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A Bilingual NEWSLETTER From LGBRIMH

DIRECTOR'S MESSAGE

I pen these few lines with hope and aspirations that this 2nd edition of Dolong-the Bridge reaches each one of you in good health.

No doubt, the times have been difficult and staying within the limited boundary seems to be the new-normal.

Toughest times have been faced by the Doctor, Nurses and other health workers and the common man. Much more challenges are ahead.

The pandemic has spared none across all nations, with life and work grounding to a halt. As conjectures on the nature of the virus float around, the only way forward seems to be 'donning the mask and never doffing the precautions'.

As the repercussions on the mental health and life of people take a huge toll, which in reality is yet unfathomable, let us all take a pledge in our mind to take care of self first and be responsible for all around us by practicing precautions.

Dr. S. K Deuri

REMINISCENCE

স্মৃতি ৰোমন্থন

আগৰ খণ্ডৰ পৰা-

NA: আমাৰ মানসিক স্বাস্থ্য প্ৰতিষ্ঠানখন আজিৰ এই উন্নত অৱস্থা নিশ্চয় এদিনত হোৱা নাই। আপোনালোকৰ চকুৰ আগতেই অলপ অলপকৈ উন্নতিৰে আজিৰ অৱস্থা পাইছেহি। উন্নতিৰ এই যাত্ৰাখিনি আমি আপোনালোকৰ মুখৰ পৰা শুনিব বিচাৰিছো।

AB: হয়, আমি প্ৰথম ইয়ালৈ অহাৰ সেই সময়খিনিত ইয়াৰ পৰিবেশ আজিতকৈ বহুত বেলেগ আছিল। দাদাই ইতিমধ্যে তাৰেই কিছুমান কৈছেই। ইয়াৰ উপৰিও তেতিয়া পুৰুষ ৰোগীয়ে কাপোৰ নিপিন্ধে, কাপোৰ দিলেও ফালি পেলায়। ঠাইবোৰ চিকৰাৰে ভৰ্ত্তি আৰু ইয়াৰ পৰা হাত সাৰিবলৈ ৰোগীসকলে নিমৰ পাত চিঙি আনি বিছনাত তুলি কম্বলৰ তলত থৈ দিছিল। সেই সময়ত পুৰণা hospitalৰ ভিতৰত বহুত নিমগছ আছিল আৰু তাৰে কিছুমান এতিয়াও আছে। আজি কালি উপলব্ধ হোৱা ঔষধবোৰ তেতিয়া নাছিল আৰু যাৰ ফলত Patient Managementত বহুত অসুবিধা হৈছিল।

সেই সময়ত যদিও Mental Health Act 1987 খন বলবৎ কৰা হৈছিল তথাপিও প্ৰায় সকলোতে পুৰণা Lunacy Act 1912ৰ মতেহে NCL (Non Criminal Lunatic) হিচাপে ৰোগীবোৰ ভৰ্ত্তি হৈ আছিল বা কিছুমানক Jailত ৰখা হৈছিল। ইয়াক লৈ সমাজকৰ্মী Sheela Barseয়ে কৰা এটা কেছৰ আধাৰত গোটেই উত্তৰ পূৱত NCL হিচাপে ভৰ্ত্তিহৈ থকা ৰোগীবোৰক মোকলোৱাৰ উদ্দেশ্যে Supreme Courtয়ে শ্ৰীগোপাল সুব্ৰমনিয়ামক One Man Commission হিচাপে নিয়োগ কৰে। ১৯৯৪ চনত শ্ৰীগোপাল সুব্ৰমনিয়ামে আমাৰ hospital পৰিদৰ্শন কৰিবলৈ আহে। তেখেত অহাৰ আগদিনাখনহে আমি তেওঁ আহিব বুলি Notice পাইছিলো। ডাঃ দেউৰী সেইদিনা তেজপুৰৰ বাহিৰত আছিল। অৱশ্যে ডাঃ হাদি আলম বৰা, SDMO, প্ৰমূখ্যে আমি বাকী ডাক্তৰ কেইজন আছিলো। প্ৰথমদিনা শ্ৰী সুব্ৰমনিয়ামে আমাৰ hospital আহি মোক আৰু ডাঃ বৰা ক লগত লৈ তেজপুৰ কেন্দ্ৰীয় কাৰাগাৰ visit কৰিলে। তালৈ গৈ তেওঁ মোক কলে "You identify the patients"। তাত ৰোগীবিলাকৰ ভিতৰত যিসকলৰ আমাৰ hospitalত চিকিৎসাৰ প্ৰয়োজন আছিল সেইসকলক মই চাই উলিয়াই দিলো। তেওঁ লগে লগেই চিনাক্ত কৰা ৰোগীসকলক আমাৰ hospitalত ভৰ্তি কৰিব লাগে বুলি D.C.ক order কৰি দিলে আৰু বাকীখিনিক কেন্দ্ৰীয় কাৰাগাৰৰ পৰা মুকুলি কৰি দিলে। তাৰ পিছত ডাঃ দেউৰী তেজপুৰ ঘুৰি অহাত তেওঁক লগতলৈ শ্ৰী সুব্ৰমনিয়ামে উত্তৰ পূৱৰ সকলোবোৰ কাৰাগাৰ পৰিদৰ্শন কৰিছিল আৰু সকলোতে যিসকল ৰোগীৰ চিকিৎসাৰ প্ৰয়োজন আছিল বুলি ডাঃ দেউৰীয়ে চিনাক্ত কৰিছিল তেওঁলোকক আমাৰ ইয়ালৈ পঠিয়াবলৈ আৰু বাকীখিনিক মুকলি কৰি দিবলৈ D.C. ক order দিছিল। কাৰাগাৰবোৰ পৰিদৰ্শন কৰি উঠি আকৌ আমাৰ hospital লৈ আহিছিল আৰু একেদিনতে সেইদিনা থকা ৭৫০ গৰাকী ৰোগীৰ ভিতৰত প্ৰায় ৩০০ ৰোগীক ছুটি কৰি দিছিল। তাৰ পিছত আমাৰ গোটেই Campus টো পৰিদৰ্শন কৰিলে আৰু শেষত কৈছিল যে "এইখন এখন বহুত ডাঙৰ hospital আৰু ইয়াৰ status improve কৰিবলৈ বহুত scope আছে"। And he suggested to the supreme court that it should be a mental health care institute like NIMHANS. And accordingly we have come to the present status now. তেখেতৰ visit টো আমাৰ কাৰণে এক আৰ্শীবাদ আছিল।

