali, East and West Champaran,

				Bihar mentioned the DMHP is functional in 8 districts	Gopalganj, Purnea, Banka, Jamui, Rohtas and Kaimur) posts in process of being filled up
Chandigarh	1	Nil	1-Chandigarh	1	Active DMHP; 1648 new and 4388 old registrations; MO no training in mental health; no NCD integration
Chattisgarh	27	Nil	6 (Bastar, Bilaspur, Dhamtari, Raipur, Raigarh, Durg)	9	**No details provided**
Dadra & Nager Haveli	1	Nil	1 (Silvassa)	**No details**	
Daman & Diu	2	1 (Daman & Diu)	1 (Daman and Diu)	1	Affidavit says programme being implemented but rapporteur visit says it has been discontinued
NCT, Delhi	11	1 (Chattarpur)	5 (Chattarpur, NW, West, SW, North)	5- South (Chattarpur) North-West (Jehangirpuri) South-West (Dwarka) West (Moti-Nagar) North (Timarpur)	Fully implemented. Patient data provided. Most drugs available. Supervised programmes. Shortage of manpower and erratic funding serious problems. Need for greater involvement of voluntary agencies
Goa	2	1 (South Goa)	1 (South Goa)	2	**No details**
Gujarat	29	1 (Navsari)	8 (Navsari, Amreli, Godhra, Surendranagar, Dang, Porbander, Junagarh, Banaskantha)	8 (Surendranagar (HMH, Ahmedabad/BPA) Junagadh (Rajkot MC/BPA) Porbander (Junagadh MC/Ashadeep Foundation) Ahwa, Dang (Surat MC/BAIF) Godhara (HMH Vadodara/TRU) Palanpur (HMH Bhuj/Altruist) Amreli (Bhavnagar MC/Altruist) Navsari (Civil Hospital/NAB) Mehasana (HMH Ahmedabad/Altruist)	Funds partially released. In most districts, stopped after first installment. No patient data provided. Only state to run a Taluka Mental Health Programme through its own funds

				Kheda (HMH Ahmedabad/Altruist) Dahod (HMH Vadodara/Altruist) Rajpipla (HMH, Vadodara/Altruist)	
Haryana	21	1 (Kurukshetra)	3 (Hisar, Gurgaon, Kurukshetra)	3- (Hisar Gurgaon Kurukshetra)	Some patient data provided. Most commonly CMDs and MR Home visits done in Kurukshetra Most essential psychotropics available Some training of ASHA and doctors Rapporteur-need to strengthen administration of DMHP
Himachal Pradesh	12	1 (Bilaspur)	2- (Kangra and Bilaspur)	2- (Kangra and Bilaspur)	Some patient data provided Drugs available Training activities carried out As per Rapporteur, Bilaspur almost non-functional and no staff are recruited in Kangra
Jammu and Kashmir	20	Nil	3-(Jammu, Kathua, Rajauri, Udhampur)	6-(Jammu, Udhampur, Rajouri Kathua, Srinagar, Budgam (By respective District Hospitals)	No patient data provided In most places, medications not available Lack of monitoring Only few doctors trained at NIMHANS As per Rapporteur, DMHP functional in only 4 districts. Manpower and medicine shortage
Jharkand	24	Nil	3- (Dumka, Daltoganj, Gumla)	4-(Dumka, Jamshedpur, Daltonganj, Gumla)	Functional. Some provided. Jamshedpur started by state government Doctors also visit central jails of Ranchi, Hazaribagh and Khunti RINPAS nodal centre
Karnataka	30	Nil	4 – (Chamrajnagar,	12	No information

			Gulbarga, Karwar, Shimoga)		provided regarding the DMHPs in the affidavit
Kerala	14	2 (Thrissur and Thiruvananthapuram)	5- (Thiruvanathapuram, Thrissur, Idukki, Kannur, Wayanad	8-(Kasargod, Kannur, Kozhikode, Wayanad, Malappuram, Idukki, Thrissur and Thiruvananthapuram)	Apart from budget provision, very little information provided. No patient data. Little technical guidance and monitoring. Inadequate record keeping. Good medicine supply. Plan to extend to all other districts jointly by the NRHM under the CMHP of the State.
Lakshadweep		Nil		1 district proposed	**No details provided**
Maharashtra	36	1 (Raigad)	6-(Raigarh, Amravati, Buldhana, Parbhani, Jalgaon, Satara)	12- (Amaravathi, Ahmednagar, Alibagh-Raigadh, Bhandara, Buldhana, Gadchiroli, Jalgaon, Nashik, Osmanabad, Parbhani, Satara and Wardha)	**No details provided**
Madhya Pradesh	51	1 (Shivpuri)	5- (Shivpuri, Dewas, Sehore, Mandla, Satna)	5	**No details provided**
Manipur	9	1 (Imphal East)	5- (Imphal West, Imphal East, Chaura Chandpur, Chandel, Thoubal)	5- (DMHP, Imphal West, Imphal East, Chaura Chandpur, Chandel, Thoubal).	Has provided detailed figures for the running DMHPs Psychotropic medications appear adequate Has a regular training calendar
Meghalaya	7	Nil	2- (Jaintia Hills, West Garo Hills)	2	Some patient data provided. Few other details
Mizoram	8	1 (Aizawl)	2- (Aizwal, Lunglei)	4- (Champhai, Saiha Aizawl , Lunglei) The state proposes to implement DMHP in all districts by 2017	DMHP fully implemented in 2 districts (Champhai & Saiha) and partially in Aizawl and Lunglei No details provided
Nagaland	11	Nil	Nil	1	**No details provided**
Odisha	30	Nil	7- (Mayurbhanj, Puri, Balangir,Dhenkanal, Karaput, Keonjhar, Khandamal, Khurda)	12 DISTRICTS	**No details provided**
Puducherry	4	Nil	Nil	2- (Puducherry, Karaikal)	**No details provided**
Punjab	22	1 (Mukstar)	3 – (Mukstar, Sangrur, Hoshiarpur)	3 Proposed to be started in 10 more districts	Said to be fully implemented No details provided
Rajasthan	33	1 (Sikar)	1- (Sikar)	1-Sikar	Fully implemented.

					According to the Special Rapporteur, the programme has been discontinued
Sikkim	4	Nil	1-(East Gangtok)	4-(East, West, North, South Sikkim)	Patient data mentioned, but low number of registrations. Registrations mostly substance use (West) and epilepsy (South) Drug availability variable- adequate in North and West, inadequate in South and East. IEC being carried out
Tamil Nadu	32	3 (Trichy, Ramanathapuram, Madurai)	16-(Trichy, Ramanathapuram, Madurai, Kanyakumari, Theni, Dharmapuri, Erode, Nagapattinam, Kancheepuram, Thiruvallur, Cuddalore, Perambalur, Virudhanagar, Thiruvarur, Namakkal, Chennai)	25 Districts	Questionnaire filled by 26 PHCs- either patient data for 1 month or no data; medication supply adequate. Each district has not consolidated and submitted the district level information
Telengana	10	1 (Medak)	2- (Nalgonda, Mahaboob Nagar)	12 districts (as mentioned in affidavit)	**No details provided**
Tripura	8	Nil	2-(West and North)	**NR in affidavit**	
Uttarakhand	13	Nil	Nil	5	Partially implemented Details not provided
Uttar Pradesh	75	1 (Kanpur)	12-(Kanpur, Azamgarh, Banda, Faizabad, Gazipur, Ghaziabad, Itawah,Mirzapur, Moradabad, Muzzafarnagar, Rai Bareli, Sitapur)	10- (Kanpur, Faizabad, Raibareilly, Sitapur, Banda, Etawah, Ghaziabad, Moradabad, Muzaffar Nagar through four medical colleges / institute.	Run by KGMC Lucknow (4); GSVM College (2) and Meerut Medical College (3); Allahabad Medical College (1) Patient data provided Satisfactory monitoring IEC activities regular Regular staff training including ASHA, school teachers, nurses, pharmacists. Sensitization of Gram Panchayat members and other administrative personnel in all

					DMHP districts
West Bengal	18	1 (Bankura)	4-(Bankura, Jaipalguri, West Midnapur, South 24 Parganas)	13- (North 24 Parganas, South 24 Parganas, Howrah, Hooghly, Purbo Mednipur, Nadia, Uttar Dinajpur,Dakshin Dinajpur, Purulia, Coochbehar, Darjeeling, Jalpaiguri	**No details provided**

All districts are covered in Chandigarh, Goa and Sikkim. This fact has to be confirmed for Telengana, as no details are provided. Telengana mentions 'all 12 districts' (although the government portal mentions only 10 districts in Telengana).

Half or more districts have District Mental Health Programmes has occurred in Kerala, Mizoram, Puducherry and Tamil Nadu.

OLD ASPIRATIONS, RENEWED HOPE

The recent attention to mental health concerns following the Hon'ble Supreme Courts directives to States to submit affidavits, visits of Inspection Committees and the initiatives by state governments have all started producing some preliminary results. This was evident at the **meeting organized by the NHRC in August 2015**, where some of the states presenting their plans for upscaling. Some of the states had senior representatives of the health department making the presentation, which was encouraging and perhaps a sign of increasing engagement of the state machinery in developing mental health services.

ASSAM

The presentation was made by the Professor of Psychiatry at the Guwahati Medical College.

1. Three of the 5 medical colleges with departments of psychiatry had initiated post graduate training.
2. 12 districts with psychiatrists have 10 bed psychiatric wards.
3. The DMHP is functioning in 4 districts and planned to expand to 4 more districts with state support.
4. A core committee for the rescue, care, treatment and rehabilitation of homeless mentally ill persons has been developed.

5. 15 NGOs have been identified and supported to provide sheltered care for the homeless with financial support from the Social Welfare Dept and medical support by the Health Department.
6. As per the High Court Directive, the process of establishment of rehabilitation centres/shelters is ongoing.
7. At the GMCH, a child psychiatric unit has been initiated, faculty posts have been created in psychiatry. Plan to start an MPhil Psychology course through the University of Health Sciences.
8. Four hospital facilities, two each in the North and South Bank of the Brahmaputra have been suggested.
9. All district hospitals to have a psychiatry ward in a phased manner.
10. Starting of MPhil in psychiatric social work and training of government medical officers, nurses and paramedical staff.
11. Training of NGOs.
12. A proposal for COE in mental health in the state of Assam.

BIHAR

The affidavit submitted by the State mentions that the DMHP is functioning in 1 district, and planned to be expanded to 11 districts.

