ISSN: 0975-8585

Research Journal of Pharmaceutical, Biological and Chemical Sciences

A Cross-Sectional Study On Patients Seeking Mental Health Services At A Tertiary Health Care Centre In Puducherry.

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ABSTRACT

An understanding of the way people seek care for mental disorders is important to know for planning mental health services, provision of appropriate training to the health care providers, and mental health reforms. Reasons for choosing a particular service help in understanding how the population perceive mental illnesses and respond to them. This knowledge can be helpful in developing community awareness programs so as to remove myths and misconceptions about mental illnesses and sensitize the people with the availability of various sources of help available in the community. Henceforth, we conducted the study with the following objectives. 1. To identify the health-seeking pathway of care adopted by psychiatric patients. Out of total 100 patients, majority 47 (47%) patients experienced somatic complaints as the first symptom of illness, 34 (34%) patients reported affective symptoms and the remaining 19 (19%) patients presented with hallucination as their first symptom of illness. Among the disease distribution, the most common psychiatric disorder diagnosed was schizophrenia for 28 (28%) patients followed by anxiety disorder for 20 (20%) patients and alcohol use disorder for 18 (18%) patients. Patients with mental health problems seek help from psychiatrists, nonpsychiatric physicians, faith healers, alternative system practitioners, and traditional faith healers for multiple reasons. It is important to sensitize various nonpsychiatric physicians with early identification and optimum management of mental disorders.
Keywords: Help seeking, mental illness, outpatient, psychiatry

https://doi.org/10.33887/rjpbcs/2020.11.2.18

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ISSN: 0975-8585

INTRODUCTION

Mental illnesses are commonly associated with higher disability and burden than many physical illnesses [1]. It is estimated that at any point of time, in India, 2–5% of the population is suffering from serious mental illnesses, while another 10% of the population is suffering with minor mental illnesses [3]. There are a very small number of qualified psychiatrists in India, mostly concentrated in the metropolitan and the urban areas, to deal with this huge problem, further compounding the issue [4].

WHO provided seven reasons for that, which are as follows:

- Low awareness of available services;
- A lack of well-organized primary mental health care;
- Inadequate links between services;
- A lack of knowledge among rural populations about the causes of and treatments for mental disorders, resulting in the underutilization of mental health services;
- Inadequate mental health training of general practitioners and traditional healers, contributing to low rates of detection, treatment, and referral of mental disorders in traditional and primary care settings;
- Failure of mental health services to actively identify cases in the community, users being required to find and access available pathways.
- Difficulty in accessing specialist services, partly associated with the need for professional referral to specialist program [2]

There is a need for further research to delineate psychiatric pathways of care and their determinants in the developing countries. Definitely, this information is most likely to assist service providers and policy makers to purposefully plan for culturally appropriate and accessible psychiatric services providing easy, cost-effective and favourable pathway of care for psychiatric patients as per the community needs. Also, there is a need to increase the awareness about psychiatric disorders and services for better help seeking behaviour and favourable pathway of care.

METHODOLOGY

The study was conducted in the department of Psychiatry in a tertiary care teaching hospital, Puducherry over a period of 1 year and 6 months from October 2020 to April 2021. It was a hospital-based cross-sectional study design. All patients(n=100) reporting to the psychiatry outpatient department for the first time at tertiary care hospital were recruited for the study. Data collection was done based on a convenient sampling method. All eligible patients were included in the study. Written informed consent was obtained from each patient before their inclusion in the study. Each patient was assessed in detail including complete history and examination, based on the ICD-10 criteria. The diagnosis was made by the treating psychiatrist and reviewed by a senior Psychiatrist in the department. Data was collected in a semi-structured questionnaire that was administered by face-to-face interview. The questionnaire was developed based on the pathway encounter form, developed for the WHO collaborative study. This study tool was used to collect data on the number of patients with mental disorders that sought services in psychiatry OPD. It included identification data, socio-demographic information such as age, sex, socio-economic status, occupation, education, marital status, total duration of illness (in episodic illness, this referred to the onset of the first episode), presenting symptoms with duration and diagnosis of condition as per ICD-10 criteria. The Pathway to care proforma contained five questions, namely “who was first seen, how long ago, who initiated first contact, what symptoms caused the decision to seek help, and what treatment was offered?” with respective multiple options for the questionnaire.

Inclusion Criteria

- All participants who are reporting for the first time in the psychiatry outpatient department.
- All participants who gave reliable and adequate data for analysis.
- The participants with psychotic disorders were less likely to give correct information, and therefore, information from the caregivers will be used.
- Caregivers such as family members, relatives, or friends should be 18 years or older.