তাৰ পিছত Board of Administration (BOA) এটা গঠন হ'ল যাৰ বিষয়ে ডাঃ হাজৰিকাই বেছি ভালকৈ কব পাৰিব। তাৰ পিছত মনত আছে BOA ত বহুকেইজন সদস্য আছিল আৰু Board টো Supreme court ৰ Retired Judge, Mr. K.N. Kalita ৰ তত্বাবধানত চলিছিল। তেওঁলোকেই hospital খন State Govt.ৰ পৰা Central Govt.লৈ নিয়াৰ কামখিনি কৰিছিল। সেই সময়তে hospital খনক Institute status দিবলৈ ১৯৯৭ চনত Faculty post বোৰ Create হ'ল আৰু December মাহত postবোৰৰ Interview হ'ল। ১৯৯৮ ৰ January মাহত ডঃ ছনিয়া আৰু ডঃ অৰুনজ্যোতি আৰু April মাহত ডাঃ কংকন পাঠক আৰু মই Faculty হিচাপে Join কৰো। তেতিয়াৰ পৰাই বিভাগ তিনিটা আৰম্ভ হ'ল, অৱশ্যে তেতিয়া Psychology Dept. ত কোনোৱে Interview appear কৰা নাছিল। Dept. বোৰ আৰম্ভ হোৱাৰ লগতেই আমি course বোৰ খুলিবলৈ পৰিকল্পনা কৰিছিলো আৰু প্ৰথমে ২০০১ চনত DPN course টো আৰম্ভ হৈছিল। DPN course টো খোলাৰ সময়ত Indian Nursing Councilৰ inspection হৈছিল। তেতিয়া courseৰ requirement হিচাপে student hostel দৰকাৰ হৈছিল কিন্তু আমাৰ তেতিয়া কোনো hostel নাছিল। পিছত single family য়ে ব্যৱহাৰ কৰি থকা accommodation বোৰ এক ৰাতিতে hostel লৈ পৰিবৰ্তন কৰা হৈছিল। তাৰ পিছত বেলেগ course বোৰো আৰম্ভ কৰিবলৈ যো-যা চলোৱা হ'ল আৰু যাৰ বাবে University ৰ Recognition ৰ দৰকাৰ হ'ল। তাৰ বাবে আমি প্ৰথমতে Tezpur University ক approach কৰিলো কিন্তু তেওঁলোক Non-affiliating University হোৱাৰ বাবে আমাক recognition দিব নোৱাৰিলে। তাৰ পিছত আমি Gauhati University ক approach কৰিলো, কিন্তু কামবিলাক বৰ দেৰি হোৱা দেখি আমি সেই সময়ৰ অসমৰ ৰাজ্যপালক লগ কৰিলো, ৰাজ্যপালে যেতিয়া matterটোত হস্তক্ষেপ কৰিলে তেতিয়াহে কামবোৰ হ'বলৈ ধৰিলে। তাৰ মাজতে ২০০৬ চনত আমি DNB Psychiatry course টো আৰম্ভ কৰিলো। আমাৰ Institute টো Central Govt. হোৱা বাবে NBE য়ে আমাক DNB course টো দিবলৈ ইচ্ছুক আছিল। ক্ৰমান্বয়ে ২০০৭ত M.Sc Nursing (Psychiatric Nursing), ২০০৯ চনত M.Phil in Psychiatric Social Work, ২০১০ চনত M.D. in Psychiatry আৰু ২০১১ত M.Phil in Medical & Social Psychology আৰম্ভ কৰা হয়। যিহেতু MCI ৰ মতে এখন Hospital ত DNB আৰু MD একেলগে চলাব নোৱাৰি, Course দুটা একেলগে চলাবলৈ হলে দুখন পৃথক hospitalৰ প্ৰয়োজন। সেয়েহে 2013 চনত আমাৰ DNB course টো বন্ধ কৰিবলগীয়া হ'ল।

NA: ধন্যবাদ বাইদেউ, এইখিনিতে মই আমাৰ প্ৰতিষ্ঠানৰ প্ৰশাসনিক দিশৰ উন্নতিৰ যাত্ৰাৰ বিষয়ে Hazarika ছাৰৰ পৰা জানিব বিচাৰিম।

BKH: Administration অলপ গত লোৱাৰ পিছত ইতিমধ্যে BOA আহিছিল আৰু Hospitalখন Upgradation কৰিবলৈ কামখিনি কৰিবলৈ কলে। আমি কামখিনি কৰিবলৈ বহুত লাগিবলগীয়া হৈছিল। BOA ই faculty post খিনি create কৰিছিল পিছে meeting বিলাকত কলো যে, অসম চৰকাৰে facilities খিনি দিব নোৱাৰে কাৰণ তেওঁলোকৰ পৰ্যাপ্ত ধন নাই, কিন্তু আমাৰ হাতত Central Govt. আৰু NEC য়ে দিয়া টকা আছে গতিকে সেইখিনি BOA ই ৰোগীৰ facilities ৰ বাবে খৰছ কৰিব লাগে। তেওঁলোকে প্ৰথমতে মনা নাছিল যদিও পিছলৈ সেয়া দিছিল। তাৰ আগতেই diet Money টো supreme court ৰ নিৰ্দেশ মৰ্মে অসম চৰকাৰে বঢ়াই ৩০ টকা কৰি দিছিল। ঠিক তেনেদৰে চিকৰা মাৰিবলৈ ঔষধ প্ৰয়োগ কৰিবলৈও লাগিব লগীয়া হৈছিল।

মোৰ আগৰ কৰ্ম অভিজ্ঞতাৰ পৰা গম পাইছিলো যে Deltamethrin নাম ঔষধবিধ আঠুৱাত ব্যৱহাৰ কৰিলে যিকোনো ধৰনৰ Body lice আৰু মহৰ পৰা হাত সাৰিব পাৰি। কিন্তু Deltamethrin টো অলপ দামী হোৱা বাবে ইয়াক কিনিবলৈ approval পোৱা নাছিলো। মই পিছত Retired Judge শ্ৰী ৰাজখোৱাৰ নেতৃত্বত হোৱা এখন meeting ত তেওঁক কোৱাত approve কৰি দিছিল। তাৰ পিছত আমি ৰোগীৰ গাত direct কোনো দৰব ব্যৱহাৰ নকৰাকৈ Deltamethrin ৰ দ্বাৰা সকলো ধৰণৰ কীট-পতঙ্গ আৰু Body lice ৰ পৰা মুক্তি পাইছিলো। সেই সময়ছোৱাত BOA ৰ কামখিনি Justice A. K. Patnayak ৰ তত্বাবধানত হৈ আছিল। পিছে কামবোৰ যেনেকৈ Supreme Court ৰ order মতে হ'ব লাগিছিল তেনেদৰে হ'বলৈ অলপ অসুবিধা হৈছিল। যাৰ বাবে তেখেতে hospital খনকে Govt. of India ৰ অধীনত নিবলৈ উপদেশ দিছিল আৰু শেষত ১৯৯৯ৰ February মাহত প্ৰতিষ্ঠানখন NEC ৰ অধীনত যায় আৰু তাৰ পিছতে এই Development ৰ আৰম্ভণি ঘটে।

