MENTAL HEALTH SERVICES IN UTTAR- PRADESH: A CASE STUDY OF BAREILLY MENTAL HOSPITAL

A Dissertation Submitted to Jawaharlal Nehru University in Partial fulfillment of the requirement for the award of the degree of

Master of Philosophy

PRIYANKA SINGH

Center for Social Medicine and Community Health

School of Social Sciences

Jawaharlal Nehru University

New Delhi-110067

India

2012

CERTIFICATE

This dissertation entitled **"Mental Health Services In Uttar Pradesh: A Case Study Of Bareilly Mental Hospital"** is submitted in partial fulfillment of the requirements for the award of the degree of Master of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work.

Priyanka Singh

We recommended that this dissertation be placed before the examiners for evaluation.

Prof. Ritu Priya Mehrotra
(Chairperson)

Dr. Ramila Bisht
(Supervisor)

Dedicated to

My Sweet Family

CONTENTS

ACKNOWLEDGEMENT

True meaning of life is to plant trees under whose shadow you do not expect to sit

- Nelson Henderson

This dissertation is a result of not just my hard work but the guidance and support of many people. I would like to take this opportunity to thank my supervisor Dr. Ramila Bisht. My work would not have been what it is without her insightful comments and constant guidance. Thank you ma'am for your emotional support, motivation and encouragement to complete my dissertation.

I express my sincere thanks to Prof Ritu Priya Mehrotra, Chair Person of CSMCH for allowing me to carry out this work in this institute.

I would like to thank all the faculty of CSMCH for building my knowledge about issues around health.

I would also like to extend my gratitude to Prof. Rama V. Baru and Dr. V. Sujatha from the Ethics Committee for approving my research tools and giving useful feedback for improving it.

I would also like to thank Dr.V. Sujatha for giving me an opportunity to go for a field visit to Institute of Human Behaviour

and Allied Sciences (IHBHAS), Delhi with students of Centre for Social System.

My sincere thanks to the Directorate General, Health Services, UP for giving me permission for data collection in Bareilly Mental Hospital. I would also like to thank the Dr. J.P. Tiwari, Director, Bareilly Mental Hospital (BMH) as well as all the staff at the Bareilly Mental Hospital who supported me during data collection at the Bareilly Mental Hospital. A special thanks to Ms Meena Khare, the clerk at the BMH who went out of her way to help me during data collection and provided several important reports and suggestions. My heartfelt gratitude for all the families of patients with mental illness, who gave their precious time and shared their problems and experience at the BMH.

I should also thank Uncle and Aunty for letting me stay with them in Bareilly during data collection and making my stay so comfortable.

I would like to thank the staff at the different libraries for allowing me to access important material. I should start with thanking Mr Dinesh and Ms Ganga at the Documentation Cell at CSMCH for providing timely help. Staff at libraries the All India Institute of Medical Sciences (AIIMS), Delhi; Institute of Human Behaviour and Allied Sciences (IHBHAS), Delhi and Geriatric and Psychiatric Department, Chhatrapati Sahuji Maharaj Medical University, Lucknow extended their support in finding material useful for my research.

I would like to thank my friends for their support in proof reading and editing my dissertation. Thank You Ritumoni, Saya, Pranjali, Neetu , Ankita and Atreyi , without your help and time despite being busy in your own work. Without your support it would not have been possible to write a good dissertation.

Thoughts once awakened never again go to slumber. I thank Veda Yumnam who introduced me to SPSS, I can dream of analyzing any data I may further take to work upon.

My Friends had always been my Comfort zone and cushioned me in the tough times. I should also thank all my friends and my seniors from CSMCH, who kept me in high spirits and made my stay in JNU unforgettable.

At this moment I must thank those who helped me at a very difficult time during my illness. At the time when I underwent my dental surgery and later was bedridden due to de-hydration, without their help, care and support I would not have been able to stay in JNU and complete my work. Thank you Ritu, Ashwini, Anjali, Pranjali, Kuheli, Shishir and Nidhi for being by my side when I most needed friends.

Some people deserve more than just thanks. I would like to express my heartfelt gratitude to my friend Alok and Neetu who accept me with all my shortcomings and helped me in all my ups and downs.

Last but not the least I would extend my thanks to, Ma, Papa, didi and baba. You are the pillar of strength in my life. You support me in every way, protect me from falling and push me to achieve things I never thought I could. I would not have achieved anything without you. And finally my brothers who's teasing and fights give me some cherished moments.

No act of kindness, however small, ever goes wasted.

PRIYANKA SINGH

List of Abbreviations

BMH	Bareilly Mental Hospital
DMHP	District Mental Health Program
ECT	Electroconvulsive Therapy
IPD	Inpatient Department
NIMHANS	National Institute of Mental Health and Neurosciences
NMHP	National Mental Health Program
OPD	Outpatient Department
WHO	World Health Organization

List of Tables

List of Maps

List of Pictures

List of Appendix

Chapter 1

Introduction and Review of Literature

Chapter 1

Introduction and Review of Literature

Health is an essential quality in human being. It is defined as a state of complete physical, mental and social well- being and not merely the absence of disease (Mishra, 2003). This definition intends to embrace the other components that contribute to positive health like spiritual, emotional, behavioral and cultural. When we talk about health, we have the tendency to think only of physical health devoid of mental health. Mental health is a crucial part of health. It is one of the least priority health conditions despite the suffering and consequences to mentally ill individual. Some of its components like ability to enjoy life, cope with stresses, flexibility and productivity are essential aspect of a healthy life. Generally, people show little concern towards the mentally ill patients and treat them with unsympathetic behaviour. They have double jeopardy in life that first they struggle with the symptoms and disabilities along with the discrimination by society and family. Researchers on mental health issue have highlighted that such low priority and discrimination of mentally ill individuals is due to myths and misconception associated with mental health (Patrick et al, 2002).

The spectrum of consequences due to mental disorders and illness is quite huge. They experience many disabilities in various sectors of life such as limitation of physical, psychological and social functioning. Due to this, their quality of life is poor and not only the individual their family and community are also affected. Mental health has long been neglected in health and higher number of patients with mental disorders has been segregated and seen as different, unreal and incurable. While mental disorder and mental illness are major part of global burden of disease, it has given least priority by health professionals and community leading to this neglected state of mental health (Ustun, 1999).About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance use disorders and psychosis. Such estimates have drawn attention to the importance of mental disorders for public health. The burden of mental disorders is likely to have been underestimated because of inadequate

appreciation of the connectedness between mental illness and other health conditions. Mental disorders have other indirect effects and increase risk for communicable and non-communicable diseases and contribute to unintentional and intentional injury (Prince et al, 2007)

For good mental health there is need for the promotion of well-being, the prevention of mental disorders, treatment and rehabilitation of people. Despite the huge burden, health services paid less attention on mental health services while both kinds of health services (physical health and mental health services) are necessary for well being. There is inadequate provision of mental health services and the least available services are not availed by the patients due to stigma, social and cultural belief about its causes and other barriers like poverty (Desai et al, 2004).

According to Malik (2004) “Sometimes based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance in placed on faith cures. Serious conditions of mental disorders require hospitalization and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower” (Malik, 2004).

However, mostly mental health programs emphasize community care for patients with mental illness rather than hospital care and specialist care. The family and community have always played important role in the management of chronic patients with mental illness in the community (Thara et al, 2008). Community care is important to reduce discrimination and stigma from society however we cannot neglect hospital and specialist care. Any disability (mental or physical) requires special care provided by hospitals under specialist’s observation. Until and unless we give equal attention to hospital care and community care, we will not be able to improve mental health properly. Therefore it’s become important to pay attention to hospital based care. Generally people have negative attitude about mental illness as well as mental hospital. Such hospital itself has stigma and people also have belief about ill treatment of patients at hospital (Murthy, 2005). Due to this, hospital care gets least attention. Therefore it is necessary to further explore

mental health services provide by mental hospital as well as peoples' perception regarding hospital care.

Review of Literature

In this study we divide review of literature into six sections. In the first section, historical development of mental health and care is discussed. Second section made an attempt to highlight the prevalence of mental illness and disorder. Quality of mental health services is discussed in third section. Fourth section discussed the utilization of mental health services. Fifth section discussed the stigma as barrier in availing mental health services. Lastly, we tried to understand the role of hospital care and specialized care for mentally ill people.

Historical Development of Mental Health Services

This section is divided in two sub- section. First sub section talks about development of mental health services in colonial period and post-colonial period in second sub- section. This section is necessary to understand the structure and growth of mental hospital in India, and its problem and needs.

Development of Mental Health Services in Colonial Period

Before independence, mental health care consisted largely of building lunatic asylums. These asylums were custodial rather than therapeutic. Asylums in India were greatly influenced by British psychiatry and catered mostly to European soldiers posted in India at that time. The Lunatic asylums were visible in the early colonial period from 1745 to 1857 till first revolution for Indian Independence started (Kumar, 2004).

Surgeon Kenderline started one of the first asylums in India in Calcutta in the year 1787. The first government lunatic asylum was open in Monghyr in Bihar, especially for insane soldiers. In 1794, the first mental asylum for Southern India was set up at Kilapauk (Madras) by Surgeon Vallentine Conolly. During that period patients were treated by opium, hot baths, blood-letting and blistering. Music was also use as therapy for relaxing the severe patients in some mental asylums. In western India, the first mental asylum was established at Colaba (Bombay) in 1806 (Kumar, 2004).

In 1858 the Lunacy Act was enacted, detailing the procedures for admitting patients. After 1858, there was a more determined expansion of colonized India and more mental asylum was established in the next twenty years. By 1874, there were six mental hospitals at Calcutta, Patna, Berhampur, Dallunda, Cuttak and Dacca. In the Madras Presidency, new ones were set up at Waltair (1871), Tiruchirapalli (1871), and again in Madras (1871). In the Bombay presidency, six more such institutions were established at Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri and Hyderabad. In 1876, a new mental asylum was opened at Tezpur after the separation of Assam and Bengal; the central provinces also witnessed similar expansion- Jabalpur (1866), Elichpur (1866), Banaras (1854), Agra (1858) and Bareilly (1862) (Kumar, 2004)

In 1912, under the Lunatic Act, a European Lunatic Asylum was set up in Bhowanipore for European patients and after that established mental asylum at Ranchi for European patients in 1918 (Nizamie and Goyal, 2010). The terminology “Lunatic Asylum” in the act was change to “Mental Hospitals” (Somasundaram, 1912). In 1922, the origins of psychiatric rehabilitation in India can be traced to initiative service programs, which were initiative at the Central Institute of Psychiatry when occupational therapy was started at Central Institute of Psychiatry (Nizamie and Goyal, 2010).

Development of Mental Health Services in Post-Colonial Period

The Health Survey and Development Committee 1946, known as “Bhore Committee” reported on the condition of nineteen mental hospitals with 10,801 beds. The Committee found that asylums were designed for custodial care rather than for cure, in many hospitals the conditions were most pathetic (Kumar, 2004).The Committee suggested for improvement and modernization of most hospitals and attachment to medical collages (Nizamie and Goyal, 2010). Therefore the Committee envisaged the setting up a health administrative unit for every three million population, with primary health centers for every 20,000 and a specialist general hospital with 2,500 beds that would include care of the psychiatric patients as well (Jain, 2003). Since independence number of mental hospital has increase from 31 to 45 in India (Krishnamurthy, 2000)

On the recommendation of the Bhore Committee, All India Institute of Mental Health was established in 1954, which later became the National Institute of Mental Health and Neurosciences (NIMHANS) at Bangalore in 1974. In 1978-79 first training program was stated for primary health care (Krishnamurthy, 2000).

In 1960, need of district psychiatric clinic was recognized by Mudaliar Committee. It also noted the serious shortage of trained mental health manpower. In early 1970, an important national level initiative followed the discussions of the Indian Psychiatric Society at Madurai, which voiced the need to integrate mental health care with general health care. After that discussion in 1975, Expert Committee on Mental Health of WHO published a document. That document put to test at National Institute of Mental Health and Neurosciences (NIMHANS) at Bangalore and Post Graduate Institute of Medical Education and Research (PGIMER) which took up pilot programs to integrate mental health services with general health services during 1975-1981. The experience of these two centers led to the development of National Mental Health Program (Murthy, 2011).

The National Mental Health Program (NMHP), 1982 was started by government of India. The program provided training to physicians at the level of the primary health center in every district along with basic medicine for management of mental ill persons. Objectives of the program were: to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of the population, to promote community participation in mental health service development and to stimulate efforts towards self-help in the community and to encourage application of mental health knowledge in general health care and in social development (Padmavati, 2005).

National Mental Health Program however had a major weakness. Entire emphasis of the program was on curative care rather than preventive and promotive mental health care and also there were shortage of personnel (Padmavati, 2005).

The District Mental Health Program (DMHP) was developed during 1984-90 under the National Mental Health Program. “This program extended initially to 4 states, then to 25 districts in 20 states during 1995-2002 and over 125 districts in the next seven years”

(Murthy, 2011). Objectives of District Mental Health Program were to provide sustainable basic mental health services to the community and to integrated these services with other health services, early detection and treatment of patients within community itself, to ensure the patients and their relatives do not have to travel long distances to go to hospitals or nursing home in cities, to take the pressure off from mental hospitals, to reduce the stigma attached towards mental illness through change of attitude and public education and to treat and rehabilitate mental patients discharged from the mental hospital with in the community (Murthy, 2011).

DMHP has inadequate technical support from professionals. It emphasizes only on training and drug supply rather than clinical outcome. It does not have any advisory committee or plan to monitor and evaluate outcomes in a regular and continuous manner. (Murthy, 2011)

It is found that Program; Plan and Act related to Mental Health Program are not implemented in proper manner as it is not seen as a priority in developing countries. Therefore there is no separate allocation of fund for development of mental health services and institutions. (Goldberg et.al 2000)

In 1987, Mental Health Act has replaced the term “mentally ill” with the term “persons with mental illness”. (Mental Health Act Draft, 2010, pp.9) This Act was done for simplified admission and discharge procedure. This Act introduced licensing of psychiatric hospitals and recommended for separated state and central mental health authorities. This Act also argued for separate facilities for mental retard patients and persons with addiction. State mental health authority (SMHA’s) primary role was encouraged as planning, implementation and monitoring of mental health program and activities in the state (WHO-AIMS, report on mental health system in Uttarakhand, India, 2006, pp 10).

In 1995, “Persons with Disabilities Act (Equal opportunities, protection of rights and full participation) was formulated. Under this Act mental illness has been recognized as one of the disabilities. This Act has provisions for non-discrimination, free education,

employment and financial assistance and social security (WHO-AIMS, report on mental health system in Uttarakhand, India, 2006, pp 10)

In August 2001, 31 persons with mental illness died in a tragic fire accident in Informal Care Center at Erwady in Tamil Nadu. After the unfortunate accident, the Hon'ble Supreme Court took action against the matter, which shows concern for provision of mental health services and some other human rights issues, like the use of physical restrain and direct Electroconvulsive therapy (ECT) (Malik, 2004)

Status and Extent of Mental Health Problems

This section covers the prevalence rate of mental illness and disorders in India as well as Uttar Pradesh. Prevalence can be simply defined as total number of persons in the population who have a psychiatric disorder at a point in time. It refers to both old (existing) and new (occurring) cases.

Prevalence of Mental Illness in India

Based on the studies related to prevalence of mental illness in India during 1960-2010, this section provides pictures of burden of mental illness in India.

Reddy & Chandrasekhar (1998) did a meta-analysis of thirteen psychiatric epidemiological studies which covered a period from 1967 to 1995. Seven of the studies were conducted in the state of West Bengal. Two studies were conducted in the Uttar Pradesh and one each in Tamil Nadu, Punjab, Kerala and Union territory of Pondicherry. It was conducted both in rural and urban areas of above mentioned states covering a total of 6550 families with 33,572 persons. Total estimated prevalence rate of mental disorders was 58.2% per thousand populations. Different categories of disorder covered were- Organic psychosis 0.4%, schizophrenia 2.7%, affective disorders 12.3%, mental retardation 6.9%, epilepsy 4.4%, neurotic disorder 20.7 %, alcohol drug addiction6.9% and miscellaneous group 3.9% were estimated. Based on the findings, this study indicated that there are 1.5 crore people suffering from severe mental disorder in India. Prevalence rates of urban and rural was 80.8% and 48.9% respectively. Only epilepsy and hysteria were high in rural communities whereas depression, mental retardation, all

neurotic disorders (except hysteria), behavioral and emotional disorders were significantly high in urban communities. Female have high prevalence rate of 64.8% than male i.e. 51.9%. Manic affective psychosis was higher in males and organic psychosis, manic depression, endogenous depression and all neurotic disorders were significantly higher among females (Reddy & Chandrasekhar, 1998).

In 2000, Ganguli conducted a meta-analysis of fifteen epidemiological studies on psychiatric morbidity in India. The study attempted to find out the followings: (1) National level prevalence rate for all mental disorders (2) National level prevalence rates for specific disorders (3) Rural- urban differences (4) Morbidity in urban industrial population as compared to rural and urban general populations and (5) Stability of Schizophrenia rate. Finding of this study were: all India prevalence rate for all mental disorder was 73% per 1000 persons with 70.5% in rural and 73% in urban. Prevalence rate for five mental disorders: 2.5% for schizophrenia, 34% for depression (psychotic and neurotic), 16.5% for anxiety disorders, 3.3% for hysteria and 5.3% for mental retardation. Schizophrenia and hysteria was more prevalent in rural as compare to urban. Mental retardations' prevalence rate is higher in urban and there was marginal rural- urban differences for affective and anxiety neuroses. The study also showed the urban industrial morbidity and found that factory workers have a prevalence rate of two and half time more than general city dwellers (Ganguli, 2000).

In 2001, Murali analyzed ten Indian studies on psychiatric morbidities in the state of Uttar- Pradesh, West Bengal, Gujarat, Tamil Nadu, Kerala, Andhra Pradesh and Delhi. This study revealed that prevalence rates for all mental disorders were65.4% and for specific disorders prevalence rate was: 2.3% for Schizophrenia, 31.2% for affective disorders (depression-psychotic and neurotic), 18.5% for anxiety neurotic, hysteria and 4.2% for mental retardation. Data shows that prevalence rate in urban area is marginally higher than rural (Murali, 2001)

In 2010, Math and Srinivasaraju conducted sixteen epidemiological studies between 1960 and 2009. The studies selected for analysis were done on general population, either urban, rural or mixed from India. Most of the studies were community based epidemiological studies on mental and behavioral disorders reporting varying prevalence

rates, ranging from 9.5 to 102 per 1000 population. Another finding for overall prevalence rates of individual mental disorders is approximately 190-200/1000 population which highlights that 20% of the population is suffering from one or other mental health problem. Other finding showed that each mentally ill patient requires 500 Rs/ per month for mental health care including medication cost, doctor fees and travelling cost to meet the doctor. Therefore approximately total cost required per month will be 10,000 Rs/ crores (Math and Srinivasaraju, 2010)

Prevalence of Mental Illness in Uttar- Pradesh

Based on the studies related to prevalence of mental illness in India during1970-1998, this section draws a picture, burden of mental illness in Uttar Pradesh.

First major survey of psychiatric problems was conducted in Agra (rural and urban), Uttar Pradesh. Dube(1970) conducted study with 29,468 samples in Agra to estimate prevalence rates of all mental disorders. The study reported prevalence of mental health disorders as per the following break up- rural 18 per 1000 population, semi-rural 25 per 1000 population, urban 25 per 1000 population and total 23.8 per 1000 population (Dube, 1970).

In 1972, Sethi, Gupta and Kumar conducted a study on 500 rural families from four village (Gauri, Amausi, Gehru and Natkur) situated at a distance of 12 to 20 miles from the center of Lucknow. This study covered a total of 2691 population sample. This study reported that 17% of the families were found to by psychiatrically disturbed. Out of the 2691 population 106 were psychiatric patients. Thus the psychiatric morbidity rate was 3.9% or 39 per one thousand. According to diagnostic breakup, findings showed that mental retardation was 64.2%, psycho- neurosis-17.0%, schizophrenia-2.8%, epilepsy-5.7%, personality disorders-3.8% and miscellaneous group-6.5%. This study also found psycho-neurosis and psychosis to be much less common in rural population compare to an earlier urban survey (Sethi, Gupta and kumar, 1972)

In 1974, Sethi et al conducted another study that covered 850 families with 4,481 populations from Lucknow city (urban). This study reported that prevalence rate for all mental illness to be 67 per 1000.According to diagnostic breakup, the result showed that

neuroses was 41%, affective disorders- 12%, schizophrenia- 4%, mental retardation- 16 %, Organic brain syndrome (non- psychotic)-7% and miscellaneous group-21%. Prevalence rates were higher for psychiatric disorders in the age group of above 30 years. Result also showed that prevalence rates were higher for housewives, separated, widowed and unemployed (Sethi et al, 1974)

Thacore, Gupta and Suraiya conducted a study in 1975 for psychiatric morbidity in a North Indian community over a period of one year reported and covering 2,696 individuals. Out of these, 220 individuals were found to be suffering from psychiatric illness. This study reported that prevalence rates for all mental disorder as 82 per 1000 population with significantly higher in the age group 26-65 years and married population compared to unmarried. The prevalence rates for mental retardation and alcoholism was higher in slum areas (Thacore, Gupta & Suraiya, 1975)

In 1998, Tiwari and Srivastava conducted a study on geropsychiatric morbidity ("the study and treatment of psychiatric aspects of aging and mental disorders of elderly people or the functional/mental disorders of people") in rural Uttar Pradesh which was a field based. It reported that prevalence rates for psychiatric illness in geriatric group was 42.2% and neurotic depression, manic depressive psychosis- depressed and anxiety state were more prevalent. The study reported that psychiatric morbidity was much higher in geriatric population (42.2%) compare to the non-geriatric population (3.97%) (Tiwari & Srivastava, 1998)

Quality of Mental Health Services

The availability of mental health infrastructure in India is mainly limited to large size custodial institutions which provide services to a limited population. These institutions are a great source of stigma. In 1998 and 2008, identify the lacunae in these institutions and changes that occurred over a decade. The situation of mental hospital during was highly unsatisfactory. 38% of the mental hospitals still retain the jail like structure. In Varanasi, Indore, Murshidabad and Ahmadabad, mental hospital's patients are expected to urinate and defecate to an open drain in public view. 70% mental hospitals have problems with running water storage facilities, 38% with inadequate lighting, 43%

mental hospitals have cells for isolation of patients and privacy for patients was present in less than half the hospitals. Only 14% of the staff felt that their mental hospitals inpatient facility was adequate but in most hospitals case file recording was extremely inadequate and less than half the hospitals have clinical psychologists and psychiatric social workers, trained psychiatric nurses were present in less than 25% of the hospitals. Routine blood and urine tests were not available in more than 20% hospitals. (Murthy, 2011)

The developments, however, in general mental health services have been confined to urban areas only and the vast majority of rural population remains unattended even today. Basically, development of general mental health services has been interlinked with general health services and primary health care. However, the inadequacy of mental health professionals has been a major bottleneck in caring for people with mental illnesses in India. In a survey, WHO (2005) reported poor human infrastructure availability in India to combat mental health problems of the community (see table 1.1).Actual treatment of both general and severe mental disorders is being provided at primary (community), secondary and tertiary care levels. At primary level, it is being provided mostly by faith healers, quacks, AYUSH (Ayurvedic, Yoga, Unani, Siddha and Homeopathic) and occasionally by allopathic practitioners. At secondary level, it is being provided by qualified psychiatrists and general allopathic practitioners from other medical disciplines, AYUSH practitioners and faith healers as well. At tertiary care level qualified mental health care professionals provide the services. In addition, various non-governmental organizations are also providing different types of services. WHO survey in 2001 reported existence of only 47 mental hospitals in the country and the availability of beds in different setups, which speaks for its poor status (Tiwari and Panday, 2012).