1. At the NHRC meeting, the Bihar representative mentioned that the DMHP had been initiated in 8 districts. A total of 308 cases (old and new) had been seen across 8 centres in a month (roughly translating to about 38 old and new cases monthly at each centre).
2. In the presentation, it was mentioned that day care for mentally retarded children (Chaman Programme) was being initiated in 5 districts (Bhagalpur, Darbhanga, Purnea, Saharsa and Saran).
3. Shelter home for women with mental retardation (Ashiana) was being initiated in 3 districts (Darbhanga, Nawada and Purnea) and shelter homes for men with mental retardation (Saket) was being initiated in 3 districts (Munger, Muzzafarpur and Saharsa).
4. 108 ambulance service was to made available to transport persons with mental illness to the district hospital.
5. Funds were being disbursed under the NRHM to the 11 districts and a nodal officer had been identified.
6. Rate contract had been prepared for the medications required under the programme. IEC materials had been distributed.

Chattisgarh

1. The presentation highlighted the disproportionately low number of psychiatrists in the government sector in comparison to the private sector.
2. Psychiatry outpatients have been initiated in 9 district hospitals with 1651 patients having attended in the first quarter.
3. Counseling has been initiated in these centres.
4. 10 bed psychiatry units are planned in each district hospital.
5. 13 psychotropic medications have been available at the district hospitals. The state is exploring the use of telemedicine.
6. The state plans training of existing staff, constitution of state and district level authorities,, mental health units at the district hospital (posts have been sanctioned in 9/27 districts).
7. The state plans to establish a de-addiction unit at JNM Medical College Raipur and CIMS Bilaspur in 2015-16

Delhi

1. **T**he State Government has taken over the DMHPs and has a plan to extend it to all the 11 districts.
2. Service for homeless populations are planned
3. It is planned to expand the mobile mental health units
4. Training for GPs and family physicians and an urban mental health programme has been planned.

Gujarat

The state presented a comprehensive plan for mental health services in the State.

1. It is already providing taluka mental health services in 13 of its 226 talukas through a grant-in-aid.
2. The state has been expanding its human resources consistently.
3. The state has more meticulously calculated its beds (totaling 1373 beds) which will make it easy for the state to update the affidavit information which was provided some months earlier. Through the district programmes, 1409 disability certification have been issued (time frame unclear).
4. Several mental health pilot programmes for adolescents, tribals, community based rehabilitation, prevention of domestic violence and marital discord, rehabilitation of street

children with mental health problems, distress and suicide prevention and family integration of the wandering mentally ill has been undertaken.

5. The state has made a plan of its requirements for rehabilitation, day care as well as inpatient; for addressing its human resource gap (enhancement of MD seats from 25 to 40 per year; Clinical Psychology from 12 to 50 per year; PSW to 30 per year; Psychiatric Nursing from 20 to 50 per year; Occupational Therapy from 10 to 30 per year; Peer Support Workers to 20 per year).
6. The state plans to develop a cadre of Community Mental Health Worker who will work like ASHA and assist in the early identification of psychiatric problems; management of psychiatric emergencies; administration and supervision of maintenance treatment under guidance of supervisors; counseling in problems related to alcohol and drug abuse and public education.
7. The State has since developed a State Mental Health Plan for the next 5 years (including a 50 bed psychiatry unit at the district general hospital in 3 regions not covered by the psychiatric hospitals; a 20 bed unit at 20 district general hospitals; a 10 patient day care centre at the district level; a 20 bed mother and baby unit at the 3 psychiatric hospitals and 6 government medical colleges; a 20 bed de-addiction ward and a 20 bed geriatric ward at the 3 psychiatric hospitals and 6 government medical colleges.

Gujarat has identified 8 strategic areas:

- Upgradation of the HMH Ahmedabad to a Centre of Excellence and other psychiatric hospitals including closure of seclusion units and replacement with intensive care units
- Strengthening of all government run medical colleges- specialized units, UG/PG support, involvement with schools and strengthening of psychiatric units in district general hospitals
- Provision of day care, rehabilitation, short and longstay facilities in all districts with NGO collaboration
- Suicide prevention strategy in the state
- Community based programme to address women's based issues (mainly domestic violence and peri-partum mental health problems)
- School mental health programmes
- Community based services for the elderly (using the Kerala model of community care for persons with dementia)
- Engage all the government departments (Social Justice and Empowerment, Law, Police, Judiciary), NGOs as well as the private sector.

Jharkand

The representative presented information for the 4 DMHPs in the previous 5 years.

1. In the DMHP, the district of Dumka had trained gram pradhans, teachers and students.
2. All the districts had engaged with family members. In Dumka and Jamshedpur, pathways of care included old patients, NGOs, general practioners and psychiatric institutions like RINPAS.
3. Concerns raised was the very poor research and record keeping; poor vertical co-ordination.
4. The state has begun to collate its human resources in mental health.
5. 17 districts are still without psychiatrists.

Karnataka

The update revealed the following facts:

1. 99 licensed private psychiatry hospitals, 47 Medical Colleges/General Hospitals, 20 district hospitals
2. Manochaitanya Super Tuesday primary care clinics and Manasadhara programmes for rehabilitation
3. Minimum norms available under the Rules for setting up various residential facilities

Kerala

Kerala is a pioneer of community based rehabilitation for mental illness and the first collaborative community based rehabilitation was started at Trivandrum in 1998.

1. There is active inter-sectoral collaboration with other agencies and involvement with the National health mission.
2. Home based care for the homeless mentally ill has been developed. Started as a pilot project in 2009 in Trivandrum, one centre each for men and women. The infrastructure is provided by the Local Self Government (LSG) department, running cost by the Social Justice and Empowerment, care by the Health Dept and run by the NGOs; Asha Bhavans are run by the Social Justice Ministry.

3. Day care centres are functioning in all the 14 districts as part of CBR. This is funded by the State and there are separate centres for men and women. They are supported by the DMHP clinics and district panchayats.
4. Residential centres and long stay homes have been set up.
5. Different models of care include those in the government sector, those set up by the Social Justice Department, Centres run by Community Based Organizations and those in the private sector.
6. Many residential centres have come up in the private sector- 33 have applied for license for rehabilitation centres and 14 for care homes.
7. At MHC Kozhikode, rehabilitation is offered by IMHANS, which is providing rehabilitation care to 100 patients. IMHANS rehabilitation reports an annual turnover of 1.2 crores.
8. Kerala envisages one CBRC in every block panchayat supported by CBOs and local panchayats.

Madhya Pradesh

The salient features were:

1. DMHP implementation in the 5 districts of Satna, Shivpuri, Mandla, Sehore and Dewas.
2. A collaborative effort between the DHS, DMHP Sehore, Public Health Foundation of India and Sangath to create visibility for mental health services, training of health professionals at the block level and a stepped care collaborative model (the funded PRIME project).

Maharashtra

1. DMHP under NMHP was started in the state in 1997 with one district ie Raigadh as pilot project. Rs. 26.20 lakhs was sanctioned.
2. In 2003-04 another 5 districts namely. Satara, Parbhani. Amravati, Buldhana and Jalgaon were added under this programme Rs. 26.20 lakhs per each district received.
3. However after that only Raigadh & Satara continued to receive some funds while other four districts, (Parbhani, Amravati, Buldhana and Jalgaon) were not provided any funds until now.
4. The state has plans for half-way homes, residential homes and vocational rehabilitation facilities.

Mizoram

1. The DMHP was launched in Aizawl in 1999-2000 and in Lunglei in 2006-2007. These 2 districts stopped functioning due to lack of funds.
2. Two other DMHPs launched in Champhai and Saiha in November 2014.
3. Community and outreach are carried out through these DMHPs. Components include inputs in schools, setting up of an OST centre (for opioid dependence), mental health inputs to orphanages and other homes, distribution of IEC.
4. Problems encountered include shortage of human resources, lack of a psychiatric institution in the state (there is only a 24-bed ward at Kulikawn Hospital.
5. SMHA was set up in 1999, but is not functioning because of lack of funds.
6. Disability certification is not being done presently.
7. There are a few NGOs in mental health, but their lack of functioning is attributed to poor funds
8. Lack of awareness, superstitions and myths about mental illness and stigma are widely prevalent.
9. A 100-bed psychiatric facility (INHUBAS) is proposed under the DoNER Ministry in 2014-15.
10. Two high priority districts have been identified (Mamit and Lawngtlai) in the supplementary PIP and submitted to NHM. The State expects to cover all the districts by 2016-2017.
11. The State is in the process of tying up with the LGBRIMH for training of medical officers and other staff in the field of mental health.
12. Training in mental health has been conducted in collaboration with the Social Work Department and Mizoram University.
13. Rehabilitation Centre for juveniles with mental health problems has been set up by the Social Work Department
14. A Core Group for Mental Health is being set up.

Odisha

The DMHPs are being run by the medical colleges in Odisha.

1. Of the 12 DMHPs, SCB Medical College ad Hospital is the nodal institution for 6, MKCG Medical College and Hospital for 4 and the VSS Medical College and Hospital for 2.
2. The State has developed the Niramaya Scheme to make psychotropic drugs freely available.
3. The ADMO (PH) is the nodal officer for the DMHP. There are 10 beds (5 male and 5 female) earmarked in 12 districts

4. Joint co-ordination with Women and Child Department and Disability Department for rehabilitation of destitute, orphans and other mentally ill is being undertaken.
5. DMHP surveillance figures for 6 months have been made available (which means it is possible to collect this information)
6. 108 ambulance has been functioning since 2012- so far (upto July 2015) 3402 cases have been transferred from home to the hospital, 3719 from one hospital to the other and 4798 referred to the MHI Cuttuck.
7. Regular disability camps are conducted and 5986 disability certificates for adults with intellectual subnormality (MR), 3399 for mental illess and 1150 for children with intellectual problems have been distributed.
8. Regular capacity building is carried out.
9. Schizophrenia, psychosis, depression, mental retardation are the most common disorders seen across the DMHPs.
10. Mental health rehabilitation is occurring through NGO participation (Dayashram in Puri, Sakha in Cuttuck, Mission Ashra, Basundhara (residential rehabilitation), Biswa in Bhubaneshwar, Janani (social assistance) in Cuttuck and Asswasana in Cuttuck. Treatment non-compliance and lack of skilled human resources are the main challenges.

Puducherry

1. The strength of the state is in its general hospital psychiatric services and efforts at rehabilitation
2. The state has consistently worked at improving its human resources
3. The state has identified 13 NGOs working for the mentally ill
4. New posts have been approved for the DMHP
5. Psychiatry nursing course started in 2011.
6. DNB training in psychiatry to be started in Government General Hospital Pondicherry waiting for approval
7. Suicide prevention and crisis help line (24hrs) from government sector in collaboration with NGO to be started soon.
8. Proposal to start day care centers and half way homes from government sector has been sent.

Punjab

The state presented a cumulative picture of its resources and facilities. Here again, there appear to be a greater number of psychiatrists in the private than the government sector. Detailed hospital statistics were presented.

1. The state has initiated a 3 tier system for the treatment of addictions (at primary level training of GDMOs, at secondary level in DH and SDH, OPD and IPD and at tertiary level 5 model de-addiction centres)
2. 21 rehabilitation centres, one for each district is ready
3. Shortage of psychiatrists is the state's biggest challenge

Rajasthan

The state was granted 6 DMHP districts out of a proposed 12. For 2015-16, an additional district Sikar was granted.

