Indian Journal of Private Psychiatry ISSN 2319 – 5363

Original Research Paper

PATHWAYS TO PSYCHIATRIC CARE –

An Experience in Kerala

P. N Suresh Kumar,

Abstract :

The aim of this study was to evaluate the pattern of treatment seeking behaviour by the families of patients with psychiatric illness in a literate state like Kerala.

Methods: The study was conducted in a medical college hospital in Kerala with bed strength of over 600. 100 consecutive patients and their service providers visiting the OPD were interviewed using a semi-structured demographic data sheet and modified version of World Health Organization (WHO) 'encounter form.

Results: 74% of the subjects made initial contact with a psychiatrist for their illness while 12% initially consulted a general practitioner. Only 14% initially visited indigenous practitioners. Majority of the patients reached a definitive psychiatric setup within two years of the onset of symptoms (Mean= 24.4 months; SD= 52.4 months). 40 % changed their service provider within one month. 31% went to a second service provider while 26% each utilised **a third or more** service providers. Among patients with subsequent service providers, 64% utilised psychiatrists. Only 25% received psychosocial treatments from the subsequent service providers. The relatives of the patients were satisfied with the treatment in only 48% of the cases with subsequent service providers.

Discussion: The good first contact rates with mental health professionals suggest the positive effect of literacy. Poor retention duration by the first service providing mental health professionals point towards the inadequacy of psycho education regarding nature of illness and the management.

Key words: pathways, psychiatric care, help seeking

Corresponding Author

Prof. P. N. Suresh Kumar, MD, DPM, DNB, PhD, MRC Psych, Professor of Psychiatry, KMCT Medical College, Calicut, Kerala, India . Email – drpnsuresh@gmail.com

Introduction :

The sequential contacts that a person makes prior to utilising mental health services is known as the psychiatric help seeking pathway.[5] An understanding of the help-seeking behaviors of patients with mental illness is crucial to the effective planning of psychiatric services across the country. [1] An exact knowledge about the help-seeking pathways of patients is pivotal in providing early interventions and thereby in supplying specialized and focused health care .[2] The pathways toward mental illness care are diverse and dependent on socio-cultural and economic factors, including the conventions governing referral, the availability/accessibility of mental health services, and the relationship between mental health services and the rest of the disciplines .[3.4]

The stigma attached to mental illness is still prevalent in our country. Due to cultural and social factors, there are many myths and superstitions associated with mental illness. Hence people resort to various indigenous methods of healing for mental health problems often delaying psychiatric treatment. [6,7,8,9,10] Illiteracy, lack of awareness are added barriers for seeking mental health services. Even the educated group do not bring the mental patient to psychiatric set up directly and immediately. There is a dearth of research information on this important area often leading to difficulty in initiating large-scale primary or secondary preventive measures. This is more so in developing countries like India comprising of a multitude of cultural practices and life styles.

Aims :

The aim of this study was to evaluate the treatment seeking patterns of the mentally ill in Kerala. The study evaluated the extent to which mentally ill and their care givers in a fully literate state like Kerala resorted to indigenous practices before seeking psychiatric care. We also evaluated the levels of satisfaction with treatment, modality of treatment provided etc.

Methodology:

Subjects:

The study was conducted in a medical college hospital in Kerala. 100 consecutive patients and their service providers who visited the OPD from 1st January 2013 to 31st January 2014 were interviewed using a self developed semi-structured questionnaire. Individuals with definite physical illnesses and those suffering from any primary memory disorders like amnesia, dementia were excluded from the study. All patients who were not able to give informed consent and those without relatives were excluded from the study.

Instruments: A modified version of World Health Organization (WHO) 'encounter form' prepared for a multicentre pathways study was used.[11] It included items related to gender, literacy status, domicile, type of family, preference for first caregivers and presenting symptoms of the patients. The information was collected from both patients and caregivers accompanying them. Psychiatric diagnosis was made in accordance with DSM IV criteria.[12]

Statistical procedures:

Data analysis was done using EPI-Info software package, version 5.0. Chi-square test was used for studying differences for categorical variables. Fisher's exact test was performed wherever required. 'P' value less than 0.05 was considered as significant.