Table 1.1: Availability of Human Resources in India

Manpower	**Availability**
Psychiatrist per 1,00,000	0.4
Psychologists per 1,00,000 population	0.02
Social workers per 1,00,000 population	0.02
Number of psychiatric nurses per 1,00,000 population	0.04
There are 200 mental health workers of other types.	

Source: World Health Organization (2005), "Mental Health Atlas", World Health Organization, Geneva, pp 234

Table 1.2: Mental Health Professionals (as per recommendations)

Mental Health Professionals	**Per Populations**
1 Psychiatrist	50,000
1 Clinical psychologist	25,000
1Psychiatric social worker	25,000
1Psychiatric nurse	25,000

Source: Desai et al (2004), "Urban mental health services in India: How complete or incomplete?, *Indian Journal Of Psychiatry*, 46 (3), pp 203

Recommendations as following Desai et al (2004), As mention in table 1.2,one psychiatrist per 50,000 populations, one clinical psychologist, one psychiatric social worker and one psychiatric nurse per 25,000 populations (Desai et al (2004).

Table 1.3:Availability of Infrastructure Facilities in India- WHO, 2005

Infrastructure	Availability
Total psychiatric beds per 10 000 population	0.25
Psychiatric beds in mental hospitals per 10 000 population	0.2
Psychiatric beds in general hospitals per 10 000 population	0.05
Psychiatric beds in other settings per 10 000 population	0.01

Source: World Health Organization (2005), "Mental Health Atlas", World Health Organization, Geneva, pp 234

Mental health problems are the primary cause of morbidity, disability which reduces the quality of life. To manage these problems medication, specific infrastructure for out and in patient care, trained professionals, psychosocial support & intervention, training facilities for care givers (family member as well as professionals) etc. is very much needed. It requires resource allocations. However, till now only a small percentage of the total annual budget is allocated and spent on general health, because in India it has been a low priority area. The allocation for health is 3% of total budget of India, even less than that for education (6%). India spends on health only 1.3% of GDP and along with household expenditure it is about 6% of GDP whereas in USA and UK this expenditure is about 12% of GDP. Furthermore, general mental health is being treated as a part of the general health services. Till 2001, only 0.3% of total general health budget was allocated in the name of mental health. Recently, in the Tenth Five-Year Plan (2002-2007), there was an eight-fold increase in budget allocation for the National Mental Health program and now country is spending 2.05% of the total general health budget for mental health. From this it is obvious that still low priority is given to mental health (Tiwari and Panday, 2012)

Another study also showed that government spending on mental health in most of the relevant countries is lower than its needs. And the poorest countries spend the lowest percentage of their overall health budgets on mental health and human recourses are also limited in most low income and middle income countries. They are also inequitably

distributed between countries, regions and within communities and this study also shows that stigma of mental disorders also constrains use of available resources (Saxena et.al 2007).

Thirunavukarasu and Thirunavukarasu (2010) study estimated the deficit of psychiatrist. This study was using the data sourced from National Survey of Mental Health resources carried out by Directorate General of Health Services 2002. They calculated the estimated deficit of psychiatrists and ideal number required (1.0 per 100,000). According to this study Uttar- Pradesh has 93.07% deficit of psychiatrists and the average national deficit was 77%. 17 state/ UTs were below this average (Thirunavukarasu and Thirunavukarasu, 2010).

A study by Desai et al (2004) showed the deficits in human resources. There is disturbing deficit of clinical psychologists and psychiatric social workers and also partially qualified professionals working in mental health setting. Finding of this study revealed the deficit of psychiatrist even in the three cities Chennai, Delhi and Lucknow and lack of sub-specialty services like rehabilitation services, child mental health services and substance use services. The results also showed that 40% people do not availing mental health services due to poverty. The major barriers to seeking care were identified to be economic problems and transport related problems. Providers and users give suggestion for improvement in mental health services in terms of increase awareness through education program, media and camps and increase the number of specialist services for drug abuse and for other serious mental health problems and availability of free medical facilities (Desai et al, 2004).

Availability of Mental Health Services in Uttar Pradesh

This state maintains three mental hospitals for the treatment of mentally ill patients. They are located at Agra, Bareilly & Varanasi. The mental hospitals at Agra and Bareilly are meant exclusively for non-criminal patients. Previously only criminal patients were admitted in the mental hospital at Varanasi. But now some non-criminal beds have been provided there to facilitate treatment of patients from the neighboring districts. District mental health program is started in four districts (Raibareilly, Faizabad, Sitapur and

Kanpur) of Uttar Pradesh (Regional Review Meeting of National Mental Health Program, 2010, pp.3).

Appendix 1.1 found that 95787 persons in the state were suffering from severe mental disorders like as psychosis, bipolar mood disorders. The table also shows25510 severe patients treated in psychiatric hospitals, 29033 patients treated in only four Medical collages and 41254 severe patients treated in other facilities. 137124 persons in the state were suffering from common mental disorders like as neurotic problem and 19228 persons with common mental disorders treated in psychiatric hospitals, 19228 patients treated in medical collages and 76011 patients treated in other facilities. Data showed that people prefer to seek treatment from other facilities compare to psychiatric hospitals and psychiatric department of medical colleges. Stigma and shortage of mental health facilities could be one of the reasons behind this (Regional Review Meeting of National Mental Health Program, 2010, pp.1).

As mentioned in appendix 1.2, in addition to 3 government hospitals, Uttar Pradesh has thirteen private psychiatric hospitals and they are located at Agra (2), one Allahabad, four Lucknow, two Gorakhpur, one Varanasi, one Kanpur, one Ghaziabad and one Bareilly. Data of appendix 1.3 showed that Uttar Pradesh has nine medical colleges and these colleges provide fourteen seats for MD psychiatry, two for DNB and one for DPM per year. Under the District mental health program huge number of human resources has been trained. 155 medical officers, 136 staff nurse and other man power. (See appendix 1.4)

Even though, every year fourteen psychiatrists are pass out and huge number of human resources being trained under District Mental Health Program, government sector has 20 psychiatrist and private sector have 206 psychiatrists. We can see huge gap between private and government sector regarding to all human recourses. It could be one of the cause of people prefer to go to private sectors. (See appendix 1.5)

Poor Utilization of Mental Health Services

Earlier report of mental health care shows that community do not utilized the available mental health services. Out of all the mentally ill patients, twenty percent patients need specialist treatment. Proportion of mentally ill patients without treatment is much higher in India compare to Western countries. High numbers of patients do not take treatment because of ignorance, fear stigma, misconceptions and faulty attitudes regarding mental illness (Murthy et al, 2005).

Chadda2001 conducted a study that highlight that study treatment facilities utilized by patients before coming to the hospital and reasons thereof. Findings of that study showed that a wide range of services was used by the patients varying from professionals care to faith healers. They choose a particular services by important reason like trust, easy availability and accessibility, recommendations by the significant others and belief in supernatural causation of illness. That study showed that substantial number of patients suffering from severe mental disorders seeks non-professional care (Chadda et al, 2001).

Recent study shows that patients suffering from severe mental illness choose psychiatric services as first contact of treatment and patient suffering from neurotic and stress related and organic mental disorders choose non- psychiatric treatment as their first source and very less patients choose faith healer as first source of treatment, female patients choose non-psychiatric treatment as first contact. These choices are based on good reputation, easy accessibility and those who prefer non-psychiatric services were due to accessibility, good reputation and time given for consultation. Reasons for going to faith healer included belief in supernatural power, recommendation by someone, easy accessible and availability on low cost (Nagpal et al, 2011).

Stigma and Belief about Mental Illness in Availing Mental Health Services

Majority of patient do not take any treatment because of ignorance, fear, stigma, misconceptions and faulty attitudes regarding mental illness. General people have belief that mental illness is caused by evil spirits, black magic, bad stars and bad deeds in the present and past life. Therefore mentally ill patient seek the treatment by the faith healers and magicians. People have own fear about mental hospitals. They felt that mental hospital is a place where dangerous mental patients are locked up. Patient treated in mental hospital stigmatized, they become isolated and discriminated in the community. Due to this patient family do not go for treatment in mental hospital, therefore they do delayed in treatment thereby increasing disability (Murthy et al, 2005).

A study was conducted on outpatient setting at the department of psychiatric, All India Institute of Medical Sciences, New Delhi in 2011. This study covered 200 patients (125 male and 75 female). These patients come from Delhi, Uttar- Pradesh, Bihar, Haryana and rest of the patients comes from other states. This study finding shows that 91 patients (45.5%) had consulted with psychiatrist as their first contact, 88 patients (44%) were consulting with non- psychiatrist, 16 patients (8%) had firstly gone to traditional faith healer and 5 patients (2%) had chosen alternative medicine. The study reported that reason for choosing psychiatrist were 87.8% reasoned for specialist, 78.1% stated for good reputation, 63.4% informed for accessibility. The reason for choosing non-psychiatrist: 81.8% reported for easily accessibility, 78.4% stated for good reputation and 68.2% reported given time for consultation. The reason for choosing traditional healer as a first contact were 75% reported that belief in supernatural cause for mental disorders, 75% stated for recommended by someone, and 68.8% reported for easy accessibility and 43.8% informed that low cost of treatment. Another finding of this study was that more male patient contacted a psychiatrist as a first contact compare to female patients (Nagpal et al, 2011).

Another most recent of the stigma studies conducted by Murthy (2011) covered 27 countries including India. In this study face to face interviews were conducted with 732 participants. This study described the direction and severity of anticipated and experienced discrimination reported by people with schizophrenia. Finding of the studies

showed that negative discrimination reported by 47% of the respondent in making friends, 43% from family members, by 29% in finding a job, by 29% in keeping a job and 27% in intimate or sexual relationships. Positive discrimination was rare. Anticipated discrimination affected 64% in the matter of applying for work, and in training or education, and 55% while looking for a close relationship, 72% of the respondents felt the need to conceal their diagnosis. Over a third of the respondents anticipated discrimination when seeking jobs and close personal relationships, even when no discrimination was experienced (Murthy, 2011).

Report of mental health care showed that generally people have belief that mental illness are caused by evil spirits, black magic, witchcraft, bad stars and bad deeds in the present and past life. Therefore mentally ill patient seek help of faith healer and magicians (Murthy et al, 2005).

Another study conducted by Jorm (2000) showed that in Western countries, people's belief that social environment and recent stressors are cause of depression and schizophrenia. Public give less importance for biological factors compare to environmental causes and in some Non- Western cultures people belief that mental illness cause by supernatural power, such as witchcraft and possession by evils sprits. In Malaysia, belief by psychiatric patients in supernatural causes was associated with their illness so there is greater use of traditional healers and poorer compliance with medicine (Jorm, 2000).

Stigma about mental illness was a pervasive and serious concern. A study conducted on 46 patients recruited from community and day mental health services in North London revealed that stigma can take different forms according to diagnosis and treatment. Stigma is a pervasive concern to almost all participants. People with psychosis and drug dependence were most likely to report feelings and experiences of stigma and were most affected by overt discrimination (verbal abuse, physical abuse, discrimination and loss of contacts) and participants with depression, anxiety and personality disorders also affected by feeling of stigma even in the absence of such overt discrimination. Particular treatment and therapy such as lithium prophylaxis and ECT (electroconvulsive therapy) could intensify feeling of stigma and make disclosure even more difficult (Dinos et al, 2004).

As mention by Renu Addlakha (2008), “mental illness in women also attracts a quite amount of shame and dishonor for the family, especially when women play such a pivotal role in the everyday management of domestic activities and relationships” (Addlakha, 2008).

According to National Institute of Mental Health and Neuro-Sciences (NIMAHANS), Banglore document on mental health care mentioned that people have own fears about mental hospital, they felt that mental hospital is a dangerous place where dangerous patients are locked up. Due to this patient’s family feel uncomfortable to admit their relatives in mental hospital (Murthy et al 2005).

The Role of Hospital and Specialized Care for in Mental Health Services

Hospital and specialist care play important role in improving mental health apart from community care. It is necessary to manage acute as well as severe cases and sometimes for rehabilitation under hospital observation by trained psychiatric professionals. Sometimes, some patients require full attention because of their harmful and risky behavior for themselves as well as for others.

“Hospitalization for psychiatric patients is often necessary when it is determined that their behaviors are acutely dangerous to themselves” (Latha and Shankar 2011). Psychiatric rehabilitation is to help persons to compensate for or reduce the functional deficits, interpersonal and environment barriers created by the disability and to restore ability for independent living, socialization and effective life management. Interventions help the individual learn to compensate for the effects of the symptoms of the illness through the development of new skills and coping techniques and a supportive environment (Pillai 2010).

One study shows that patients with psychosis or personality disorders were also readmitted more rapidly than patients with organic disorders. Therefore community care is important for removing stigma but use of psychiatric hospital care are also very important for some kinds of mental disorders (Korkeila 1998).

Chladsinska et al (1997) explain the role of psycho-education in relapse prevention of schizophrenia. They decided that in the prophylactic approach of treatment, which combines pharmacotherapy and psychosocial treatment; psycho-education program was observed to be effective in preventing relapse of schizophrenia. Ruzanna et al (2010) have tried to observe the role of psycho-education in improving insight of patient with schizophrenia. 70 patients with schizophrenia who underwent a psycho-education program were selected for the study. This study reported an improvement in insight after the psycho-education program. This study result showed that psycho-education intervention is important for improving insight in to mental ill patients. Therefore it needs to be provided as soon as possible during the early stage of mental disease. Such specialized care is more likely to be made available in hospital set up (Ruzanna et al, 2010).

After reviewing the above literature, we can see the huge burden of mental illness in India and particularly in Uttar Pradesh. Despite of huge load of mental illness; health services do not give priority to mental health services. At present mental health services are underdeveloped with less manpower despite its burden in the national level as well as state level i.e. UP. In order to improve the situation of mental health, it is the time to focus and balance our resources to both community level scares as well as specialized hospital care. Even though few services are available, they are not in optimal use by patients because of the stigma, discrimination and beliefs they have about the mental hospitals. This has been highlighted by literature reviewed above. And we further need to explore more on the patients' perspective and their dynamics with mental health care set up and social realities.

Chapter 2

Research Methodology

Chapter 2

Research Methodology

The present chapter discusses the methodological approach that has been adopted in this study. The topic of the topic is "*Mental health services in Uttar- Pradesh: a case study of Bareilly Mental Hospital"*.

Conceptualization of the Study

Mental health is an essential part of public health because good health includes physical, mental and social well being. Therefore, it is well known fact that when people get affected by mental illness they have to face many problems in social, occupational and personal domains and it also has huge impact on their families. According to the 10^{th} five year plan ten million people are affected by serious mental disorders (planning commission, pp 126). Therefore, it has becomes an important area to care and mental health services turn out to be very important component of health service delivery in the community. The national programs introduced for mental health focuses primarily on community care. There has been comparatively less attention paid to hospital care and specialized institutionalized care. While primary care and community care are very crucial for accessing mental health services, reducing stigma and for protection of human rights as many mentally ill patients require specialized hospital or institutionalized care, care as well as rehabilitation services. Thus inpatient facilities and specialized care are crucial for managing acute mentally ill patients. For this, mental hospitals or hospitals with special resources and personnel have been become very significant.

India has 2,263,821 and Uttar-Pradesh has 286,464 mentally ill patients. Uttar Pradesh has highest absolute number of cases of mental illness compared to other states (Kale 2010). With such a large number of cases of mental illness, availability and quality of mental health services become very important. Those with acute mental health problems may face a different set of problems in accessing services. The availability and quality of these services is very important for patients with acute mental illness.

In this study the researcher attempted to understand the condition of mental health services in Uttar Pradesh through analysis of secondary data. This study attempted to understand gaps in availability of mental health services in the set up of a mental hospital. Further through a case study of Bareilly mental hospital, attempt was made to document the nature, extent and quality of health services available to the patients suffering from mental health problems. The researcher tried to find out this through interviews of the in-door and out-door patient (IPD family ward and OPD) patients, their relatives and family members as well as the staff of the hospital. Thus through the study an attempt was made to highlight the gaps, issues and concerns in delivery of mental health services, especially in the state of Uttar-Pradesh

For the purpose of this study, only mental health services provided by government mental hospital of Uttar-Pradesh (UP) and Bareilly Mental Hospital (UP) were included. Counseling, referrals or specialized treatment were considered to find out the availability of manpower, infrastructure and related resources alongside the nature of mental health services provided.

Objective of the Study

Broad Objective of the Study: To develop a profile of mental health services in the Uttar-Pradesh through secondary literature and further to explore qualitatively its state through a case study of Bareilly Mental Hospital.

The Specific Objectives of the Study

1: To develop a profile of mental health services available in the state of Uttar Pradesh in terms of infrastructure and personnel in both public and private sector.

2: To understand the state of mental health services in Bareilly Mental Hospital in term of infrastructure, staffing pattern, patient profile in both IPD and OPD.

3: To analyze the shortages and deficiencies in the mental health facility in Bareilly Mental Hospital from the perspective of the health personnel and the patients and patient’s family members.

Research Question

1: What is the state of mental health services in Uttar Pradesh in terms of availability (Infrastructure, personnel and other resources) in public and private services with reference to specialist hospital?

2: What kind of infrastructure and personnel are available in Bareilly Mental Hospital?

3: What are the shortfalls and deficiencies?

4: What kinds of patients are being treated in Bareilly Mental Hospital both in IPD & OPD?

5: What are experiences of the patients and their family members who are accessing and availing mental health services in Bareilly Mental Hospital?

6: What are the providers perception regarding providing services and functioning of this mental hospital?

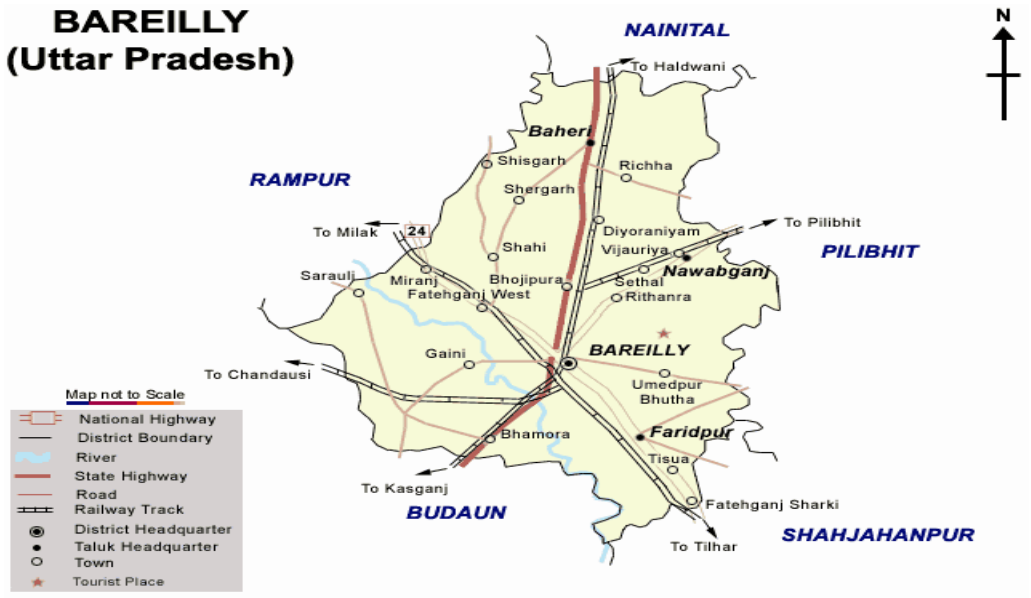
Research Design

This study is exploratory in nature. The aim of the study is to obtain ideas and insights into the problem, to gain familiarity with a phenomenon and to achieve insight into it. Being a highly under -researched area, not much published work is available on the topic of research and hence exploratory research design was selected. As an exploratory design, the research plan needs to be flexible enough to accommodate every new information that is brought about by the scouting operation. In this type of research design, both types of data are used- primary data and secondary data. Further the study attempted to use case study method for profiling the mental health services in Bareilly Mental Hospital. “Case study is an empirical inquiry that investigates a contemporary phenomenon within its real- life context, when the boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence are used like as: open interview, narrative, observation, documents and so on” (Exworthy and Powell, 2012, pp 4-5) .