NECৰ Take over ৰ সময়ত বহুত official কাম হৈছিল, সেইখিনি মই আৰু ডাঃ দেউৰীয়ে ৰাতিলৈ বহি সেইবোৰ কৰিছিলো। কেতিয়াবা current নাথাকে, জেনেৰেটৰৰ Back-up নাছিল গতিকে মম জ্বলাইয়ো কাম কৰিবলগীয় হৈছিল।

NECৰ অধীনত থকা সময়ছোৱাতো যিমানখিনি উন্নতি হ'ব লাগিছিল সেয়া হৈ উঠা নাছিল। তেতিয়া Fund বিলাক ইমান smoothly পোৱা নাছিলো। আমাৰ অসুবিধাবোৰ তেওঁলোকে বুজিবলৈ অলপ টান পাইছিল, বহুত চালি-জাৰি চাইহে proposal এটা approve কৰিছিল।

সেই সময়ৰ অসমৰ ৰাজ্যপাল শ্ৰী অজয় সিং Board of Governor ৰ Chairman আছিল আৰু তেখেতে আমাৰ hospital visit ও কৰিছিল। তেওঁৰ visit ৰ সময়ত আমাৰ ইয়াত ১৯২০ চনৰ পৰা চিকিৎসা লোৱা সকলো ৰোগীৰ Record ৰখা system টো চাই খুব আপ্লুত হৈছিল আৰু এইখন hospital directly Central Govt.ৰ অধীনত হ'ব লাগে বুলি suggest কৰিছিল আৰু ২০০৭ত Central Govt.ৰ অধীনলৈ যায়।

NA: ধন্যবাদ sir, এতিয়া আমি শৰ্মা ছাৰৰ পৰা এই বিষয়ত অলপ জানিব বিচাৰিম।

ACS : ১৯৯৫ চনৰ পৰা আমাৰ hospital ত Lunacy Act ৰ সলনি Mental Health Act. খন প্ৰযোজ্য হ'ল, ক্ৰমান্বয়ে চিকিৎসা পদ্ধতি বোৰৰ উন্নতি হ'ল আৰু লগে লগেই আমাৰ ইয়াতো নতুন নতুন দৰৱ ব্যৱহাৰ কৰিব আৰম্ভ কৰিলে। তেতিয়া ৰোগীৰ তেজত দৰৱৰ মাত্ৰা আৰু side effect monitoring ৰ লগতে শাৰিৰীক স্বাস্থ্যৰ পৰ্যবেক্ষণৰ বাবে Laboratory ৰ প্ৰয়োজন হ'ল। পোন প্ৰথমতে আমি semi auto analyzer আৰু সৰু সৰু কেইটামান Microscope কিনি OPD তে সৰুকৈ এটা Laboratory আৰম্ভ কৰিলো। ইয়াৰ পিছত Diagnostic facility অলপ বেছি কৰিবৰ কাৰণে ২০০৯ত Pathology ৰ ডাঙৰ Lab. এটা আৰম্ভ কৰিলো। Administrative / Academic building ৰ এটা wing ত লাহে লাহে automatic machine আৰম্ভ হ'ল আৰু diagnostic facility বোৰ বাঢ়ি গল। তাৰ পিছত আমাৰ ইয়াত DBT (Department of Biotechnology, Govt. of India) ৰ এটা research project আহিল আৰু ৫ বছৰৰ ভিতৰতে আমি সেইটো শেষ কৰি চৰকাৰক Report জমা দিলো।

এইটো আনন্দৰ কথা যে, সি সময়ত গোটেই উত্তৰ পূৰ্বাঞ্চলত তিনিখন Project য়ে 'A' grade পাইছিল আৰু তাৰ ভিতৰত আমাৰটোও এটা। এতিয়া আৰু further

EDITOR'S MESSAGE

Amidst a very difficult pandemic we bring you the second edition of Dolong- the Bridge. Covid-19 has spread at a rate that has alarmed the world. The pandemic has changed the conduct of normal day to day activities and shelved social and economic programs. Due to these unique circumstances we have decided to publish our 2nd edition of Dolong- the Bridge in the digital platform.

Dolong- the Bridge, picks up from where we left earlier to conclude the reminiscences from the previous edition and gives a brief insight into child mental health. We also have a brief awareness on Covid-19.

Wear mask, maintain physical distance and wash hands frequently!! Stay Safe

Dr. Sobhana

development ৰ বাবে Neurology আৰু Neurosurgery ward আৰম্ভ কৰিবলৈ যিখিনি Lab. Facilities ৰ দৰকাৰ তাৰ বাবে জো-যা চলি আছে।

DC: After listening to all three of you, I feel as though you have taken us on a travel through the last 25-30 years. Now, I am tempted to ask a question to each of you. What is the most important event that was a turning point in the history of our institute? I am sure that there might have been so many events that had helped in stepping forward, but what is **THE** event according to each of you, that has been the "seed" of actually what we are seeing today.

BKH: For me it is the PIL by Ms. Sheela Barse.

AB: For me also it is the same, the visit of Shri Gopal Subramaniam and his suggestions to the Supreme court to upgrade our hospital similar to NIMHANS.

ACS: Yes, Gopal Subramaniam visited all the jails in North-East and after that everything changed.

BKH: Subramaniam's report recommended that all the suggestions be entirely approved.

D.C.: Was this in 1994 ?

AB: He visited us in 1994 and the order came in 1995 so as a transition, the Board of Administration was created as per his suggestions for transition from Govt. of Assam to Govt. of India.

DC: I have seen a project report of 1998 where all the planning and starting of academic section were mentioned.

BKH: Yes, it was during NEC's time. There were also two stalwarts from psychiatry who were involved in this process. One was Dr. S. D. Sharma from IHBAS and the other was Dr. S. M. Channabasavanna of NIMHANS.

DC: They also visited our institute ?

