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Pathways to Psychiatric Care – A Study from Tertiary Level General Hospital of Western India

KEYWORDS: Pathways to Care, Major Psychiatric disorders, General Hospital

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ABSTRACT *Background: Early diagnosis and prompt treatment is essential for effective management of psychiatric disorders. Understanding patterns of consultation and factors affecting it help us in achieving it.*

Aim: To study the help seeking patterns and pathways traversed by psychiatric patients.

Settings and Design: A general hospital based cross sectional qualitative study of patients visiting out-patient department / emergency setting for the first time.

Methods and Material: 50 patients with major mental illness were assessed using a semi-structured questionnaire to study patterns of previous consultations and experiences with them.

Statistical Analysis used: Mean, t test and chi-square test were used for quantitative data and pooled responses for qualitative data.

Results: Treatment by traditional healers & family doctors is preferred but unsuccessful whereas psychiatric treatment is effective and satisfactory but largely unavailable, costly and distant.

Conclusions: The unmet needs of psychiatric patients demand an effective change in the mental health care service delivery system.

INTRODUCTION:

India with a heterogeneous socio-demographic profile has variety of cultural, religious, traditional beliefs and customs influencing the health seeking behaviors of patients with mental illnesses. Relative shortage of trained mental health professionals, along with cultural factors has led to predominant involvement of traditional healers and non-psychiatric doctors in the care of mentally ill.

On the other side, there is relative paucity of literature on 'Pathways to Care' and treatment-seeking behaviors of individuals with major psychiatric illness have not been investigated.[1] Research related to help seeking behavior and attitude toward mental illnesses and services which primarily determine the pathway of care has been carried out mainly in developed nations. There is, however, deficiency of information from the developing countries.[2]

It is important to know why / how do people reach / do not reach psychiatric services. An understanding of the way in which people seek care for mental disorders is important for planning mental health services, for the organization of training and for the organization of referrals to psychiatrists from other sources of health and social care.[3]

This study was carried out with an aim to study help-seeking patterns in patients with major psychiatric disorders, pathways people traverse to reach Psychiatric services and factors governing and affecting help-seeking.

MATERIAL AND METHODS:

It was a general hospital based cross sectional qualitative study of 50 subjects attending out patient or emergency services of Psychiatry department for the first time. All participants who met the diagnosis of a major psychiatric illness like Schizophrenia, Bipolar Mood Disorder (BMD) or Major Depressive Disorder (MDD) as per DSM-IV were explained about the purpose of the study and consent for voluntary participation.

Patients and care givers were interviewed using a semi-structured questionnaire to trace various persons and agencies seen en route from their first episode of psychiatric illness, their help seeking patterns and factors governing the same. The questionnaire focused on areas like socio demographic profile, clinical condition, time spectrum of illness, successive consultations (non-psychiatric & psychiatric) & experiences with them, reasons for delay in reaching psychiatric services, source of information about illness or treatment, Knowledge-Attitude-Behavior about mental illness and services, whether normalization is used as coping mechanism, their locus of control and coping styles.

Data was gathered and analyzed using Excel and Epi Info to generate results.

RESULTS and DISCUSSION:

A total of 50 patients/caregivers participated in the survey. Out of which majority were from urban area (70%) and belonging to middle socioeconomic class (81%). Family structure revealed an average family size of five persons with a good support system (primary care taker). In most of the cases, the primary earning member in the family was self followed by sibling, father & husband and the primary decision maker was father followed by mother & husband respectively.

Out of 50 participants, 24 (48%) had Schizophrenia, 17 (34%) had MDD and 9 (18%) had BMD.

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Table 1: Pattern of previous consultations (figures within the diagram) & successive consultations (percentage)

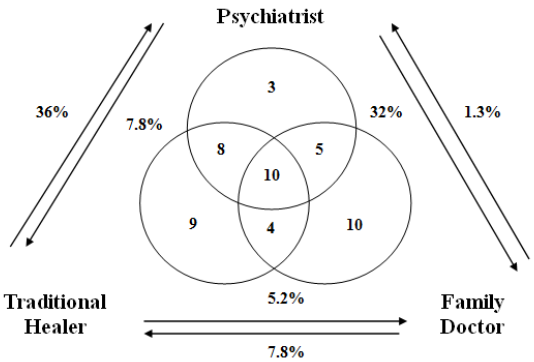

Table 1 shows the pattern of previous consultations, wherein 52%, 58% and 62% of patients had consulted Psychiatrists, Family Doctor (FD) or Traditional Healer (TH) in past either independently or in various combinations. On an average there were three previous consultations before the patient reached the psychiatric facility at tertiary care level general hospital setup. Multiple consultations with various practitioners and switching between them make it interesting to evaluate the reasons for the same. Surprisingly, the tendency to visit TH and psychiatrists were same, irrespective of age, sex, locality, religiosity or level of education.