Map 2.1: Map of Uttar Pradesh

Source-http://www.censusindia.gov.in/maps

Map 2.2: Map of Bareilly



Source:http://www.censusindia.gov.in/maps

Study Area

In this study the researcher selected Uttar Pradesh as the area of the study. (See figure 2.1). Population of Uttar Pradesh as per Census 2011 is 19, 95, 81,477 (Approx 20 crore, total male 104, 596, 415 and total female 94, 985, 062). Density of the Uttar-Pradesh is 828 (per km). (www.census2011.co.in).For the case study, the researcher selected Bareilly Mental Hospital from Uttar Pradesh. This hospital is situated in Bareilly District (see figure no 2.3). Bareilly district is bordered by Uttarakhand on the North, Shahjahanpur and Badaun districts on the South, Pilibhit district on the East, Rampur and Badaun districts on the West (www.nlrindia.org/index.ph?section=12&category=uttar-pradesh&page=496). In 2011, population of Bareilly district was 4,465,344 of which total male are 2,371,454 and total female are 2,093,890. Density of the Bareilly district is 1,084 per km. (www.census2011.co.in).

Bareilly district has the following health facilities: District Hospital for male and female-1, Community Health Center-6, Primary Health Center-9, Additional Primary Health Centre-50, and FW/MCH centers-365, Female Hospital-1, Urban Health Posts / Maternity Centers-05, Ayurvedic Hospitals-01, Medical Colleges-02, Training Schools-1 and Training Schools-1(www.nlrindia.org/index.ph?section=12&category=uttar-pradesh&page=496).

Selection of mental hospital: Uttar Pradesh has three Mental Hospitals situated in Agra, Bareilly and Varanasi. Bareilly Mental Hospital was purposively selected because the researcher had familiarity with the hospital. She had done her internship in this hospital during her post graduation. Further Bareilly Mental Hospital was 180 km. far her home town Lakhimpur Kheri. Therefore, it was convenient to collect data from there.

Sampling: The respondents for the study were selected purposively. Approximately 10% from the health personnel and patients (IPD family ward and OPD) were selected for this study. General ward patients were not interviewed following the suggestions by the ethical committee of CSMCH, JNU. The Ethical Committee had suggested that these patients should not included in the study due to their severe mental condition and the

non- availability of their family members. IPD and OPD patients were selected after taken consent from the service providers, patients and/or their family members.

Selection of IPD and OPD Patients

a: Selection of Patients from OPD: On an average 70-80 patient attend the OPD of Bareilly Mental Hospital for treatment per day. The following criteria's for patient selection from OPD were implied: number of visit (new and old case), gender and habitat (rural and urban). Based on this, a total of 8 OPD patients (approximately 10%) were selected as shown in table number 2.1

Table 2.1: Respondents of OPD:

Gender	**Old Case**		**New Case**		**Total**
	Rural	Urban	Rural	Urban	
Male	1	1	1	1	4
Female	1	1	1	1	4
Total	**2**	**2**	**2**	**2**	**8**

b: Selections of Patients from IPD: At the time of data collection 6 patients were admitted in family ward (4 male and 2 female) of the Bareilly Mental Hospital. From the admitted patients, 2 patients of family ward (1 male and 1 female) were selected for the depth interview, purposively based on their willingness to talk and permission from the hospital authority.

Selection of Providers

At the time of the research study, Bareilly Mental Hospital had 3 psychiatrists, 1 chest specialist, 1 Chief medical officer, 4 general nurses, 3pharmacist, 1 lab technician, 1 female instructor , 23 sweepers (18 male and 5 female), 1 barber and 69 ward attendees (50 male and 19 female).

From them, the following service providers were selected: 4 doctors (Chief medical officer did not agree to give the interview), 4 nurses, 1 pharmacist, 1 lab technician, 1

female instructor, 1 barber, 1 male and 1 female sweeper and 3 male and 3 female attendant. In total 20 providers were selected.

Tool for Data Collection

In this study the researcher collected secondary and primary data both. Secondary data collected from documents of State Mental Health Services Uttar- Pradesh and through review of articles and review of works done by various organizations at the National and State level. For information of Bareilly Mental Hospital, secondary data was gathered from the documents and monthly report of Bareilly Mental Hospital. Primary data from Bareilly Mental Hospital was collected through semi-structured interview schedule and observation.

Data Collection Process: Data collection process was divided in two phase.

Phase 1:

Preliminary Visit of Bareilly Mental Hospital: The researcher visited the Bareilly Mental Hospital before finalizing the synopsis, to assess the possibility of carrying out the study in this hospital. The researcher was asked to get written permission from State Directorate of Mental Health Services for data collection in Bareilly Mental Hospital. Thereafter the researcher went to Lucknow to get the permission from State Directorate of Mental Health Services, Uttar Pradesh. This permission was provisionally accepted by CMO of Bareilly Mental Hospital, but on the ground that the researcher acquired ethical clearance from Center of Social Medicine and Community Health (CSMCH). The proposal and tools were then presented to the Ethical Committee of the Center of Social Medicine and Community Health. After the ethical clearance was granted, the researcher was permitted by the CMO of Bareilly Mental Hospital to carry out the study.

Phase 2:

Pre-testing of Tool: In order to develop her tool, the researcher visited Bareilly Mental Hospital and Institute of Human Behavior and Allied Sciences (IHBAS) in Delhi. Based on these visits, interaction with patients and providers, she developed a separate semi-structured interview schedule for patients and providers. These tools were then pretested on two OPD patients and two providers. Thereafter they were finalized for data collection.

Rapport Establishment: Data collection with patients and their family members requires building a rapport with them before conducting the actual interview. It is a very important part of data collection. Therefore, effort was made to build the support and make the patients and their family members comfortable. When the patient was not willing to the interviewed then another patient fulfilling selection criteria was selected for the interview.

Conducting the Interviews: Interviews were conducted with service providers, patients and their family members. A semi-structure interview schedule was used for interviewing providers, patients and patient's family members (See Appendix 2). Informed consent was taken before conducting the interviews. If patient was not in a condition of giving responses for interview then the interview was conducted with family members of the patients after seeking their consent.

Observation: For data collection the researcher also used observation technique. With an observation checklist, she observed the condition of IPD and OPD services in Bareilly Mental Hospital. She made notes on the patients living condition, hygiene, general appearance and daily routine. She examined the attendants work schedule and made notes on the attendants and patients interaction and also how attendant managed severely ill patients. In the OPD, the researcher observed doctor patient interaction.

The researcher took permission for taking some photographs in the hospital which she has also used as data.

Method used for Analysis of Data

In this study the researcher used both quantitative and qualitative analysis. The interviews were done in Hindi and were later translated into English. The common themes were identified, organized and responses under them clubbed together. Narratives and photographs/images were used when necessary to bring out the true picture of Bareilly Mental Hospital, their services and also patients' conditions. Quantitative data was cross tabulated in order to understand the inter-relation of categories among each other.

Ethical Consideration

This research involves respondents with mental illness. Hence it carries several significant ethical considerations, for which the researcher was sensitive while conducting the research. The most important ethical consideration was respecting dignity of individuals. The researcher fully respected the dignity of individual patients. This was important because these patients were suffering from mental illnesses and in some cases were not be able to take informed decision about them. In such cases where the respondents are not in a condition to give informed consent, their caregivers were interviewed for full details. Only when their caregivers wanted to participate in the research, with full informed consent, they were interviewed.

Persons with mental health disorders face stigma and discrimination from the society and sometimes even from their own family. Therefore, the researcher felt it was very important to keep their right to privacy in mind. Further, mental illness is often very distressing both for the patient and the family. Even small change around them can agitate the patient emotionally or even physically. In such a sensitive situation, the researcher consulted both the doctor and the family about the possibility of interviewing the patient. Only if they did not perceive it as harming the patient's interest, the interview was conducted. Special care was taken to avoid any question that may distress or agitate the patient. This was done after consulting the doctor and the patient's family. If a patient was going through a difficult time and was not in a condition to respond, then the researcher made sure not to disturb the family or patient in such a difficult time.

The individual identity of the patients along with their medical condition has not been disclosed. The patient's interest was deemed as most important consideration. The researcher made sure that there was no harm to the patients in any way because of the research. The research was undertaken with the larger purpose of benefiting the mentally ill patients, and purely for academic purpose.

Need and Significance of this Study

After reviewing the literature, the researcher found a huge burden of mental disorders and limited resources for mental health services. Therefore, it became important to understand why mental health services are limited. Especially in the context of Uttar Pradesh which has the highest absolute number of mental health cases (Kale, 2010), there is need to understand the availability of these services in UP.

Problem Encountered during the Study: The researcher faced many problems during data collection:

1. Getting the permission for data collection in Bareilly Mental Hospital took time. This involved getting permission from Director of Bareilly Mental Hospital. The researcher had to take permission from Directorate of State Mental Health Services of Uttar-Pradesh as well as she had to acquire the ethical clearance from JNU before the Director of Bareilly Mental Hospital permitted the researcher to begin her data collection in the Hospital. This process led to loss of precious research time.

2. Despite ethical clearance and the Directorate's permission, the doctors of Bareilly Mental Hospital did not allow the researcher to sit in his consultation chamber for observation and often the providers also did not cooperate in interview

3. Rapport building with the patients was challenging. Several patients were not in a condition to understand the purpose of research or respond to the questions.

4. Sometime the patients got very violent. It was often difficult to predict their behavior. Some patients and/or patient's family members left the interview incomplete in the middle. Due to this the researcher had too many a time conduct a new interview with another patient and/or patient's family member.

Limitations of the study

1. The study is based on researching patients with mental health problems. Therefore, despite efforts sometimes building rapport with the patients turned out to be difficult. This may have had implications on the details/depth of the interview

2. Despite the researcher attempt to elicit cooperation of all staff and management of the hospital, cooperation of the hospital management was not always fully available. This created some hurdles in data collection.

3. In this research study the researcher has used a case study method for profiling the Bareilly Mental Hospital. This method has own limitations. Case studies are considered of limited use since they do not allow generalization.

Chapter 3

Profile of Bareilly Mental hospital

Chapter 3

Profile of Bareilly Mental hospital

This chapter tries to explain the profile of Bareilly Mental Hospital as well as patients of IPD (inpatient department) and OPD (outpatient department). The chapter contains three sections, first section describes the profile of Bareilly Mental Hospital (available infrastructure, staff and other facilities) , second is a description of Profile of patients (IPD and OPD) and the third is a profile of respondents (doctors, nurses, attendants and other staff).

Profile of Bareilly Mental Hospital

Bareilly Mental Hospital was established in 1862 by the then British government. Today the controlling authority of this hospital is the State Government of Uttar-Pradesh. According to hospital administration, in earlier days this hospital was a “Lunatic Asylum” which meant that those mental patients who were caught on the streets were brought here and were locked up as prisoners. Each patient was locked in a separate room and had to stay as well as defecate in the same room. Those patients who were aggressive and could harm themselves were tied with iron chains to restrict movement. Some of these rooms are still there in Bareilly Mental Hospital, but remain closed and are in ruins today. The following images depict the present status of rooms that were used in previous lunatic asylum to lock the male and female patients (See picture 3.1- 4).

Picture 3.1 & 2:Locked Room for Male Patient of the Old Bareilly Mental Hospital

Picture 3.3 & 4:Locked Room for Female Patient of Old Bareilly Mental Hospital

Picture 3.5 & 6: Old Main Gate & Old OPD of Bareilly Mental Hospital

Picture 3.7& 8: New OPD of Bareilly Mental Hospital

Physical Infrastructure of Bareilly Mental Hospital

After the Mental Health Act (1987) came in to action, this Lunatic Asylum was turned into a "Mental Hospital". It is situated at civil lines about two miles from Bareilly railway station. It covers the area of about 56 acres.

Another set of changes took place in 2003 when the Bareilly Mental Hospital was provided with additional infrastructure. Several new blocks were built for providing improved facilities. The above picture (Picture 3.5) shows the old main entrance of Bareilly Mental Hospital while figure number 3.6 is a picture of the old OPD. Before 2003, OPD of Bareilly Mental Hospital was close to the old entrance gate. After construction of the new blocks, the OPD facilities have been shifted from the old block to the new block along with pathological services and Electroconvulsive therapy (ECT) facility. Today the old OPD and old pathological services are not in use.

The figures below (Picture 3.7 and 3.8) illustrate the new OPD block of Bareilly Mental Hospital constructed in 2003. Along with this new OPD block, new blocks for Administration, ECT, Pathology and a family ward were also constructed. The New OPD block consists of a pharmacist room, personal cabin for the doctors, a waiting hall for the patients, two toilets and a registration room. The OPD timing is 8:30 am to 2:00 pm. The hospital provides the general OPD services for six days in a week expect Sunday. The hospital does not provide any specialized OPD services for drug addicts, mentally retired patients and other kind of psychiatric problems. Patients have to pay one rupee for OPD registration.

After the construction of the new block, the number of wards and beds has increased in the hospital. At present Bareilly mental hospital has the facility of total 354 beds and eight wards. (See the table number 3.1).

Table 3.1: Number of Wards and Beds in Bareilly Mental Hospital

Ward name	**Capacity**	**Location**
Male ward-1	56 beds	Old building
Male ward-2	56 beds	Old building
Male ward-3	56 beds	Old building
Female ward-1	56 beds	Old building
Female ward-2	56 beds	Old building
Open ward male (Family ward)	48 beds	New construction
Open ward female (Family ward)	16 beds	New construction
Private wards	10 rooms	Operational (under construction)
Total bed strength	354 beds	

Source: Based on the field visit of Bareilly Mental Hospital

Bareilly Mental Hospital has both open and closed wards. The general wards for both male and female patients are closed wards (See picture 3.9 and 10) where patients get treatment without their family member. The male and female wards are located quite far from each other. Males (except doctors) are not allowed to enter in the female wards. There are three male closed wards. Each ward has the capacity of 56 beds. Ward no 1 and Ward no 2 are for psychiatric patients while the Ward no 3. is meant for the psychiatric patients having any physical problem (like asthma, diabetes, heart disease and tuberculosis)or emergency problem (any kind of injury) along with psychiatric problem .This ward (Ward no 3) is also known as the Infirmary Ward.

The female inpatient facilities in the hospital include two female closed wards. Each ward has the facility of 56 beds. Patients getting treatment in the wards have to pay Rs 34/- as

admission fee and Rs 70/- as food expenses per month. Shelter home for destitute women called Nari Niketan also send psychiatrically ill patients to the hospital. The admission fees for these patients have been given by the government. The same trend is followed in case of legally alleged psychiatric patients admitted by the police. Of late the hospital has come up with the policy of conducting a pregnancy test prior to the admission for all female inmates who are admitted by the shelter home. Only patients found negative in pregnancy test are admitted in the hospital.

In 2003, a new facility of Family Wards was introduced in Bareilly Mental Hospital for both male and female patients. Male and female family ward face each other with reasonable distance between them. In the family ward patients are allowed to stay with their family members. For admission to the Family Ward patients have to pay Rs 102/- per day. Family ward for male and female patient are depicted in the picture 11and 12.

According to doctors the main purpose behind the facility of family ward was to admit the patient with their near ones so that they do not feel lonely, abandoned and discriminated by the family or society and that they will be accepted easily again in their homes.

Availability of Personnel in Bareilly Mental Hospital

Table 3.2 presents the staff requirement for a mental hospital as per the norms set out in the Mental Health Act (1987). The Bareilly Mental Hospital has a huge vacancy in all staff posts (See table number 3.2). The Hospital has five Doctors (three Doctors have M.D in Psychiatry, one Doctor has diploma in Psychiatry and one Doctor is an MBBS Physician), four nurses and 69 attendants. There is a huge gap between the ideal (as per the norms) and present status of staff availability. Three posts for doctors, four for clinical psychologist, social workers or occupational therapist, thirty seven for staff nurses and ten for attendants are vacant.

Picture 3.9 &10: General Ward for Male and Female Patients

Picture 3.11& 12: Family Ward for Male and Female of Bareilly Mental Hospital

Table 3.2: Staff Requirement as Per Norms

Name of the post	Norms	No. of posts	Vacancy	Working
G.D.M.O	1:50	Male- 6 Female- 2 Total- 8	Male-1 Female-2 Total-3	Male- 5 Female- 0 Total- 5
Clinical Psychologist	1:100	04	4	0
Occupational Therapist	1:100	04	4	0
Psychiatric Social worker	1:100	04	4	0
Staff Nurse	1:10	41	37	4
Attendants	1:5	79	10	69

Note: as Notified under Mental Health Act, 1987 vide Government of India Gazette 31 May, 2007

Available facility in Bareilly Mental hospital: This section aims at describing the available facilities in Bareilly Mental Hospital. Therefore, this section is divided in to two parts -first describes the OPD facilities and second the IPD facilities of Bareilly Mental Hospital.

a: OPD Facility at Bareilly Mental Hospital: The New OPD block has consultation chambers and rooms for administering injection and for keeping patients under observation. There is a waiting lobby with proper seating arrangement along with eight toilets. The hospital also has an ECT block, pathology block, office block and medicine block for mentally ill patients. OPD patients have to pay one rupee for registration. This registration fee includes consultation with doctors and medicine free of cost. This registration is valid for seven days. OPD is open from Monday to Saturday and the timings of OPD 8.30 AM to 2.00 PM**.** Patients get medicine free of cost. Most of the psychiatric medicines are available inside Mental Hospital.

Picture 3.13 & 14: Pharmacist Block of Bareilly Mental Hospital

Picture 3.15 &16: Male Recreation Room and Female Recreation Room of Bareilly Mental Hospital

The picture 3.13 and 3.14 shows the Pharmacist room of Bareilly Mental Hospital which became operational in 2003. According to the pharmacist a budget of 30 to 40 lakhs is available for medicine in this hospital. The medicines are provided to patient on the basis of doctors prescriptions. These medicines are provided for only 15 days but if the patient belongs to a distant place and requests medicine for longer duration, then medicines are prescribed for one month.

i: Pathological Facilities: According to the lab technician, the hospital provides the facilities of some important tests at low cost like Hemoglobin test, TLC, DLC, ESR, Blood Sugar Fasting, Blood Urea, Urine RM, Serum Biluribim, Serum Creatnine, SGPT, SGOT, Serum Cholesterol, and Serum Triglesride (see table 3.3). OPD, IPD general and IPD family ward patient have to pay different rates for different test. For example, General IPD patients have to pay three rupees, OPD patients have to pay five rupees and IPD family ward patients have to pay 10 rupees for Hemoglobin, TLC, DLC, ESR tests. While there is an X-ray machine in the hospital but the Radiologist is not available.

b: IPD Facility at Bareilly Mental Hospital: This section describes the available IPD services for the patients. When patient is admitted in General ward or in Family ward they have to fill a form for treatment consent and provide other information about themselves and about their family. For admission in General ward, patients have to pay Rs 104/- for one month and for Family ward the charges are Rs.102 r/- per day. This fee covers only bed and food expenses. The hospital provides breakfast, lunch, evening tea and dinner for IPD patient. In Family ward food is provided only to the patient and not for the patient's family member. Patient's family members have to take food from outside the hospital on their own expense. The hospital also provides clothes, woolens and slippers to the General ward patients.

In Bareilly Mental Hospital, X-ray, pathological tests and ECT facilities are also available for IPD patients. When IPD patient need other specialized medical services (like Gynecological help etc.), and other tests that are not available in the mental hospital then the hospital refers their patient to Ram Murti Medical Collage, Bareilly or Lucknow Medical collage on the expense of Bareilly Mental Hospital.

Recreation hall and agriculture land is also available for IPD patients. Separate Recreation hall is available for male and female General wards patients. We can see recreation room in picture number 3.15 and 3.16.

Male recreation room has T.V, games like carom, ludo, badminton, play cards and crafts. Female recreation room contains T.V, games, dholak, manjera and crafts. The recreation room is open from 10:00 a.m to 2:00 pm.

Picture 3.17: Agriculture Land of Bareilly Mental Hospital:

Agriculture land is also available for IPD patients but only for male patient as female patient is not allowed to come outside the female ward. Agriculture land can be seen in picture no, 17. Patients are involved in agricultural work only when they are adequately improved.

Table 3.3: Cost of Pathological Tests

Name of tests	Cost for General ward	Cost for OPD patient	Cost for Family ward patients
Hemoglobin test	Rs 3/-	Rs 5/-	Rs 10/-
TLC	Rs 3/-	Rs 5/-	Rs 10/-
DLC	Rs 3/-	Rs 5/-	Rs 10/-
ESR	Rs 3/-	Rs 5/-	Rs 10/-
Blood sugar PP	Rs 5/-	Rs 10/-	Rs 20/-
Blood sugar fasting	Rs 5/-	Rs 10/-	Rs 20/-
Blood urea	Rs 5/-	Rs 10/-	Rs 20/-
Urine RM	Rs 5/-	Rs 10/-	Rs 20/-
Serum Biluribim	Rs 10/-	Rs 20/-	Rs 40/-
Serum Creatine	Rs 10/-	Rs 20/-	Rs 40/-
SGPT	Rs 10/-	Rs 20/-	Rs 40/-
SGOT	Rs 10/-	Rs 20/-	Rs 40/-
Serum Cholestrol	Rs 10/-	Rs 20/-	Rs 40/-
Serum Triglesride	Rs 10/-	Rs 20/-	Rs 40/-

Profile of Patients of Bareilly Mental Hospital

This section describes the patients' profile of Bareilly Mental Hospital. It is divided in to two parts, profile of OPD patients and Profile of IPD patients.

Patients in the OPD of Bareilly Mental Hospital

In Bareilly Mental Hospital approximately 70 to 80 patients visit every day for psychiatric treatment. Doctors of the hospital reported that patients come from both rural and urban background and in terms of age, more number of the patients belongs to the age group of 18 to 25 years in comparison to 30 to 45 years. According to hospital staff, old age patients are less likely to visit the Bareilly Mental Hospital for treatment. Doctors also reported that patient come to the hospital from various regions like Bareilly District itself along with Saharanpur, Lakhimpurkheri, Sitapur, Lucknow, Kanpur, Barabanki, Faizabad, Ambedekernagar, Uttarakhand districts and occasionally from Bihar and Nepal.