1. The State has been facing a challenge getting psychiatrists even on a contractual basis.
2. An order has been passed to the available psychiatrists in DMHP districts other than the 6 districts to implement mental health services and disability certification.
3. Currently psychotropic medications are being made available under RMSCL.
4. IEC posters sent to all districts.
5. An order has been issued to police officers regarding their responsibilities with respect to the wandering mentally ill.
6. Survey formats sent to all 6 district CMHPs for identifying cases and further referrals.
7. A case referral system has been established in the DMHP.
8. Shortage of human resources, lack of budget are the main problems encountered.
9. There is a lack of availability of training modules for community health workers.

Tamil Nadu

The presentation indicated the state's aspiration to bring all districts under the DMHP.

1. A post of nodal officer has been created to oversee the programme in Tamil Nadu.
2. The DMHP has been tied up with all the government medical colleges.
3. 10 bed psychiatric ward were established in all the DMHP District Head Quarter's Hospital.
4. Suitable NGOs for Networking for implementing Rehabilitation programme have been identified
5. Short-term training courses for doctors, nurses, panchayat leaders, ANMs, teachers, judicial officers, police, volunteers occurring regularly.

6. District Level Mental Health Society was formed and District Collector periodically reviews the progress of the programme.
7. A mobile psychiatric team comprising a psychiatrist, psychologist, psychiatric social worker and pharmacist visits one taluk every day.
8. Various government facilities for rehabilitation and support to patients and families include vocational rehabilitation centres, free bus pass and other incentives, free medical care and free land pattas.
9. Families of carers have been involved in self-help groups and micro-credit programmes.
10. Job fairs for employment opportunities have been regularly held.
11. The MGNREGS is being tapped for job placement. Recently, the Govt.of Tamil Nadu has issued an order to include all the disabled population, especially Persons with Mental Disabilities in this scheme.
12. Collaboration with Tamil Nadu Veterinary and Animal Sciences University, Chennai, and Tamil Nadu Pudhu Vaazhvu Project for generating employment for persons with mental illness has been undertaken.
13. Families have been empowered through collaboration with Pudhu Vaazhvu Thittam (Empowerment and Poverty Alleviation Project).
14. Suicide Prevention and School Mental Health Programme have been initiated in **25 districts** where DMHP is being implemented and also in the psychiatric wing of all Government and Private Medical Colleges.
15. Suicide prevention counseling is being provided through the State 104 helpline.
16. Psychoeducational training has been imparted to school teachers
17. Rehabilitation centres have been set up at the District Level
18. Ramnad District Mental Health Programme is coordinating with the Erwadi Dargah Committee implementing a unique mental health programme in Erwadi in the name of 'Marunthum and Markkamum' . On seeing the success of the programme, the government came forward to construct a mental health institute at Erwadi and the Dargah committee donated **One acre of land** for the construction of a **50 bed Rehabilitation** Institute near the Dargah. A similar programme has been planned at St Anthony's Shrine.
19. Free legal aid cell has been initiated in Madurai.

Uttar Pradesh

A presentation was made on the DMHPs

1. A one year record of the 6 DMHPs indicates new registration of 10021 patients and follow-up of 29287- this is a demonstration that it is possible to generate annual data for the DMHP.

2. The presentation discussed the issues and challenges in the implementation- mainly financial- Late receipt of RoP, delay in approval of PIP, lack of ownership of the programme by the district officials as the programme is being implemented by the medical colleges.
3. Human resource shortage.
4. Huge private sector demand for psychiatrists.
5. Lower emphasis on Diploma in Psychiatry by the MCI.
6. Lack of availability of day care and residential centres.
7. Future plans indicated implementation of DMHP by the District Health Society to increase ownership of the programme by district level officers; mentoring and monitoring by medical colleges and psychiatric hospitals; increase in the district uptake under DMHP; Upgradation of the hospitals at Varanasi and Bareilly to teaching institutions; training of district and block education officers in mental health; training of medical officers of CHC, PHC for early detection, management of CMD and referral; training of community health workers; life skills education in schools.

5. SUMMARY OBSERVATIONS OF THE TECHNICAL COMMITTEE

The report of the Technical Committee has been primarily based on the State affidavits submitted to the Hon'ble Supreme Court by the respective states and supplemented where available with collateral information from the NHRC Special Rapporteurs, the Inspection Committee of Mental Hospitals to verify facts and any other information available.

The salient observations of the TC have been the following:

1. **Only 6 of the 36 States/UT (17%) have submitted mostly complete affidavits.** These include Chandigarh, Delhi, Gujarat, Meghalaya, Sikkim and Lakshadweep (where there are very limited facilities).

   In 19 States/UTs (53%), the information is partially complete.

   In 11 States/UTs (30%), the information is deficient.

   Even amongst the regions that have provided mostly complete information, the information on the facilities available/patients seen in the medical colleges/general hospital psychiatry units and DMHPs is incomplete. This makes it very difficult to accurately calculate the ratios of facilities like beds available, personnel available per 100,000 population (as assessed by WHO).
2. The state level questionnaire (Section 1) was to be consolidated by each state from the Appendices 1,2,3 and 4 (Psychiatric Institutions, Medical College/DH/GHPU, NGOs and DMHPs). However, most of states, including the ones that have submitted mostly complete affidavits have not consolidated the information about the mental health resources they have completely. The state representative should have consolidated the information provided for each section by individual facilities and presented the consolidated figures in the State Level Questionnaire.
3. It is evident from the above that states do not readily have information on parameters related to mental health. This is important to prepare a blueprint for development of mental health services in the State/UT.
4. In terms of the estimate of persons with mental illness in the State/UT, some have based this estimate on the persons seeking treatment as per medical record data. This

represents only a fraction of the persons with mental illness in the state, as treatment gaps for mental disorder are in excess of 85-90% in developing countries. A few have not provided any estimate (Andhra Pradesh, Assam, Chandigarh, Himachal Pradesh, Kerala, Nagaland, Punjab, Sikkim, Tamil Nadu, Tripura). The state of Tripura has not provided even the basic socio-demographic data of the state, which is readily available on its official state portal.

5. In the initial State Government Reports, the information on the Central Institutions located in these states was initially missing, and was provided later. Although the funding mechanisms of the Central institutes may be different, a large part of their clientele is drawn from the state they are located in. Thus, this information needs to be factored in by the state. This omission may be a reflection of tensions between central and state institutions.
6. Where the data on mental health burden has been reasonably calculated, a better understanding of how mental health services can be expanded emerges (e.g. in Delhi, Chandigarh).
7. It is important to have an estimate of the service needs for persons with different kinds of mental disorders- acute psychotic disorders, chronic disorders like schizophrenia, mood disorders, common mental disorders, substance use disorders etc.
8. Very few states have an idea about the number of children with intellectual disabilities, number of children and adolescents with mental disorders, number of elderly with mental disorders, number of persons in institutional settings like prisons, correctional homes, children's homes, destitute homes with mental disorders. These groups have special needs and to plan services, it is necessary to know what the service need is.
9. With regard to the availability of beds, the information on government psychiatric hospitals has been recorded satisfactorily and has been verified by the Inspection Committee in 44 mental health institutions (of a total of 47). The psychiatric facilities in Arunachal Pradesh, Chattisgarh and Haryana were not visited by the IC.

10. The UT of Andaman and Nicobar and Lakshadweep, as per the affidavit has no inpatient beds at all. Information regarding inpatient beds from the medical colleges/DH/GHPUs is incomplete in most states.
11. Information from private psychiatric facilities is also incomplete from most states (with the exception of Chandigarh, Delhi and Maharashtra).
12. Since the information on the facilities is incomplete, the numbers of outpatient registration and follow-up, as well as inpatient admissions is also incomplete.
13. In terms of the follow-up, there is variability in the information recorded, with some facilities mentioning the number of follow-ups, rather than the number of patients in regular follow-up.
14. There is very poor recording of the emergency cases seen, particularly in the medical colleges and general hospital psychiatry units. These facilities handle a large number of such cases, and it is important that this information is captured.
15. Information from the Army Hospital has been included in Delhi, but not from the other states.
16. In most states, the information on outpatient registration and number of admissions has been provided largely for the government psychiatric institutions and not the other facilities.
17. Based on the current information on inpatient beds, it is evident that bed ratios in Chandigarh, Goa (has recorded only the IPHB beds), Maharashtra, Meghalaya and Puducherry are within the global average ratios. However, in Maharashtra, a large number of these beds are in the private sector. Overall, as per current calculation (which definitely needs review when more complete information is available), the inpatient bed ratio is 2.15 per 100,000 population, much lower than the global bed to population ratio of 6.5. In developed countries, the ratio is as high as 41.8 beds per 100,000 population.
18. The Directorate of Health Services, at the behest of the Apex Court, carried out a mental health resource mapping in 2002. At that time, a majority of the beds were in the government sector. The states of Himachal Pradesh, Manipur, Meghalaya and the UTs

of Chandigarh, Delhi and Puducherry have made a concerted effort to increase the number of beds. There has been no change in Lakshadweep, Daman and Diu, Dadra and Nager Haveli and Nagaland, although the populations have increased since 2002.

19. Although the figures are incomplete, trends suggest a reduction in government psychiatric hospital beds, offset by a marginal increase in beds in medical colleges/GHPUs.
20. Beds in the private sector have not been counted in a majority of the states.
21. There are no government psychiatric institutions in Andaman and Nicobar, Chandigarh, Dadra and Nager Haveli, Daman and Diu, Lakshadweep, Mizoram, Puducherry and Sikkim. In these States/UTs, there are not enough facilities in the government medical colleges/GHPUs to compensate, with the exception of Chandigarh and Puducherry. In the latter, beds have been created in the government medical colleges, district hospitals and GHPUs.
22. Follow-ups are better at government psychiatric facilities. Cost and free medication may be important determinants of follow-up.
23. In the government psychiatric institutions, the commonest category of psychiatric illness is schizophrenia, followed by bipolar mood disorder and alcohol and other drug abuse. In the private sector, schizophrenia, alcohol and drug abuse, depressive disorders, anxiety disorders and bipolar mood disorders are the most common conditions encountered.
24. Obtaining similar information for medical colleges, GHPUs and district hospitals is important.
25. States do not appear to document and address the problem of suicides. Clearly, some states have high suicide rates, and attention needs to be paid to the reasons for such high rates and how to address them.
26. Little is done regarding the problems of the homeless, particularly the homeless mentally ill. The homeless have high rates of mental illness and it is important to address the needs of this constituency, particularly their shelter and safety needs in the immediate term, as well as their long-term needs of treatment, living and livelihood.

