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Original Research Article

A Cross-Sectional Study of Socio-Demographic and Illness Factors Affecting the Pathway to Psychiatric Care

Sabbella Chandana[1], Medikonduri Vijaya Lakshmi[2], Swathi Ponnada[3], Anuhya Guyton G[4], Pabbathi Lokeswara Reddy[5]

[1]Senior Resident, Department of Psychiatry, NIMHANS, Bengaluru
[2]Associate Professor, Department of Psychiatry, Andhra Medical College, Visakhapatnam
[3,4]Assistant Professor, Department of Psychiatry, Andhra Medical College, Visakhapatnam
[5]Professor, Department of Psychiatry, Andhra Medical College, Visakhapatnam

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Corresponding Author: Dr. P Lokeswara Reddy
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Abstract:

Introduction: There is a significant treatment gap for Psychiatric disorders and some of the reasons being lack of knowledge about psychiatric illness as well as its treatment, stigma and misconception that mental illness was due to supernatural causes. The reasons for a significant delay in consulting a psychiatrist can be understood by studying the pathway to psychiatric care. This study was aimed to assess the relationship between socio-demographic and illness variables with the first care provider and to assess the perception of care givers in help seeking behavior.

Methods: This cross-sectional, hospital-based study involving a total of 367 patients who had been newly registered in Government Hospital for Mental Care, Visakhapatnam was conducted using a convenient sampling method. Semi-structured proforma containing socio-demographic and illness variables, World health Organization (WHO) encounter form and care givers perception of mental illness proforma were used for data collection.

Results: In this study, it was found that subjects who were female, belonging to a rural background and low socio-economic status, having less than 10 years of education, diagnosed with a major mental illness, residing at a distance of more than 150 kms from the hospital approached traditional healers first when compared to their counter parts. Those who had visited traditional healers in their initial consultation had more mean duration of untreated illness and high mean number of consultations.

Conclusion: The pathway to care might vary based on regional and socio-cultural factors. The current study highlights the necessity for community education programmes about identification of psychiatric disorders as well as the sufficient training of non-psychiatric health care workers regarding the symptomatology of psychiatric disorders so that the patient could receive a psychiatric referral as early as possible.

Keywords: Pathway to Psychiatric Care, Health Care Professional, Faith Healer.

Introduction

Mental health problems are quite prevalent and contribute to significant amount of morbidity. According to National Mental Health Survey, the weighted life time prevalence of 'any mental morbidity' was 13.7% and the current prevalence was 10.6%. [1]

Although India has been developing, there is a significant treatment gap in terms of mental health. According to WHO study, the treatment gap of mental disorders in developing countries was 76% – 85%.[2] According to NMHS, the treatment gap of any mental disorder in India was reported to be as high as 84.5%.[3] It was caused by a number of factors, including the stigma associated with mental illness, a lack of knowledge about psychiatric illness as well as its treatment, lack of adequate mental health facilities, lack of accessibility to mental health facilities, and misconception that mental illness was due to supernatural causes.

Due to cultural beliefs or lack of awareness about mental health conditions, most people don't approach mental health facility as their first resort. They tend to approach other care providers like faith healers, traditional practitioners who practice Ayurveda, homeopathy, Siddha, Unani and other allopathic practitioners. As one of the factors which determine the prognosis in psychiatric illness is the duration of untreated illness, it will be of utmost help to the patient if there is early recognition of symptoms and subsequent referral to a psychiatrist. The reasons for a significant delay in consulting a psychiatrist can be understood by studying the

pathway to psychiatric care. Pathway to psychiatric care is defined as the series of consultations made by a person with mental illness or their care-givers before seeking psychiatric help. It helps in assessing the time taken to seek first help from a care provider, duration of untreated illness, number of consultations before reaching for psychiatric care, referral patterns and how the patient ultimately reached a psychiatric facility. Care providers play an important role in deciding the pathways to psychiatric care, the first care provider was of utmost importance in paving a path to seek further help.

Studying the pathway of care helps us in the planning of mental health services at community level, for the organization of referrals to psychiatrists from other sources of help. In India there were limited studies regarding pathway of care restricted to reputed hospitals and research centres. Therefore, this study was planned to understand the pathway of care followed by psychiatric patients.

Aims and Objectives:

- To estimate the relationship between socio-demographic and illness variables with the first care provider.
- To determine the perception of care givers in help seeking behavior.

Materials and Methods:

It was a cross-sectional, hospital-based study conducted after Institutional Ethical committee approval and the subjects for this study were recruited from Government Hospital for Mental Care, Visakhapatnam. A total of 367 patients who had been newly registered during the study period were included using convenient sampling method.

Patients aged between 18 to 60 years and their care-givers attending the study centre and those who gave informed consent were included in the study.