Table 3.4: Patient's Attendance in OPD during last four years

Years Jan-Dec	Male	Female	Total
2005	21762 (67.96%)	11256 (35.15%)	32018
2006	23674 (69.72%)	10278 (30.27%)	33952
2007	25950 (65.21%)	13840 (34.78%)	39790
2008	25896 (64.74%)	14104 (35.26%)	40000

Table 3.4 presented the patient's attendance in OPD during last four years. Patient's attendance has been increasing decade wise. It can be seen in this data that female patient's attendance has been less in OPD in comparison to male patients.

Table 3. 5: Number of Patient Treated by Bareilly Mental Hospital during four Years

Year Jan-Dec	No. of new patient	No. of old patient	Total no. of patient
2005	32018 (65.08%)	16178 (32.88%)	49196
2006	33952 (65.84%)	17655 (34.23%)	51567
2007	39790 (66.22%)	20292 (33.77%)	60082
2008	40000 (65.72%)	21083 (34.64%)	60863

Above data shows, the number of old cases treated by Bareilly Mental Hospital during four years. These data shows that old and new patients coming for treatment in Bareilly Mental Hospital are increase decade wise. Data also shows number of new patients are more in comparison to old patients every year.

Illness Profile of Patients of Bareilly Mental Hospital

According to Doctors, almost all kind of psychiatric patients visit the Mental hospital for treatment. The data of table 3.6 presents the number of patient with psychotic and neurotic mental disorders treated by Bareilly Mental Hospital during ten months. Male patients (psychotic and neurotic) visit the hospital more for treatment in OPD of Bareilly Mental Hospital in comparison to female patients (psychotic and neurotic).

Table 3.6: Number of Patients with Psychotic and Neurotic Mental Disorders Treated in OPD of Bareilly Mental Hospital during Dec 2010 to Sep 2011

Month	Patients with psychotic illness #		Patients with neurotic illness ##	
	Male	Female	Male	Female
Dec.2010- Jan 2011	183	121	315	172
Jan – Feb	1700	958	729	410
Feb- March	1988	1159	851	496
May-June	1798	1162	770	498
June-July	1715	957	735	409
July-August	743	990	747	437
Aug-Sept.	839	461	1960	1073

#Psychotic illness: Schizophrenia, bipolar disorder, Severe depression and severe obsession compulsive disorder (OCD); ##Neurotic illness: Anxiety, headache, hysteria, depression

Patients in the IPD of Bareilly Mental Hospital

Patients who needs continuous observation and hospital care are admit in the hospital. Psychotic patients who run away from their home due to the psychiatric condition and are often found without ticket in bus or train are also admitted in the hospital by police. Hospital Attendants reported that many of the patients are admitted due to property matters. Table number 3.7 shows the number of admission or discharge over last five years in Bareilly Mental Hospital. More number of male patients admitted for treatment in Bareilly Mental Hospital than females.

Table 3.7: Admission and Discharge over last five Years

Year(Jan-Dec)	Admission			Discharge		
	Male	Female	Total	Male	Female	Total
2005	405 (78.79%)	109 (21.20%)	514	393 (77.05%)	117 (22.94%)	510
2006	326 (73.58%)	117 (26.41%)	443	325 (75.93%)	103 (24.06%)	428
2007	391 (80.28%)	96 (19.71%)	487	354 (76.95%)	96 (20.86%)	460
2008	141 (69.11%)	63 (30.88%)	204	166 (62.17%)	101(37.82%)	267
2009	289 (73.35%)	105 (26.64%)	394	310 (74.87%)	104 (25.12%)	414

Data of table number 3.8 shows the no. of male and female patients admitted in Bareilly Mental Hospital during last ten months before the study was conducted. Data shows that more number of male patients admitted in IPD in comparison to female patient.

Table 3.8: Number of patient admitted during Dec 2010 to Sept 2011

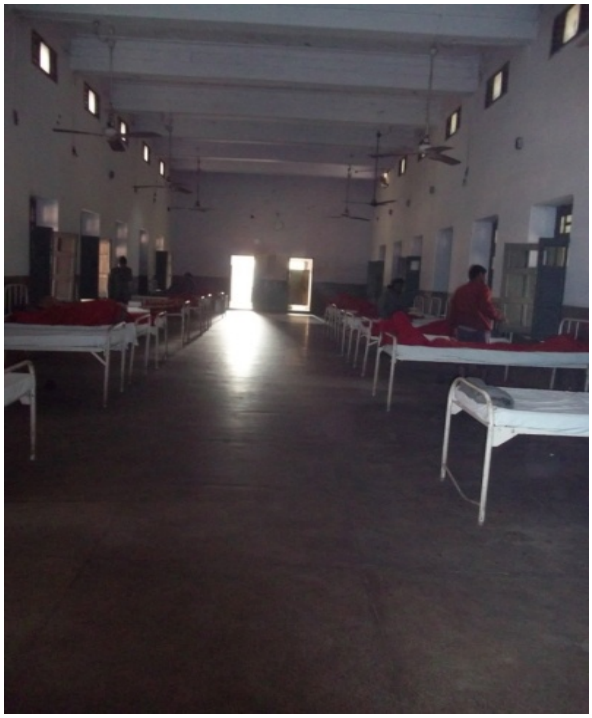
Month	Admission in IPD	
	Male	Female
Dec 2010- Jan 2011	28	6
Jan-Fab	25	9
Fab-March	29	4
May-June	30	9
June-July	21	7
July-August	21	14
Aug-Sept	12	5

Living Condition of Patients in Bareilly Mental Hospital

The following pictures (Picture 3.18-20) show the male ward of the hospital. Patients with violent and aggressive behavior are locked in closed room till they become stable and manageable.

Female ward is shown in picture number 3.21-22. As is evident from the picture, the Wards are properly ventilated. Separate bedding is provided to the patients by the hospital. Each ward has two attached bathrooms and two lavatories. Wards, bathroom and lavatories are cleaned by the sweeper every morning. (See picture number 3.23-26)

Picture 3.18, 19, and 20: General Male Ward 3 of Bareilly Mental Hospital



Picture 3.21 and 22: General Female Ward of Bareilly Mental Hospital


Picture 3.23 and 24: General Female Ward's Lavatory of Bareilly Mental Hospital:


Some patients with severe psychotic disorder used to defecate in the open places when the attendants are not around due to psychological confusion.

Daily Routine of the Patient: Patients generally wake up at 6:30 am. All patients get fresh till 7:30 and have breakfast at 7:30 am. Tea, one glass of milk and porridge are served every day to the patients. After breakfast, medicines are distributed to patients as per the doctor's prescription. Then patient take bath under attendant's observation. Prayers are conducted every day by the instructor at 10:00 am. After that patients are involved in some recreational activities like playing games, reading news paper, watching T.V and stitching clothes etc in recreation room. At 11:30 am lunch is served to the patient. For lunch patients usually get *roti, sabji, daal, chawal*. Patients usually take food under the tin shad. The tin shade meant for lunch was constructed in 2003. (See in picture number 3.27-28). Earlier patients use to sit on the floor and eat. Medicines are distributed by the staff nurses after lunch and then patients are sent to take rest in their respective wards. At 3:30 pm evening tea is served to the patients in winters and "aam ka pana" during summer's season. Patients have dinner followed by medicines at 6:00 pm. After that the head of the staff nurses counts the patients and sends them to their respective wards and doors of the wards are locked till next morning.

Picture 3.25 and 26: General Female Ward's Bathroom of Bareilly Mental Hospital

Picture 3.27 and 28: Teen Shades for Eating Food

Profile of the Respondents

The researcher selected ten patients from IPD and OPD of Bareilly Mental Hospital for the study purpose. Eight patients were selected from the OPD and two patients were selected from the IPD (family ward). Details of the respondents are given below in the following tables.

Table 3.9: Profile of the Respondents (education and religion)

Education	**Religion**			**N=10, Total & percentage %**
	Hindu	Muslim	Sikh	
Illiterate	-	2	-	2 (20%)
Primary -metric	2	1	1	4 (40%)
Inter-graduation	2	1	-	3 (30%)
Post grad- above	1	-	-	1 (10%)
Total	**5 (50%)**	**4 (40%)**	**1 (10%)**	**10 (100%)**

The data given in the table 3.9 shows that 5 respondents belong to Hindu community and 4 respondents belong to Muslim community and rest of the respondent belong to Sikh community. In terms of educational profile two respondents are illiterate and rest of the respondents are educated up to post graduation.

Table 3.10: Respondents' Age, Gender and Diagnosis

Age	**Gender**	**Diagnosis**			**N=10,Total & percentage %**
		Psychotic	Neurotic	Drug abuse	
10-20	M	1	-	-	1 (10%)
	F	-	-	-	
20-30	M	-	1	1	2 (20%)
	F	3	2		5 (50%)
30-40	M	1			1 (10%)
	F				
40 and above	M	1			1 (10%)
	F				
Total		**6 (60%)**	**3(30%)**	**1 (10%)**	**10 (100%)**

M-Male and F-Female

Data in table 3.10 shows that most of the respondents are 20 to 30 years old. All the female patients belong to20-30 years' old age group whereas five patients of male group belong to different age groups. Out of ten patients six respondents have severe psychiatric illness, 3 respondents are diagnosed with neurotic mental illness and only one respondent is diagnosed with drug abuse disorder.

Table 3.11: Respondents' Place, Number of Visit and Distance from Bareilly Mental Hospital

Distance	**Place**	**No. of Visit**		**N=10,Total & percentage %**
		***New case	****Old case	
10-100 km	*R	2	2	4 (40%)
	**U	1	1	2 (20%)
100-200 km	R	1		1 (10%)
	U		2	2 (20%)
200-300 km	R			
	U			
300-400 km	R			
	U			
400 & above km	R			
	U	1		1 (10%)
Total		**5 (50%)**	**5 (50%)**	**10 (100%)**

*R-Rural; **U-Urban; ***New case- visited Bareilly Mental Hospital for the first time;****Old case- two or more visits of Bareilly Mental Hospital

Table 3.11 data shows that five respondents are new in Bareilly Mental Hospital and rest of the respondents are old cases. Five respondents belong from rural area and rest of the respondents belongs from urban area. Most of the respondents come to the Mental hospital from 10-200 km.

Conclusion

Bareilly Mental Hospital which was established in 1862 by the then British government has gone through various crucial changes from lunatic asylum to a hospital specialized for the treatment of psychiatric disorders with a more advanced approach of today. It has improved not only in terms of treatment approach but in terms of infrastructure and facilities. Specialized psychiatric care is provided by the hospital on minimal expenses. However apart from these developments there are some limitations. Although various new infrastructures were provided by the government to the hospital, still the huge land which is an asset of the hospital is not fully utilized. As we have discussed and also observed from the data that the number of psychiatric patients attending the hospital is increasing day by day, therefore in future more infrastructural development will be needed. There is also a huge gap between the availability of mental health professionals and the ideal standards which hinders the path of proper care. Even the facilities which should be given to the patients by the government could not be fully utilized for the patient's benefits as there is a lack of man power in the hospital. Psychiatrics have to attend many patients daily as there are only four doctors specialized for mental health care. Due to this they have less time to attend to individual patients and it cannot be justified specially in terms of psychiatric disorders that need more attention and time of the doctors. Some important domains of care (like psychological, social and family therapies) are lacking in the hospital as there is no specialized man power appointed for the vacant post. Rehabilitation services provided by the hospital are also not sufficient. No community services and awareness campaign were conducted by the hospital which is the need of the day. Thus it can be observed from the data that although several important developments have taken place over the years, there is a vast scope of further improvement in terms of various domains of psychiatric care in the Bareilly Mental Hospital.

Chapter 4

Aspects of Help Seeking Behaviour of Patients with Mental Health Problems in Bareilly Mental Hospital

Chapter 4

Aspects of Help Seeking Behaviour of Patients with Mental Health Problems in Bareilly Mental Hospital

This chapter presents the analysis drawn from primary data interpretation. The data was gathered through interviews with patients/patients' family and providers and also through observation of services and facilities at Bareilly Mental Hospital. This chapter is broadly divided into three sections, first is patterns of resort/pathway to care, second is barriers in access and third is quality of health services of Bareilly Mental Hospital. First section describe pathway to care in this section tried to explain how to people decide for care and what are the factors play important role in seeking help on the basis of quantitative data. Second section is based on quantitative and qualitative data both, this section found out some themes from first section and tried to describe these themes according to patients/ patients' family and provider's perspective and third section describes quality of health services of Bareilly Mental Hospital along with patients/ patient's family members and providers suggestion for improvement health services of Bareilly Mental Hospital.

Section 1-Patterns of Resort/ Pathways to care:

This section described that points such as: source of first visit, reasons for choice of place of first visit, time taken to seek help for mental health concerns, reason for eventual visit to Government psychiatric hospital, main source of information on Government mental health care services, reasons for delay in accessing Government mental health care services, mean duration of treatment with the different service providers and perception about mental health services

Table 4.1: Source of First Visit

Source of first visit	No of patient
Private practitioner/ clinic (general)	1* (10%)
Private psychiatric clinic	2 (20%)
Government mental hospital	2 (20%)
Faith healer#	4, 1* = 5 (50%)
Total	**10**

Faith healer – " Ojha" "Tantrik", perform religious activities

* IPD patients

Table above shows that majority of the patients (5) went for faith healing and equal number of patient (2each) went in to private psychiatric clinic and government mental hospital and only one of the patients went to private practitioner / clinic (general).

If we further look at the data we find that most of the female patients (4) chose faith healing as a first source of treatment compared to male patients. One of the male patients visited in private clinic (general) and one other male patient visited in private psychiatric clinic as a first source compare to female patients. This data also shows differences in residential area regarding first source of treatment: most of the rural patients (3) opted for faith healing as a first source of treatment. Researcher has not found much difference in religion wise (see Appendix 3.1). Patients (4) who had with primary level of education opted for faith healing as a first source of the treatment compared to patients who had secondary level and higher level education. Two of the patients who opted for government mental hospital as first source, one had secondary level education, but the other one was illiterate. If we go by the diagnosis of the interviewed patients, we find that most of the psychotic patients (3) opted for faith healing compared to neurotic patients (2). Two patients chose private psychiatric general clinic as first source of treatment. One of them was suffering from psychotic problem and other one was involved in drug abuse; both were well educated (see Appendix 3.2).

Table 4.2 Reasons for Choice of Place of First Visit

Reasons for choice	**Number of patients**
Family reputation	3 (30%)
Cost of care	1 (10%)
Attitude of providers	2 (20%)
Believe system	3, 1* = 4 (40%)
Convenience	1* (10%)
Good reputation	1 (10%)
Total	**12**

Note- This table shows the total number of respondents is more than ten as some respondents given multiple responses

Data of table 4.2 shows that these patients reported some reasons for choice of place of first visit. Out of the five patients who went to the faith healer as mention in table 4.2, majority (4) stated that due to belief system they chose faith healing (super natural power as cause of mental illness which required faith healing) as first source of treatment and some of the patients (3) chose faith healing as a first source of treatment so that family reputation does not get affected.

Appendix 3.4 data shows that out of total five female patients, four female patients opted faith healing due to family reputation and own belief about causation of mental illness. One female patient opted faith healing due to both reasons (family reputation and own belief). Two patients opted because of belief and other one patient opted due to family reputation. Out of five male patients, only one male patient opted for faith healing to save his family reputation and own belief about cause of mental illness. Here we found more significant differences between genders. Most of the rural patients (3) and their family opted for faith healing as a first source because of their beliefs in disease causation which guided them to faith healers. . One patient chose government hospital as first source of treatment due to hospital's reputation and other one chose because of their service was available at low cost and because he was poor ,daily wage earner. Only one patient chose private clinic according to his convenience, he was educated and belong from urban area.

Table 4.3: Time Taken to Seek Help for Mental Health Concerns

Time duration	**Number of patients**
I week -II week	3 (30%)
III week- IV week	1, 2* = 3 (30%)
V week- VI week	3 (30%)
VII week -VIII week	1 (10%)
Total	**10**

Table no.4.3 data shows that most of the patients had taken time for seeking help for mental health concerns between I to VI week. This time duration is approximately one and half month. Out of ten patients three patient had taken time I –II week, three patient taken time III – IV week and other three patients had taken time V-VI week. One patient had taken time VII- VIII week. Appendix 3.6 data shows that female patients had taken more time between IV-VIII week compare to male patients. Data do not show much difference between rural and urban people in terms of time taken to seek help for mental health concerns. If we see by education then we found significant differences between education level, Education level also affect on take time for seek help for mental health cancers data shows, out of total four primary level educated, three primary level educated patients and their family taken time between V-VI week for help seeking and out of total three secondary level educated patients and their family taken time between III-IV week for help seeking. (See appendix 3.7)

Table 4.4: Cause of Delay in Seeking Help for Mental Concerns

Cause of time taken to seek help	**Number of patients**
Ignorance	4 (40%)
Lack of awareness about mental illness and lack of awareness about mental health services#	3 (30%)
Lack of resources	1(10%)
Negative attitude regarding mental illness	3, 1* = 4 (40%)
Total	**12**

Note- **1-** #-Those people had taken time due to "no knowledge about mental illness as well as lack of awareness mental health services.2- This table shows, total no of respondents more than ten because of some respondents given multiple responses

Above data shows that equal number of patients and their family had taken time in seeking help cause of ignorance and negative attitude regarding mental illness. Some patients had taken time for seeking help because of lack of knowledge about mental illness and mental health services. Only one patient and her family had taken time due to poverty. As mention in appendix 3.8, cause of taken time differ by gender difference, only male patients had taken time cause of their ignorance and female patients had taken time cause of negative attitude about mental illness. If we see place of residence then we found significant difference in place of residence; rural patients had taken time because of lack of awareness about mental illness and its treatment compare to urban patients. Appendix 3.9 shows that who females (4) had negative attitude about mental illness they had primary level education and only one patient was illiterate and out of total three secondary educated patients, two patients had taken time in help seeking due to their ignorance. Data do not show any significant difference according to diagnosis.

Table 4.5: Reason for Eventual Visit to Government Psychiatric Hospital:

Reasons	**Number of patients**
Ineffective services#	6, 2* = 8 (80%)
Cost of care	1 (10%)
Reputation	1 (10%)
Total	**10**

Note: # Ineffective services **–** where patients had visited other services before Bareilly Mental Hospital like (faith healing and any private general/ private psychiatric clinic) and they did not feel any improvement.

Table number 4:5 data shows that most of the patients (8) come to government psychiatric hospital because they were non-satisfied with pervious health care services/providers. Data of the appendix 3.11 shows, Out of total six psychotic patients five psychotic patients, and out of total three neurotic patient, two patient and their family members come to Bareilly Mental Hospital after utilization of ineffective services and also data shows that primary level educated patients and their family (4) come to this hospital after utilization of ineffective services As mentioned in table 4.2, two patients went straight to government mental hospital because they found the service was available at a low cost and other because of the hospitals reputation. Data do not show any significant differences between gender, religion and place of residence.

Table 4.6: Main Source of Information on Government Mental Health Care Services

Main source	**Number of patients**
Family	2 (20%)
Medical professional	1(10%)
Friend	4 (40%)
Other patient	1, 2*= 3 (30%)
Total	**10**

Note-*IPD patient

Table number 4.6 data shows that most of the patients (4) came in this hospital through friends' suggestion, some patient (3) had came by suggestion of other patients, who had

already taken treatment in this hospital. Two patients came by family suggestion who were female (see appendix 3.12) and only one female patient came by medical professional advice. Appendix 3.12 also shows that more male patient and more psychotic patients come to government hospital through friend's suggestion.

Table 4.7: Reasons for Delay in Accessing Government Mental Health Care Services

Reasons for delay	**Number of patients**
Stigma	3, 2* =5 (50%)
Poverty	1 (10%)
Ignorance	4 (40%)
Total	**10**

Table above shows that most of the patient (5) was delay in accessing formal mental health care services due to stigma (in terms of family discouragement, gender discrimination and negative attitude about mental illness). Some patients delayed because of their ignorance. Only one patient had delayed because he had no money for travel.

As mention in appendix 3.14, out of five patients and their family members, more of the female and urban patients (4) delayed in accessing government mental hospital because of stigma. Appendix 3.15 data shows significant differences in diagnostic category as psychotic patients and their family had stigma due to this they had delayed in accessing government mental health services and also data shows that primary level educated patients more delayed due to stigma compared to secondary level educated patients and their family. Secondary level educated patients and their family delayed due to their ignorance compare to primary level educated patients and their family.

Table 4.8: Mean Duration of Treatment with the Different Service Providers before Arriving in BMH:

Months	Private clinic	Private psychiatric clinic	Government Mental hospital	Faith healer	Total
1-5		1		2,1*	4 (40%)
5-10		1		1	2 (20%)
10-15	1*			1	2 (20%)
15-20					
20-25			1		1 (10%)
Total	**1**	**2**	**1**	**5**	**9**

Note- one patient did not go for any kind of treatment before BMH

The data given in the table 4.8 shows that those patients who had gone for faith healing, they invested approximately 1-15 months in this form of treatment patients who had got treated in private psychiatric clinic or private practitioner spent approximately 1-10 month-s before reaching BMH One patient had spent 1-25 months in another government mental hospital treatment before he came to BMH.

Table 4.9: Perception about Mental Health Services

Perception about mental health services	Number of patients
Negative attitude about mental hospital	8 (80%)
Side effect of Psychiatric medicine	10 (100%)
Side effects of ECT#	1 (10%)
Ineffective psychiatric treatment	6 (60%)
Negative attitude for psychiatric providers	2 (20%)
Cost of care	1 (10%)
Total	**28**

Note-1. This table shows, total no of respondents more than ten because of some respondents had given multiple responses.