27. Fourteen (39%) of the states/UTs have some rudimentary rehabilitation services in the government sector. These are not very well developed and inequitably distributed within the state. Six of the states (17%) report NGO involvement with the government institution in rehabilitation.
28. Fourteen (39%) of states have developed helplines catering to some or other form of psychological distress including helplines for suicide prevention, addiction, domestic violence, child and adolescent mental health problems, etc. Delhi reports NGO helplines for students to deal with exam related stress.
29. Practically no state has mental health trained counselors in government run institutions such as correctional homes, children's homes, shelter homes, correctional or remand homes, homes for destitute women, old age homes.
30. Only 5 states/UTs (14%) report prison visits by psychiatrists. That apart there are no mental health services being delivered in prisons, where mental health and substance use problems are very high.
31. Innovations in rehabilitation and community care include Mobile Mental Health Service for the homeless and home-bound (Delhi), community-based rehabilitation (Karnataka and Kerala).
32. As per the affidavits, **the count of psychiatrists is 2052, which is clearly an under-estimate**, as it is lower than the count in 2002 (2219). Higher ratios (3 times or more) of private: government psychiatrists are present in Andhra Pradesh, Bihar, Gujarat, Kerala, Maharashtra, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal.
33. The target of 1 psychiatrist per 100,000 population set in the DGHS Report of 2002 or a higher ratio is present in Chandigarh (3.9), Delhi(1.2), Goa (1.4), Manipur (2.2) and Puducherry (3.9).
34. There has been a steady increase in the number of institutions offering MD in Psychiatry. Presently annual post-graduate seats in Psychiatry total 576 (434 MD, 128 Diploma and 14 DNB).

35. However, only **165 of the 412 medical colleges (40%) offer post-graduate courses in psychiatry.** Institutions offering DNB have come down drastically and DPM has come down. Net-net, there has only been a marginal increase in seats in recent times.
36. Although there has been a huge increase in PG seats from 66 in 2002 to 576 in 2015 (8 fold increase), this increase is not commensurate with the seats being offered in other medical and surgical specialties. Lack of beds and PG teachers are major limitations.
37. Although there has been a serious effort to increase PG seats in psychiatry, one wonders where the new human resource has vanished, as government psychiatrist numbers have not hugely increased. This suggests that new graduates are either going abroad or entering the private sector.
38. There are no opportunities for PG training in psychiatry at all within the State in Andaman and Nicobar, Arunachal Pradesh, Dadra and Nager Haveli, Daman and Diu, Lakshadweep. Meghalaya, Mizoram, Nagaland and Tripura.
39. Superspecialty courses Child Psychiatry (DM) are offered at NIMHANS and PGIMER. Superspecialty courses in addiction are offered at NIMHANS, PGIMER and AIIMS.
40. Eighteen States/UTs (50%) report any training at all in either one of the disciplines of clinical psychology, psychiatric social work or psychiatric nursing. Only 5 States/UTs (14%) report training across all these three disciplines. Six of the states have one or no clinical psychologists. In seven states, there is an increase in the number of clinical psychologists, but the ratios to the population are still very low. Only Chandigarh and Meghalaya appear to be able to meet the ratio of 1.5 psychologist per 100,000 population as mentioned in the 2002 document.
41. Significant increases in psychiatric social workers are evident in Madhya Pradesh, Tamil Nadu, Assam and Himachal Pradesh. The numbers of psychiatric social workers in Odisha, Puducherry, Chattisgarh, Daman and Diu, Goa, Haryana and Nagaland appear to be static over time. Lakshadweep, Nagaland, Sikkim and Tripura do not even now document a single psychiatric social worker.
42. Where Undergraduate training in psychiatry is offered, most states do not specify details of such training. Among those that do, the number of hours of theory ranges

from 10-30 hours and 2 weeks clinical posting both during training and internship. In 2011, the MCI has stipulated 40 hours of teaching (theory), 4 weeks of posting, 20 marks in the medicine paper for a compulsory question in psychiatry, mandatory internal assessment in psychiatry for the final examination, compulsory psychiatry posting during internship and integrated teaching of psychiatry, especially in community medicine.

43. Sixteen (44%) of States/UTs do not report having a single psychiatric nurse in their state. Bihar, Daman and Diu and Jharkand have not recorded this information. States which have significantly increased their mental health human resource in psychiatric nursing include Goa, Gujarat, Himachal Pradesh, Kerala, Meghalaya, Madhya Pradesh and Manipur. Dadra and Nager Haveli has doubled the number of psychiatric trained nurses. Chandigarh, and Jharkand have increased the number of psychiatric nurses marginally.
44. The Nodal Authority for mental health is not mentioned at all in the affidavits of Andaman and Nicobar, Dadra and Nager Haveli, Daman and Diu, Lakshadweep and Tripura. A multi-sectoral nodal authority comprising the State Mental Health Authority, the Directorate of Medical education, the State Legal Services Authority, Directorate of Health Services is mentioned in 15 States/UTs (42%). The SMHA alone or along with the Directorate of Medical Education/ Directorate of Health Services is mentioned as the nodal authority in 5 States/UTs (14%). The State Human Rights Commission being part of the nodal body is mentioned by 10 States/UTs (28%). In 12 States/UTs (33%), the Social Welfare department is also a part of the nodal authority. In Tamil Nadu and West Bengal, The Commissioner of Disability is also part of the nodal authority.
45. It was observed during the process of collation of the affidavits and personal clarifications that were sought from a couple of states that there were tensions and jurisdictional constraints between the SMHA, the Directorate of Health Services (the nodal officer for mental health-often at the level of Deputy Director) and the Department of Medical Education. It is possible that some part of the lacunae in data collation at the state level may be because of these constraints.

46. Apart from Delhi, which reports having a draft mental health plan awaiting approval and Karnataka, which reports having made a plan in 2003 in response to the High Court directive, none of the other States/UTs reports having a mental health plan.
47. Only 4 states have indicated the formulation of the State Mental Health Rules. This is an ironical state of affairs as there is a new Mental Health Care Bill since 2013 awaiting ratification which will repeal the Mental Health Act 1987. Twenty eight years after its enactment, only 11% of states are sure about the rules being in place. Many states have not even mentioned this information. A higher number had mentioned the presence of rules in the 2002 DGHS survey. It is therefore surprising that many state representatives are not even aware of the State Mental Health Rules.
48. Regarding the monitoring of state policy and planning for mental health, only Assam, Delhi and Kerala specifically mention such oversight. The state of Jammu and Kashmir still has to activate its State Mental Health Authority.
49. Attempts to integrate mental health care into general health care and the non-communicable diseases programme is mentioned only by 4 States/UTs- Delhi, Karnataka, Kerala and Gujarat.
50. None of the states provide any examples of high level commitment to mental health care.
51. With regard to mention of inter-sectoral co-ordination, Gujarat mentions a suicide prevention programme the state has initiated in all medical colleges in Ahmedabad. In Karnataka, such attempts are being made by the Tirthahalli Mental Health Project, Basic Needs, Siddhalghatta Community Mental Health Project and the Karuna Trust initiative for mental health training in 25 PHCs. None of the other states mention any attempts at inter-sectoral co-ordination. Such a plan to integrate mental health care into general health care was made in 1982!
52. Specific state budgets, apart from the budget for psychiatric hospitals, are mentioned for DMHPs in Delhi, Karnataka and Maharashtra. Even in these states, there is no overall budget for mental health.

53. The information on psychiatric institutions has been based on the visits of the Inspection Committee as these reports bridge some of the gaps in the affidavit replies. However, these reports are limited to the government psychiatric institutions alone. The IC visited 44 of the 47 institutions.
54. In the psychiatric hospitals, under a third (30%) have inpatient facilities for children, nearly half have inpatient facilities for the elderly with mental health problems. Under half (47%) have inpatient facilities for de-addiction. More than two-third (68%) report facilities for rehabilitation. While most institutions offer emergency services, the numbers seen in emergency are mentioned at very few hospitals. While there are substantial changes in the last two decades in most hospitals, the hospitals in Maharashtra, West Bengal, Uttar Pradesh (apart from Agra), Arunachal Pradesh, Bihar, Chattisgarh, Nagaland and Tripura have not kept pace with the other states in developing these facilities within the psychiatric institutions.
55. While overcrowding and poor hygienic environments characterized many of the hospitals earlier, under utilisation of the facilities is a problem, particularly in some of the newer hospitals.
56. The duration of inpatient stay has reduced on account of a greater focus on voluntary admissions.
57. A significant observation is that at least half of the institutions (47%) report at least one visit by the SHRC/NHRC in the last two years and 58% by the SMHA. However, such oversight is conspicuously lacking in some to the hospitals in Arunachal Pradesh, Chattisgarh, Maharashtra, Rajasthan, Uttar Pradesh and Gujarat (Vadodara).
58. Very few of the institutions report regular redressal of complaints and the procedure of reporting incidents and their resolution.
59. More than two-thirds (68%) report display of patient rights, but it is beyond the scope of this report to see to what extent these rights are protected.
60. Most hospitals (77%) report basic laboratory investigation facilities.
61. Most report satisfactory availability of medication (77%).
62. ECT services are offered in most hospitals (70%) and nearly all have modified ECTs.

63. Psychosocial counseling is available in most institutions (90%).
64. There are high rates of medical co-morbidity reported in at least a third of the hospitals.
65. While in most hospitals the annual death rates are few, on an average there is one death across the psychiatric hospitals every day. This is mainly accounted for by the hospitals in Maharashtra, Tamil Nadu, Orissa, West Bengal and Kerala (Kozhikode), which have long-stay patients. How many were age-related, or due to co-morbid physical illness is not clear. The Report has not ascertained whether regular death meetings are conducted in the hospitals to ascertain the cause of death, and remediate the cause of the same.
66. There are substantial long-stay patients, particularly in Maharashra, Punjab, Tamil Nadu and West Bengal. Projects with rehabilitation of long-stay reveal the complexities involved in their rehabilitation. Experiences from Gujarat suggest that earlier rehabilitation and active collaboration with community agencies leads to better outcomes. Longer-term follow-up from the LGBRIMH reveals some of the difficulties and the need to evolve a personalized approach to the rehabilitation of destitute patients, rather than enmasse orders to move out patients, which, though well-intended, may have unforeseen adverse consequences.
67. There is indication of growing NGO involvement with psychiatric hospitals in mental health care. Some of the hospitals have foraged collaborative partnerships with NGOs, particularly for rehabilitation and aftercare. This is an encouraging trend. However, in some of the hospitals in Bihar, Chattisgarh, Haryana, Meghalaya, Nagpur, Telengana, Tripura, Uttar Pradesh and West Bengal, the involvement of NGOs is conspicuously lacking, as reported in the affidavits.
68. More than half of the psychiatric institutions (56%) are involved with one or other aspect of the DMHP.
69. Staff vacancies are still common in many hospitals.
70. In institutes which are multi-disciplinary, it is difficult to discern how many of the staff are available for mental health care, as the break up is not specified. It is important to identify the staff involved in mental health care, because such care is human resource

dependent. Good practice guidelines and training of the staff in routine counseling, crisis intervention, violence de-escalation and management, assessment and management of suicidal risk are important areas.