BKH: Yeah, they made visits to our institute and they were also the members of executive committee (EC). এতিয়া সময়ো নাই, পিছে মোৰ আৰু কবলগীয়া আছিল।

NA: নিশ্চয় ছাৰ। আমি শুনিবলৈ ভাল পাম।

BKH: অসম চৰকাৰৰ অধীনত থাকোতে এই hospitalত ১০০০ খন Sanctioned বিছনা আছিল আৰু তাত প্ৰায় ১১০০-১২০০ মান ৰোগী থাকে। ৰোগীবোৰ বিছনাত, দুই বিছনাৰ মাজৰ ঠাইত, মজিয়া আদিত য'তে ত'তে থাকিছিল। পিছলৈ বিছনাৰ সংখ্যা কমাই ৭৫০ কৰিছিল যদিও ৰোগী ভৰ্ত্তি হৈয়ে থাকে। সেই সময়ত ৰোগীবোৰ প্ৰায়ে discharge নহয়, এইখন যেন এটা dumping ground হে আছিল। আজিকালি ইয়াত ৩৩৬ বিছনা আছে তাকো প্ৰায় full হৈ নাথাকে। এই যে ৰোগী ভৰ্ত্তিৰ সংখ্যা ইমান কমিলে তাৰ কাৰণেও আমি calculation কৰি step ল'বলগীয়া হৈছিল। আমি ৰোগীবোৰ ভাল হ'লেই ঘৰলৈ পঠিয়াব পৰা বিলাকক ঘৰলৈ পঠিয়াই দিছিলো আৰু আগতেই উল্লেখ কৰিছিলো যে গোপাল সুব্ৰমনিয়ামৰ visit ৰ সময়ত একেদিনাই ৩০০ ৰোগী discharge কৰাৰ পিছতো ৪৫০-৫০০ মান ৰোগী আছিল। আমি লক্ষ্য কৰিলো যে ভালহৈ যোৱা ৰোগীবোৰ পিছৰ মাহতে আকৌ repeat admission হয়। ইয়াৰ কাৰণ বিচাৰোতে গম পালো যে ৰোগীয়ে দৰব খোৱা বন্ধ কৰে আৰু ফলত বেমাৰে আকৌ উক দিয়ে। ঘৰৰ মানুহক সুধিলে কয় "ৰোগীয়ে ঔষধ নাখায়" ৰোগীক সুধিলে কয়"দৰব আনি দিলেহে খাম।" ঘৰৰ মানুহক দৰব আনি নিদিয়াৰ কাৰণ সুধিলে বিভিন্ন কাৰণ কয় যেনে -পইচা নাই, দৰব পোৱা নযায়, কিনিবলৈ মানুহ নাই ইত্যাদি। তেতিয়া মই আৰু ডাঃ দেউৰীয়ে calculate কৰি চালো যে এজন ৰোগীৰ বাবে সকলো খৰচ মিলাই প্ৰত্যেক দিনাই প্ৰায় ৮০ টকা খৰচ হয়। সেইখিনি ৰোগীক যদি ঔষধ দি ঘৰলৈ পঠিয়াই দিওঁ তেন্তে প্ৰায় প্ৰত্যেকদিনে ২৭ টকা খৰচ হয়। তাৰ পিছত আমি আলোচনা কৰিলো যে OPD ৰ পৰা ঘৰত খাবলৈ ঔষধ দি পঠিয়ালে admission ৰ হাৰ কমি যাব, আৰু সেইটো কৰাৰ পিছতে admission ৰ হাৰ কমি গ'ল। ইয়াৰ উপৰিও ৰোগীজন ঘৰত থকিলে ঘৰৰ অলপ কাম কৰে, ঘৰৰ মানুহৰ ৰোগীজন ইয়াত ৰখাৰ বাবে হোৱা tension ও কমিল লগতে ৰোগীৰ পুনঃসংস্থাপনতো সহায় কৰিলে। ইয়াৰ পিছত বিছনাৰ সংখ্যা কমাই ৩৩৬ কৰা হ'ল কাৰণ আমাৰ বহুকেইটা Building পুৰণা হৈ গৈছিল, মানুহ থাকিব নোৱাৰে, যি কেইটাত Buildingত মানুহ থাকিব পৰা হৈ আছিল তাক হিচাপ কৰি বিছনাৰ সংখ্যা ৩৩৬ কৰা হ'ল।

AB: মাজতে Engineeringৰ মানুহ আহিছিল আৰু তেওঁলোকে কেইটামান "Building not to be used for patient" বুলি certify কৰি থৈ গৈছিল আৰু সেইখিনি Building ত ভালেখিনি ধুবিঘাট, ৰান্ধনিশাল আদি হিচাপে ব্যৱহাৰ কৰা হৈছিল আৰু বাকীখিনিক ব্যৱহাৰ কৰা হোৱা নাছিল।

BKH: আগতে ৰোগীৰ কাৰণে পায়খানাৰ ব্যৱস্থা ward ৰ বাহিৰত আছিল পিছে ৰোগীয়ে সেইবোৰ ব্যৱহাৰ নকৰি য'তে ত'তে পায়খানা কৰিছিল। পিছত NEC ৰ visit ৰ সময়ত ward ৰ লগতে attached bath room আৰু toilet বনাই দিয়া হৈছিল with running water facilities.

NA: এইখিনিতে আৰু এটা প্ৰশ্ন মোৰ মনলৈ আহি আছে, যে শুনিছো আগতে ইয়াত চেল আছিল, ৰোগীবোৰক চেলত ৰাখিছিল, আপোনালোকে সেইবোৰ পাইছিল নেকি ?

BKH: হয় পাইছিলো, কিন্তু সকলো ৰোগীকে তাত ৰখা হোৱা নাছিল, যিসকল অতি খঙাল উগ্ৰ, বাহিৰত কন্ট্ৰোল কৰিব নোৱাৰি (তাতে তেতিয়া আজিকালিৰ দৰে দৰবো নাছিল) তেওঁলোকক হে উপায় নোহোৱাতহে ৰখা হৈছিল, কিন্তু পিছলৈ সেইটো system একেবাৰেই বন্ধ হ'ল।

DC: I am afraid that we have to windup now since it is 6 P.M. and we have already exceeded the planned time. Actually this is the opening of 'Adda' we had planned. There are many more stories to know about the development of this institute. And we are sure that we will come to know about those in subsequent 'Addas'. On behalf of the Newsletter team I thank all of you for spending your valuable time with us.

Thank You.

COMPREHENDING CHILD MENTAL HEALTH: BRIEF INSIGHTS

Dr. Irfan; Dr. Longna; Dr. Jita Baruah; Dr. Manosij Maity; Dr. Siddeswara BL

Child mental health has been one of the major thrust areas for policymakers and health professionals around the globe. Although small but significant strides are made, challenges at every level stare into the eyes. One of the areas that can assist in realizing this goal is building awareness and educating the public about mental health issues in children. Any attempt to do this will lead to questions such as below.

Why should there be a particular focus on the mental health of children?