2. # ECT- Electro convulsive treatment

Above table shows perception about mental health services, in this table many respondents had given multiple responses due to this total number of respondents more than ten. This data shows that out of ten respondent, eight had negative attitude about mental hospital, all patients belief that psychiatric medicine had own side effect, six patients stated that psychiatric treatment is ineffective, two patient had negative attitude about psychiatric providers, one patient belief that psychiatric medicines are more expensive and another one patient stated that ECT has side effect. As mentioned in appendix 3.18, more female and urban patients and their family member had negative attitude about mental hospital compare to male and urban patients and their family members and also more female and urban patients and their family state that psychiatric treatment is not effective. Only female patients had negative attitude about psychiatric providers. Only one female patient reported that psychiatric medicine more expensive. Appendix 3.19, If we see according to category of diagnosis then we found that more psychotic patients had negative attitude about hospital compared to neurotic patients and also data shows primary level educated patients and their family had negative attitude about mental hospital compare to secondary level educated patients and their family members. We do not found much significant differences in religion wise.

Section 2-Barriers in Access: A Thematic Analysis

This section describes four themes that emerged in the course of the study: stigma, Negative attitude and behaviour regarding mental illness, beliefs about causality of mental illness, lack of awareness of mental illness and mental health services and perception about mental health services. These themes have been analysed on the basis of patients/ patients' family members and provider's perspective.

Stigma

Stigma related to mental illness has always been a matter of concern to researchers and mental health practitioners, as it is not only related to illness prognosis but also affect the help seeking behaviour of the patient and their relatives. Therefore, we are exploring the stigma related to mental illness as the study will be incomplete without throwing light on this topic.

It was found in all the interviews with respondents that stigma prevails not only in the society itself but also in the families of psychiatric patients. Due to stigma, even the family members of the psychiatric patients find it difficult to accept the patient among them. To explore more dimensions of stigma related to mental illness some interrelated points are being discussed in this section. These points are: feeling of embarrassment, family discouragement and gender and health-seeking behavior.

Most of the patients and their family members are found to have a feeling of embarrassment and discomfiture about having psychiatric illness themselves and in their family. Society has a stigma about mental illness and mentally ill person. Therefore people with mental illness feel embarrassed to share his or her problem with anyone. They fear of being referred negatively and in a prejudiced way by the people of society and also worried of facing a changed behaviour towards them when people around them come to know about their illness. The family of psychiatric patients also feel awkwardness due to having a patient with mental illness. This is the reason why some patients' families don't accept that they are having a patient with mental illness and show no interest in finding out the proper treatment for their problems. Here some of the statements of respondents are given which shows these tendencies:

Parents of 27 years old Sheela (name changed) suffering with hysteria said, *"If anyone gets to know about my daughter's illness, then no one would like to invite us to any of their social function sand will avoid visiting our home."*

Anuragi (name changed) 27 years old suffering from mood disorder, her mother in-law said, *"It would not be good for our reputation, if people get to know about the psychiatric problem of my daughter in law."*

Even the providers corroborated this finding. For instance; Dr. Sanjay (name changed) 50 years old working in Bareilly Mental Hospital as a psychiatrist stated,"*Some patients do not come for treatment in the mental hospital because it might ruin their status in the society."*

Gender discrimination is quite evident when the stigma was being explored. As mentioned in appendix 3.14; female psychiatric patients are more stigmatized than male psychiatric patients. Mostly data of in first section of this chapter shows that most of the families of the female psychiatric patients show gender discrimination in health-seeking behavior When a female member of the family gets affected by mental illness, her family members usually don't accept her illness due to fear of society.(See data of appendix 3.8 shows cause of delay in seeking help for mental concerns). They avoid disclosing the fact about her mental illness with their relatives, neighbors and other people related to them. They do not seek proper psychiatric treatment in the initial phase of the illness because they are worried that others will get to know about her mental illness. Even when they visit any specialized treatment care facility they try to hide this fact from others. They think that if anyone gets to know about her illness then they and their patients will have to face many problems lifelong like in marriage, social gathering etc.Therefore most of the female patients used to visit faith healing as a first source of treatment.

The major concern of the family members of the female psychiatric patients is that if anyone in the society would come to know about the patients 'mental illness, it will be difficult for them to arrange their marriages, as no one would be ready to marry a girl with mental illness."

Parents of 26 years old Charankaur (name changed) suffering with mood disorder said *"If she was a boy then it would be better to seek treatment, as boys will always be remain with the family but in case of girls it is quite difficult because they get married and have to shift to another family where they will not be accepted unconditionally as they are in their own families"*

Even the providers confirmed this finding. For instance, one female attendant said "*if any female in the family develops mental illness, her family members do not want to take her for the treatment as they feared that it might ruin her opportunity to get married, and also might destroy the family reputation in the society. On the other hand if any married female get affected by mental illness, her in-laws refuse to accept her and try to leave her on the basis of her mental condition"*

Dr. Subhash (name changed) 52 years old working as a psychiatrist far last five years said *"one of the most prevalent query of female patient is that if her illness is curable and whether her illness affect the matter of her marriage or not."*

Thus we find that stigma is equally attached to the married and unmarried females. When female is unmarried the main concern of family is about the problems they have to face in her marriage whereas if the female patient is already married, then the main problem is that her in-laws do not want to keep her with them in their own home. They often want their son to get married again and leave his wife who is having mental illness. They used to reason out this act, by explaining the high probability of having mental illness in their next generation as well as they also have to face the adverse effects of the prevalent stigma in the society which might cause various difficulties in future. They feared being socially cut- off, as due to stigma related to mental illness- people would avoid visiting them and inviting them to their place for social gatherings.

The statement of patient named Anuragi's (name changed) mother in-law clearly depicted the prevailing stigma about mental illness of a married female, ""*My daughter in-law is pregnant and since the medicines to cure mental illnesses have a warm effect on the body, it may harm her and subsequently affect the baby too. My entire generation will be affected, m*oreover, *if any one gets to know about the psychiatric illness of my*

daughter in law, which respectable family would then seek my daughters' or sons' hands for marriage.

Here a case study is being shared to show the stigma related to mental illness

Lela (name changed), 29 years old married women was getting treatment in a family ward with her mother since three days. She was illiterate and came from a rural area. She had been suffering from paranoid schizophrenia since one year. Her in- laws had refused to keep her with them and therefore had left her at her mother's home after she started showing symptoms. Her brother and sister- in- law also did not want to look after her as they were afraid that their children might get affected, and also that it would harm their reputation in the society leading to no social interaction. However, Lela's mother fought with her son and daughter- in -law for her ailing daughter and is presently bearing all the cost of her treatment with her pension. Her mother had stated that she would file a case against her son and daughter in law once her daughter is fully treated, to restore her rights.

Negative Attitude and Behaviour Regarding Mental Illness

As it has been discussed earlier mental health problems are extremely stigmatized in the society and in the family of the patient itself. This stigma leads to negative attitude and behaviours towards the patient with mental illness as well as the people related to them. There are various misconceptions about mental illness which affect the attitude and behaviour towards psychiatric patients. People thought that people with mental illness are violent and aggressive and therefore, the source of danger for the society and for their safety; it is an incurable and unmanageable disorder and so the affected person can never function normally again in the society; if they interact more with them they might also get affected by the disorder; if one person is affected in the family, others are also prone to the disorder and the next generation will also be affected by the illness and so on.

Because of these misconceptions prevailing in the society people often have negative attitude towards the psychiatric patients. As mentioned in table 4.4 of section first, some of the patients and their family showed negative attitude about mental illness and it was evidently more in case of family members of female patients. (See appendix 3.8)

Charankaur (name changed) a 26 years old suffering from mood disorder, his father said that *"my neighbours do not send their children at my home because they assumemy daughter is dangerous for their child."*

Dr Subhash (name changed) was 52 years working as a psychiatrist also agreed that , " *people have own idea about mental illness- they consider those mentally ill- who speaks unnecessarily, uses abusive language, listening to nobody and is obstinate, whose level of understanding is poor and do whatever they want to do - wrong or right."*

Sudha (name changed) 50 years old was working as attendant since twenty years said *"Those perform madness (pagalpan) or idiotic talks (bebuddhi ki baat karne wala)."*

Mamta (name changed) 28 years old was working as a staff nurse since three years said, *"People make fun of such kind of illness."*

Beliefs about Causality of Mental Illness

We found in the interviews with respondents that some of the people have own belief about cause of mental illness. They believe that mental illness is an effect of ghosts and evil spirits which is known in local language as "prêt atma" "burasaya" "uparihawa" "deviana" etc. People also believe that mental illness is the result of black magic which is referred as "jadutona" and "kalajadu". They think that someone, who is jealous of them, performs some black magic and because of that black magic their family member lost his or her mental control. Appendix 3.4 data showed that most of the female patients and rural patients have these beliefs and therefore they opted for faith healing as a first source of treatment. (See table 4.2-resons for choice of place of first visit). Apart from this people have own believe that cause of hysteria is late marriage and they have also believe that marriage work as a treatment for hysteria and for drug abuse. Some of the examples that portray this kind of belief are given below

Sheela's (changed name) 27 years old was suffering with hysteria. Her father said, "*We had no knowledge about mental illness and about its symptoms; someone told that cause of these symptoms might be supernatural power*"

Mohit (name changed) 29 years old was suffering from depression come from rural area said, *"Initially my parents felt that somebody persuaded witchcraft."*(kisi ne kuchhkarwadiyahai).

Some providers also agree for instance; most of the doctors, nurses and attendants said that majority of the patient and their family members are superstitious and hence they opt for faith healing as a first option for treatment.Due to this kind of thinking affect on people's help seeking behaviour.

Sudha (name changed), 50 years old was working in this hospital since twenty years as an attendant. She said, "*People believe in supernatural power as a cause for his or her problems therefore they go for faith healing, I was working in this hospital since 20 years, my sister-in-law had some mental illness but we did not accept her problem as a mental illness and we went for faith healing."*

Mukesh' (name changed) father said, *"My son started cannabis since two year before. When I come to know that my son involve in drug abuse than I took him to the de-addiction clinic for treatment because I know that my son's condition was critical and he need treatment therefore I admitted him in to the de-addiction center for two months but after his treatment he again started his addiction, then someone said that after marriage he would leave addiction therefore I arranged his marriage but he was not leave his addiction moreover his wife leave him."*

Bena (name changed) 45 years old was working as attendant since fifteen years, she too said, "*mostly people believe that late marriage is a cause for hysteria in females and mostly doctors are also believed like that."*

Case study of Anuragi's shows the nature of beliefs that some patients had about the causation of the disease.

Anuragi (changed name) 27 years old pregnant women having mood disorder hailing from Bhojipura an urban area of Uttar Pradesh. She was educated up to fifth standard. The patient did not respond to the questions asked to her. She was having a constant smile on her face and her smile was the only response that researcher gets from her. The

blink rate was also quite less. According to her husband she often mutters to herself, even weeps and laughs at times without any apparent reason. Her husband informed that her wife had been suffering from mood disorder from two years. Her husband said that initially he was not able to understand the cause of her behaviour and also did not notice that her symptoms and activities are the result of some mental illness because he had no knowledge about mental illness or their symptoms. After some time he started noticing his wife's odd behaviour and realized that his wife was having some mental illness. "*I was not able to think that it can be a mental illness as no one near us is having such illness and I could not imagine my wife as being affected by such symptoms.* He also added that when he realized that her condition had been worsening day by day, he took her to a faith healer. In front of the faith healer his wife started behaving strangely swaying her head vigorously, jumping and saying in a heavy voice that she is a sprit (jinh) and she would destroy the faith healer (Ojha). Faith healer tied her to a tree. This incident made her husband and her family members believe that she was possessed by a sprit. Therefore they continued her treatment with the faith healer (Ojha) for one year but her condition did not improve. Only after that he brought her to Bareilly Mental Hospital for treatment.

Sheela (name changed) 27 years old has come to Bareilly Mental Hospital with her mother from Bareilly (rural). Her qualification was primary level. She was visiting the hospital for the second time at the time of interview. She was suffering from Hysteria since past six months. She stated that initially she did not recognize her symptoms as a possible mental illness. At that time she was suffering from heavy headache, laziness, helplessness and she was also fainting quite often. She used to faint at least once or twice in a day. But her family did not notice her problem and did not accept it as illness. Her family believed that she was pretending to seek attention because of she want to do marriage.

Lack of Awareness of Mental Illness

People have own believe about causes of mental illness as it has been mentioned above. We found that some people do not have knowledge about mental illness as well as its treatment. They do not understand their problem in initial phase because of lack of knowledge and ignore their problem and also think that this problem is not so serious to require treatment. Table 4.4 of section one shows that some patients and their family member delay in help seeking for mental health concern because of ignorance. Those patients do not have knowledge about mental illness they do not have knowledge about mental health services. As mention in appendix 3.6, rural patients and their family have lack of knowledge about mental illness and mental health services. Here some patients and their family member's statement present lack of knowledge about mental illness and ignorance of problem.

Husband of Dewaki (name changed), 27 years old illiterate women was five months pregnant suffering from depression hails from Sahi (a rural) said, " When we were went for checkup of her in government hospital that time lady doctor said that she need for psychiatric treatment then we know about her problem. We did not know about mental illness and its treatment." (Dimagi bimari aur eske ilazz)

Mohit (name changed) 29 years old suffering from depression said, "I was understanding my problem as normal physical problem because I do not know about symptoms of mental illness, therefore I ignore my problem in initial phase."

A Pharmacist working since ten years in BMH said, "*mental hospitals are being consulted when problems become unmanageable." (jate jab hai jab paani sir ke upper chadhjatahai.)*

Perception about Governmental Mental Health Services

As we have been discussed above mental illness are extremely stigmatized in society as well as in family of the patients with mental illness. Because of that mental health services are also stigmatized in society. Therefore most of the patients and their family members have negative perception about mental health services. Due to this most of the people do not want to take treatment in government mental hospital. Some negative perception about mental health services discussed here are as follows: negative attitude about mental hospital, side effect of psychiatric treatment, ineffective psychiatric treatment, perception about providers and cost of care.

a- Negative Attitude about Mental Hospital

We find that generally people do not see mental hospital as a treatment and curable place they felt that mental hospital is a place where dangerous and violent patients are locked up with mental illness. This perception about mental hospital is extremely stigmatizing. Therefore patients and their family have negative attitude and behaviour about mental hospital because of which they thought of mental hospital like "pagal khana" (madhouse) where "pagal" or "mad" people are getting treated in inhuman manner. Also people do not see mental hospital as a hospital. Table 4.9 showed that more patients and their family member have negative attitude about mental hospital, as evident mention in appendix 3.18, female patients and their family have more negative attitude about mental hospital compared to male patients and their family. Some examples showed negative attitude about mental hospital.

Sheela's mother said that Sheela said, "Consultation to a mental hospital is not required (Pagal khane jakar ilaz nahi karwana hai)

Dewakar (name changed) 50 years old patient having mood disorder getting treatment in family ward since five days, hailing from urban area. His wife said, *"When we came in this hospital first time, my husband said that I will not go to a mental hospital (pagal khane).If anyone hears that I went to a mental hospital, then they will tease me."* Providers also informed for instance like Dr. Sanjay (name changed) who has been working for last five years as psychiatrist in the BMH also said, "Patients do not come in

mental hospital because they understand that mental illness as “pagalpan”(madness) and mental hospital as “Pagal khana”(madhouse) where doctor give electric shock to every patient”.

Komal (name changed) 28 years old working as staff nurse since three years said, *“People have several misconceptions about a mental hospital. My relatives and friends often laugh at me, saying that I might go crazy working in a mental hospital.”*

b- Side Effects of Psychiatric Treatment or Faith Healing

The researcher found that the people had their own perceptions and apprehensions about the medicines being used for treatment of mental illness. They thought that psychiatric medicines and Electro convulsive therapy (ECT) have extreme side effects, which leads to much kind of problems like medicine addiction, cardio vascular disease, asthma etc. Table 4.9 in the first section shows that all of the patients and their family reported that psychiatric medicine has many side effects. Such beliefs were equally prominent in rural and urban people with or without education as mention in appendix 3.18 and 3.19. Some of the examples presented here.Mohit (name changed) 29 years old, suffering from depression, said, *“Medicines are like sleeping pills. If one takes it, one feels sleepy all the time. Besides all these medicines are addictive in nature and induce lethargy in the body.”*

The wife of Dewakar, (name changed) a 50 years old patient said, *“ my husband has had this problem since five years and doctor has given ECT approximately four to five times. Therefore, my husband is now suffering from cardiovascular (dil ki bimari) disease along with mental illness.”*

Even the providers agreed that psychiatric medicines have certain side effects. Dr Radhesh, (name changed) 54 years old, working as a psychiatrist at the hospital, said that *“the patients and their family generally believe that the doctors administer only sleeping drugs as psychiatric medicine. (Khali neend ki dawa hoti hai).Some medicines are indeed sleeping pills but not all. However, some psychiatric medicines have their own side effects, as do general medicines.”*

Apart from these views about psychiatric treatment, people also mentioned the ill effects of faith healing. People believe that during faith healing, the faith healer uses injurious techniques for the treatment of mentally ill patients. This led to the patient suffering from many kinds of problems like body pain, injury in some body parts etc. Appendix 3.19 data shows that only one patient and their family beliefs that faith healing has side effects that were educated and they went to the formal psychiatric hospital as a first source of treatment. The following case study and some statements would attempt to discuss the ill effects of faith healing.

Sukant (name changed), 17 years old having schizophrenia, hailing from Battiea urban area was educated up to class 12th. The patient was not in a position to give an interview, so the researcher spoke to his father. His father is a headmaster in government primary school. He had taken leave from his job for one week and had come to Bareilly Mental Hospital for the treatment of his son. His son's condition was very critical. He would frequently open his clothes in OPD and shout at other people. His uncle tried to control him because he would not listen to him. The patient would even beat his father with his shoes. No one could control him except his uncle. His father said that the patient has undergone treatmentat the Central Institute of Psychiatry, Ranchi (CIP), Institute of Human Behavior and Allied Sciences, Delhi (IHBAS) and many private clinics but his condition improved for 2-3 months only. The family then sought treatment by a faith healer. The faith healer ("Tantarik") touched the patient's tongue with a hot iron rod. As a result, Sukant could not properly consume food thereafter which led to a worsening of his condition.

The mother in-law of 27 years old Anuragi (name changed) suffering from mood disorder said, *"I went to "Pani Wale Baba". That "Pani wale Baba" gave some water for my daughter in-law, but her condition did not improve after taking that water, rather she was vomiting frequently and her condition was becoming worse"*.

c- Ineffective Psychiatric Treatment

From the information we gathered through the interviews with various patients and their families, we found that another popular perception regarding mental illness is, that once it occurs psychiatric treatment can only give a temporary cure and there is no permanent solution to that. However they opt for medical treatment and visit hospital to have relief at least for some time period. The data we have analysed suggests that, it is mostly the female patients and the patients from urban areas whose families called psychiatric treatment ineffective. (See appendix 3.18). For instance Sukant's father said, "*My son has undergone treatment at many places, but his condition improved for only two to three month. The symptoms keep recurring; no medicine seems to have any effect.* Dewakar's wife said, *"My husband has been suffering from mental illness since five years, we have to come in this hospital every year for ECT. After ECT my husband's condition improves for seven to eight months, however my husband's condition has not improved permanently"*

Even the providers mentioned their inability to cure certain disorders. One doctor said, "psychiatric *treatment takes long time for good prognosis but there are some disorders that not curable permanently and may recur."*

A pharmacist working for the last ten years said that there was no effective treatment for patients suffering from drug abuse. Some doctors also stated that psychiatric treatment take long time for good cure and people do not want take medicine in accordance with the for the prescribed period and also they want get quick relief.

d- Perception about the Providers

We found that the patients and their family have a negative attitude and behaviour about psychiatric providers (See in table 4.9 of section first). It is evident in Appendix 3.18, that most of the family members of female patients think that the providers in the mental hospital misbehave with female patients in IPD and OPD. Sheela's mother said, *"I did not send my daughter alone with her father to mental hospital, but accompanied them because all sorts of persons come for treatment, and had also heard about the doctors' misconduct*

Even some female providers stated that some female patients and their families did not want to go to a mental hospital because of misbehaviour of some doctors and other male staff. The following statements of the respondents reflect the perceptions regarding such misbehaviour. Sudha (name changed) working as an attendant said, *"Some family members of the female patients believe that during consultation the doctors meet female patients alone and administer some neurotic drug, after which the doctors misbehave with the patient while the latter are in a state of unconsciousness".* Another attendant agreed that this was not just a misconception, but true.

An attendant shared another disturbing incident with the researcher. She said, *"A doctor of this hospital does disgusting things. The doctor sees female patients in a closed room while the patient's family waits outside the doctor's cabin. Once a patient had come from a rural area with her mother, and they went inside the doctor's room for consultation. The mother waited for her daughter outside the cabin for an hour but her daughter did not come out. The mother became extremely worried and knocked at the door and shouted. After some time, the door opened and the mother found her daughter in an unconscious condition, her cloths loose and unbuttoned. Her mother shouted at the doctor, but everyone tried to calm down the mother. No one raised a voice against that doctor. Most of the poor, rural female patients have to face this kind of problems because they are very unaware".*

e- Cost of Care

The cost of care is a strong factor affecting treatment. As mentioned in appendix 3.18, we found that mostly rural and poor people think that psychiatric medicines are very expensive; the doctors also charge a good amount for consultation. The faith healer also asked for a high amount besides other expensive things in kind. In addition to this, there was the burden of travel and conveyance charges for going anywhere, be it private clinic, government hospital or faith healing.

Dewaki (name changed), 27 years old, suffering from depression had come to Bareilly Mental Hospital with her husband and mother in-law. She is illiterate and hails from Sahi (a rural). She was five months pregnant. When the researcher met with her, that time

Dewaki was very depressed and refused to talk to anyone. According to her husband, she had been displaying symptoms since last two months. He also added that she was neither sleeping nor eating properly. Moreover, she seemed to have lost interest in any work or interacting with anyone and would cry most of the time. He said that as he had no money and had a meager earning as a daily wage laborer therefore he could not go for his wife's treatment initially. He could only afford his wife's treatment once he saved some money and also borrowed from his relatives.