Results :

The socio-demographic profile of the sample is shown in Table 1. So far as sex distribution is concerned, it was observed that there was no significant difference between male and female respondents regarding their choice of first caregivers for mental health problems. Choices - for caregivers were analyzed with

Indian Journal of Private Psychiatry ISSN 2319 – 5363

TABLE -1

Socio-demographic Characteristics

	Category	%
Sex	Male	76
	Female	24
Marital status	Unmarried	49
	Married	51
Religion	Hindu	58
	Christian	30
	Muslim	12
Education	Illiterate	4
	Primary	28
	Higher Secondary	53
	Graduation & above	15
Occupation	Skilled	7
	Unskilled	17
	Unemployed	76
Habitat	Rural	74
	Urban	8
	Mixed	18
Type of family	Nuclear	37
	Joint family	4
	Partially joint	59
Monthly income (Rs.)	Below 1000	25
	l00l-3000	55
	3001 – 5000	11
	Above 5000	9
Relationship with patient	Parent	44
	Sibling	20
	Children	10
	Spouse	24
	Others	2

Age (years) - **mean- 35.2, SD- 13.4**

respect to the domicile status of the respondents. Psychiatrists were preferred by the primary caregivers followed by other allopathic doctors and faith healers. It was observed that the respondents from rural areas preferred psychiatrists much readily than their urban counterparts (p=0.006). However, the respondents from the urban areas preferred to visit doctors other than psychiatrists as first care givers (p=0.001).

So far as the choice for first caregivers according to literacy status is concerned, it was observed that the later did not have any influences on the pattern of preference for the caregivers. Similarly, the type of the family did not have any influence on the help--seeking behaviour of the respondents with respect to the choice for their first caregivers.

The clinical characteristic of the sample is shown in table 2. The symptom based preference for first caregiver is interesting in a way that paradoxically the patients presenting with somatic symptoms mostly sought psychiatric consultations as compared to those having psychic symptoms (p<0.001). On the contrary patients presenting with psychic symptoms mostly sought allopathic doctors other than psychiatrists as their first caregivers (p<0.001).

Table 3 shows the details of contact with first care givers. Table 4 shows the details of subsequent care givers.

Discussion :

The study evaluated the treatment seeking patterns of mentally ill patients in a literate society. It also assessed the nature of services provided, patient care satisfaction and its impact on the pathways of care. Analysis of socio-demographic profile revealed that more than half of the patients were Hindus. This may be because the hospital is situated in a predominant Hindu area. Socioeconomic profile, gender characteristics and marital status was generally representative of the population attending the hospital OPD. There was adequate social support considering that all patients visited the centre accompanied by a care giver.

A vast majority of the patients were psychotic or had mood disorder. Number of patients with neurotic disorders was negligible.

TABLE - 2
Clinical Characteristics

	Category	%
Time taken for first consultation	Within 1 month Within 1 year More than 1 year	38 81 19
Time taken to reach RMP	Within 1 month Within 1 year More than 1 year	46 80 20
Time taken to reach a psychiatrist	Within 1 month Within I year More than 1 year	14 76 24
Distance covered to reach 1st care giver (Kilometers)	Below 10 Below 50 Above 50	33 71 29
First symptoms of illness	Somatic Psychic	2 98
Diagnosis	Schizophrenia Mood disorder Substance dependence Other disorders Neuroses	39 23 6 28 4
Duration of illness (years)	Mean SD	6.8 6.2
Duration of treatment (Years)	Mean SD	4.3 8.2
Family history of mental illness	Yes No	49 51