71. The medical superintendent is not a psychiatrist in more than a third (28%) of the hospitals. The earlier reports of the NHRC recommended that a psychiatric institution should have a psychiatrist as medical superintendent considering the special administrative and medico-legal requirements that may be associated with running a psychiatric facility.
72. About half the psychiatric institutions (52%) are involved in academic activities. It is of concern that this is not present in the hospitals of Maharashtra and some of the hospitals in Uttar Pradesh and West Bengal. It is also absent in Arunachal Pradesh, Bihar, Chattisgarh, Himachal Pradesh and Tripura.
73. There is a doubling of institutions now offering post-graduate training in mental health disciplines compared to 1996. This is an encouraging trend. However, only a few institutions have made a consistent effort at training all cadres of mental health professionals. This is important to have multi-disciplinary teams to address all the needs of persons with mental disorders.
74. Many of the hospitals in the government sector which have faculty have not started post-graduate courses, unlike their counterparts in many medical colleges, particularly in the private sector. Having an academic atmosphere, and having younger people come into the institution is a stimulus for improvement as has been pointed out in earlier NHRC reports.
75. The IC report observes that there has been massive transformation in the mental health care institutions (psychiatric hospitals), with infrastructural improvement, enhancement of facilities, and varying levels of recreation and rehabilitation of patients. It also notes the inadequate use of ECT because of non-availability of anaesthetists, problem of long-stay patients, particularly destitute patients and variations in the oversight by agencies like the SMHA and SHRC. It recommends more autonomous structure and operational flexibility, enhancement of human resources, making anaesthetists available, starting of

academic training, attention to medical problems among patients with mental illness, supportive neurological and neurosurgical facilities, rehabilitation programmes for the long-stay, specialized wards for the children and elderly and for de-addiction, forensic services, more open wards, further improvement in food preparation and distribution, efforts to re-integrate reception order patients to their families, setting up of half-way homes under the Social Work Department, alternative residential facilities, vocational rehabilitation, proper record maintenance, more prominent display of patient rights, inter-agency co-ordination, sensitization of the magistracy and mechanisms for grievance redressal.

76. Some of the psychiatric institutions provide exemplary examples of good mental health care. NIMHANS is now recognized as an Institute of National Importance. Introduction of online screening, residential rehabilitation, free legal aid, liaison to address mental health care issues in other non-communicable diseases, on-line and face-to-face training of health professionals in substance use disorder management, life skills training, centre for well-being, a mother-baby unit for perinatal care are some of the recent developments. IHBAS has received NABH accreditation, introduced programmes of care for the homeless mentally ill, mobile units, detailed grievance redressal mechanisms for patients. HMH Ahmedabad has also received NABH accreditation and set up various quality improvement committees. Nine mental health institutions in Gujarat have participated in the implementation of a quality rights in mental health initiative which has led to a host of changes in mental health service delivery in the State. The PDH in Srinagar has taken several measures to improve care. A legal aid clinic has been started. The hospital provides services for the mentally ill prisoners in jails. Patients have been promptly vaccinated when there was an illness outbreak.

77. Appendix 3 of the questionnaire pertaining to NGOs indicates a substantial increase in the number of NGOs, with upwards of 325 NGOs working in the area of mental health. This suggests a substantial increase in NGO presence in the country. Areas they work in include mental health advocacy, awareness, counseling, provision of medication, residential care, follow-up and after care, long-stay rehabilitation, social and legal

assistance, day care, suicide prevention and crisis intervention, community outreach, helplines, substance abuse interventions, medical care, home-based programmes, training in leadership in mental health, development of psychosocial interventions, domestic violence, school and adolescent mental health, special populations, children with intellectual and learning disabilities, and a few in PPP models for the DMHP. However, the NGOs are also clustered in some of the states and there are few working in rural areas. When it comes to the care of persons with serious mental disorders and severe disability, the staff is unable to handle such problems and are dependent on the psychiatric hospitals they work with for such inputs.

78. There are very few user-carer groups in the country.
79. Appendix 4 pertains to the District Mental Health Programmes (DMHP) in the country. Chandigarh, Goa, Sikkim and Telengana presently report complete coverage of districts in the DMHP.
80. The expansion of the DMHP has been very slow, increasing from 4% in 2002 to 27% presently. Thus only about a quarter of the districts in the country are covered by the DMHP. In some states, although the DMHP exists on paper, it is not functioning due to lack of funds (e.g. in Andhra Pradesh, Daman and Diu, Himachal Pradesh, Rajasthan)
81. The details provided under the DMHP are extremely unsatisfactory. It is not possible to accurately determine the number of persons registered in a year, the number of follow-ups, the kind of services provided, and the impact of the DMHP.
82. What is evident from some of the reports is that common mental disorders like depression and anxiety, substance misuse (alcohol and drugs), mental retardation are some of the common disorders seen in the DMHP settings.
83. Apart from budget constraints, human resource shortages to run the DMHP are evident.
84. In the state of Jammu and Kashmir, the Special Rapporteur notes the lack of medications, the lack of monitoring and the lack of trained human resources to effectively run the DMHP.
85. What is very evident is that the DMHPs in many states are locked up in bureaucratic hurdles- usually related to the non-receipt of central funds – which in turn is attributed

to lack of submission of statements of expenditure and utilization certificate. Thus, most of the information related to the DMHP constitutes sheets and sheets on SOE's, UC's and pending funds statements, rather than useful information on who were the beneficiaries; what were the achievements/challenges/barriers to care and substantive reports of the activities undertaken under the DMHP.

86. Some states have taken the partial or complete ownership of the DMHP. These include Assam and Gujarat. Kerala proposes to expand the DMHP to all districts in the near future.
87. One thing that stands out is that psychotropic medication is reasonably well available in many DMHPs.
88. The lack of consistent information from most states makes the DMHP very difficult to evaluate (unlike the psychiatric institutions, where it has been relatively easier to comment on the areas of positive development and the areas of concern and the changes across the last two decades). This is especially necessary given the criticisms of the DMHP (mentioned in the review), but the general impression that it was the way to go forward.
89. A presentation by select states at a symposium organized by the NHRC in August 2015 revealed some positive trends- a more comprehensive statement of the resources, a clearer enunciation of recent developments, tentative plans for phased expansion of mental health facilities and training.
90. From the presentation, it was evident that Gujarat had made a fairly comprehensive plan covering 8 strategic areas; Jharkand paid attention to training gram pradhans, teachers, students and families; Punjab had developed a 3-tier system to address substance addiction at primary, secondary and tertiary care levels; Delhi had focused on developing interventions for the homeless mentally ill persons.

SUMMARY AND RECOMMENDATIONS

The Fundamental/Human Rights enshrined in Article 21 of the Constitution includes the right to live with human dignity and the right to health.

There is no health without mental health.

Mental health needs to be a part of every health intervention. However, this does not automatically occur. Mental health services have lagged behind services for physical health. There are many reasons for this. One glaring drawback has been the shortage of human resources. Another has been the poor resource allocation to mental health. However, when budgets were suddenly increased for mental health (in the 11th five year plan and beyond), human resources, managerial and other administrative systems not being in place, these budgets did not get utilized adequately. What has been lacking is a systematic, planned and regularly monitored and evaluated comprehensive programme for mental health promotion, for the timely recognition of mental disorders, their effective management, rehabilitation and reintegration of persons suffering from mental disorders.

In the development of comprehensive mental health services, the following points are important to keep in mind:

In the enthusiasm to develop services for persons suffering from mental disorders, we must not get lost in emotive debates of institutional versus community care, outpatient versus residential care; family based services versus socially assisted services. We are presently not in a position to argue because we need **ALL** of these services, **being grossly deficient in ALL of them.** Many of these are specialized services, and trained human resources, **BOTH human resources with specialized qualifications and non-specialised health-care professionals** with proper training are needed to meet the needs of persons with mental disorders.

Mental health service development must be responsive to two primary issues-

a. The extent and patterns of mental disorders in the community and treatment gaps in service delivery

b. The needs of individuals with mental disorders and their carers.

   The needs of individuals include the following:

   - Available, Affordable, easily Accessible treatment services.
   - Rights-based treatment with dignity and humaneness and not as objects of charity.
   - Treatment provided by competent (properly trained) professionals.
   - The range of treatments required available together (to reduce travel and cost).
   - Confidentiality and respect for privacy.
   - A continuum of services ranging from emergency and acute care to psychological and pharmacological treatments as appropriate as well as psycho-social rehabilitation, that addresses basic needs like food, shelter, clothing, safety, proper engagement in some meaningful activity, integration with family and friends as much as possible, access to social services, equal opportunity for education, equal opportunity to work, be gainfully employed, ownership of assets, travel benefits, right to marriage and a complete family life (All of which is enshrined in various international treaties, guidelines and declarations affirming Human Rights of persons with mental illness[84]).

c. Provision of disability benefits and extension of benefits available in the country for others; special benefits that persons with mental illness and its ensuing disabilities need.
d. A forum for redressal if rights are violated and support to obtain such redressal.
e. Collaborative treatment planning (including the person with the mental disorder, family or carer and treating professional).
f. Addressing special needs of homeless persons with mentally illness, destitute persons with mental illness and persons in restrictive settings (jails, remand homes etc) with mental health issues, mental health needs of persons in extreme situations (disaster, emergencies, displacement).

[84] Mental Health and Human Rights 2008 ibid

g. Protection of property if any, so that the person is not cheated of deprived of enjoying the right to property on account of mental illness.
h. Protection of job and access to proper treatment if in employment.
i. Proper support to make decisions during times of acute illness.

Carer needs usually include:

a. All that their ward needs.
b. Access to help when their ward is acutely ill.
c. A system that will be supportive to their ward and to them when they are emotionally disturbed.
d. If old and infirm and not in a position to take care of the ward, either support to do so or arrangements for their proper care in the community.
e. When the carer should pass on, facilities and a support system for the ward to be cared for.

The development of mental health services should thus develop based the needs of individuals with mental disorders (often referred to as Users) and families and others who are involved in the care of persons with mental disorders (often referred to as Carers). The problem with the use of the term 'Users' is that many persons with mental disorders do not 'use ' mental health services, because these are not available easily to them, are difficult to access because of poor knowledge, cost, stigma and other factors.

Development of mental health services must be proactive and responsive to societal needs, and not merely reactive. It is evident that most of the action has occurred in a reactive manner either following public interest litigations or public tragedies.

But we do not ever want another Erwadi.

We now know that the mental health citizens varies depending upon their developmental stage (children, elderly), gender, type of disorder, living conditions (rural/urban; poverty; institutional settings, homelessness). Development of mental health services must consider these factors.