One pharmacist, 38 years old, working since the past ten years said, "*The patients belonging to low socio-economic groups come to government mental hospitals because they get medicine and treatment free of cost, yet they have to pay for travel. Private clinics and faith healers however charge large sums of money. Private Doctors charge 300-400 rupees for one consultant and faith healers also demand goat, hen, alcohol, clothes and 101-1001 rupees for treatment.*"

Section 3-Quality of Mental Health Services of Bareilly Mental Hospital (BMH)

We have profiled the facilities and infrastructure of Bareilly Mental Hospital (BMH) in Chapter third. Present chapter aims at putting light on the quality of health services of BMH. Present chapter describes the gaps/ unmet needs and strategies to improve services and utilization of BMH on the basis of patients/patient's family members and provider's perspective. For description of this chapter, we use quantitative and qualitative data both.

Quality of mental health services determined by some factors like quality of providers (regarding to attitude of providers and doctor gave less time for consultation), specialist services (means rehabilitation for mild and severe patients, specialist OPD for drug abuse and other severe problems and psychometric testing/ pathological testing for patients with mental illness), standard of food and hygiene, strength of mental health professionals and other factors like safety of the patients and providers and abandoned patients of Bareilly Mental Hospital. We describe these factors in section of gaps and unmet needs of BMH.

Gaps and Unmet Needs of BMH

This section discussed these factors on the basis of patient / patient's family members and providers (doctors, nurses, pharmacist and other hospital staff). Below quantitative data shows only patients/patients' family members' perception.

Table 4.10: Patients/ Patients' Family Members' Perception of Gaps/Unmet Needs

Gaps/unmet needs:	**Number of patients**
1-Quality of providers	3 (30%)
2-Lack of mental health professionals	4 (40%)
3-Lack of specialist services	2 (20%)
4-Standards of food and hygiene	1 (10%)
Total	**10**

Data of the table number 4.10 shows that more patients (4) stated that this hospital has shortage of staff, some of the patients (3) reported about the quality of providers and few patients (2) informed that this hospital has no specialist services like rehabilitation for severe cases. One patient complained about the standards of food and hygiene in Bareilly Mental Hospital. As mentioned in appendix 3.20, out of four patients, three female patient's family member reported of shortage of staff and out of three patients who reported for quality of providers, two were female patients. As mentioned in table 4.10 two patients complained for specialist services. Both these patients were educated and came from urban area (See appendix 3, 20 and 3.21)

a. Quality of providers: We describe here quality of providers in terms of consultation and interaction between providers and users.

i: Consultation

After observation in OPD, the researcher found that the doctors give two to four minutes for consultation with patient. They do not take a proper case history but ask the patients only about the symptoms. During consultation there is no proper eye contact between patient and doctor. The statements by some of the patients' family members are given below.

Suresh's (name changed) 27 years old, suffering from schizophrenia since two years, has been prescribed Electro convulsive therapy (ECT) by the doctor after consultation. His mother said, *"The doctor gave only two minutes for consultation and prescribed ECT. Had the doctor seen my son properly, it could have been possible that my son's condition improved by taking only medicines. When I said this to the doctor he did not listen to me and got angry."*

The husband of Anuragi (name changed), 27 years old suffering from mood disorder, said, *"We came to the hospital at 8.30 am in the morning and my wife could consult the doctor only after 1:00pm. We have to wait for three to four hours and doctor gave only two to three seconds for consultation."*

ii: Interaction between Users and Providers

The issues of ill behavior of the providers also create concern. For instance the pharmacist of the hospital often misbehaves with patients if the patients or their family members do not understand about the dosages of medicine and enquires him repeatedly about the same. The following are the patients' families' statements regarding the interaction between providers and users.

Sheela's (name changed) mother said, *"the doctor we were consulting earlier did not come today so we consulted another one but he also did not see my daughter properly and also did not behave well."*

Father of 17 years old boy Sukant, (name changed) suffering from schizophrenia said, "The *chaprasis*(translated best as peon, though the term used for them, in the hospital, is attendants)" *here behave as if they are doctors*."

Apart from the pharmacist and the doctors' behaviour, we found that the attendants also use a stick to intimidate patients who do not take a bath willingly. The attendants claim that the stick is never used to hit the patients but only to threaten them into taking a bath or being given a bath as the case may be. Severe female patients are given a bath in the open grounds in the female ward with no clothes on. If the patients do not listen to the attendants' orders, then the attendants shout at the patients. Patients w ho are able to take care of other patients are involved by the hospital staff in activities like giving bath to other patients, serve food etc (see in picture number 4.4).

Sudha (name changed) working as attendant said, *"We involve some able patients in some activities related to the care of other patients, because when patients are involved in work then his or her mind is diverted from his or her illness and they learn daily activities."*

b: Strength of Professional Staff

As evident from table 4.11, most of the patients and their family complain for shortage of staff. As data of appendix 3.20 shows that, most of the female patients' family members and providers stated that there was a lack of mental health professionals in this Hospital. We found that they have to face many problems due to the shortage of staff like delays in registration, in receiving medicines and also consultation. Apart from this we found that this increased the work load on the hospital staffs too (Doctors, pharmacist, nurses, attendant and other staff). Some patients' family members' mentioned the following problems

The father of Mukesh, (name changed) 28 years old patient, being treated for drug abuse said that *"Only one pharmacist distributes medicines to all the patients. He also explains about the medicine dosage and use due to which he is unable to give sufficient time to anyone for explaining the prescription.*

Parents of 29 years old Lela (name changed) getting treatment in family ward, suffering from paranoid schizophrenia said, *"Here no attendant is available to control severe patients. Patients do not listen to their family and often beat their family members, but no one comes for controlling them."*

Most of the nurses said that "*in this hospital we have 41 posts for nurses but at present only 4 nurses are available. Due to this we have to do work equal to 41 nurses. Besides in this hospital, there is no male nurse therefore we see the male ward also*"

Dr. Radhesh said, "*due to shortage of doctors, we do not take proper case history of patients and also do not give more time for consultation."*

c: Lack of Specialist Services

We found lack of specialist services in terms of rehabilitation of different kind of patients and psychometric and pathological testing. Table 4.10 data shows that most of the patients complain for lack of specialist services. As mention in appendix 3.21, educated patients and their family members and also the providers complained about the lack of specialist services. According to the father of Mukesh, (name changed)a 28 years old

victim of drug abuse "*Bareilly Mental Hospital's basic facilities are good but there are no specialists or separate care facilities for addicts."*

The father of Sukant (name changed), 17 years old patient, suffering from schizophrenia said that the Bareilly Mental hospital does not have specialist care for severe mental disorders. He added that the doctors in this hospital only consult a patient for few seconds and simply prescribe medicine.

Kamal (name changed) 45 years old has been working in this hospital since ten years as a lab technician. He said, *"In this hospital they have only basic tests and this hospital has no facilities for any psychometric test."*

Shikha (name changed) 28 years old has been working in this hospital as a staff nurse. *She said, "In this hospital we do not have any emergency services for patients."*

Dr. Radhesh (name changed) 54 years old has been working in this hospital as a psychiatrist. He said, *"In this hospital no facilities are available for counseling and no separate wards and specialist services available for geriatric and child patients."*

d: Standard of food and hygiene

We found that this hospital provides food to patients three time per day -"breakfast" "lunch" and "dinner" along with evening tea. However, for the dinner, food comes in the wards at 5:00 pm and patients have to eat by 6:00 pm because after that the patients are counted and locked in their wards. Patients have to take dinner very early and therefore feel hungry later in the evening, but the hospital staff does not provide food later. In this hospital, four diabetic patients had been admitted but these patients also had to eat the same food that all patients ate. Therefore hospital does not provide patients food according to their dietary needs.

Some of the patients and their families' expressed strong views about the quality of the food. For instance, Shama (name changed) 35 years old patient who has lived in hospital since two years said, *"You cannot eat this food, hard chapattis, mixed rice and tasteless vegetable and pulses."* (Also see picture number 4.1). Wife of 50 years old Dewaker (name changed) suffering from mood disorder, getting treatment in family ward also

reiterated that the, *"Food is not good in this hospital; however we are forced to eat this food."*According to some other patients in the IPD *"the menu is good but food quality is not good*."

The wards are cleaned every morning but even after the cleaning some patients defecate or urinate in the ward itself or dirty the wash room. That place is then often not cleaned till the next morning. Patients have to use dirty toilets. Staff does not do anything about this. At most sometimes the staff may instruct the patients to clean up the dirty place. One 35 years old patient living in the ward since four years said "*some time we clean the ward ourselves because the sweeper come only in the morning and we have to live in the ward whole day."*A 50 years old attendant working since twenty years in the hospital said "*we cannot clean lavatories and ward, it is sweeper's work"*

Komal (name) 28 years old working since three years as a staff nurse said, "*We cannot do anything for this, it is administration's responsibility, administration should appoint sweepers for the whole day. I cannot do cleaning work."*

Other Issues

a: Safety of the Patients and Providers

Bareilly Mental Hospital has a huge open area and greenery (see picture number 4.2-4.3). But, due to this the hospital has lots of insects and reptiles like snakes, scorpions, and other insects. Some time back a patient died due to snake bite.

Komal (name changed), 28 years old, working as staff nurse for the past three years said, *"Patients often try hiding in the bushes around this place, exposing them to insect bites. Some time back, a patient was stung by a snake. Her mental condition, however, was very serious due to which she did not even realize that she was stung."*

Providers also had expressed concern about their own safety. For example, Charu (name changed) staff nurse was working in this hospital since three years. She said, *"I am afraid of night shift but I have no substitute for night duty therefore when I come for night duty then I continuously give horn between main gate of this hospital and female ward's gate. This hospital looks very dangerous at night."*

Subhash (name changed) 56 years old, has been working in this hospital for the last 20 years as a Barber. He said, *"Some time back, a male patient stole my knife from my bag and put it to my throat. Another patient present there at that time saved me. Who would take responsibility for this (the safety of the staff)?"*

b: Abandoned patients in Bareilly Mental Hospital

We found that Bareilly Mental Hospital had many abandoned patients both male and female. According to hospital administration in this hospital, 25 female and 10 male abandoned patients live. Some patients' family members did not want them back. Some patients' families had written the wrong address at the time of admission, probably for the same reason. The following case studies show the problems of abandoned patients.

> *One 40 years old patient Shalu (name changed) admitted in Bareilly Mental Hospital was suffering from chronic schizophrenia. She was busy in calculating the days she had spent in this hospital. She asks the staff, almost daily, "Is there any letter or call from my family". Her uncle had been admitted in this hospital around a decade back. After treatment she had recovered and was fit to live a normal life. But none of the family members came to take her back home. According to the administration, after forwarding several letters to her home one day they received a reply that none of the family members want her back. She had become mentally fit but was forced to stay in the mental hospital because her family members were not ready to accept her.*

Citing another case, a female Attendant told the researcher about a 34 years old patient named Mamta (name changed) who was admitted in Bareilly Mental Hospital for last 8 years. She was suffering from Mood Disorder, but had recently recovered from her illness. Her family members did not reply to any letter or responded to any call from the hospital. Therefore, the hospital administration had to send her home with an attendant. The attendant said, *"Her mother in-law was standing at the main gate and did not take Mamta inside the house. The attendant called the police and left Mamta at home forcibly."*

Both patients were not the only woman paying the price of being a mental patient. In this hospital around 35 other patients whom the doctors had declared mentally fit were still

waiting for their family members. Female patients face this problem far more when compared to the male patients.

Picture 4.1: Food for IPD Patients

Picture 4.2: Ward of Bareilly Mental Hospital

Picture 4.3: Open Place in Ward of Bareilly Mental Hospital

Picture 4.4: patients' Involvement in Work

Strategies to Improve Services and Utilization

In the course of our interviews, patients/patients' family and providers had several suggestions to improve services and utilization. The following section deals with strategies suggested by patients/patients' family and providers for improvement of BMH).

4.11: Patients/ Patients' Family Members' Perception of Strategies to Improve Services and Utilization

Strategies to improve services and utilization:	**Number of patients**
1-Create awareness	3 (30%)
2-Quality of care and treatment	4 (40%)
3-Improve availability	3 (30%)
Total	**10**

Table number 4.11 shows that, most of the patients (4) and their family members reported that the quality of care can be improved. Equal number of patients and their family (3) suggested for improving availability. Three patients and their family members also suggested that awareness be created about mental illness and its services.

Awareness about Mental Illness

We found that some patients and their family mentioned that awareness about mental illness needs to be spread among people. They said that due to the lack of knowledge people do not utilize available services therefore one should make others aware. They also suggested mechanisms for increasing such awareness about mental illness. As mentioned in appendix 3.23 most of the educated patients and their family suggested for

improvement in services. Some of the statements given below discuss the different suggestions.

Sukant's (name changed) father is a head master in government school. He said, *"There is a need to create awareness about mental illness through advertisements, newspapers and TV. Banners and posters should also be used for this purpose. When people will become aware about mental illness and its symptoms, they will utilize mental health services properly*.

Mohit (name changed) 29 years old, suffering from depression said, *"to the patients and their family should be made aware about mental illness during consultation."*

Dr. A.K Singh (name changed) 55 years old, has been working here for the last 6 years. He said, *"People should be made aware about mental illness and its services through the government."*

Quality of Care

We found from gathered information through interview and observation that most of the patients and their family (see table 4.11) and providers (doctors, nurses and other hospital staff) suggested improving the quality of care in terms of improving food quality, specialist facility, and a better admission and discharge procedure. Some patients and their family members' statements are given here. Some patient and their family suggested that they *should be given more time for consultation by doctors and also that the doctors should listen to patients' problems properly."* Shama (name changed) 35 years old patient said, *"Quality of food should be improved"*

Mukesh, (changed name) is a 28 years old patient is involved in drug abuse. According to his father, *"Bareilly Mental Hospital should be providing specialist cares or separate facilities for addicts and other severe patients."*

Sukant's (name changed) father said, *"Counseling session should be provided to patients and patients' family also because while the patients are suffering from mental illness their family undergoes immense mental stress."*

Providers also stated, for instance; Dr. Radhesh (name changed) said, "*This hospital should start a separate rehabilitation center for mentally ill patients.*"

Dr. Radhesh also said," some strict changes should be applied in the admission and discharge process by hospital administration because families of many patients provide wrong address as they do not want the patient to come back home."

Improve Availability

As mention in table 4.11 some patients suggested for improve availability of staff and improvement in pathological testing/ psychometric testing. Most of the providers suggested that Bareilly Mental Hospital should fill all the vacant staff posts, and then this hospital will be able to do some quality work for patients.

Pathologist Abdul (change name) 38 years old was working since six years said, " *This hospital need to improve some psychometric testing and some specialist pathologist testing like CT scan, Intelligence quartile (IQ) testing etc.*"

Patients' family members also show concerns about availability of testing and mental health professionals. For instance; Father of Sukant (name changed) said, "*Bareilly Mental Hospital has less staff therefore we have to wait for long time, therefore this hospital should be appoint more doctors.*"

Other suggestion

Hospital Collaboration with NGO

We found that one doctor suggested that the hospital should collaborate with NGOs. He is 52 years old and he has been working in Bareilly Mental hospital for the last four years and his qualification is MBBS + MD. His designation is that of a psychiatrist in the Bareilly mental hospital. Before joining Bareilly Mental hospital he was working in Agra Mental Hospital. He suggested that this hospital should start working with NGOs to ensure quality mental health services. The quality of human resource will also be better in an NGO as it is a private body which pays its staff only on the basis of performance and work efficiency.

Conclusion

In our society, people have extremely negative attitudes about mental illness and mental health services, because very little attention is paid to mental health and mental health services as compared to other health problems and health services. Most of the rural people who are uneducated have no knowledge about mental illness and its treatment or have misconceptions about mental illness. They often believe that some supernatural power ("upari chakkar") is the cause of mental illness and therefore seek faith healing. However, some educated people have knowledge about mental illness and its treatment yet they confuse their problems with other normal physical problem like body ache and headache etc. When they realise the problem, then they do not accept the problem as mental illness because of embarrassment and the fear of society. Most of the female patients have to face more problems after their illness compared to the male patients because gender discrimination is widely practiced in our society. Besides the determining factors of stigma and negative attitudes about mental illness and its treatment, deficiencies in health services in the Bareilly Mental Hospital should also be taken into consideration. The patients that came for treatment to this hospital after their dissatisfaction with other ineffective services (faith healing, private general clinic and other psychiatric clinic), mostly remained dissatisfied and went back with negative attitudes about mental hospitals in general and not only Bareilly Mental Hospital. This hospital has severe shortage of staff, due to which there is a huge work load on the existing staff and hence they do not do quality work and also become irritated easily and shout at patients and their family members. The hospital should take into consideration the needs and priorities of the patients and strive for improving health services accordingly.

Chapter 5

Discussion and Conclusion

Chapter 5

Discussion and Conclusion

Plenty of the studies on mental health and mental health services have especially focused on the burden of mental illness and mostly studies focused on community care rather than hospital care for patients with mental illness. Therefore in this study, the researcher has attempted to draw the picture of hospital care for patients with mental illness. In the present chapter the researcher discusses the various issues faced by the patients and their family members during mental illness on the basis of the study findings.

Pathways to care

We found that those patients who have come to Bareilly Mental Hospital already have undergone treatment in other places like private general clinic, private psychiatric clinic and faith healing before coming to the hospital. Our study finding shows that more patients are opting for faith healing as a first source of treatment. We also found gender discrimination in accessing mental health services. The number of female patient and primary level educated patients and their family opting for faith healing as a first source of treatment is often more compared to male patients and secondary level educated patients and their family. Male patients and secondary level educated patients and their family chose private practitioners and private psychiatrist compared to female patients and their family. Only one male and female patient chose government hospital as a first source of treatment (one patient belong to a rural area and also illiterate and other one belong an urban area and he qualified up to intermediate). As mentioned earlier in study by Nagpal et al' (2011), more male patients opted for psychiatric treatment compared to non- psychiatric and faith healing and mostly female patients opted for non-psychiatric treatment as first source. Our findings are different form this study's finding partially. Our study shows that more patients chose faith healing and fewer patients chose psychiatric treatment, the number of female patients being even higher than their male counterparts.

From the finding we find that female patients chose faith healing due to family reputation and their belief about mental illness. Female patients and rural patients and their family have own believes about cause of mental illness which circles around spiritual power "burasaya", "jadutona". "devimataana" and "uparichakkar". This majorly prevalent belief system leads female and rural patients to opt for faith healing as first contact of treatment. Findings of our study also agree with Report of Mental health Care (2005) and Jorm (2000) study shows that generally people have belief that mental illness are caused by supernatural powers. Therefore mentally ill patient seek help of faith healers and magicians (Murthy et al, 2005).

The findings reveal that male patients and their family chose private practitioner and private psychiatrist due to doctor's attitude and their convenience. Female patients come to government mental hospital through family suggestion and male patients and psychotic patients come through friend's suggestion. Very few patients and their family come to government mental hospital through suggestion of medical professional. Most of the patients and their family come to government mental hospital because they were dissatisfied with previous health care services/ providers. Our findings are somewhat similar to earlier study conducted by Chadda (2001), which shows that a wide range of services was used by the patients varying from professionals care to faith healers. They choose a particular services for important reasons like trust, easy availability and accessibility, recommendations by the significant others and belief in supernatural causation of illness. Chadda's study also shows that substantial number of patients suffering from severe mental disorders seeks non-professional care. (Chadda et al, 2001)

Our findings show that most patients have negative attitude about mental hospital. A negative attitude is more prevalent among female patients and their family than the male patients and their family. Secondly presence of negative attitude is also more among psychotic patients in relation to mental hospital compared to neurotic patients/ patient's family. Mostly female patients have negative attitude about psychiatric providers and more number of female patients and their family member state that psychiatric treatment is not effective. This finding is similar to National Institute of Mental Health and Neuro-

Sciences (NIMAHANS), Banglore document on mental health care which states that people have own fears about mental hospital (Murthy et al, 2005).

Barriers in Availing Mental Health Services

The findings also demonstrate that stigma is a very important cause in availing mental health services. Gender discrimination is evident when we explore stigma.Female patient's have less attendance in OPD of BMH compare to male patient during last four years (2005-2008).The number of female patients treated is also less than male patients in BMH. Result shows that admission (IPD) and discharge is also less for female patients compared to male patients over last five years 2005-2009. We also found that female psychiatric patients are more stigmatized compared to male psychiatric patients and their family do not want to accept her manifestation of symptoms of mental illness as "illness" due to fear of losing reputation in society. As the finding shows female patients often delay in accessing government mental health care services due to stigma (family discouragement, gender discrimination and negative attitude about mental illness). Primary level educated patients and their family delayed in accessing government mental health services because of stigma compare to secondary educated patients and their family. The finding of this study somewhat similar to Dinos et al study (2004). This has been earlier discussed in the first chapter that stigma is a pervasive concern to almost all participants. Our study also shows stigma as an important barrier in availing mental health services.

Our study also reflects stigma attached with unmarried psychiatric patients as well as married psychiatric patients. The unmarried female patient's family members are mainly concerned about the fact that men would refuse to marry her due to her illness. The female patients who are married face a difficulty from her in- laws who are reluctant to keep them.Renu Addlakha (2008) study of patients in Delhi also shows that "mental illness in women also attracts a huge amount of shame and dishonor for the family because women play important role in every day management of domestic activities and relationships".

The results also shows that male patients had taken time in seeking help for mental health concerns, because of their ignorance and female patients had taken time mainly due to negative attitude about mental illness. Most of the rural patients and their family take time due to lack of awareness about mental illness as well as mental health services.This study results are somewhat similar from earlier Mental Health Care Report (2005) shows that proportion of mentally ill patients without treatment is much higher in India compared to Western countries. High numbers of patients do not take treatment because of ignorance, fear of stigma, misconceptions and faulty attitudes regarding mental illness (Murthy et al, 2005).