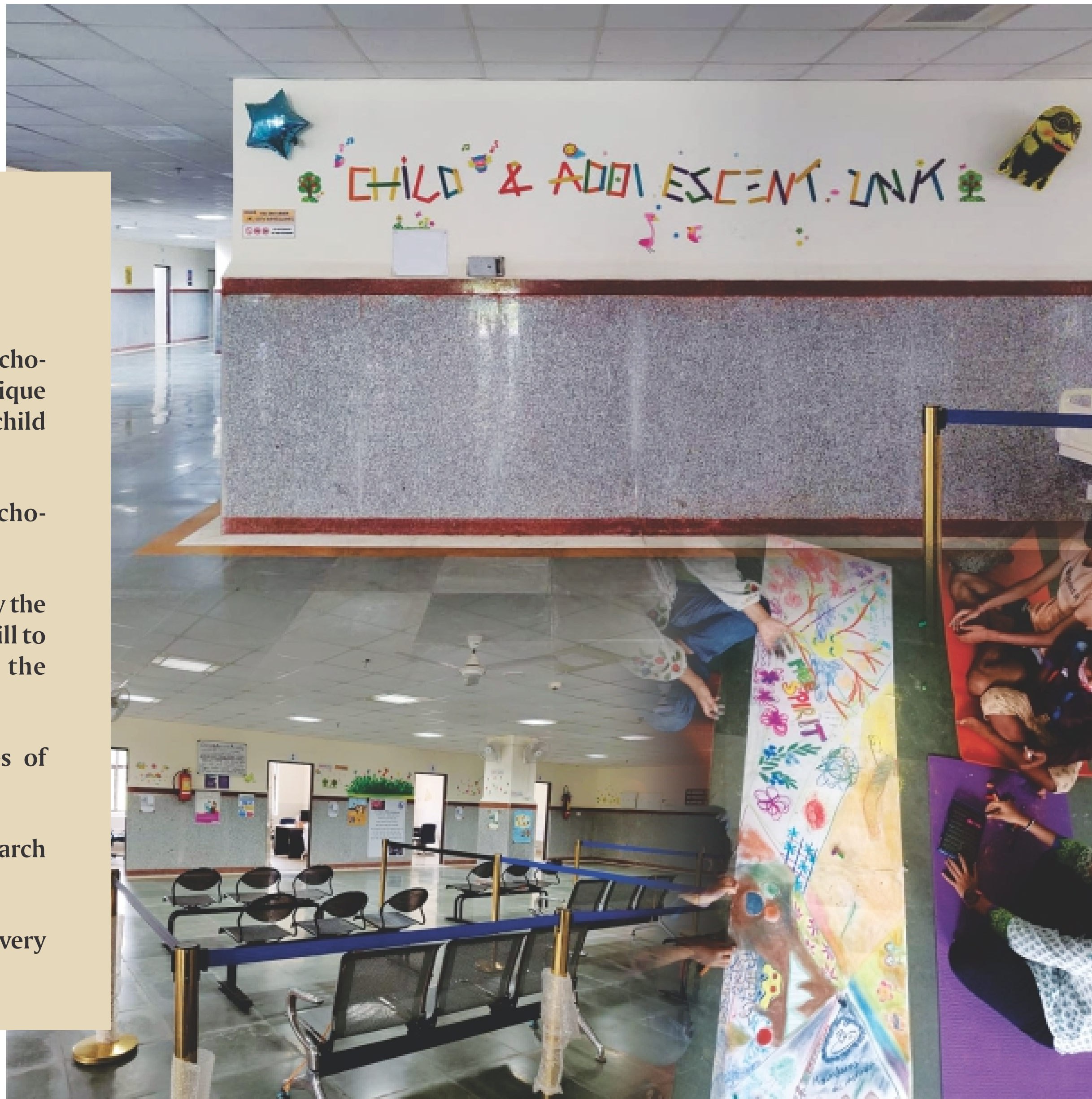
Childhood is considered to be a distinct formative phase of life with the highest potential to metamorphose. Limited understanding of children leads to their lowered ability to find solutions by themselves, contributing to more vulnerability to environmental or biological insults. These insults can have not only immediate effects but also long term adverse effects. Early years provide a window of opportunity to intervene when they are potentially more malleable. In other words, there is an enormous scope of prevention and promotion.

Additionally, the National Mental Health Survey 2015-2016 suggests that nearly 9.8 million children aged between 13-17 years require active interventions. Considering this estimate does not include mental health morbidity in the younger age group, it is clear that there is a mammoth task ahead of us.

How child mental health differs from adults?

The difference in mental health as a function of age is answered to an extent in the above paragraph. However, additional issues that warrant mention are concepts related to:

1. Critical/Sensitive periods that characterize childhood.
2. Continuity of risk/morbidity into adulthood.
3. Mechanisms of complex interactions of risks leading to psycho-pathogenesis across development. Thus lending to a unique life-course clinical perspective that is a prerequisite for a child mental health professional.
4. The bidirectional influence of development and psycho-pathogenesis.
5. The limited ability of children to express problems, thereby the risk of parents/professionals falsely assuming too much; skill to infer from keen observations contribute partly to the difference.
6. A significant influence of parents/caregivers in the lives of children unlike adults.
7. Capacity to give consent and ethics in treatment/research warrant special attention.
8. More significant potential for achieving remission and recovery with intervention.



Why are children more vulnerable?

The question needs to be answered from a biopsychosocial perspective integrating evolutionary, legal, and economic aspects. It is needless to mention that the issues discussed here are also intricately connected to the issues pointed in the above paragraphs. CNS (Central Nervous System) maturation continues into late adolescence or young adulthood. In other words, we are dealing with immature CNS and its expressions in the form of behaviors, thoughts, and feelings. These ongoing changes can make the individual more susceptible to influences. For example, an adolescent with limited earning ability to finance a motorcycle is restricted by law to ride it as well. However, many adolescents would crave for one such motorcycle; such thoughts can have origins from bio-psycho-socio-cultural influences. By all the above discussion, one must not conclude that childhood per se is a risk factor, or risk factors operate independently to cause mental illness.

What are the common mental health problems that children face?

Children tend to have mental health problems that vary with age and contexts. Mental health issues commonly reported are related to excessive worries, sadness, behavioral problems, school, and learning difficulties. Children also present with severe illness such as schizophrenia, albeit rare, which are characterized by significant deviances in behavior, thought, mood, and perception. It is essential to understand that many of these problems continue into adulthood. Additionally, research suggests that 50% of adults with mental health problems had their origins in their childhood. They are thus emphasizing the importance of early recognition and intervention.

What parents can best do?

Parents/caregivers are probably in the best possible position to recognize the problems of their children at an early phase. Many times changes in a child's behaviors are overlooked, assuming it to be healthy, or parents may reassure themselves that the problem is self-limiting. Although, general wisdom supports this idea, as statistically normative variations in behaviors far outnumber pathological ones in nature. However, for the reasons mentioned above, children have limitations to express, understand, solve their problems. Therefore, the risk of letting a child slip on the slippery slope, which can have cascading accruing long term effects. However, this does not mean that parents must hover above their children 24x7 and bring the child to a mental health professional at the slightest change in the pattern of behaviors. It calls for a balanced, informed approach, avoiding delays in seeking help with minimizing over-protectiveness.

