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Pathways to tertiary care adopted by individuals with psychiatric illness

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ABSTRACT

Awareness of mental illness as a cause of morbidity is increasing the world over. Of the top ten causes of disability, five are psychiatric illnesses. Availability and accessibility of psychiatrists as well as treatment facilities is meagre, making pathways to psychiatric care tortuous hence delayed, affecting outcomes negatively.

With an attempt to study the pathways to psychiatric care, a cross sectional study was undertaken, on 63 consecutive first contact patients in tertiary care centre in Bangalore, India. Socio demographic details, time taken to reach professional help, and reasons for delay were noted. Pathways to care were recorded using 'WHO pathways to care' proforma.

One third of the study population were aged between 31 and 45 years, mostly Hindus. Two thirds of them had received about 10 years of formal education, hailed from urban areas and lived in nuclear families.

Majority sought help from trained medical professionals, with almost 40% seeking psychiatric help initially itself. While the choice of consultation was influenced by people in the immediate environment, that of first contact was based on the physician or treating facility. Almost 57% had more than two referrals before reaching the tertiary care centre.

Though the urban educated population are well aware of the nature of psychiatric illnesses, need for medical intervention and its availability, there was a delay in seeking help from a tertiary psychiatric centre. There is thus a need to educate medical professionals about timely referral to these centres, as early and appropriate interventions result in a favourable outcome.

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1. Introduction

'Awareness' of mental illness as a significant cause of morbidity is increasing worldwide, caused by the steady decline of morbidity due to nutritional disorders, communicable diseases and other forms of physical illness, especially in countries undergoing epidemiological transitions (shift in epidemiological attention from communicable diseases, malnutrition and problems associated with pregnancy and childbirth, to chronic non communicable diseases) (Fahad et al., 2006).

A significant disease burden is attributable to mental illness globally. Out of the top ten leading causes of disability throughout the world, five are psychiatric illnesses (Banerjee, 1997), and six neuropsychiatric conditions have figured in the top 20 (Trivedi and Sethi, 1979). According to WHO, mental illnesses account for 11.5% of the global burden of disease—a figure that is projected to increase to 15% by 2020. Majority of those with mental illnesses live in the developing world (Pradhan et al., 2001) approximately half of them are living in the Asia Pacific regions (Syed et al., 2012). It is estimated that, at any point in time, in India, 2–5% of the population is suffering from serious mental illnesses, and 10% from minor mental illnesses (National Institute of Health and Family Welfare (NIHFW), 2005).

Prevalence rates of psychiatric disorders in India range from 9.5 to 370/1000 population (Jilani et al., 2009; Lahariya et al., 2010). The number of psychiatric beds in the country is only about 0.2/one lakh population and there are two psychiatrists per ten lakh population (Roger and Cortes, 1993), mostly concentrated in the metropolitan and the urban areas (Sharma et al., 2007). Professional psychiatric help thus being non available, it is only understandable that the path leading to it is long, punctuated by

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penury, stigma, and superstitions associated with mental illness, coupled with an unwillingness or inability of families to care for their mentally ill relatives (Jain et al., 2012). In addition, only a minority of individuals attribute their illness to psychological causes, prompting them to seek help from faith healers, with a few seeking the help of general practitioners before approaching a psychiatrist. The first line of treatment for the mentally ill constitutes the most important stage of psychiatric care. It thus becomes important to understand pathways to care so as to be able to ensure that those individuals with mental illnesses have direct access to professional help. The current study is thus undertaken with an aim to trace the pathway taken by the mentally ill to reach professional care, and elicit the factors responsible for their choice of help seeking.

2. Material and methods

As the aim of the study was to trace the pathways taken by the mentally ill to reach professional psychiatric help and to delineate the factors influencing the same, a cross sectional study was designed and consecutive patients presenting to the department of psychiatry in a tertiary care hospital, located in the city of Bangalore, India, during a period of three months (June to August 2013) were recruited. After obtaining clearance and approval from the institutional ethics committee, 68 patients and their relatives, aged above 18 years were included in this study. A written consent was obtained from both the patients and their relatives. All patients were diagnosed using ICD-10(DCR) (World Health Organization, 1993) and only patients presenting to us for the first time were included. A total of 68 patients fulfilled the inclusion criteria, of whom three were unable to complete the study and two of them were residents of a destitute home with no relatives, hence the results are based on the data of 63 patients.

The time taken to reach professional help was noted, being defined as the time between onset of illness as described by the informant and the current consultation. Details of the chosen pathways and reasons for the same were collected as reported by the informant as well as the patient where relevant. Socio demographic details were obtained by a proforma developed for the study, while pathways to care were recorded using the 'WHO pathway to care proforma' developed by Gater et al. (1991). To avoid bias, all the interviews (lasting for about one hour each) were conducted by a single well trained psychiatrist, who had the previous experience of working with the study instruments.

3. Results

3.1. Sociodemographic details

36.5% of the study population were aged between 31 and 45 years, with 54% of them being males. Majority of them were Hindus (95%), with 60% having had 10 years or more of formal education. They hailed from urban areas (75%) and lived mostly in nuclear families (70%) 40% were unemployed while 36% had a monthly income of between five and ten thousand per month (Table 1).

3.2. Tracing the pathway

Half the study population had an onset of illness more than five years ago. A small percentage of the patient population approached a native healer as first contact of care (6.3%) while a large majority of them sought trained medical help for initial consultation (90%), with 39% of these patients having approached a psychiatrist initially (Table 2). It was found that on an average it took the patients 69.3 months to reach tertiary psychiatric care (Table 3).

Table 1
Depicting the socio-demographic details of the patients.

Socio-demographic details	Numbers ($N=63$)	Percentage (%)
Age		
<30 years	27	42.8
>30 years	36	57.2
Gender		
Male	34	54
Female	29	46
Marital status		
Unmarried/widowed	21	33.3
Married	42	66.7
Education		
Educated	38	60.3
Uneducated	25	39.7
Occupation		
Unemployed/student	36	57.1
Employed	27	42.9
Residence		
Rural	16	25.4
Urban	47	74.6
Family type		
Joint	18	28.6
Nuclear	45	71.4
Income		
<10,000	41	65.1
>10,000	22	34.9

The choice for the first consultation was influenced by either a relative or a friend in 73% of the patients, while only 11.1% of the patients made the choice themselves (Table 4). Majority of them (59%) made their choice based on care related issues such as faith in the consulting physician, previous experience with the treating facility, and the preference for a multi speciality hospital. Some made their choice based on their personal likes for the hospital/clinic (28.5%), while others (21%) based their decision on environmental factors such as location, affordability, referral practices of their local doctors and the opinion of those around them. 27% of them had a single referral before reaching trained professional help, while 35% had two and 22% had three referrals.

Table 2
Depicting the first contact of care.

Help sought from	$N=63$	Percentage (%)
Native healer	4	6.3
Medical practitioner (GP)	21	33.3
Gen. Hospital	14	22.2
Psychiatrist	22	35
Ayurveda/homeopathy	1	1.6
Others	1	1.6
Total	63	100

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