Newly registered patients who had been referred through magistrate or police without care giver, patients with Intellectual disability and organic psychiatric disorders and patients or their care-givers who did not give valid consent were excluded from the study.

After taking consent, a semi-structured proforma containing socio-demographic and illness variables, encounter form which was taken from WHO Study "Pathways of patients with Mental disorders, a multi-centre collaborative project",[4] a semi-structured care-givers perception of mental illness proforma were used for data collection by interviewing the patient and the care-giver. Statistical analysis was done using SPSS version 26 and the data was analyzed using measures like Mean, Standard deviation, Independent sample 't' test and Chi- square test.

Results and Discussion:

In our study we found that:

- Males slightly outnumbered females by 0.5% which was similar to a study done by Dinesh Kataria et al [5] and Mutalik NR et al.[6]
- Most of the patients (36.2%) belonged to the age group of 18-29 years followed by 30- 39 (30%) which was similar to studies done by Jilani AQ et al,[7] Nikhil Jain et al,[8] Bhui et al [9] and Teshager et al.[10]
- Most of the patients were married which is similar to other studies done by Nikhil Jain et al,[8] Dhanesh Kumar Gupta et al,[11] Khemani et al,[12] Kar et al,[13] Chadda et al, [14] Dinesh Kataria et al,[5] Jilani AQ et al,[7], Kurihara et al, [15] Nuri NN et al,[16] Lamichhane N et al.[17] It differs from western studies by Anitha Jeyagurunathan et al,[18] Bhui et al,[9] Teshager et al[10] where majority were unmarried. This might be because of the fact that marriage was considered as a social norm in India and also majority of the people in India get married at a younger age compared to west and as our study population represents younger people more, it might be one of the reasons for the majority of the patients to be married.
- Majority of the patients were Hindus which is similar to other studies done by Manjula Simiyon et al,[19] Kar et al,[13] Dinesh Kataria et al,[5] Jilani AQ et al,[7] Grover S et al.[20] This might be because of Hindus representing majority of population in India.
- Majority of the patients belonged to rural background (59.1%) which is in line with other studies done by Dhanesh Kumar Gupta et al,[11] Khemani et al,[12] Kar et al,[13] Lahariya et al,[21] Jilani AQ et al,[7] Grover S et al[20] and Lamichhane N et al [17].This might be due to the fact that patients from rural areas come here as the study centre was an exclusive psychiatric government hospital in Andhra Pradesh where services are free of cost and also because of the non-availability of psychiatry services in most of the regions of Andhra Pradesh and also Orissa.
- Most of the patients belonged to lower socio-economic status (57.3%). This might be because the study centre being a government one, majority of the people belonging to lower socio-economic status come here due to unaffordability of private psychiatric services for a long time as most of the psychiatric conditions require usage of medication for prolonged periods.
- For the purpose of statistical analysis, upper lower (51.8%) and lower (5.4%) were grouped into 'lower' socio-economic status group and upper middle (15.3%) and lower middle (27%)

were grouped into 'middle' socio-economic status group and upper socio-economic status group (0.5%) was excluded.

- Most of the patients (70%) had less than 10 years of education and majority (67%) had their residence at less than 150 kms from the study centre.

For the purpose of statistical analysis, people in this study were divided into two groups. Two groups here include people who approached Faith Healers versus those who approached HCP (Health Care Professional) group. People who approached medical practitioners and MHP (Mental Health Professional) were combined into HCP group.

Table 1: Comparison of socio-demographic variables of study population with the type of first consultation:

First consultation with					
Variable		n (%)	HCP – n(%)	**FH - n(%)**	**p-value**
Gender	Male Female	185 (50.4) 182 (49.6)	129 (69.7) 109 (59.9)	056 (30.3) 073 (40.1)	0.048*
Religion	Hindu Non-Hindu	334 (91.0) 033 (09.0)	219 (65.6) 019 (57.6)	115 (34.4) 014 (42.4)	0.36
Domicile	Rural Urban	217 (59.1) 150 (40.9)	119 (79.3) 119 (79.3)	098 (45.2) 031 (20.7)	0.0001*
Marital Status	Married Unmarried Separated/Widow/ Divorced	201 (54.8) 121 (33.0) 045 12.3)	139 (69.2) 076 (62.8) 023 (51.1)	062 (30.8) 045 (37.2) 022 (48.9)	0.06*
Education in years	Less than 10 years More than 10 years	257 (70.0) 110 (30.0)	153 (59.5) 085 (77.3)	104 (40.5) 025 (22.7)	0.001*
Socio-economic status	Lower SES Middle SES	210 (57.3) 155 (42.8)	126 (60.0) 110 (71.0)	084 (40.0) 045 (29.0)	0.03*
Distance from Hospital	Less than 150 km More than 150 km	246 (67.0) 121 (33.0)	171 (69.5) 067 (55.4)	075 (30.5) 054 (44.6)	0.008*
HCP – Health Care Professional FH – Faith Healer *Statistically significant					

Table 1 shows Comparison of socio-demographic variables between the groups**.** When Gender was compared between both the groups, majority of both males (69.7%) and females (59.9%) were approaching a Health care professional first rather than a religious healer and the chances of male gender being taken to a Health care professional were more and the difference between both the groups was found to be statistically significant (p value is 0.048). This might be due to the fact that males were the bread-winners of the family and were cared more by their family members and being taken to a health facility rather than religious healer.