What service providers and policymakers can best do?

The burden of mental health problems in children of our country is at prohibitive levels if we have to rely on the estimates. There are good enough reasons to believe as well, considering the multiple risks that children face. Therefore, addressing the ill will not suffice. It requires a larger plan to encompass healthy children so that they do not develop an illness. In other words, focus on promotive and preventive mental health strategies is the need of the hour.

Collaboration at all levels from policymakers to the end-user is required. Enhanced co-operation within multidisciplinary teams to come up with multilayered, multipronged, and multimodal strategies can be the difference. Mental health Programs should be equipped with both cross-sectional and longitudinal components. This machinery must have an inbuilt surveillance mechanism to refine the approaches. To a certain extent, it has been the case until now and needs to continue.

Conclusion

"It is easier to build strong children than to repair broken men" (Frederick Douglass). Therefore, change in the mindsets of policymakers, professionals, and caregivers is a must, considering the long term potential of healthy children to society. Additionally, to recognize child mental health as a priority, it requires an appreciation of childhood as a distinct period of life associated with unique strengths and vulnerabilities. Therefore it calls for a specialized approach to study these aspects and requires necessary thrust from critical stakeholders.

COVID 19: Basic information and mental health

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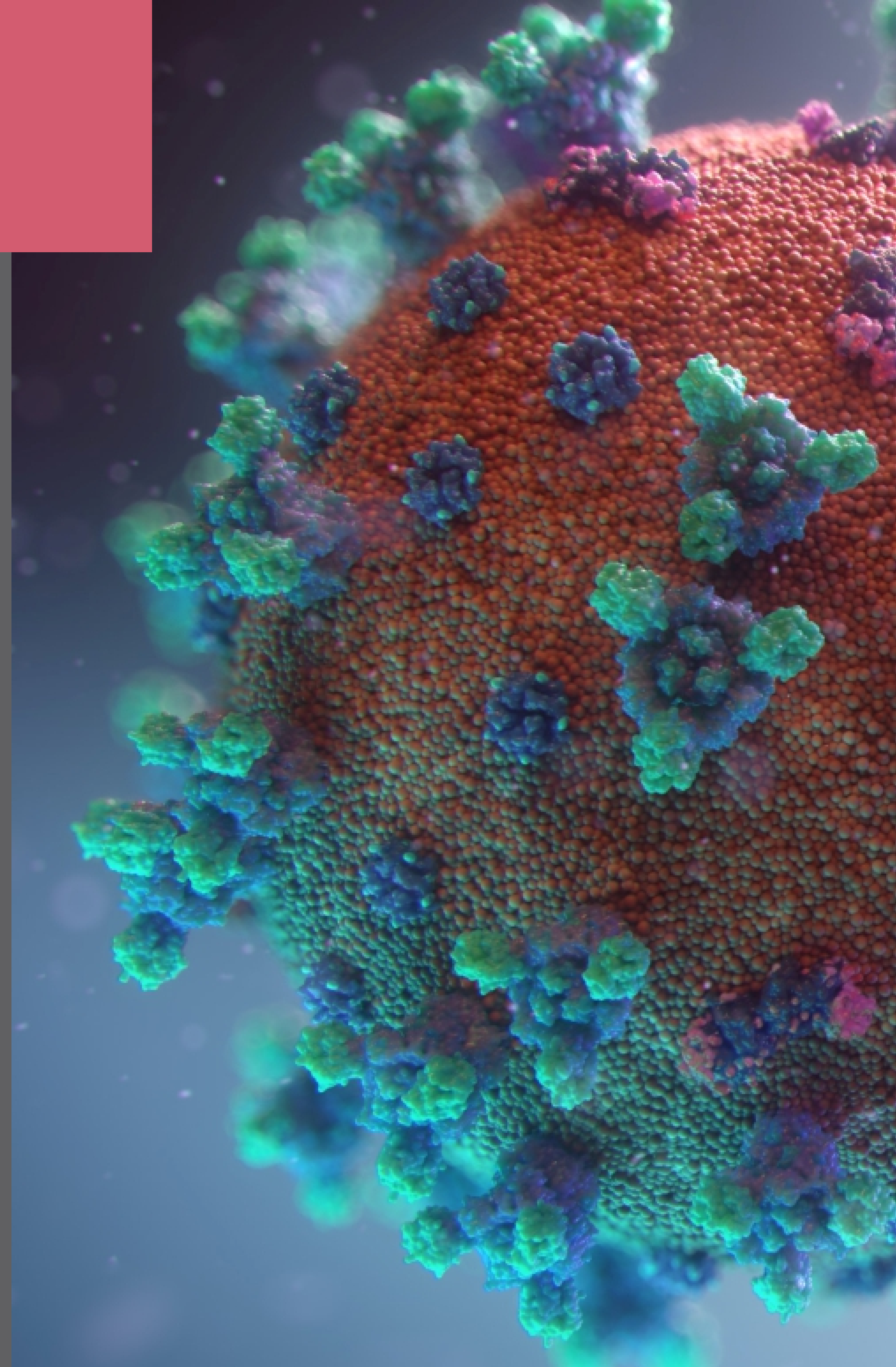


When we look back into the history of evolution of diseases, we can see that different infectious diseases have erupted at different points of time. In last few decades, diseases like HIV-AIDS, MERS, SARS etc. were discovered among the humankind. Very recently, one more infectious disease has been diagnosed in China, which is found to be highly contagious and currently has spread all over the globe creating a state of pandemic. The official name of the disease was declared by WHO in February 2020 as COVID 19 in which, *CO* stands for *corona*, *VI* for *virus* and *D* for *disease*, while *19* signifies the year of outbreak. Since the disease is discovered very recently, very little is known about it. This fact creates various obstacles in the prevention and control of this disease. The nature of this virus and its effects is creating undue fear and anxiety, generating various misconceptions leading to many mental health issues. Equipping ourselves with the right information can help us to protect ourselves and our family better.

Let us have a look at the information about COVID 19!

What causes the disease?

The disease is caused by a newly discovered virus called SARS-Cov-2 (Severe Acute Respiratory Syndrome Coronavirus-2). The virus is also called as novel corona virus.

How is the disease transmitted?

- The disease primarily spreads among people during close contact and through respiratory droplets from coughs and sneezes.
- There is evidence of indirect contact transmission too, i.e, the droplets containing the virus are deposited on the surface of any object which may be touched by people. The virus from the contaminated hand may get passed to the mucosa of oral cavity, eyes or nose and thus leading to infection.