TABLE - 3
Details of First Contact

	Category	%
First care giver	Psychiatrist MBBS Ayurvedic Homeopathy Faith healer	74 12 3 1 10
Duration of treatment by first care giver	Up to one month Up to one year More than one year	40 37 23
Whether drugs given by first caregiver	Yes No	78 22
Whether advice given by first care giver	Yes No	29 71
Relative's response to treatment	Satisfactory Unsatisfactory Worsened	25 56 2
Referral made by first care giver	Yes No	7 93

TABLE – 4
Details of Subsequent Care Givers

	Category	%
Number of subsequent care givers	Nil One Two Three or more	17 31 26 26
Type of subsequent care givers	Psychiatrist RMPs Traditional Mixed	64 4 6 9
Period of treatment by subsequent care givers (years)	Mean SD	29 71
Whether drugs given by subsequent care givers	Yes No	50 50
Whether advise given by subsequent care givers	Yes No	7 93
Relative"s response to treatment	Satisfactory Unsatisfactory Worsened	48 31 4

This is understandable as the hospital is a tertiary referral centre. It is also possible that neurotics may seek treatment from faith healers more often than other groups.

More than 3/4th of the patients reached a psychiatric treatment centre within one year of the onset of symptoms. This finding corroborates with findings from another study from Bangalore.[3] An important finding of our study is that vast majority of the subjects first contacted a psychiatrist. In a multicentre collaborative study from India regarding first care givers of mentally ill patients, Kerala was ahead of other states where more than half of the patients had directly come to the psychiatrist as their first contact.[10] This could be attributed to the higher literacy status and mental health awareness in the state as a whole.

Only a small number first went to an indigenous practitioner. This result is different from studies conducted at other states in India, where more than half of the patients contacted faith healers and only a small number first

contacted a psychiatrist.[6,7,8,9,13] Our finding is also in agreement with a cross cultural study conducted in many developed countries as well as in Bangalore where a significant proportion had psychiatrist as the primary contact.[3]

Another interesting observation regarding the choice of caregivers involves the domicile of the respondents. Most of the rural folk preferred psychiatrists,, whereas their urban counterparts preferred other medical practitioners. Although this phenomenon is difficult to explain it could partly be due to the fact that the urban respondents had greater choice of caregivers than rural people. The other point, which is not property understood, is the findings that the mentally ill patients presenting with somatic symptoms tend to consult psychiatrists more readily than the patients with psychic presentation of illness, who mostly prefer general practitioners as their primary caregivers. This is in contrast to the popular expectation that the mentally ill should readily consult a psychiatrist. This again could possibly be a reflection of the somatizing nature of psychiatric syndromes.

As far as the gender differences of the study subjects are concerned, there was a male predominance in treatment seeking behaviour. This represents the sexual discrimination in health seeking behaviour. In Indian set-up, female attendance in hospitals is less because of the prevalent socio-cultural practices and stigmatizing nature of the mental disorders, which affects females mostly. This can be explained by the fact that the sample was not a true representation of the community and in a clinical set-up, especially in a developing country; males may have an easy access to a tertiary care center compared to the females.[14]

The significantly better mental health service utilization could be related to the high literacy and awareness in Kerala. This suggests that improving the basic education level and awareness does have an impact in decreasing the duration of untreated illness. This can significantly reduce the morbidity and socio-economic burden. Also duration of untreated illness has important implications in the prognosis of psychotic illness.

A significant proportion of the patients changed their psychiatrist within one month of treatment. Also the level of dissatisfaction with the care provided appears to be significant with primary service provider. This suggests a lack of adequate psycho-education during initial visits regarding the usual time taken for a pharmacological response and the nature of the illness. The poor level of specific psychosocial intervention given could be the culprit for the lack of retention.