Most of the patients from both rural and urban background were approaching a health care professional first rather than a religious healer, but when compared with rural population, urban people are more likely to take a consultation with health care professional which was statistically significant (p value is 0.0001). This might be due to the fact that awareness about mental health, accessibility to the psychiatric services were more in urban when compared with rural people.

When Socio-economic status was compared between the groups, most of them in middle (71%) and lower socio-economic status (60%) group approached a health care professional first but patients belonging to middle socio-economic status group have consulted HCP more compared to the counterpart which was statistically significant (p value is 0.03). This might be because people with middle socio-economic status had more chances of pursuing education or chances of better employment when compared to lower Socio-economic status group and hence there was more chance of awareness about psychiatric services and less belief towards faith healing among them.

People with both more than 10 years of education reached HCP first compared with those less than 10 years of education (p value is 0.001) and this could be due to the fact that people who were educated more had less belief about supernatural causation of the illness and had better knowledge and awareness about the mental illness.

People who resided beyond 150 kms from are more likely approach Faith healer compared to those who resided within 150 kms from the study centre, which was statistically significant (p value is 0.008). This was because people with more accessibility of mental health services might have more chances of being aware that mental illness can be managed medically by a HCP. There was no significant difference between both groups based on religion and marital status.

Table 2: Comparison of illness variables with the type of first consultation:

Illness Variables	HCP	FH	p-value
Mean duration of untreated Illness (months)	4.8	11.6	0.0001*
Mean number of consultations before visiting a psychiatrist	0.29	4.03	0.0001*
Types of mental illness Major mental illness n (%) Minor mental illness n (%)	182 (59.1%) 056 (94.9%)	126 (40.9%) 003 (05.1%)	0.001*
HCP – Health Care Professional FH – Faith Healer *Statistically significant			

Table 2 shows comparison of illness variables between the two groups. Mean duration of untreated illness was more among patients seeking their first consultation from a faith healer (11.6 months) when compared to those who reach a HCP (4.8 months) first and the two groups differed significantly (p value is 0.0001).

This might be due to the fact that people who believed in faith healing practices went on from one faith healer to another, wasting lot of time before eventually consulting a HCP as they were unaware about the nature of the illness, thereby the duration of untreated illness was more among them and most of the native healers never suggested them to take medical help.

Mean number of consultations before visiting a psychiatrist were more in patients seeking their first consultation from a faith healer (4.03) compared to other group (0.29) and the two groups differed significantly (p value is 0.0001). This might be because of the fact that people, who consulted one faith-healer when not cured, consulted all the available faith healers in that area as they felt that the patient might get cured by someone. Due to these deep routed cultural beliefs and unawareness about the symptoms of mental illness, the mean number of consultations was more in people who consulted a religious healer first.

Between the two groups, people with both major and minor mental illness reached HCP first but when compared with other group people with minor mental illness (94.9%) approached HCP first which was statistically significant (p value is 0.001).

This might be due to the fact that patients, who had minor mental illness, were aware of their symptoms and able to communicate it with their care-givers and also as some of the minor mental illness present with somatic complaints there were more chances of them being taken to HCP first rather than a religious healer.

Table 3: Diagnosis and mean duration of untreated illness in study population

Diagnosis of the study population	n(%)	Mean duration of illness (months)
Mental and behavioural disorders due to psychoactive substance use	073 (19.89)	02.2
Schizophrenia spectrum	160 (43.59)	07.3
Acute and Transient psychotic disorder	019 (05.18)	00.6
Bipolar Affective disorder	056 (15.26)	01.2
Depressive episode	032 (08.72)	03.4
Anxiety disorders	015 (04.09)	03.7
Obsessive Compulsive Disorder	005 (01.36)	31.3
Dissociative disorder	003 (00.82)	02.1
Personality disorders	003 (00.82)	31.1
Acute stress reaction	001 (00.27)	00.3
HCP – Health Care Professional FH –Faith Healer *Statistically significant		