After how many days of virus contact does the person show symptoms of COVID 19?

Usually an infected person shows symptoms within 1 to 14 days of viral exposure. However, in some cases there have been reports of symptoms being exhibited after a period of 24 days.

What are the common signs and symptoms of COVID 19?

A person infected with the virus may be asymptomatic or have flu-like symptoms. The most common symptoms of COVID 19 are fever, dry cough, fatigue, cough with sputum production, loss of smell, shortness of breath, muscle and joint pain, sore throat, headache, chill, nausea/vomiting, nasal congestion, diarrhea etc.

How can the disease be treated and prevented?

There is no definite treatment for COVID 19 yet. The disease is treated symptomatically. The process of inventing the vaccine is going on, however at this time, the best way to prevent the illness is to avoid being exposed to the virus. The measures that help in preventing the disease are:

- Staying at home or away from contact of people unless it is very essential
- Covering mouth while coughing and sneezing with tissue paper or cloth and throw it into dust bin immediately
- Wearing mask outside home or at public places
- Proper hand washing with soap and water before eating and after coughing, sneezing, blowing nose and use of toilet
- Using alcohol-based hand sanitizer frequently
- Avoid touching eyes, nose and mouth

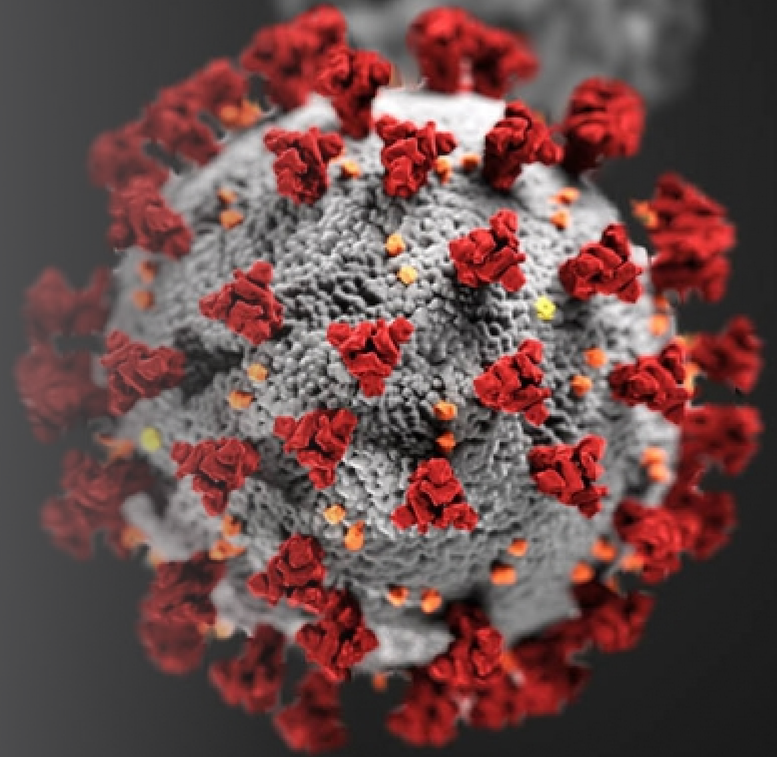
Mental health issues related to COVID 19

Physical health and mental health are always inseparable. The COVID 19 pandemic has had a significant impact on peoples' mental health too. This has created great amount of fear, anxiety, and stress among people. Those infected or those taking care of them are stigmatized by the society. The main reason for these mental health issues are- lack of adequate knowledge about the disease and virus, change in daily and social life, restrictions in routine

activities and financial and economic slowdown caused by the pandemic situation. Maintaining one's mental health in this situation is equally important with the measures to prevent the spread of the disease to combat the outbreak.

Tips to maintain the mental health during the pandemic

- Minimize exposure to news, information related to COVID-19, specially ignore the information flooded in the social media.
- Keep in touch with family, friend or loved ones over phone etc.
- Amplify the positive and hopeful stories related to the pandemic
- Do not blindly believe any information; rather find the true fact from reliable sources and then work on it accordingly.
- Practice hobbies, regular yoga and meditation.
- Accept the reality and do the best you can from your side to prevent it.



LGBRIMH 24 * 7 HELPLINE for Psychosocial Support during COVID 19 Pandemic

- The 24 * 7 HELPLINE for Psychosocial support during COVID 19 pandemic was initiated under the mandate of the Ministry of Health and Family Welfare (MoHFW) with NIMHANS as the Coordinating agency.
- Initially, NIMHANS (Bengaluru), LGBRIMH (Tezpur) and CIP (Ranchi) collaborated and started the Helpline with the number 08046110007. Later, many other organizations also joined the services.
- From LGBRIMH, a total of 9 phone numbers were provided to receive calls in three languages (Assamese, Hindi and English). Volunteers took turns to attend the calls and help the caller.
- The IVRS system was based in Bengaluru and was coordinated by NIMHANS.

VIJAY GOGOI Digitally signed by VIJAY GOGOI Date: 2020.09.17 10:32:44 +05'30'

Dr Vijay Gogoi
Nodal Officer, Helpline
Associate Professor, Psychiatry

The Seen Unseen

Dr. Sobhana H and Dr. Sonia P Deuri
Department of Psychiatric Social Work,
LGBRIMH, Tezpur

You see them hustling about in bus stands or railway stations, clad in tattered and soiled clothes. You see them foraging through garbage bins or shaking their heads and muttering to themselves; you see them sitting on the roadside with a vacant look in their eyes. The sight of them often evokes feelings of repulsion, fear, and helplessness in the minds of the young and old. Common as it may seem, scenes like these seldom make us reach out to them.

We often turn a blind eye to them, not because we are inherently unkind and unempathetic, simply because of our instinctual need to flee from what we perceive as danger and a sense of helplessness stemming from the sheer number of people we see trapped in situations like these.

So, who are these ill-kempt, seemingly aimless, people seen huddling around in huge numbers on our streets? These are the less fortunate homeless

persons with mental illness. These include individuals who have been disowned by families, displaced from their homes by their families or those who happened to have wandered off far away from home fuelled by the symptoms of their conditions and now are oblivious to their identity or their roots. Untreated chronic mental illnesses could cause displacement of people from their homestead, family and social roles. They remain on the fringes of the society, mostly ignored and neglected by the socio-political systems and fellow humans. The spotlight falls on them only when they disrupt the peace in the neighbourhood or when a good Samaritan is moved by their plight enough to extend help. Most often they are 'rounded up' on administrative orders or as a part of the 'clean up' drive initiated during a dignitary visit.