Result of our study also shows that people have many misconceptions about mental illness like mental health patients are violent and aggressive and also that it is incurable and unmanageable. Because of these misconceptions prevailing in the society, people often have negative attitude towards the psychiatric patients. They avoid interacting with the patient and their family members. Psychiatric patients are being humiliated by the people even though they when their state improves and becomes manageable. Employers avoid selecting them if they come to know that they were having mental illness earlier. Rarely anyone wants to have marriage relation with the person who is having mental illness in the past even when he or she is treated and is well after the treatment. It is often found that people make fun of mental illness and laugh about it. This attitude and behaviour is not only found in society in general, but also prevail in the patient's own family. Even family members avoid, humiliate, criticise and try to keep away from the responsibility of the patients. Overall it is found that once a person is tagged with the mental illness, even though he gets improved, patients' near and dear ones and the society in general, do not whole heartedly accept him or her among themselves. Some of the examples given in the previous chapter first reflect this kind of negative attitude.

India has a large number of poor families and they do not have money or other help to take the patient to the hospital or buy medicines for regular and complete treatment (Murthy, 2005). Our study's finding shows that lack of resources figures as an important factor for inability in availing mental health services. We found that rural patients and their family do not accesses mental health services due to their poverty. Another study

conducted in Delhi, Chennai and Lucknow by Desai et al, 2004. This study finding shows that 40% people do not availing mental health services due to poverty. This study identified that the major barriers in seeking care were identified to be economic problems and transport related problems. Findings of this study is somewhat similar our findings. This result shows that poverty is a strong barrier to seeking care. Because of lack of money people often are unable to go for any kind of treatment *viz* faith healing, private clinic or government hospital. Though Government hospital provides services for free of cost, there are other costs associated such as cost of travel. Therefore poor people do not utilize available services.

Unmet Needs of Mental Health Services

The hospital data shows that there is shortage of mental health professionals in the hospital. The lack of mental health professional also is a concern raised by the patients and their family. The complaints related to lack of professional were present more amongst female patients and patients coming from rural areas compared to male and those who are from urban areas. Hospital data shows that Bareilly Mental Hospital has deficit of mental health professionals and some mental health professionals are not available such as clinical psychologist, psychiatric social worker. Female patients and rural patients have more complaints related to quality of providers (interaction, time of consultation) compared to male and urban patients. Hospital data shows that Bareilly Mental Hospital does not have any specialist services (rehabilitation, special service for drug abuse etc). There were also concerns about quality of services. One urban male patient complains about poor quality of food and lack of proper cleanliness in the hospital. Our findings agree with Desai et al, (2004) and Thirunavukarasu and Thirunavukarasu, (2010) studies. Mental health services have lacunae in terms of professionals and specialist services.

Suggestion for Improvement

Mental health services need improvement at various levels such as mental health personnel and specialist services. There is a need to improve utilization and accessibility of mental health services and also to improve awareness about mental health and mental health services. As similar to Desai et al (2004) study, our study finding shows that only educated patients / patient's family and providers (doctors, nurses, attendants, pharmacist and other hospital staff) have given suggestions for improvement of mental health services of BMH in terms of mental health professionals, specialist services (rehabilitation, specialist services for drug abuse) and improvement in awareness about mental illness and mental health services.

Conclusion

The following conclusion is drawn about the mental health services in Uttar- Pradesh: a case study of Bareilly Mental hospital. A finding of our study helps to describe the condition of mental health services and people's perception about mental health and mental health services. Our study shows that global burden of mental disorders is high as well as other organic and non communicable disease in India and particularly Uttar-Pradesh. Despite of high prevalence of mental illness government pay less attention on mental health and mental health services compare to other health services. Our finding shows that there is a notable human resources deficit on all levels and also lack of availability of specialist services and rehabilitations for severe and mild patients. Due to shortage of staff and specialist services people are not satisfied after treatment at Bareilly Mental Hospital. Some people have bad experiences about mental health services like doctor, pharmacist and attendants' behaviour. Due to this people have negative perception about mental illness and its treatment also. Mental illness and mental health services are also attached with stigma because of which people do not want to accept mental illness as an illness. Our study shows gender discrimination in the context of availing mental health services. Due to this gender discrimination female patients opt for faith healing compared to male patients. Our finding also shows differences in the context of treatment seeking, stigma and suggestions for improvement in health care between high education and less educated people and place wise (rural and urban). Rural and

uneducated people do not have any knowledge about mental health and mental health services and therefore they delay in availing any formal mental health services. Some educated patients and their family also give some suggestions for improvement in mental health services. However it is indeed important that Government plan for an active policy planning and implementation for increase in human resources and specialist mental services for mild and severe patients with mental illness. Government should be implementing educational program for mental health and mental health services as well so that awareness is generated and more and more people opt for treatment.

Bibliography

1. Addlakha, R. (2008), "Deconstructing Mental Illness, An Ethnography of Psychiatry, Women, and the Family," Zubaan, New Delhi, pp.6-303.

2. Agarwal, S.P. et al (2004), "Mental Health an India Perspective (1946-2003)," Directorate General of Health Services Ministry of Health and Family Welfare, New Delhi, pp 75-125.

3. Almeida, J.M.C. and Killaspy, H. (2011), "Long- term Mental Health Care for People with Severe Mental Disorders", *European Union*, pp 1-20.

4. Banerjee, G. (2011), "Mental Hospitals and Healing Practices in Colonial India," Mental Health Review, as available on http://www.psyplexus.com/excl/mhhp.html as access on 6th May, 2012.

5. Bedell, J.R., Hunter, R.H. and Corrign, P.W. (1997), "Current Approaches to Assessment and Treatment of Person with Serious Mental Illness," *The International Journal of Psychosocial Rehabilitation*, Vol. 28, No.3, pp 217-228.

6. Chadda, R.K., Agarwal, U., Singh, C.M. and Raheja, D. (2001), "Help Seeking Behaviour of Psychiatric Patients Before Seeking Care at a Mental Hospital", *International Journal of Social Psychiatry*, Vol. 47, No.4, pp.71-78.

7. Chakravarti, U. (2002), "Is' Suffering inevitable? State, Society and Disability," Unpublished M. Phil Dissertation, Jawaharlal Nehru University, New Delhi.

8. Chladsinska, K.S. et al (1997), "Psycho-Education in Schizophrenia Relapse Prevention", *Indian Journal of Psychiatry*, Vol.31, No.5, pp 595-606.

9. Corrigan, P.W. and Watson, A.C. (2002), "Understanding the impact of Stigma on People with Mental Illness," *World Psychiatry*, pp 16-17.

10. Corrigan, P.W, Markowitz, F.E and Watson, A.C. (2004), "Structural Levels of Mental Illness Stigma and Discrimination," *Schizophrenia Bulletin*, Vol. 30, No.3, pp. 481-488.

11. Curtis, S., Gesler, W., Fabian, K. et al (2007), "Therapeutic Landscapes in Hospital Design: A Qualitative Assessment by Staff and Service Users of the Design of a new Mental Health Inpatient Unit," *Environment and Planning: Government and Policy,* Vol. 25, pp.591-610.

12. Das, P.P. et al (2008), "International Self-Harm Seen in Psychiatric Referrals in a Tertiary Care Hospital," *Indian Journal of Psychiatry,* Vol.50, No.3, pp187-190.

13. Desai N.G, and et al. (2004), 'Urban Mental Health Services in India: How Complete or Incomplete*? Indian Journal of Psychiatry*, Vol 46, No.3, pp195-213.

14. Dinos, S., Stevens, S., Serfaty, M. et al (2004), "Stigma: The feelings and Experiences of 46 People with Mental Illness: Qualitative Study," *The British Journal of Psychiatry,* Vol. 184, pp.176-181.

15. Dube, K.C**.** (1970), 'A study of prevalence and biosocial variation in mental illness in a rural and urban community in Uttar Pradesh, *Act a Psychiatric Scandivica*. Vol.46, pp 32.

16. Exworthy, M. and Powell, M. (2012), "Shaping Health Policy: Case Study Methods and Analysis (ed) Exworthy, M et al, University of Bristol, pp.4-5.

17. Gandotra, S. and et al (2004), "A Preliminary Study of Rehabilitation Needs of In-Patients and Out-Patients with Schizophrenia," *Indian Journal of Psychiatry*, Vol. 46, No.3, pp 244-255.

18. Ganguli, H.C. (2000), 'Epidemiological findings on prevalence of mental disorders in India, *Journal of psychiatry,* Vol.42, No 1, pp 14-20.

19. Gautam, S., Gupta, I.D. and Batra, L. et al (1998), "Psychiatric Morbidity among Victims of Bomb Blast," *Indian Journal of Psychiatry,* Vol.40, No.1, pp.41-45.

20. Goldberg, D., Mubbashar, M. and Mubbashar, S. (2000), "Development in Mental Health Services-A World View", *International Review of Psychiatry,* Vol. 12, No.3, pp.240-248.

21. Government of India (2010), "Draft Mental Health Care Act," Ministry of Health and Family Welfare, New Delhi.

22. Gururaj, G., Girish, N. and Isaac, M.K. (2005), "Mental neurological and substance abuse disorders: strategies towards a systems approach, *NCMH background papers- Burden of disease in India,* pp 228-235.

23. http://www.censusindia.gov.in/maps as access on 27th April, 2012.

24. Jacob, K.S. (2001), "Community Care for People with Mental Disorders in Developing Countries: Problems and Possible Solutions," *British Journal of Psychiatry,* Vol.178, pp. 296-298.

25. Jain, S. (2003), "The Confinement of the Insane: International Perspective, 1800-1965 (ed) Porter, R. and Wright, D., Cambridge University, New York, pp. 273-298

26. Jorm, A.F. (2000), "Mental Health Literacy: Public Knowledge and Beliefs about Mental Disorders," *The British Journal of Psychiatry,* pp 396-401.

27. Kale, S. (2010), "Emerging issues in health," (ed) Mahal, A. and et.al, India Health Report, as available on www.indicus.net/media/index.php/booksandrsports/1584-India-health-report-2010 as accessed on 16th September, 2011.

28. Karkeila, J.A and et al (1998), "Frequently Hospitalized Psychiatric Patients: A Study of Predictive Factors, *Social Psychiatry and Psychiatric Epidemiology*. Pp.67-89

29. Krishnamurthy, K., Venugopal, P. and Alimchandani, A.K. (2000), "Mental Hospital in India," *Indian Journal of Psychiatry*, Vol.42, No.2, pp 125-132

30. Kumar, A. (2004), 'History of mental health services in India, *Journal of Personality and Clinical Studies*, pp 171-180

31. Kumar, A. (2005), 'District mental health program in India: a case study, *Journal of Human and Development*, Vol 1, pp 2-8

32. Kumar, K.V.K., et al (2008), "Mental Health Care in Primary Care for Medical Officers my Work Book," National Institute of Mental Health and Neuro Sciences, Bangalore.

33. Latha, K.S and Shankar, R. (2011), 'Hospital related stress among patients admitted to a psychiatric in-patient unit in India," *Online Journal Health Allied Sciences, as available on* http://www.ojhas.org/issue37/201 as access on 16th May, 2012, Vol.10

34. Malik, S.C. (2004), "Mental Health Program and Legislation in India: Some Observations and Experiences," *India Journal of Psychiatry*, Vol.46, No.1, pp 15-14.

35. Manchanda, M and Manchanda, R. (1978), "Neuroses in Children: Epidemiological Aspects," *Indian Journal of Psychiatry*, Vol. 20, pp. 161-165.

36. Markes, I. M. and et al (1994), "Home Based Versus Hospital-Based Care for People with Serious Mental Illness as available on http://bip.rcpsych.org/content/165/2/179.short as access on 5th May, 2012.

37. Martin, J.K., Pescosolido, B.A. and Tuch, S.A. (2000), "Of Fear and Loathing: The Role of 'Disturbing Behaviour, ' Lables, and causal Attributions in Shaping Public Attitudes toward People with Mental Illness," *Journal of Health and Social Behaviour*, pp. 14-28

38. Math, S.B and Srinivasaraju, R. (2010), "Indian Psychiatric Epidemiological Studies: Learning from the Test," *Indian Journal of Psychiatry*, Vol.52 January, pp 95-98.

39. Math, S.B., Murthy, P. and Chandrashekar, C.R. (2011), "Mental Health Act (1987): Need for a Paradigm Shift from Custodial to Community Care," *Indian Journal of Medical Research*, Vol. 133, pp. 246-249

40. Medical and Health Department, Lucknow (2010), "Regional Review Meeting of National Mental Health Programme," held at Agra, U.P. pp. 1-60.

41. Mishra, R.K. (2003), "*Mental Health and Public Health Some Methodological Issues,*" Unpublished M. Phil. Dissertation, Jawaharlal Nehru University, New Delhi.

42. Mishra, M. (2006), "Gendered Vulnerabilities: Women's Health and Access to Health Care in India," Center for Enquiry in to Health and Allied Themes (CEHAT), Mumbai, pp1-49.

43. Murali, M.S. (2012), “Epidemiological Study of Prevalence of Mental Disorders in India,” *Indian Journal of Community Medicine*, Vol. 26, No.4

44. Murthy, R.S. (1989), “National Mental Health Program in India (1982-1989) Mid-Point Appraisal,” *Indian Journal of Psychiatry*, Vol.31, No.4, pp 267-270.

45. Murthy, R.S. (2004), “Mental Health in the New Millennium: Research Strategies for India,” *Indian Journal Medical Research,* No.120, pp. 63-66.

46. Murthy, R.S. et al (2005), “Mental Health Care by Primary Care Doctors,” National Institute of Mental Health and Neuro-Sciences, Bangalore, as available on http://www.nimhans.kar.nic.in/dmhp/manuals/man1.pdf as access on 20th April, 2012, pp 1-218.

47. Murthy, R.S. (2011), “Mental Health Initiatives in India (1947-2010), “*The National Medical Journal of India,* Vol. 24, No.2, pp 26-34.

48. Nagpal, S. J. S. et al (2011), “Changing Trends of Services Used as First Contact by Patients with Mental Health Problems,” *National Medical Journal of India,* Vol.24, No.3, pp.148-150.

49. Nambi, S.K., Prasad, J., Singh, D. et al (2002), “ Explanatory Models and Common Mental Disorders among Patients with Unexplained Somatic Symptoms Attending a Primary Care Facility in Tamil Nadu,” *The National Medical Journal of India,* Vol.15, No.6, pp 331-335.

50. National mental health profile (2005), “Central Bureau of Health Intelligence, Directorate General of Health Services.

51. Nizamie, S.H. and Goyal, N. (2010), “History of Psychiatry in India, *Indian Journal of Psychiatry,* Vol. 52, pp 7-11.

52. Olenja, J.M. (2003), "Health Seeking Behaviour in Context," *East African Medical Journal,* Vol. 80, No. 2, pp. 61-62

53. Padmavati, R. (2005), ''Community Mental Health Care in India, *International review of psychiatry,* Vol.17, No.2, pp103-106.

54. Pal, D.K., Das, T., Sengupta, S. and Chaudhury, G. (2002), "Help-seeking Patterns for Children with Epilepsy in Rural India: Implications for Service Delivery," *Epilepsia,* Vol.43, pp.904-911.

55. Pattison, S. and Armitage, P. (1986), "An Ethical Analysis of the Policies of British Community and Hospital Care for Mentally Ill People," *Journal of Medical Ethics,* Vol.12, pp-136-142.

56. Pereira, Y.D.S et al (2002), "Geriatric Patients Attending Tertiary Care Psychiatric Hospital," *Indian Journal of Psychiatry,* Vol.44, No.4, pp. 326-33.

57. Pillai, R.R.(2010), "Rehabilitation Needs with Major Mental Illness in India, *International Journal of Psycho-social Rehabilitation,* Vol.14, No.2, pp 95-104.

58. Prince, M. et al (2007), "No Health without Mental Health," *Lancet,* pp. 859-77.

59. Ptammatter, M. and et al (2000), 'Vocational rehabilitation in chronic mental illness. The current passion, *Fritsch neural psychiatry,* No.2, pp.61-69.

60. Reddy, M.V and Chandrasekhar, C.R. (1998), 'Prevalence of mental and behavioral disorders in India: a meta-analysis, *Indian Journal of psychiatry,* Vol.40, No.2, pp 149-152.

61. Ruuzanna, Z. et al (2010), 'Does psycho education improve insight of patients with Schizophrenia? *Malaysia Journal of Psychiatry,* Vol.19, No.2.

62. Sarojini, N.B. et al (2006), “Women’s Right to Health,” National Human Right Commission, New Delhi, pp. 9-133

63. Saxena, S. et al (2007), ‘Resources for mental health: scarcity, inequity and inefficiency, *Lancet*, Vol.370, pp 878-881.

64. Sethi, B.B. and Gupta, S.C. (1972), “A Psychiatric Survey of 500 Rural Families,” *Indian Journal of Psychiatry*, Vol.14, pp. 183-196

65. Sethi, B.B., Gupta, S.C., Mahendru, R.K. and Kumari, P. (1974), “Mental Health and Urban Life: A Study of 850 Families,” *The British Journal of Psychiatry*, Vol. 124, pp. 243-246.

66. Sharma, S. (1990), ‘Mental hospital in India, *Directorate General of Health Services, New Delhi.*

67. Skeate, A., Jackson, C., Birchwood, M. and Jones, C. (2002), “Duration of Untreated Psychosis and Pathways to Care in First- Episode Psychosis: Investigation of Help-Seeking Behaviour in Primary Care, “ *The British Journal of Psychiatry*, Vol.181, pp.73-77.

68. Somasundaram, O. (1987), “The Indian Lunacy Act, 1912 The Historic Background,” *Indian Journal of Psychiatry*, Vol. 29, No.1, pp. 3-14.

69. Tenth five year plan (2002-07), ‘Planning Commission Government of India, New Delhi, pp126-130.

70. Thacore, V.R, Gupta, S.C and Suralya, M. (1975), ‘Psychiatric morbidity in a north India community, *British Journal of Psychiatry*, Vol.126, pp.364-369.

71. Thara, R., Padmavati, R., Aynkran, J.R and John, S. (2008), “Community Mental Health in India: A Rethink,” *International Journal of Mental Health Systems*, pp. 1-7.

72. Thirunavukarasu, M. and Thirunavukarasu, P. (2010), “Training and National Deficit of Psychiatrists in India-A Critical Analysis, “*Indian Journal of Psychiatry,* Vol.52, pp83-84.

73. Thornicraft, G. and Tansella, M. (2003), “What are the arguments for Community –Based Mental Health Care?,” *World Health Organization Regional Office for Europe’s, Health Evidence Network (HEN),* pp.4-10

74. Tiwari, S.C. and Srivastava, S. (1998), “Geropsychiatric Morbidity in Rural Uttar-Pradesh,” *Indian Journal of Psychiatry,* Vol.40, No.3, pp.266-273

75. Tiwari, S.C., Sitholey, P. and Sethi. B.B (1999), “Mental Health Care: Perceptions and Expectations of Rural Population in Uttar-Pradesh- A Brief Report,” *Indian Journal of Psychiatry,* Vol.41, No.1, pp. 37-41.

76. Tiwari, S.C. and Pandey, N.M. (2012), “Status and Requirements of Geriatric Mental Health Services in India: An Evidence-based Commentary,” *Indian Journal of Psychiatry,* Vol.54, No.1, pp.8-14.

77. Trivedi, J.K. (2002), “Urbanization and Mental Health: A New Challenge,” *Indian Journal of Psychiatry*, Vol. 44, No. 1, pp. 1-2.

78. Wirth, J.H and Badenhavsen, G.V.(2009), “ The Role of Gender in Mental-Illness Stigma,” *Association for Psychological Science,* pp 1-5.

79. World Health Organization (2005), “Mental Health Atlas”, WHO, Geneva, pp1-552.

80. World Health Organization**,** (2001), Atlas: Country profile**,** WHO, Geneva.

81. World Health Organization (2006), "WHO-AIMS Report on Mental Health System in Uttarakhand, India," Regional Office for South East Asia: WHO.

82. www.census2011.co.in as access on 16th May, 2012.

83. www.nlrindia.org/index.php?section-12&categery=60uttarpradesh&page=496 as access on 16th May, 2012.

84. Ustun, T.B. (1999), "The Global Burden of Mental Disorders," *American Journal of Public Health*, Vol. 89, No. 9, pp. 1315-1318.

Appendix

Appendix: 1

A.1.1: Number of Patient in the State Suffering from Severe and Common Mental Disorders and how Many Cases Treated by Medical College, Psychiatric Hospital and other Facilities.

Categories	No. of persons in the state	No. being treated in psychiatric hospitals	No. being treated in Med. College dept of psych.(only from 4medical college)	No. being treated in other facilities
Severe mental disorders (Psychosis, bipolar disorders)	95787	25510	29033	41254
Common mental disorders	137124	19228	41879	76011

Source: (Regional Review Meeting of National Mental Health Program, 2010, pp.3).

A.1.2: Service Available in the Uttar Pradesh

Categories	No. of hospitals
1: Government psychiatric hospitals	3
2: Private psychiatric hospitals	13

Source: (Regional Review Meeting of National Mental Health Program, 2010, pp.3).

A.1.3: Training of Mental Health Professionals per Year

No. of college and seats	Total number
1: No of medical college in the State	9
2: Annual no of MD psychiatry seats	14
3: Annual no of DNB seats	02
4: Annual number of DPM seat	01

Source: (Regional Review Meeting of National Mental Health Program, 2010, pp.3).

A. 1.4: Training of Human Resources under District Mental Health Program

Human resources	Total number
Health worker	10
Staff nurse	136
Pharmacist	29
School teacher	434
A.W.W.	61
Member of Gram panchayat	31
Medical officer	155

Source: (Regional Review Meeting of National Mental Health Program, 2010, pp.3).