ISSN: 0975-8585

Exclusion Criteria

- Participants who refuse to give consent and did not give complete information.
- Participants who had attended the psychiatry outpatient earlier or had attended any other specialty psychiatric health facility.

Statistical analysis of the data was done by SPSS (IBM SPSS Statistics for Mac, Version 25.0, Armonk, NY: IBM Corp. Released 2017). Frequencies with percentages was calculated for categorical variables and mean and standard deviation would be calculated for continuous variables. The data was compared using chi-square (x2) test for categorical variables. Pearson Correlation coefficient was done to find the linear relationship between continuous variables. Univariable and multivariable binary logistic regression analysis was performed to assess the relative influence of socio-demographic characteristics on the first place patient sought psychiatric care. p-value of <0.05 was considered statistically significant

RESULTS

The mean age of the participants was 38.8± 13.69 years. Out of the 100 patients seeking mental health services, 63 (63%) patients belonged to the age group of 20-40 years, 28 (28%) were in the middle age group of 41-59 years, 8(8%) were in the elderly age of 60 years and above and only one (1%) belonged to the adolescent age group of 10-19 years. Predominantly, 64 (64%) were males by gender and the majority 83 (83%) patients were able to read and write whereas only 17 (17%) patients were illiterates. Regarding marital status, almost half of the patients 49 (49%) were unmarried, 6 (6%) were separated and 5 (5%) were divorced. The majority of 62 (62%) patients belonged to the lower socioeconomic class and 38 (38%) were from the middle-class socioeconomic status. By occupation, 36 (36%) patients were unskilled workers, 25 (25%) were skilled workers, 13 (13%) were professionals, 8 (8%) were students and the remaining 18 (18%) were unemployed (Table 1).

Table 1: Sociodemographic characteristics of patients seeking mental health services: N=100.

Sociodemographic characteristics	n (%)
Age of the patients (years)	
10-19	1 (1)
20-40	63(63)
41-59	28 (28)
≥60	8 (8)
Gender	
Male	64 (64)
Female	36 (36)
Educational status	
Illiterate	17 (17)
High school	45 (5)
Undergraduate degree	33 (33)
Postgraduate degree	5 (5)
Marital status	
Unmarried	49 (49)
Married	40 (40)
Separated	6 (6)
Divorced	5 (5)
Socioeconomic status	
Lower class	62 (62)
Middle class	38 (38)
Occupation	
Unemployed	18 (18)
Unskilled	36 (36)
skilled	25 (25)
Professional	13 (13)
Student	8 (8)

Table 2: Psychiatric morbidity profile of patients seeking mental health services: N=100

The first symptom experienced	n (%)
Somatic symptoms	47 (47)
Affective symptoms	34 (34)
Hallucination	19 (19)
Diagnosis	
Schizophrenia	28 (28)
Other anxiety disorder	20 (20)
Alcohol use disorder	18 (18)
Generalized anxiety disorder	12 (12)
Bipolar affective disorder	8 (8)
Depression	7 (7)
Personality disorder	4 (4)
Obsessive Compulsory Disorder	3 (3)

Out of total 100 patients, majority 47 (47%) patients experienced somatic complaints as the first symptom of illness, 34 (34%) patients reported affective symptoms and the remaining 19 (19%) patients presented with hallucination as their first symptom of illness. Among the disease distribution, the most common psychiatric disorder diagnosed was schizophrenia for 28 (28%) patients followed by anxiety disorder for 20 (20%) patients and alcohol use disorder for 18 (18%) patients (Table 2).

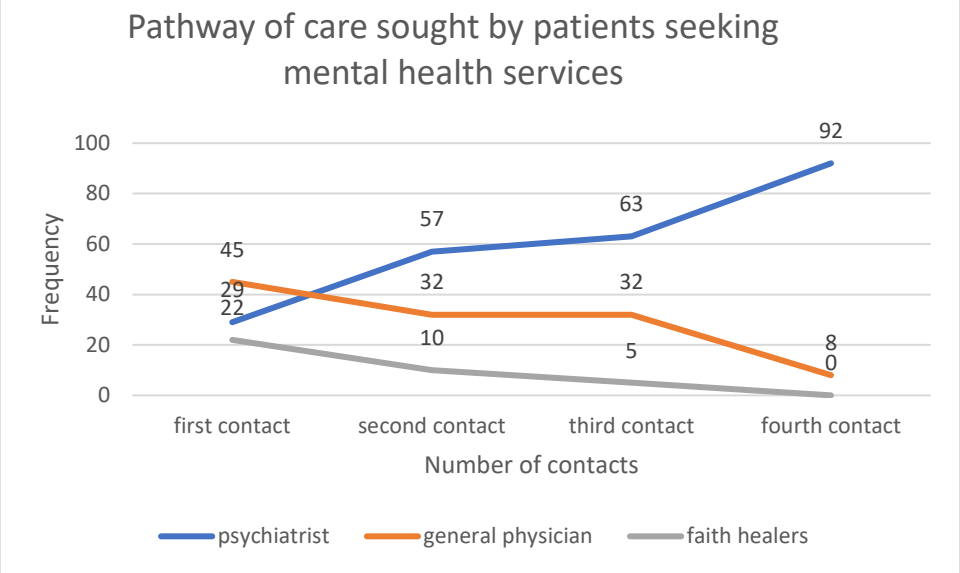
Table 3: Health-seeking behaviour of psychiatric patients: N=100