Limitations :

Our study has some limitations. First, this study was performed in a tertiary hospital, which is open to selected patients only. Second, the small sample size makes it difficult to evaluate the effect of variation in diagnostic categories and characteristics of participating facilities in Kerala. Third, convenient sampling was used in this study, so there is a potential selection bias on sampling patients. Fourth, information gathered in this study was based on the willingness of patients to acknowledge their previous source of care. Thus, patients may have been reluctant to disclose contacts with cares, such as religious or traditional healers.

Despite these limitations, this study is noteworthy in that this is the first study on pathways to care for patients with mental health problems in Kerala, and this will shed light on planning psychiatric services in the region in future. We hope that this study will generate hypotheses and studies focused on ways of improving the mental health care system in Kerala.

Conclusion :

A vast majority of the patients with mental illness in Kerala seek specialised mental health care directly. The rates are much better than other states. This could suggest that improving the basic literacy and awareness positively affects the treatment seeking behaviour among the mentally ill. The initial retention rates during first contact with a psychiatrist are low suggesting the inadequacy of psycho-education about the illness and treatment. The study findings need to be replicated in a general hospital setting with a population having predominant neurotic illness.

References :

1. Giasuddin NA, Chowdhury NF, Hashimoto N, Fujisawa D, Waheed S. **Pathways to psychiatric care in Bangladesh.** *Soc psychiatry psychiatric epidemiol* 2012, **47:**129-136.
2. Platz C, Umbricht DS, Cattapan-Ludewig K, Dvorsky D, Arbach D, Brenner HD, Simon AE. **Help-seeking pathways in early psychosis.** *Soc psychiatry psychiatric epidemiol* 2006, **41:**967-974.
3. Gater R, De Almeida E, Sousa B, Barrientos G, Caraveo J, Chandrashekar CR, Dhadphale M, Goldberg DAL, Kathiri AH, Mubbashar M, Silhan K, *et al*. **The pathways to psychiatric care: a cross-cultural study.** *Psychol med* 1991, **21:**761-774.
4. Patel V, Simunyu E, Gwanzura F. **The pathways to primary mental health care in high-density suburbs in Harare, Zimbabwe.** *Soc psychiatry psychiatric epidemiol* 1997, **32:**97-103.
5. Vanhaecht K, Bollmann M, Bower K, Gallagher C, Gardini A, Guezo J, et al. **Prevalence and use of clinical pathways in 23 countries – an international survey by the European Pathway Association (www.E-P-A.org).** J Integr Care Pathways 2007; **10:**28–34.
6. Sethi BB, Trivedi JK & Sithoely P. **Traditional healing practices in psychiatry** . *Ind Journal of Psychiatry* 1977; **19:9**-13.
7. Somasundaram O. **Religious treatments in Tamil Nadu**. *Ind Journal of Psychiatry* 1973; **15**:38-44.
8. Sarma PG & Sathyanarayanan G. **Temple visiting psychiatry patients**. *J of Social work* 1992; **3**: 244-9.
9. Setija DC, Natimat SS, Singh D, sharrna A. **A study of patients attending Jelenandepur temple - Psychiatric and psychodynamic aspects**. *Ind Journal of Psychiatry* 1982; **12**: 395-79.
10. Pradhan SC, Singh MM, Singh RA, Das J, Ram D, Patil B, et al. **First care givers of mentally ill patients: A multicenter study**. **Indian J Med Sci** 2001; **55**:203–8.
11. Gater R, Goldberg D. **Pathways to psychiatric care in South Manchester**. Br J Psychiatry 1991:**159**:90-96.
12. American Psychiatric Association. **Diagnostic and Statistical Manual for Mental Disorders** – IV 1994: Washington DC.
13. Trivedi JK, Sethi BB. **A psychiatric study of traditional healers in Lucknow city**. **Ind J psychiatry**. 1979; **21**:133–7.
14. Khanna R, Gupta N, Shankar S. **Course of Bipolar disorders in Eastern India.** Journal of Affective disorder. 1992; **24**:35--41.

Conflict of Interest - Nil
Source of support - Nil

****