Successive consultations among various practitioners (Table 1) revealed that 32% of patients visiting family doctor (20% are referred formally) and 36% of patients visiting a TH eventually consult a psychiatrist. Around 8% of patients visiting psychiatrist or FD shift to TH later on, 5% of patients visiting a TH shift to FD and hardly 1% reach a FD from a psychiatrist. The pattern shows that patients largely consulted each practitioners independently and switched among them but majority of them finally shift to psychiatrists and stay with them. This shows a positive trend towards acceptance and efficacy of psychiatric treatment / facilities.

In line with previous studies, co-consultations of TH with psychiatrist and various THs were a common phenomenon observed in 14% of cases.

Among the first ones to be consulted, TH and FD were consulted in 40% of the cases each and psychiatrists in 20% of cases. FD and psychiatrists were first consulted more commonly in MDD and TH in case of Schizophrenia and BMD ($p<0.01$). In previous studies, first contact with Psychiatrist was made by 14.10% of patients.[3] Pradhan et al. (2001) had observed that only one-third of the subjects had contacted a psychiatrist as their first care provider in their study.[2] Lahariya et al. (2010) had also found that only 9.2% patients consulted a psychiatrist as the first helping agency.[4]

Table 2: Factors related to Delay in identification & consultation

		Identifying illness / symptoms	Contacting someone for help	Contacting a Psychiatrist
Average delay after identification		0 week	1 week	5 weeks
Factors	Affecting	Females Uneducated Unemployed Marital status - separated Urban Schiz.>MDD>BMD	Avoidant Normalization as coping Urban 21-50 years of age MDD>Schiz.>BMD	Do not know that it is a illness Not aware of mental health services Married Employed
	Not affecting		Sex Level of education Religion Marital status	Sex Religion
Family history of Psychiatric illness	Present (24%)	0 weeks	0 weeks	49 weeks
	Absent (76%)	2 weeks	1 week	77 weeks
Locality	Rural			12.4*
	Urban			51*
Age (years)	<20			9.8*
	21-50			50.6*
	>50			13.25*
Diagnosis	Major Depressive Disorder			76.9*
	Schizophrenia			9.9*
	Bipolar Mood Disorder			8.8*

*$p<0.01$

Table 2 shows the factors related to the delay in identification and consultation of psychiatric illnesses. Factors like being female, uneducated, unemployed, separated, living in urban area and having Schizophrenia were all related to delay in identifying illness. This trend shows that being dependent / having poor social support were impairing early identification but surprisingly living in an urban area also delayed identification which may be due to cultural factors.

After identification of the illness there was an average delay of 1 week in contacting someone for help largely due to factors like living in urban area (cultural), middle age, having neurotic illnesses (without explicit symptoms) and using avoidance and normalization as coping styles. Though gender differences, level of education, religion and marital status did not affect delay in seeking help.

Importantly, there was a delay of 5 weeks in contacting a psychiatrist after the identification of the illness due to factors like being married & employed (daily responsibilities / busy life style), not knowing that it can be a mental illness and lack of information about mental health services, whereas gender difference and religion did not affect the same.

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Table 3: Experiences with Consultations

Consultation with		Traditional Healer	Family Doctor	Psychiatrist
Distance traveled for		0-5 km	0-5 km	5-50 km
Reason for consultation		-Advised, available nearby -Belief regarding etiology -Try all approach	-Convenience -Belief regarding etiology -Try all approach	-Advised -Referred -Earlier experience -Belief regarding etiology
Reason for continuing consultation		-Advised by others -Belief regarding etiology	-Convenience -Faith/Rapport	-Earlier experience -Advised by others -Free consultation and drugs.
Reasons for discontinuing consultation		-Not improving or worsened	-Not improving or worsened -Referred	-Relapse -Cost factor -Distance
How do people come to know about them?		Informed by others (100%) (1/2 of them were unknowns)	-Known (65%) -Informed by relatives (22%) -Available in general hospitals (13%)	-Informed by others (70%) (1/3 had history of successful treatment) (1/10 had medics / paramedic as relative) -Referred (27%) -Reputation (3%)
Methods practiced	Explanations given	-Possession by evil spirits/Gods/ Goddess -There is no possession	-Psychiatric illness -Medical illness -There is no problem	Psychiatric disorders
	Common practice	-Sacred thread -Sacred water -Prayers/Mantras -To eat grains - "Pichhi" -Referral	-Drugs -Referral	-Medicines -Counselling -ECT
Mean Expenses incurred (Rs.)		1316	1705	1895
Outcome (%)	Recovered	0	0	50
	Improved	6	27	25
	No change	86	63	25
	Worsened	8	10	0
Level of Satisfaction (%)	Highly satisfied	0	0	40
	Satisfied	6	27	32
	Neither satisfied nor dissatisfied	80	51	21
	Dissatisfied	14	21	7

Family history of psychiatric illness (past experience) helped in prompt identification and urgent help seeking behavior but still there was a substantial delay of 49 weeks (almost a year) before a psychiatrist was consulted (reasons could be stigma, cultural beliefs or availability of mental health services).