They are brought to the mental health systems as the 'unknowns'--- with no name or identity. With good care and treatment many are able to recall their name and family details. However, there are several who never turn the corner and embrace the identity of the 'unknown' even unbeknownst to self. They end up as nobody's children, forbidden to enter the core of the society; the subjects of a society pushed to anonymity.

They remain vulnerable whether on streets or within the four walls of a mental health institution. On the streets they are subject to neglect, ridicule or abuse. Many homeless women with mental illness who have been abused end up with either sexually transmitted diseases or find themselves pregnant with no memory of events that led up to it. When they recover enough to look after themselves, they find themselves straddled with an additional responsibility with no means to support self.

We have, in our professional encounters, seen some grateful and tearful families travelling thousands of miles to receive back their lost relative and some others who take them only to set them out into the streets again. We have seen one village celebrating the return of its member who strayed into oblivion for decades and another who wanted to do away with its member who had assaulted another at the height of his/her symptoms. We have been able to set up some in state supported homes where they have stayed on till their last breath. And we have also seen many who have remained within the walls of mental health centers for the rest of their lives because no family came forward to take them back and no homes had a place for them. Only very few of these homeless persons with mental illness get fully reintegrated with their family and community.

There have been changes with regards to upholding the rights of persons with mental illness. Acts have been amended and rightly so, to accommodate the needs of persons with mental illness. However, thus far, there is no policy or act that accommodates the special needs and rights of homeless persons with mental illness. Once they enter a mental health system or a state home, there is hardly a viable exit policy for them. The formidable question of 'who will take the responsibility of these people' looms forever around homeless persons with mental illness.

It is a fact that they may have to remain as the 'responsibility of the state' or the 'ward of the state' for the rest of their lives. They need a place where they can live within their limitations with dignity and respect, for some time in their life before the illness took over, they were like one of us- with an acceptable livelihood and homestead. They need a protective and open environment where they can move around without being stigmatized and assaulted. Initiatives must be taken up through combined efforts of the society, the governments and mental health professionals to create a safe space for such individuals.

They also matter. They are somebody's children!

MUSINGS OF REALIZATION

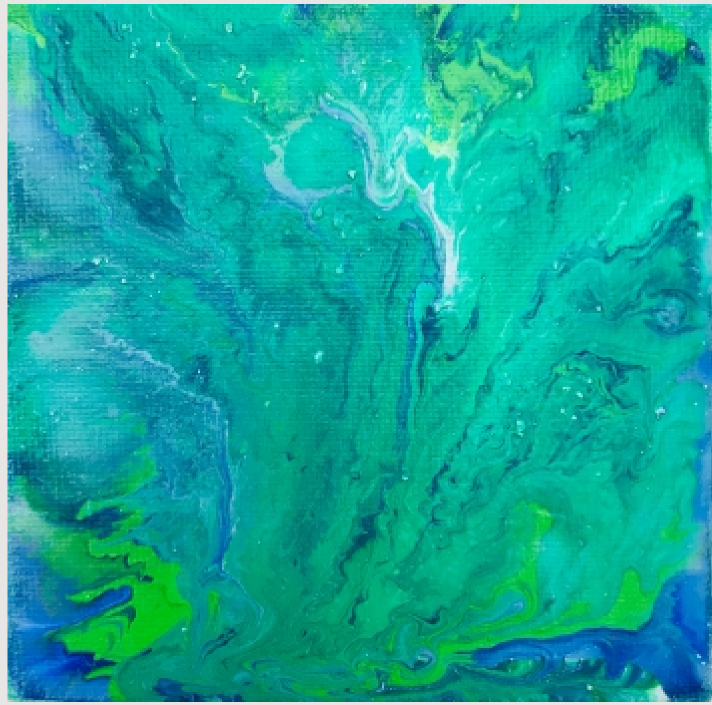
Pramita Sengupta
Mphil Clinical Psychology 2nd Year Trainee

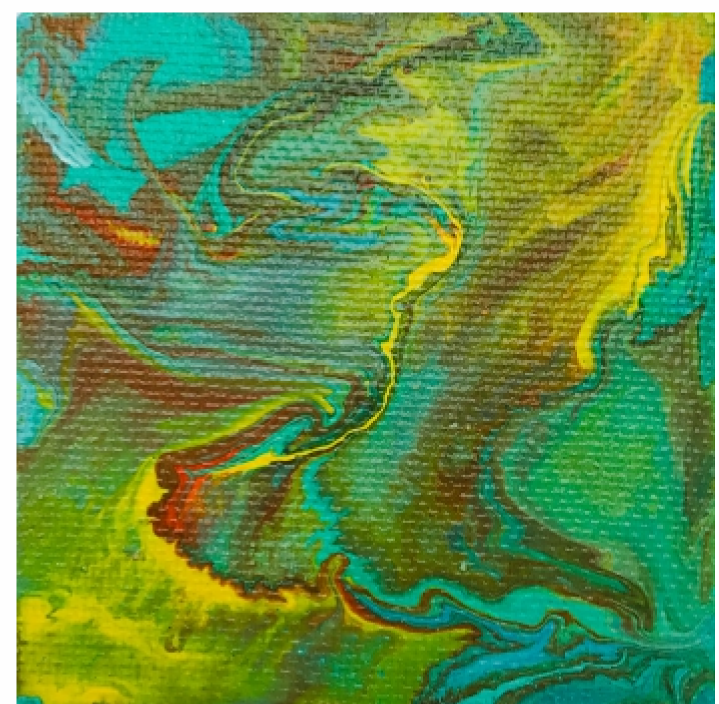
I used to always look for seizing the 'right' moment, the best opportunity, the best job, a mind-blowing road trip, a perfect love life, a confidant; in a nutshell timely attainment of every milestone that I am supposed to achieve. An invisible clock used to hover around me; "I need to settle down soon"...tick tick voilà!!! time's up !!!. Enraged and distressed I realized that settlement is a utopia, settlement is a myth. I realized that I had stopped listening to my heart only to blindly follow the clock and the timing of the clock was not even set according to my comfort-discomfort 'zone' !!!

I realized that hours, minutes, seconds can be filled with a pinch of self - love, faith, spirit and hope to customize the clock to my zone. I realized settlement starts from the place where I accept to settle again with the unsettling debris of failure and disappointment.

I am travelling with time, not competing with it. So, whenever I reach, that's the 'right' time and even if I don't reach I am sure to end up in a different place...until then, let me continue to explore and set the clock according to my comfort-discomfort zone, let me imbibe that 'it's never too late', let me believe that I am not looking for a final destination, rather the journey itself is worthy of my patience, care, love & gratitude.

"Tu khud ki khoj mein nikal
Tu kisliye hataash hai Tu chal, terewajoodki
Samay ko bhi talaash hai
Samay ko bhi talaash hai"...





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