1. The mental health of children has an impact on the mental health of their carers. Their overall health also has an impact on nation building and development of happy and productive citizens. Mental health services for children must include proper ante-natal care, supervised deliveries to ensure no peri-natal brain damage, early detection and remediation for intellectual delays, facilitation of the emotional and intellectual growth among children in school and out of school, life skills education, detection and treatment of childhood mental disorders, inpatient facilities for children that include family settings for support, substance abuse prevention and treatment. But mental health needs of children require provisions within and outside the health system- children need safe and stimulating environments to grow in, measures to enhance their self-esteem and confidence; proper nutrition, exercise, sleep and immunization; early detection and remediation for specific learning disabilities, educational and vocational opportunities and other benefits for differently- abled children; destitute children and children in conflict with law need arrangements for the stay, care, counseling and support. Staff in children's institutions need training in addressing the mental health care issues of these children; parents need support to care for children with special mental health care needs; there are also several legal issues involved when addressing mental health care of children, including guardianship, protection of child rights, provisions under the Juvenile Justice Act and National Trust Act etc.

2. Similarly, with a growing population of the elderly, their care must include mental health care components. Supporting and educating families in caring for their elders' emotional needs, training health professionals in the recognition and management of mental health problems including dementia, depression, substance use and other problems in the elderly; benefits for the elderly with mental health problems; training of staff in in-patient and residential facilities, legal issues including protection from any form of abuse, protection of property, supported living, avenues for stimulation and purposeful engagement, provision of support to minimize disability are all important for the elderly. Laws regarding health of the elderly need to include mental health components.
3. Gender-related mental health needs are often overlooked, both in community as well as in in-patient settings. Health professionals need to be trained in gender specific mental health

issues, mental health issues related to domestic violence, substance abuse in the family members, peri-natal mental health issues, legal aid, accompanied referrals for health and other needs.

4. The homeless and destitute persons with mental illness, both men and women need shelter, health care and support, rehabilitation, extension of disability facilities, access to privileges that other citizens have (identity cards, opening of bank accounts etc), opportunities for vocational rehabilitation and employment, as well as other rights.
5. Persons in correctional and other custodial locations have higher mental morbidity and mental health care needs and require specialized attention by trained professionals
6. Persons with severe psychological distress (following personal crises, psychological trauma, natural calamities) need to be provided emotional care and psycho-social support.
7. It would not be sufficient to roll out funds centrally, without a comprehensive mental health plan and programme. It is not enough to do things in fits and starts. An example is the expansion of the NMHP in 1996, re- awakening to it after the Erwadi tragedy and the Hon'ble Supreme Court Directive to map resources and re-strategise the NMHP in 2002, and now again twelve years later. There needs to be a plan, time-bound programmes with budget allocation, regular monitoring and evaluation.
8. Human resource shortage has been a major problem for several decades. But the last decade shows promise that it is possible to enhance human resources with proper planning and execution. The first challenge is to have adequate human resources. The next challenge will be to have equitable distribution so that all citizens will have access to trained professionals to meet their mental health care needs.
9. Emergency services to handle crises related to mental disorders (violence, self-harm, agitation etc) must be available and the public must know how to access them.
10. Comprehensive development of mental health services will involve integrated mental health care in primary health care, mental health care by solo-providers (like general practitioners), mental health care in general hospital psychiatry units, district hospitals, medical colleges as well as in psychiatric institutions.

It will also involve integrating mental health care in both communicable disease and non-communicable disease programmes. Thus, this involves training of undergraduates in medicine as well as the social sciences in mental health issues; training of primary health care professionals (medical and non-medical); production of adequate number of specialists (psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses) who will not only provide mental health care directly, but will participate in the sensitization and training of all health care providers, as well as other professionals critical to the care of the mentally ill (judiciary, executive, professionals working in institutions, correctional settings, NGOs.

11. However, comprehensive mental health care cannot be provided by health care services alone. The welfare sector, labour sector, educational sector, legal sector, housing sector, all need to play a key role.
12. Institutional settings continue to need oversight to ensure humane, prompt and optimal treatments for persons with mental disorders with adequate attention to the person's right to treatment, confidentiality and grievance redressal. Adequate and trained human resources, regular funds, regular monitoring, periodic review and adaptation are all necessary to ensure that institutional settings do not revert to being custodial in nature, but become centres for specialized care, development of human resources and carry out on-the-ground research to evolve better strategies of treatment and care for mental disorders. The danger of large Institutions is the risk of getting so bogged down with red tape and bureaucracy that patient needs sometimes lose their primacy.
13. With a large number of medical colleges and general hospital, these settings offer an ideal location for integrating mental health and general health care. This needs to be systematically evaluated and strengthened.
14. Primary care should not remain a distant dream. The focus should be on how to make it a reality in the next decade.
15. Centre-State collaboration, central institute/state collaboration, inter-agency collaboration, public-private collaborations are critical to optimal service delivery in the present context.

Effective Mental Health Care Planning

The most effective way to plan mental health care is to have:

- A clear assessment of the problem
- An analysis of the resource available
- Assessment of treatment gaps
- Preparing a road map for mental health care for the next two decades.
- Defining joint responsibilities of the Central Government and State
- Greater involvement of professional bodies like the Indian Psychiatric Society
- Identify monitoring bodies and have a plan for monitoring

The gap between people's needs and existing services is extremely wide. Attempts to bridge this chasm include improving access and utilization of mental health care services at all levels, particularly primary care, training all health professionals to address basic mental health care, developing specialized mental health resources, putting into place systematic governance to oversee and monitor development and expansion of mental health services in the States/UTs, ensuring adequate budgets for mental health care delivery, improving education and awareness of mental health promotion, ways to reduce psychological distress and access treatments for mental disorders, develop services in the community that foster mental health and support the care and rehabilitation of persons with mental disorders.

SPECIFIC RECOMMENDATIONS OF THE TECHNICAL COMMITTEE

The following recommendations stem from the observations of the Technical Committee based on the State/UT affidavits, Special Rapporteurs' reports and Inspection Committee reports. As the ownership of the mental health services primarily rest with the States/UTs, the recommendations begin with them, but the fruition of many of these recommendations will require collaborative engagement of State and Centre, Health and Welfare, GO and NGO.

MENTAL HEALTH CARE ACTION PLAN- THINK MENTAL HEALTH 2016-2025

BY STATE GOVERNMENTS

1. **Every state will address the lacunae in its reporting and provide an accurate documentation**. While it is understood that some facilities may not exist, where they do (especially information on medical colleges, general hospitals, private psychiatrists etc), the gaps in the information will be filled and the state level questionnaire updated.
2. In addition to this, the **States/UT will review and revise their mental health report** to self-assess where they stand presently.
3. An updated **State Mental Health Report** (based on the completed State Level Questionnaire affidavit earlier submitted to the Hon'ble Supreme Court) will be submitted by the State/UT **in the next 3 months** to the NHRC.

A. Based on this, the state will make a **comprehensive mental health plan** (in dialogue with the other relevant local bodies)**,** which will define its goals for mental health care, strategies, and make a time-bound action plan. This must be submitted to the Hon'ble Supreme Court and NHRC.

   The State and Central Governments should follow a stepped care approach to mental health services.

   - ❖ Health education
   - ❖ Health promotion through School Mental Health Programmes.

- ❖ Counselling centres.
- ❖ Early diagnosis and effective management/emergency services.
- ❖ Short periods of hospitalization when required.
- ❖ Aftercare and facilities for rehabilitation.

This plan should be readied **in the next 6 months**. The time-lines for implementation from 2016-2025 must be indicated.

SUGGESTED METHODOLOGY

4. This activity must be directly overseen by a senior officer in the state. It is evident that the nodal officer who has been made responsible (in many cases the Deputy Director Health) is unable to collate information that falls in the jurisdiction of medical education and other departments. A senior officer from the administrative cadre (Designated as Special Officer for Mental Health Services) to whom all the agencies from health, welfare and other departments must be identified. The officer must work closely with the nodal agencies as well as the nodal officer for the DMHP to collate the relevant information.
5. For planning the comprehensive services (health, welfare, rehabilitation, education, labour, human rights), key functionaries from Health, National Health Mission (state level), Medical Education, Social Services, Rehabilitation Services, Legal Services (State Legal Services Authority), Human Rights (State Human Rights Commission), State Commission for Women, State Child Right Commission, experts from central and state psychiatric institutions, professional bodies including the State Medical Council, State Branches of the Indian Psychiatric Society, Clinical Psychologists, Psychiatric Social Workers, Nursing Councils must be involved. Where the professional bodies do not exist, a representative from a recognized psychiatric institution or facility may be co-opted. There must be representation from a mental health service user and carer (group representative or individual if no group exists). There must be a representation of non-governmental organizations.

Any other sectors thought relevant for mental health care service delivery can be co-opted.

6. The plan will indicate the activities to be undertaken, immediate, short term (1-5 years) and long-term (5-10 years) plans, the nodal agency and the key functionary/ies for the activity, as well as the support that exists/that needs to be mobilized.
7. The above committee may be called the State/UT Mental Health Services Planning Committee.
8. Resources to be provided by the State/UT and the Centre may be outlined in the document.
9. The document needs to include a **systematic plan** as to how the state will address the various issues detailed subsequently.

HUMAN RESOURCES

10. **Augment the mental health human resources** – Upgradation of psychiatric institutions and medical colleges to PG training centres - List of which are the medical colleges/psychiatric institutions where such training can be carried out; a phased plan for implementation; listing of the sanctioning agencies involved (e.g. Medical Council of India, Rehabilitation Council, Nursing Council of India etc);

    Where facilities for post-graduate training do not exist, the State/UT may identify training institutions in the region; a special Memorandum of Understanding with those institutions for a commitment of enhancing human resources for the state must be undertaken, along with a longer-term plan to develop human resources within the State/UT.

    The Medical Colleges must be encouraged to start P.G. Training in Psychiatry. Where needed, funds may be provided to upgrade the infrastructure. The National Mental Health Programme in the last and current plans provides such funding to several State run Medical Colleges to upgrade the infrastructure of psychiatry departments.

Credit system must be put in place in all states to encourage all practicing psychiatrists to undergo continuing medical education.

Psychiatry Centres may develop super specialty courses or newer courses in branch of psychiatry to meet the growing need for expert teachers. Such higher super specialty courses have already been started at NIMHANS, PGIMER. Super-specialisation in branches such as addiction, child psychiatry, geriatric psychiatry, forensic psychiatry, community psychiatry, rehabilitation etc.