A.1.5: Availability of Human Resources in Government and Private Sector in the State

Human recourses	Government sector	Private sector
Total no of psychiatrists	20	206
Total no of clinical psychologists	15	100
Total no of psychiatric social worker	45	100

Source: (Regional Review Meeting of National Mental Health Program, 2010, pp.3).

Appendix: 2

Mental Health Services in Uttar- Pradesh: A Case Study of Bareilly Mental Hospital

M.Phil Dissertation Research Project

Semi- Structure Interview Schedule

A.2.1: Semi- structure Interview Schedule for IPD patients

Personal information of patient:

1: Case no: 2: Age: 3: Gender

4: Marital status 5: qualification: 6: Address:

7: Diagnosis: 8: Number of visit:

9: Duration of hospitalization:

1: What is your problem?

2: From where did you know about Bareilly mental hospital and did you visit any other institute before it, what made you to come here?

3: How is the behavior of staff members and doctors, does providers giving you enough time to discuss your queries?

4: What are the processes for hospitalization?

5: Doctors give you more medicine or less and how do you feel after consuming it?

6: Do you feel comfortable here, how is the food facilities?

7**:** Do you want to stay here or you want to go back to the family?

8: Dose your family members come along with you for the treatment, and how is the behavior of family members towards you?

9: What is your work schedule per day?

10: Who serve food and cook food for patients?

11: What is the food menu of one week?

12: What are the timing of breakfast, lunch and dinner?

A.2.2: Semi- structure Interview Schedule for OPD Patients

Personal information of patient:

1: Case no: 2: Age: 3: Gender

4: Marital status 5: qualification: 6: Address:

7: Diagnosis: 8: Number of visit:

1: What is your problem?

2: Did you come for the first time or other?

3: From where did you know about Bareilly mental hospital and did you visit any other institute before it, what made you to come here?

4: How long you have to stand for registration, do you have to wait for a long time for meeting the doctor and do you think this procedure is difficult?

5: How is the behavior of staff members and doctors, does providers giving you enough time to discuss your queries?

6: Doctors give you more medicine or less and how do you feel after consuming it?

7: What you have to go to private pathology center for testing?

9: Doctors prescribe medicine for how much days?

10: How much medicine you have to purchase from private medical shop?

A.2.3: Semi- structure Interview Schedule for Family Member of IPD Patients (family ward)

Personal information of the patient

1: Case no: 2: Age: 3: Gender

4: Marital status 5: qualification: 6: Address:

7: Diagnosis: 8: No of visit:

9: Duration of hospitalization:

Personal information of the informant

1: Name: 2: Age: 3: Gender:

4: Relation with the patient:

1: What is your problem?

2: What relation do you have with the patient?

3: From where did you know about Bareilly mental hospital and did you visit any other institute before it, what made you to come here?

4: How long you have to stand for registration, do you have to wait for a long time for meeting the doctor, what is the process for hospitalization and do you think this procedure is difficult?

5: How is the behavior of staff members and doctors, does providers giving you enough time to discuss your quarries?

6: Doctor provides more medicine or less and how do the patient feel after consuming it, do you observe any improvement?

7: What is your opinion about the treatment procedure like medicating, counseling shock therapy etc?

8: Do you think patient is comfortable here, how is the food facilities?

9: Who serve food and cook food for patients?

10: What is the food menu of one week?

11: What are the timing of breakfast, lunch and dinner?

12: Where do you live and eat?

13: How much medicine you have to purchase from private medical shop?

14: What you have to go private pathological center for testing or these services available in this hospital?

15: What do you think about facilities of this Bareilly Mental Hospital?

A. 2.4: Semi- structure Interview Schedule for Family Member of OPD Patients

Personal information of the patient

1: Case no: 2: Age: 3: Gender

4: Marital status 5: qualification: 6: Address:

7: Diagnosis: 8: No of visit:

9: Duration of hospitalization:

Personal information of the informant

1: Name: 2: Age: 3: Gender:

4: Relation with the patient:

1: What is your problem?

2: What relation do you have with the patient?

3: From where did you know about Bareilly mental hospital and did you visit any other institute before it, what made you to come here?

4: How long you have to stand for registration, do you have to wait for a long time for meeting the doctor, and do you think this procedure is difficult?

5: How is the behavior of staff members and doctors, does providers giving you enough time to discuss your quarries?

6: Doctor provides more medicine or less and how do the patient feel after consuming it, do you observe any improvement?

7: What is your opinion about the treatment procedure like medicating, counseling shock therapy etc?

8: How much medicine you have to perches from private medical shop?

9: What do you think about facilities of this Bareilly Mental Hospital?

10: What you have to go private pathological center for testing or these services available in this hospital?

A.2.5: Semi- structure Interview Schedule for Doctors

Personal information of Doctor

1: Name: 2: Gender: 3: Qualification:

4: Designation: 5: Period of work:

1: What all kind of mentally ill person visits in this hospital and with what symptoms?

2: They are come from which part of India rural or urban?

3: What is their economic, social, cultural background?

4: What kind of difficulty do you face to handle these patients?

5: What is the opinion of patients regarding drugs, they want more or less?

6: What kinds of patients are given shock therapy and what is the opinion of patients and patient's family members for the same, how far it is successful?

7: Are family members willing to participate in the treatment process, if not how do you convince them?

8: What is your experience regarding taking consent of the patient for the treatment, or parent's consent for behalf of patients?

9: What is the strength of staff members in the hospital and your opinion regarding the proportion of staff members and patients?

10: Is the budget that is sanctioned by the government for this hospital enough for its requirement?

11: How are the facilities available here? Is the need for any improvement?

12: If patient needs to come back for treatment again, do they prefer to this hospital and any other?

13: According to you what is the cure rate here?

14: Has people’s awareness about mental health and mental health services increased from the past?

15: What are your working schedule and your work as a Doctor for OPD and IPD patients?

16: How many you have to visit in wards per week?

17: What are the difficulties you have to face during your working period?

A.2.6: Semi- structure Interview Schedule for Nurses

Personal information of Nurse

1: Name: 2: Gender: 3: Qualification:

4: Designation: 5: Period of work:

1: What kind of mentally ill person visit in this hospital?

2: They are come from which part of India rural or urban?

3: What is their economic, social, cultural background?

4: What kind of difficulty do you face to handle these patients?

5: Do you think there is need for any other facility for female patients?

6: What are the facilities available for female patients when they having period?

7: What do you think about this hospital's facilities? Is the need for any improvement?

8: What is the strength of staff members in the hospital and your opinion regarding the proportion of staff members and patients?

9: What do you think after treatment in this hospital patients satisfied or not?

10: What are the facilities available in this hospital for any emergency?

11: What are the problems you have to face in this hospital during your working period?

12: What are the responsibilities for IPD and OPD patients as a nurse?

13: What is your working schedule?

A.2.7: Semi- structure Interview Schedule for Ward Attendees

Personal information

1: Name: 2: Gender: 3: Qualification:

4: Designation: 5: Period of work:

1: Patients are come from which part of India rural or urban?

2: What is their economic, social, cultural background?

3: What kind of difficulty do you face to handle these patients?

4: What do you think after treatment in this hospital patients satisfied or not?

5: What are the facilities available in this hospital for any emergency?

6: Do you think available staff members are sufficient for this hospital or not?

7: What do you think about this hospital's facilities? Is the need for any improvement?

8: If patient needs to come back for treatment again, do they prefer to this hospital and any other?

9: Are you trained for handle severe patient?

10: What are the food facilities available for IPD patients and who are serving and cook food for the patients?

11: What are the problems you have to face in this hospital during your working period?

12: What are your working schedule and your work responsibilities for OPD and IPD patients?

A.2.8: Semi- structure Interview Schedule for Pharmacist

Personal information

1: Name: 2: Gender: 3: Qualification:

4: Designation: 5: Period of work:

1: What are the medicines available for OPD and IPD patients?

2: How much medicine provide to OPD patients regarding prescription?

3: How much medicine patients have to purchase from private medical shop?

4: How much medicine provide to OPD patients for how many days?

5: How much budget available for drug, is it sufficient or not?

6: What are your responsibilities for IPD and OPD patients?

7: How many registers you have to maintain?

8: What is your working schedule?

9: What are the problems you have to face during your working period?

A.2.9: Semi- structure Interview Schedule for Lab-technician

Personal information

1: Name: 2: Gender: 3: Qualification:

4: Designation: 5: Period of work:

1: What is the pathological testing available?

2: How much charge patient have to pay for testing?

3: How much budget available for pathology center, is it sufficient or not?

4: What are your responsibilities for IPD and OPD patients?

5: What is your working schedule?

6: What do you think these pathological testing sufficient for the patients?

7**:** What are the problems you have to face during your working period?

Appendix 3

A.3.1: Respondents' First Place of Presentation (religion, gender and place of residence)

First source	Religion			Total	Gender		Total	Place of residence		Total
	Hindu	Muslim	Other		M	F		Rural	Urban	
Private clinic	1*			**1**	1*		**1**		1*	**1**
Private psychiatric clinic	1	1		**2**	2		**2**	1	1	**2**
Government Mental Hospital	1	1		**2**	1	1	**2**	1	1	**2**
Faith healer	2	1,1*	1	**5**	1	3, 1*	**5**	2,1*	2	**5**
Total	**5**	**4**	**1**	**10**	**4**	**6**	**10**	**5**	**5**	**10**

Note-* IPD patients

A.3.2: Respondents' Choice of Psychiatric Hospital as First Place of Presentation (diagnosis and education)

First source	Diagnosis			Total	Education				Total
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary -matric	Inter-graduation	Postgrad-above	
Private clinic	1*			**1**			1*		**1**
Private psychiatric clinic	1		1	**2**			1	1	**2**
Government Mental Hospital	1	1		**2**	1		1		**2**
Faith healer	2,1*	2		**5**	1*	4			**5**
Total	**6**	**3**	**1**	**10**	**2**	**4**	**2**	**1**	**10**

Note-* IPD patients

A.3.3: Place of First Visit/ First Source of Treatment and Reasons for Choice of Place of First Visit:

Reasons for choice	**First visit/source of treatment**				**Total**
	Private Practitioner / clinic (general)	Private psychiatric clinic	Government mental hospital	#Faith healer	
Family reputation				3	**3**
Cost of care			1		**1**
Attitude of providers		2			**2**
Believe system#				3, 1*	**4**
Convenience	1*				**1**
Good reputation			1		**1**
Total	**1**	**2**	**2**	**5**	**10**

Faith healer – " Ojha" "Tantrik", perform religious activities

* IPD patients

A.3.4: Reason for Choice of Place of First Visit (religion, gender and residence place)

Reason for choice of	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**To tal**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Family reputation	1	1	1	**3**	1	2	**3**	2	1	**3**
Cost of care		1		**1**		1	**1**	1		**1**
Attitude of providers	1	1		**2**	1	1	**2**	1	1	**2**
Believe system	2	1,1*		**4**	1	2,1*	**4**	2,1*	1	**4**
convenience	1*			**1**	1		**1**		1	**1**
Good reputation	1			**1**	1		**1**		1	**1**
Total	**7**	**5**		**12**	**5**	**7**	**12**	**7**	**5**	**12**

Note-This table shows, total no of respondents more than ten because of some respondents given multiple responses

* IPD patients

A.3.5: Reason for Choice of Place of First Visit (diagnosis and education)

Reason	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Family reputation	1	**2**		**3**		3			**3**
Cost of care		1		**1**	1				**1**
Attitude of providers	1		1	**2**			1	1	**2**
Believe system	1,1*	2		**4**	1*	3			**4**
5.Convenience	1*			**1**			*1		**1**
6.Good reputation	1			**1**			1		**1**
Total	**6**	**5**	**1**	**12**	**2**	**6**	**3**	**1**	**12**

Note- This table shows, total no of respondents more than ten because of some respondents given multiple responses

* IPD patients

A.3.6: Time Taken to Seek Help for Mental Concerns (religion, gender and residence place)

Time duration	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
I-II week	3			**3**	3		**3**	2	1	**3**
III-IV week	1*	1,1*		**3**	1,1*	1*	**3**	1*	1,1*	**3**
V-VI week	1	1	1	**3**		3	**3**	1	2	**3**
VII-VIII week		1		**1**		1	**1**	1		**1**
Total	**5**	**4**	**1**	**10**	**5**	**5**	**10**	**5**	**5**	**10**

Note-* IPD patients

A.3.7: Time Taken to Seek Help for Mental Health Concerns (diagnosis and education)

Time duration	**Diagnosis**			**Total**	**Education**				**To tal**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
I-II week	2	1		**3**		1	1	1	**3**
III-IV week	2*		1	**3**	1*		1,1*		**3**
V-VI week	2	1		**3**		3			**3**
VII-VIII week		1		**3**	1				**1**
Total	**6**	**3**	**1**	**10**	**2**	**4**	**3**	**1**	**10**

Note-* IPD patients

A.3.8: Cause of Delay in Help Seeking for Mental Health Concerns (religion, gender and place of residence)

Reason	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Ignorance	3	1		**4**	4		**4**	2	2	**4**
Lack of awareness about mental illness and mental health services	2,1*			**3**	2,1*		**3**	2	1*	**3**
Lack of resources		1		**1**		1	**1**	1		**1**
Negative attitude about mental illness	1	1,1*	1	**4**		3,1 *	**4**	1,1*	2	**4**
Total	**7**	**4**	**1**	**12**	**7**	**5**	**12**	**7**	**5**	**12**

Note-This table shows, total no of respondents more than ten because of some respondents given multiple responses

* IPD patients

A.3.9: Cause of Delay in Seeking Help for Mental Concerns (diagnosis and education)

Cause of delay	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Ignorance	2	1	1	**4**		1	2	1	**4**
Lack of awareness about mental illness and mental health services	1,1*	1		**3**		1	1*	1	**3**
Lack of resources		1		**1**	1				
Negative attitude about mental illness	3	1*		**4**	1*	3			**3**
Total	**7**	**4**	**1**	**12**	**2**	**5**	**3**	**2**	**12**

Note-This table shows, total no of respondents more than ten because of some respondents given multiple responses

2-* IPD patients

A.3.10: Reason for Eventual Visit to Government Psychiatric Hospital (religion, gender and place of residence)

Reason	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Ineffective services#	3,1*	2,1*	1	**8**	4	4	**8**	4	4	**8**
Cost of care		1		**1**		1	**1**	1		**1**
Reputation	1			**1**	1		**1**		1	**1**
Total	**5**	**4**	**1**	**10**	**5**	**5**	**10**	**5**	**5**	**10**

Note-* IPD patients

Ineffective services – where patients had been visited before Bareilly Mental Hospital like (faith healing and any private general/ private psychiatric clinic) and they did not feel any improvement

A.3.11: Reason for Eventual Visit to Government Psychiatric Hospital (diagnosis and education)

Cause of delay	**Diagnosis**			**Total**	**Education**				**To tal**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Ineffective services	3,2*	**2**	**1**	**8**	1*	4	1,1*	1	**8**
Cost of care		1		**1**	1				**1**
Reputation	1			**1**			1		**1**
Total	**6**	**3**	**1**	**10**	**2**	**4**	**3**	**1**	**10**

Note-* IPD patients

A.3.12: Main Source of Information on Government Mental Health Care Services (religion, gender and place of residence)

Main source	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Family		1	1	**2**		2	**2**	1	1	**2**
Medical profession -al		1		**1**		1	**1**	1		**1**
Friend	4			**4**	3	1	**4**	2	2	**4**
Other patients	1*	1,1*		**3**	2	1*	**3**	1*	2	**3**
Total	**5**	**4**	**1**	**10**	**5**	**5**	**10**	**5**	**5**	**10**

Note-* IPD patients

A.3.13: Main Source of Information on Government Mental Hospital Care Services (diagnosis and education)

Main source	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Family	1	1		**2**		2			**2**
Medical professional		1		**1**	1				**1**
Friend	3	1		**4**		2	1	1	**4**
Other patients	2*		1	**3**	1		2		**3**
Total	**6**	**3**	**1**	**10**	**2**	**4**	**3**	**1**	**10**

Note-* IPD patients

A. 3.14: Reason for Delay in Accessing to Government Hospital (religion, gender and place of residence)

Reason for delay	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Stigma	1,1*	1,1*	1	**5**	1*	3,1*	**5**	1,1*	2,1*	**5**
Poverty		1		**1**		1	**1**	1		**1**
Ignorance	3	1		**4**	4		**4**	2	2	**4**
Total	**5**	**4**	**1**	**10**	**5**	**5**	**10**	**5**	**5**	**10**

Note-* IPD patients

A.3.15: Reason for Delay in Accessing to Government Hospital (diagnosis and education)

Cause of delay	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Stigma	2,2*	**1**		**5**	1*	3	1*		**5**
Poverty		1		**1**	1				**1**
Ignorance	2	1	1	**4**		1	2	1	**4**
Total	**6**	**3**	**1**	**10**	**2**	**4**	**3**	**1**	**10**

Note-* IPD patients

A.3.16: Mean Duration of Treatment with the Different Service Providers before Arriving in BMH (religion, gender and place of residence)

Months	**Gender**	**Private clinic general**			**Private psychiatric clinic**			**Government Mental hospital**			**Faith healer**			**Total**
		Religion			Religion			Religion			Religion			
		H	M	O	H	M	O	H	M	O	H	M	O	
1-5	M				1						1			**2**
	F										1	1		**2**
5-10	M					1								**1**
	F												1	**1**
10-15	M													
	F													
15-20	M	1												**1**
	F										1			**1**
20-25	M							1						**1**
	F													
Total		**1**			**1**	**1**		**1**			**3**	**1**	**1**	**9**

Note- one patient did not go for any kind of treatment before BMH

M- male, F- female, H- Hindu, M- Muslim and O- other

A.3.17: Mean Duration of Treatment with the Different Services before Arriving in BMH. (Place of residence and diagnosis)

Months	**Place**	**Private clinic**			**Private psychiatric clinic**			**Government Mental hospital**			**Faith healer**			Total
		P1	N2	D3	P1	N2	D3	P1	N2	D3	P1	N2	D3	
1-5	R				1							2		3
	U										1			1
5-10	R										1			1
	U						1							1
10-15	R													
	U	1									1			2
15-20	R													
	U													
20-25	R													
	U							1						1
Total		**1**			**1**		**1**	**1**			**3**	**2**		9

Note- one patient did not go for any kind of treatment before BMH

R- rural, U-urban, P1-psychotic, N2-neurotic and D3-drug abuse

A.3.18: Respondent's Perception about Mental Health Services (religion, gender and place of residence)

Perception about mental health services	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Negative attitude about mental hospital	4	3	1	**8**	3	5	**8**	2	6	**8**
Side effect of psychiatric medicine	5	4	1	**10**	5	5	**10**	5	5	**10**
Side effect of ECT	1			**1**	1		**1**		1	**1**
Ineffective psychiatric treatment	4	2		**6**	2	4	**6**	2	4	**6**
Negative attitude for psychiatric providers		1	1	**2**		2	**2**	1	1	**2**
6-Cost of care		1		**1**		1	**1**	1		**1**
Total	**14**	**11**	**3**	**28**	**11**	**17**	**28**	**11**	**17**	**28**

Note- This table shows, total no of respondents more than ten because of some respondents given multiple responses

A.3.19: Respondent's Perception about Mental Health Services (diagnosis and education)

First source	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Negative attitude about mental hospital	4	3	**1**	**8**	2	4	2		**8**
Side effect of psychiatric medicine	6	3	1	**10**	2	4	3	1	**10**
Side effect of faith healing	1			**1**			1		**1**
Ineffective psychiatric treatment	4	1	1	**6**	1	3	2		**6**
Negative attitude for psychiatric providers	1	1		**2**		2			**2**
Cost of care		1		**1**	1				**1**
Total	**16**	**9**	**3**	**28**	**6**	**13**	**8**	**1**	**28**

Note- This table shows, total no of respondents more than ten because of some respondents given multiple responses

A.3.20: Gap/Unmet needs (gender, religion and place)

Reason for delay	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Quality of providers	2		1	**3**	1	2	**3**	2	1	**3**
Lack of mental health professional	2	2		**4**	1	3	**4**	3	1	**4**
Lack of specialist services	1	1		**2**	2		**2**		2	**2**
Quality of services	1			**1**	1		**1**		1	**1**
Total	**6**	**3**	**1**	**10**	**5**	**5**	**10**	**5**	**5**	**10**

A.3. 21: Gaps/ Unmet need (diagnosis and education)

Cause of delay	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Postgrad-above	
Quality of providers	3			**3**	1	1		1	**3**
Lack of mental health professional	1	3		**4**	1	3			**4**
Lack of specialist services	1		1	**2**			2		**2**
Quality of services	1			**1**			1		**1**
Total	**6**	**3**	**1**	**10**	**2**	**4**	**3**	**1**	**10**

A.3.22: Suggestion for Improvement in Services and Utilization of Mental Health Services (gender, religion and place)

Suggestion	**Religion**			**Total**	**Gender**		**Total**	**Place of residence**		**Total**
	Hindu	Muslim	Other		M	F		Rural	Urban	
Create awareness	2	1	1	**4**	2	2	**4**	2	2	**4**
Quality of care and treatment	3	1		**4**	4		**4**	1	3	**4**
Improve availability	1	2		**3**		3	**3**	2	1	**3**
Total	**6**	**4**	**1**	**11**	**6**	**5**	**11**	**5**	**6**	**11**

A.3.23: Suggestion for Improvement in Services and Utilization of Mental Health Services (diagnosis and education)

Suggestion for improvement	**Diagnosis**			**Total**	**Education**				**Total**
	Psychotic	Neurotic	Drug abuse		Illiterate	Primary-metric	Inter-graduation	Post grad-above	
Create awareness	2,1*	**1**		**4**	1*	2	1		**4**
Quality of care and treatment	2,1*		1	**4**			2,1*	1	**4**
Improve availability	1	2		**3**	1	2			**3**
Total	**7**	**3**	**1**	**11**	**2**	**4**	**4**	**1**	**11**

Note-This table shows, total no of respondents more than ten because of some respondents given multiple responses

* IPD patients