On analyzing various factors related to delay in psychiatric consultation, staying in urban area, middle age and a diagnosis of MDD over Schizophrenia or BMD were statistically significant factors. The fact that staying in urban area would be associated with better education and availability of psychiatric services, yet it was associated with late consultation, possibly due to stigma/cultural factors. Patients in middle age (only bread earner on daily wages/responsibilities/no caretaker) and patients without overt psychiatric symptoms (MDD) were not able to receive psychiatric treatment early. Surprisingly, time spend in reaching a psychiatrist was 57 weeks & 20 weeks, if the first consultation was with a TH or a FD respectively and 153 weeks if both. This shows a poor state of affairs and need for sensitizing and training of all practitioners.

Gureje et al. (1995) in a study from India had found that the psychiatric patients who first consulted traditional healers, tended to arrive at a psychiatric service much later than those who consulted other caregivers.[5] There is also important role of care providers along the pathway, the first care provider being the most important, who gives a direction to the pathway of care to seek further help.[6]

Table 3 shows the experience of patients with various consultations. Distance traveled for TH and FD was much less compared to a psychiatrist who explains the preference and delay in consultations. Apart from the belief about causative factors, availability was the main reason for consulting a TH and convenience for FD. A psychiatrist was consulted only when advised / referred by someone or had a past positive experience. The reason for continuing consultation with TH was persuasion by others and with FD was trust / rapport, whereas for a psychiatrist past positive experiences as well as free consultation/drugs were the main reasons. Interestingly, patients discontinued consulting TH and FD when they did not improved / worsened, but for psychiatrists reasons were relapse, cost of treatment and long distances. Patients came to know about TH from people around, about FD as they were already treating them for other ailments, but information about psychiatrist was mainly provided by someone who had a positive past experience and at times referred by FD. TH classically explained symptoms as either 'possession by

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evil spirits' and provided sacred thread/water/grains/prayers/rituals or as psychiatric disorder and referral to a psychiatrist. FD explained symptoms as medical/psychiatric disorders and attempted to treat them with medicines or refer to a psychiatrist later on, but at times failed to identify the illness completely. Mean expenses incurred were not much different, but was more with psychiatrist than FD and TH successively. Majority of patients did not experience any change with TH or FD and some of them worsened, compared to most of them improved/recovered with psychiatrist. Surprisingly none of them recovered with TH or FD and none worsened with psychiatrist. This shows the effectiveness of psychiatric consultations. Subjective level of satisfaction was also rated much higher with psychiatric consultation compared to TH or FD.

Lastly, most of the patients reported visiting by 'free will' to a psychiatrist compared to TH (more by force) leading to better compliance with treatment.

Limitation of the study: Being a general hospital based survey of patients visiting psychiatric treatment facility; it fails to include patients not having faith in a psychiatrist / visiting only a TH or a FD. A community based study would be more appropriately justify the purpose.

CONCLUSION:

This study provides following remarkable insights into the help seeking patterns and pathways by psychiatric patients and caregivers:

- Age, sex, religion, distance & education do not affect the type of consultation.
- Urban people are late in psychiatric consultations compared to rural ones.
- Relapse, cost factor & distance can result in discontinuation of Psychiatric consultation despite satisfaction.
- TH consultation is mostly unsatisfactory, yet preferred in 40 % of new cases. Thus availability & reputation matters for patients & not the conceptual framework
- Symptoms are viewed as two separate problems by patients & THs – mental illness & possession by evil spirits. Though both can exist together.
- "The practitioner (what so ever) knows the best." – Patients don't have independent view.
- "Faith is most important for healing" – applies to all practitioners (including TH).
- Patients have no inclination / dislike for any practitioner – either TH or Psychiatrist
- Aim of the caregivers is to "cure" the patient, by any means.
- Caregivers largely do not have any pre-hand knowledge, they accept & try any nearby service they come to know about first.
- One to one information about practitioner / service travels faster and at times is the only source of information compared to media etc.
- Knowledge, Attitude & Behavior improves after contact with Mental Health professionals.
- Improvement / recovery are viewed as success of service provider, leading to satisfaction & continuing consultations.

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