The Mental Health Policy Group has recommended the following human resources **at the District Level:**

a) Two full time psychiatrists for each DMHP with population larger than 5 lakhs or daily patient attendance of more than 75 (where not available, part-time psychiatrists. Where even part-time is not available, an accredited medical officer.
b) Seven nurses (after adequate training) to deliver inpatient and outpatient care
c) Two clinical psychologists (where not available, interim arrangement of appointing a BA Psychology with appropriate training
d) Four psychiatric social workers (where not available, interim arrangement of appointing social workers having post graduate qualification in social work from a recognized university or bachelors experience in social work with appropriate experience

At the Taluk Hospital / CHC Level:

a) Medical doctor with minimum prescribed training in psychiatry – (1)
b) Clinical Psychologist – (1)
c) Psychiatric Social Worker – (1)

At the PHC Level

a) Trained medical officers
b) Community workers (2-4)

Community Mental Health Workers (CMHW or Community Counselors) are the 'front-line' mental health care providers based in each PHC. He/she will be a local resident, has studied upto Xth class and will be trained to detect mental illnesses and provide a range of psycho-social treatments for mental illnesses.

It is important to recognize that the compromise of human resource is only as an interim arrangement. Aggressive efforts to develop trained human resources must be made.

It is hoped that by 2025, there will be at least one psychiatrist at the taluk level.

Persons with mental illness should be able to access mental health services within 2-3 kms from where they live.

11. **Senstitize and train all its health care providers in mental health**- this should occur through standardized training programmes and cover the different categories of health care providers in the health services as well as general and district hospitals. The focus of the training programmes will be on both identification and first-level management of psychiatric illness and what to treat/when to refer. Training of General Practitioners who are likely to encounter mental health issues in nearly 50% of the patients they see is very important. GPs are well accepted by their patients and can be a good source of mental health care basic service delivery. Training of nurses in mental health care is an important strategy as nurses form a significant proportion of the health human resource. The nurses' role is not just medication and related physical monitoring, but also a role in offering education to patients and families as well as providing required counseling in select cases.
12. Similarly, a **sensitization and training programme for undergraduates** and other departments in medical colleges about integrating mental health issues in training (such integrated teaching models are available). The planning for this may be undertaken by a sub-committee co-ordinated by the Medical Education Department.
13. The **undergraduate training curriculum** for medicine in many medical colleges has not taken into consideration **the new recommendations of the Medical Council of India.**

This needs to be urgently reviewed and remediated. The updated report must clearly mention the action taken in this regard. A listing of all the medical colleges and their compliance must be obtained.

Over the years the under-graduate training have been strengthened with respect to psychiatry. However, unlike other subjects, such as pediatrics and ophthalmology; psychiatry has not been included as an exam subject at M.B.B.S. Level. There should be a clinical case examination in psychiatry during the annual examination.

14. Similarly, the training curricula for the inclusion of mental health components in the training curricula of **both undergraduate and postgraduate courses in psychology, social work and nursing** must be reviewed for the content and duration of training in mental health issues.

    The **Medical Council of India, Rehabilitation Council of India and Nursing Council of India** and must become active partners in the attempt to enhance human resources. The **professional bodies of mental health professionals** (psychiatrists, psychologists, psychiatric social workers, psychiatric nurse must become active partners in planning mental health services, resource mobilization and monitoring. Besides there is a need for psychiatric nurses, clinical psychologists and other trained staff. Institutes like NIMHANS, Bangalore, RINPAS, Ranchi, IMHH, Agra and others should be recognized to impart such academic training both on and off campus.

15. **Mental health evaluation and care components need to be integrated into many of the communicable and non-communicable disease programmes.** Each State will review the existing programmes and indicate its plan for integrating mental health care aspects into training; reporting formats for the other diseases should include mental health care components. This is because mental and physical co-morbidity co-exist and treating mental disorders/psychological distress improves outcomes for physical illnesses as well (an example would be detecting and managing depression in persons with diabetes; detecting tobacco and alcohol use in a person being screened for cancer and appropriate interventions). A training manual has been developed by the Ministry of Health and WHO to address risk factors including psychological stress, tobacco, alcohol

use, unhealthy diet, physical inactivity as risk factors for NCDs including mental disorders, which may be used for such training.

16. **There is a strong need to recognize and assist NGOs** who work in this sector. The convergence with the assistance programmes of Ministry of Social Justice and Empowerment is needed to ensure that genuine NGOs are involved to handle mental health care. The NGOs can be suggested by the respective mental health hospitals through their state government. Disability welfare measures and access to welfare policies must be available to persons with mental illness without means for sustenance.
17. **Training of lay counselors** – Lay counselor model has been utilized in training school and college teachers, as well as by NGOs in helping people in psychological distress through providing emotional support.
18. **Training of community health workers**- The training of community health workers in identifying and referring persons with mental disorders is crucial. Community health workers are also invaluable in providing follow-up and aftercare as well as educating the public on risk factors for mental disorders and mental health promotion. In some states, there has been a positive experience with creating **community mental health workers**. In other states, existing community workers and ASHA's have been sensitized regarding mental disorders.
19. **Formation of associations** of persons with mental disorders (service users) and their families. Globally, user and family associations are present in 64% and 62% of countries, respectively. User associations are present in 83% of high income countries.
20. Sensitisation and training programmes for **judicial officers** through the Legal Services Authority, programmes for the **police** with regard to mental health care issues, including the legal provisions in the area of mental health care.
21. Sensitisation and training programmes **for the administrators in the department of health, social services and other relevant departments** on mental health disorders and the responsibilities of the health and social sectors.

MENTAL HEALTH SERVICES

22. Each State/UT will first update the mental health services in the following areas:

- **Details about the DMHP** (many states have not provided any details except for the UC's and SOEs)
- **Details for the medical colleges/general hospital psychiatry units/district hospitals** on the above parameters (many states have listed that this is being obtained but not provided the information
- **Details of institutions offering specialized care** in the government and private sectors- inpatient beds, new registrations, number of patients maintaining follow-up, numbers retained in follow-up, major diagnostic categories; staffing; update on the other areas of the proforma.

23. A **plan** on how to expand the mental health services in the state at all these levels

a. Primary health care through DMHP- it would not be enough to say expand the DMHP- the components that require strengthening, human resources, nature of programmes, monitoring mechanisms; addressing barriers in implementation; innovations must be described

b. Strengthening medical college/GHPU's/District Hospitals to develop services

Listing of facilities; how many are functioning optimally; how many will be strengthened; how; improvements/expansion indicated in a phased manner.

Use of tele-linkages and other tele-psychiatry facilities may be exploited to provide training in mental health and their impact monitored.

c. Specific and comprehensive plans to address the mental health care needs of the following, included defined responsibilities of different sectors:

Children

Elderly

Homeless

Workplace interventions for mental health promotion, identification and management of mental health problems including substance use disorders

Prison mental health services

Other populations with special mental health needs

For e.g. with children, the plan could include strategies in schools to improve mental health, training teachers in early recognition of mental health problems; developing a state level resource directory of where these children could be provided mental health care services; specialized inpatient settings (existing and planned); special facilities for children with intellectual disadvantage and other special mental health needs; prevention of substance use among children; resources to parents on how to help children with special mental health needs; resources for children on life skills; legal assistance; child protection schemes, and so on.

d. **Gender-sensitive services.** There are several special needs of women with both severe and common mental disorders. Gender inequities in society, inequities in treatment care, stigma and barriers to care all limit gender-sensitive treatment approaches. There is a growing problem of substance (alcohol, tobacco and other drug use) among women. The State/UT, in consultation with the National Commission for Women and other agencies responsible for women's welfare needs to ensure gender-sensitive components in all aspects of mental health promotion, mental health services and legal provisions for women with mental disorders. Pregnant women with mental health problems, women in institutional settings, homeless women with mental illness and women living in other disadvantages circumstances (poverty, alcohol and drug use in the family, victims of violence etc) form special groups which may have unique needs.

e. **Addiction treatment services**- Alcohol use disorders, other drug use disorders cause serious problems associated with intoxication, dependence, physical complications and are risk factors for both communicable and non-

communicable disorders. Behavioural addictions like gambling and technology addictions are also on the rise. The treatment of substance use disorders involves the training of generalist health care professionals in their recognition and early intervention as well as specialized facilities for the comprehensive care of persons with addiction. The Department of Health and Family Welfare has regional centres which can participate in the training and development of human resources. There is a need of synergy between programmes carried out by the Ministry of Health and the Ministry of Social Justice and Empowerment, which focuses on counseling and rehabilitation.

f. **Specialised forensic psychiatry services.** Persons in conflict with the law often need mental health assessments and appropriate interventions. Persons with mental illness including substance use disorders in institutional settings like prison, correctional or remand homes etc need specialized care and treatment. There is a scarcity of experts in forensic psychiatry to develop services and trained human resources in this important area. Institutions like NIMHANS have initiated a post-doctoral fellowship in this area. It is necessary to have a Centre of Excellence in forensic psychiatry at NIMHANS and other premier institutions.

g. **Rehabilitation** of persons with mental illness is another area that has grown, but not adequately. While the idea of starting long-term residential facilities for the mentally ill under the social services and health departments to reduce institutional long-stay is desirable, care must be taken to make sure that these do not suffer the same plight that custodial institutions suffered prior to the interventions of the Hon'ble Supreme Court and the National Human Rights Commission.

   There is a need to develop trained human resources at different levels to provide therapeutic interventions at these centres. Alternate manpower development programmes can be taken up by the Rehabilitation Council of India in association with other mental health professional bodies like The Indian Psychiatric Society, Indian Association of Clinical Psychology, Psychiatric Social Work, World

Association of Psychosocial Rehabilitation etc. The Indian Psychiatric Society has developed a scale for the quantification of disability which has been accepted by the Ministry of Social Justice and Empowerment and is being widely used across the country for the certification of disability in mental illnesses. There is need for the policy changes to be implemented and translate into user friendly services,

h. **Within specialized psychiatric institutions,** the following must be ensured:
    i. Autonomy should be provided to big mental hospitals along with full administrative and financial power so that these hospitals are rapidly transformed into apex centres that will provide state of art diagnostic and treatment facilities, commence teaching of professional courses in psychiatry, clinical psychology, psychiatric social work, psychiatric nursing, train general doctors and state paramedical workers for providing needy psychiatric help and treatment at community level and undertake applied Research in Behavioral Sciences.
    ii. Regular monitoring at least annually by a body comprised by the State Mental Health Authority, State Human Rights Commission, State Commission for Women, mental health expert, NGO representative, User/Carer in addition to more frequent monitoring by Board of Visitors/other local bodies as appropriate.
    iii. Voluntary care must be emphasized
    iv. Separate budgets and funding mechanisms should continue to be ensured
    v. Medical superintendent should be a psychiatrist
    vi. Basic care needs and human rights must be provided at all times, at all costs
    vii. The range of services from psychosocial counseling, medications, other proven treatments, recreational avenues, rehabilitation must be developed.

viii. Long-stay and elderly patients must undergo regular physical examination, prompt attention to medical conditions and immunizations for persons at high risk (influenza and pneumococcal immunization).

ix. All institutions, central and state must contribute actively to human resource development in the State/UT

x. Institutions with greater capacity can mentor states to develop specialized (mental health professionals) and generalized capacity for mental health (general health professionals trained in mental health)

24. **Strategies to augment mental health promotion** within the state – this includes but is not limited to awareness about the important of mental health, information about resources for managing psychological distress and mental disorders, simple strategies to promote mental health, life skills education in schools, self-help awareness on how to cope with psychological stress; NGO engagement in awareness programmes; crisis intervention programmes. Such programmes may have to be modified for rural settings and take into consideration local beliefs and practices.