Table 3 shows the various diagnoses and mean duration of untreated illness in the study population. In our study majority of the patients were diagnosed to be having Schizophrenia and other related psychotic disorders (43.59%) followed by Mental and behavioral disorders due to psychoactive substance use (19.89%) which was similar to a study done by Manjula Simiyon et al [19] and Kauye F et al.[22] Several other studies done by Parag Suresh shah et al[23] Nikhil Jain et al,[8] Dhanesh Kumar Gupta et al,[11] Mutalik NR et al,[6] Srinivasa Rao SS et al[24] and Bhui et al[9] shows that majority of the people were diagnosed to be having Schizophrenia. This might be because many patients with psychotic disorders who were unmanageable at home were brought to the study centre as it provides in-patient care. It differs from studies done by Lamichhane et al [17] where majority were diagnosed to be having anxiety spectrum disorders and Dinesh Kataria et al [5] where majority were having depression and anxiety spectrum disorders. In our study the mean duration of un-

treated illness was highest for obsessive-compulsive disorder which is 31.3 months which was similar to a study done by Manjula Simiyon et al[19] and Mutalik NR et al[6] where mean duration of untreated illness was more for OCD than other illnesses. The delay might be because of not attributing OCD symptoms with an illness and a belief that they can control the symptoms on their own.

Table 4: Nature of first consultation among study subjects:

Nature of first consultation	n (%)
Psychiatric services at the current study centre	072 (19.62)
General hospital psychiatry services	039 (10.63)
Private psychiatrist	088 (23.97)
Other non-psychiatry specialists	039 (10.63)
Faith healers	129 (35.15)
Total	367(100.00)

Table 4 shows the nature of first contact for help by the study subjects. In our study majority of the patients contacted psychiatrists (54.22%) as the first point of contact. Psychiatrists here include psychiatric service at our hospital (19.62%), general hospital psychiatry services (10.63%) and private psychiatrists (23.97%).

This is similar to studies done by Dhanesh Kumar Gupta et al,[11] Khemani et al,[12] Chadda et al,[14] Manjula Simiyon et al[19] and Goyal S et al[25] where majority of the study participants consulted psychiatrists as first point of care. This might be because of recent increase in the public awareness of psychiatric illnesses. It differs from studies done by Lahariya et al,[21] Jilani AQ et al,[7] Teshager et al,[10] Kurihara et al,[15] Lamichhane et al[17] where majority patients consulted religious healers first and Faizan et al [26], Nuri NN et al [16] where majority consulted medical practitioners. It also differs from international studies done by Anitha Jeyagurunathan et al,[18] Kauye F et al,[22] Bhui et al[9] where majority consulted primary care clinicians.

This might be because of the graded hierarchy in the consultation of doctors in the west. In our study, among those who had visited religious healers, the mean amount spent by each patient was Rs.11576. Maximum amount spent by a patient for his/her consultations at a traditional healer is Rs 2,00,000 and minimum amount is Rs.100.

Table 5: Care giver perception about the mental illness:

Care-givers perception	n (%)
Substance abuse	044 (11.98)
Stress	085 (23.16)
Heredity	014 (03.80)
Brain/nerves problem	011 (02.99)
Doesn't know	092 (25.10)
Supernatural causation	121 (32.97)

Table 5 shows Caregiver's perception about the mental illness.

In the current study, 32.97% (n=121) of the caregivers perceived supernatural causes as the reason for the Behaviour of the patient, 25.1% (n=92) didn't ascribe the reason for the patient's Behaviour to anything, 23.16% (n=85) perceived the reason to be Stress, 11.98% (n=44) perceived substance abuse as the cause for the patient's behaviour and 3.8% (n=14) perceived mental illness is due to heredity and 2.99% (n=11) thought brain/nerves problem as the reason for patient's behaviour.

This was in line with a study done by Teshager et al,[10] and Kurihara et al[15] where majority of the people believed in supernatural causation of disease.

This might be due to the fact that despite increase in awareness about mental illness people still attribute it to supernatural causes due to cultural and religious beliefs. [20,27]

Limitations:

- As the study was done in a government psychiatric institute the results cannot be generalized. A community-based sample might give a different picture as there can be patients who might have never contacted psychiatric services or have contacted other service providers.
- Though the information about the pathway of care was taken from two to three informants, chances of recall bias cannot be excluded.
- As we utilized a convenience sampling method, our study sample may not be representative of all hospital patients so there might be a possibility of sampling bias.

Future Recommendations:

- The current study highlights the necessity for community education programmes about identification of psychiatric disorders and available treatment options and also the need of sufficient training of non-psychiatric health care workers regarding the symptomatology of psychiatric disorders so that the patient could receive a psychiatric referral as early as possible.
- The pathway to care might vary based on regional and socio-cultural factors and the planning of awareness programs should be based on that.
- Psychiatric services should be made accessible at community level so that general public will be aware of them.
- A community-based study which involves different regions and cultures with large study sample is recommended for the generalization of the results.

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