For States/UTs which lack the planning resources to develop a comprehensive mental health plan, they may seek consultancy from the states of Delhi, Karnataka, Gujarat, Chandigarh, Tamil Nadu, Puducherry and Kerala, where a considerable amount of progress has occurred in developing mental health services.

FINANCING

25. The State/UT must develop the budget and identify the sources of funding for each activity. State budgets must be committed and where Central assistance is required, the nature of such assistance must be indicated
26. There must be a separate budget head for mental health services
27. Central psychiatric institutions which have multidisciplinary facilities must have a separate budget for mental health, included supporting human resource budgets, budgets for extra-mural activities (e.g. training for expansion of human resources, community awareness and intervention etc). While it is good to have centres which

integrate psychiatric care with general health care or specialized neurology and neurosurgery care, it is easy for mental health care to be eclipsed by the high technology costs involved in other specialties. This must be constantly kept in mind when planning to set the transformed mental hospitals into specialized tertiary care institutions.

28. A budget for on the ground research, to study the impact of new interventions must be provided. This will enable the state to evaluate programme effectiveness and re-strategisation on a regular basis.

MONITORING

29. Four types of monitoring mechanisms can be conceived:

- Every mental health service in the State/UT (at primary, secondary and tertiary levels) must carry out a regular feedback with persons who utilize the service and carers
- A mental health service audit must be annually carried out by the State/UT
- Periodic monitoring central monitoring by the Central Government is necessary
- A broader oversight by national bodies such as the National Human Rights Commission, National Commission for Women, National Legal Services Authority, National Mental Health Authority, National Institute of Social Defence, other authorities who have a responsibility for health including mental health, newer agencies envisaged in pending mental health legislation and identified area experts must be provided.

INFORMATION SYSTEMS

30. The lack of monitoring mechanisms following the 2002 assessment of human resources represents a lost opportunity. It is very important to set up monitoring mechanisms within the State. This will allow the easy calculation of ratios of services to population, mental health professionals to population, inpatient beds to population and so on.

BY THE CENTRAL GOVERNMENT

The Central Government develops national policy and programming for mental health. While a National Mental Health Policy has been spearheaded by the Ministry of Health and Family Welfare, several components within the policy require engagement of the social justice and

empowerment/social sectors, welfare sector, information sector, higher education sector, panchayati raj, youth affairs, rural development and many others.

31. **Thus, the Central Government needs to identify a cross-cutting mechanism that will bring together different ministries and agencies and develop a plan of action for mental health service delivery** (actionable plans outside of the health sector including disability benefits, other supports for persons with mental disorders and their carers, shelters and residential facilities, education and employment opportunities, grievance redressal, access to all the amenities and basic citizenship rights like identity cards, voter's id cards, bank accounts etc).
32. Adequate resources need to be committed for all the activities envisaged in the National Mental Health Policy.
33. The **Ministry of Health should monitor mental health human resource development** on an annual basis, as it did in 2002. It is the responsibility of the government to ensure that there are quality services in the public sector run by competent professionals following state-of-art treatments. An i**nterim measure to engage the private and non-governmental sectors does not absolve the government from its commitment to universal mental health care.**
34. Just as it carried out the Inspection of mental health care hospitals in 2014, **it needs to oversee all components of mental health care service delivery at the state** (apart from mental health care institutions, medical colleges, general hospitals, district hospitals and the DMHP) on a bi-annual basis (once in two years).
35. **A national repository of resources** for mental health literature and training will be maintained, so that the states can draw from these resources.

NATIONAL HUMAN RIGHTS COMMISSION

There have undoubtedly been payoffs in the last three decades, primarily from judicial activism, as well as the efforts of the NHRC, but what has happened is not enough.

36. The **NHRC and other agencies now need to act in a co-ordinated manner** to bring together national agencies that have a responsibility to provide care and services to

persons with mental disorders and facilitate the development of dialogue and action for co-ordinated mental health planning in the country. This can be accomplished through a set of meetings at the national level to engage the national level agencies.

37. Subsequently, regional hand-holding meetings may be held together with respective states to discuss their mental health plans, facilitate funding, human resource development, programmatic aspects, mutual learning, overcoming barriers, addressing dissonance between laws, policies and programmes. The NHRC played a pivotal role in improving the conditions in the psychiatric hospitals. It now needs to play a similar role in a larger playing field with its counterparts in other commissions, the various ministries and civil society.
38. Law review and reform needs to occur periodically. There needs to be a convergence between laws and laws on disability must be inclusive of disabilities arising out of mental health. The Rights of Persons with Disabilities Bill 2014 is under review presently and must include and address the rights and privileges of persons with mental illness. Mental health insurance provisions should be ensured.

MENTAL HEALTH NEEDS TOP LEVEL LEADERSHIP

Even high income countries which have markedly better mental health resource ratios these countries continue to share some of the universal problems associated with mental health services according to the WHO Atlas 2014 (**Per 100000 population:** 41.8 beds, 142.3 admissions, 76% follow-up post discharge in one month in mental hospitals; 52.3 mental health professionals; 0.29 facilities, 11.5 beds, 126.8 admissions, 85% follow-up post discharge in general hospitals; 10 beds in residential community care, totaling 53 beds/100000 population, 6688 outpatient visits per year; 520 persons/100000 receiving disability benefits, much higher numbers of preventive programmes for mental health awareness/antistigma, mental health services in disasters, violence prevention, workplace mental health interventions, school-based interventions, parental interventions, maternal mental health promotion, suicide prevention etc). There has been a marginal reduction in inpatient beds with a growth in community-based

settings. Downsizing has led to newer problems like trans-institutionalisation (moving from one institution to another-e.g. hospital to prison).

Some problems are universal- the problem of long-stay patients in mental hospitals (8% greater than 5 years, 16% between 1-5 years in high-income countries); problems of suicide and homelessness etc.

The crisis of leadership for mental health care has been recognized in these countries. So much so, on 14 September 2015- announcement in the Independent[85] that in the UK the Shadow Cabinet had created a Minister for Mental Health. In Victoria, Australia[86] there is a Minister who holds portfolios for Mental Health, Housing, Disability and Ageing, Creative Industries and Equality. In New South Wales, there is a Minister who hold portfolios for Prevention of Domestic Violence and Sexual Assault, Mental Health, Medical Research and Women. She is also the Assistant Minister for Health.

Thus, unless mental health services are run in a mission mode (perhaps taking a leaf out of the book of the National Aids Control Organization- although this was intended for a communicable disease, it is an example of how good administration, policy and systematic programmes with standard operating procedures, and targeted interventions can result in favourable outcomes), it is likely that the momentum will again die out as it did in 1996 and in 2002.

39. The Technical Committee is of the opinion that it needs a mission mode to accelerate comprehensive mental health services in the country. **It recommends a National Mental Health Mission** with the objective of planning, providing governance, financial support, human resource enhancement, equitable mental health service distribution, strengthening the public sector initiatives in mental health care, developing networks and collaborations, reconciling services with newer provisions for mental health in law and monitoring and evaluating time-bound activities for expanding quality mental health services. This mission can focus on developing specialized mental health services at all levels, as well as integrating mental health care components into all the relevant programmes, ensure

[85]

[86] http://www.parliament.vic.gov.au/members/id/1695

people's participation in service development and improvement through feedback. Its vision should be making access to mental health care a universal right**.**

40. **A ministerial portfolio for mental health** would indicate national commitment to mental health on par with physical health and become a sign of such high level commitment to mental health.

A comprehensive and time-line driven mental health plan is provided below:

Table 29: Plan 2016-2025

ACTIVITY	RESPONSIBLITITY	FACILITATION	TIME FRAME
Updating of state level resource mapping, self-report of mental health service delivery (State Questionnaire)	State All the information must be consolidated by the state		3 months Report to NHRC
State Mental Health Plan 2016-2025	State	Central Government (the Ministry of Health may be the nodal ministry but all other relevant ministries to be involved) States with reasonable success with improving mental health services may serve as mentor states to those that require help in developing a state mental health plan The NHRC Special Rapporteurs may also be involved in this process	6 months*
	NHRC Other national monitoring bodies Centre	Regional meetings may be co-ordinated to review the State Mental Health Plans These consultations will help to finalise the mental health plan, include resource mobilisation, monitoring	12 months*
Setting up of a National Mental Health Mission (NMHM)/ Ministerial Portfolio for Mental Health			
Annual review of progress	State level monitoring body	Regular review of progress, review of DMHP, MC/GH, human resources, finances, consumer satisfaction	Annual*
Review, mid-course correction, adaptation	States/UTs	Regional meetings	Once in 2 years*
National Review	Organised by NMHM	All States/UTs	Once in 5 years*

*Reports to the Hon'ble Supreme Court and NHRC

IN CONCLUSION

The report of the Technical Committee on mental health care in India has made an attempt to provide a fair and comprehensive account of the development and current status of mental health and services available across India. The report identifies issues pertaining to severe mental illnesses, common mental illnesses, substance use disorders, children and adolescents with psychiatric illnesses, geriatric mental disorders, homelessly mentally ill, urban mental health needs, suicide, rehabilitation, human resources development, funding, governance, advocacy and training of mental health professionals. In addition, details of state mental health plans, state mental health rules, mental health policy in India, integration of mental health into general health care, DMHP outreach clinics, DMHP expansion and implementation status, role of NGOs in different states have also been included in the report.

This report has also attempted to identify gaps in services and provide direction for policy formulation and planning to meet out challenges and improve existing facilities and infrastructure for all round progress and development of user friendly, equitable and affordable services to persons in need of mental health services.

It is important to have a vision and a national policy for mental health care. It is equally important to translate this vision into reality and better living for persons with mental disorders and their families. This involves engaging multiple players including persons with mental illness, their carers, professionals, national bodies, activists, adjudicators, critics, multiple playing fields, funds, pragmatic planning, targets….but all of these activities must keep the final objective in sight always- protecting every citizen's mental health and ensuring a better life and an opportunity to realize the full potential of an individual with a mental disorder.

Comprehensive services are not just about providing services and making them affordable and accessible. It is about providing good quality services, providing citizens with choices, having resources to run the services in an competent and continuous manner, evolve mechanisms to improve the services, provide services in a humane manner with trained and caring professionals, address physical health, living issues, food security, environmental issues, personal growth and development opportunities and freedom from cruelty and discrimination.