Type of health facility	n (%)
Medical College	76 (76)
Government Hospital	23 (23)
Primary Health Centre	1 (1)
First contact of help	
General Physician & other specialists	45 (45)
Psychiatrist	29 (29)
Faith healers	22 (22)
Nurse/Physiotherapist/Police	4 (4)
Type of delay in pathway of care	
No delay	39 (39)
Some delay	42 (42)
More delay	19 (19)

As shown in table 3, the majority 76 (76%) patients sought health services from medical colleges at first point of contact for their perceived symptoms, 23 (23%) patients approached a government hospital, and only one (1%) approached a primary health centre for mental health problem. The majority 45 (45%) patients had contacted general physicians and other specialty doctors at their first visit. Encouragingly, 29 (29%) patients have consulted qualified psychiatrists on their first visit, whereas 22 (22%) patients approached faith healers, and the remaining 4 (4%) contacted other health personnel like nurses, physiotherapists and police for help. About 39 (39%) patients who contacted psychiatrists within the first two contacts were considered as having no delay in pathway care of the referral, 42 (42%) patients had some delay and the remaining 19 (19%) had more delay in reaching the correct professional help.

ISSN: 0975-8585

Figure 1: Pathway of care adopted by patients in seeking mental health



As seen in Figure 1, the initial care seeking to qualified psychiatrists for mental health problems was low (29%), which gradually showed an upward trend on subsequent contacts and increased to 92% of patients by the fourth visit.

Table 4: Duration of delay in seeking care from the onset of symptoms: N=100

Time delay in seeking care in months	n (%)
1	28
2	32
3	17
4	12
5	11

The time delay for seeking health care from the onset of symptoms to the first contact ranged from one month to five months with a median delay of two months. The duration of delay was two months in seeking care in 32% of patients, a one-month gap in 28% of patients, and shockingly 11% of patients sought health care only after five months (Table 4).

DISCUSSION

The possible reasons for most of the subjects in this study being 16 to 45 years may be because this is the economically productive age group; therefore, these patients have been brought for the right care[1]. Nevertheless, the presentation of psychotic disorders more in the relatively younger age group (<40 years) has also been reported by authors in the past. This distribution in this study is highly skewed toward males (64), which might be attributed to the prevailing gender bias in Indian society, where the illness of a male member is taken more seriously than that of a female patient. The findings in the present study also support the fact that psychiatric hospital services are utilized more by male patients than by female patients. Other studies from India have made similar observations. The researchers have observed that these females are more likely to be illiterate, married, and from a lower income group and the findings of our study corroborates the earlier reports[1].The majority of patients in our study belonged to the lower socio-economic status, graduates, unmarried, skilled workers. The study also noted that patients belonging to families from illiterate, and higher socio-economic status, preferred to take treatment from private practitioners or general hospital psychiatric setups. This could be due to the perceived stigma associated with mental illnesses and with that of psychiatric hospitals. Predominance of psychotic illnesses (Schizophrenia, Bipolar affective disorder), neurotic illnesses (GAD, ADS) among these patients may indicate that patients with minor and more common mental illnesses do not seek treatment from a specialty psychiatric hospital, as there is a common myth that psychiatric hospitals are for mentally ill persons,

(Patients having psychotic disorders) rather than for patients with any other psychiatric illness. Similar findings have been reported by other authors in India, and provide important lessons for the practitioners of psychiatric medicine in India. [2] In the present study, for psychiatric illness, most cases contacted faith healers as the primary helping agency. However subsequently, after not getting any relief, they sought the help of other agencies, such as, allopathic practitioners, traditional healers, and so on. A study on the treatment of psychiatric disorders in India observed that in view of the paucity of facilities, 80% of the population had to depend on indigenous treatments consisting of Ayurvedic and Unani systems of medicine, religious treatments consisting of prayers, fasting, and so on, as also various witchcrafts and magical rituals [3]. situation is more or less the same even today, and not surprisingly 59% of the cases in our study contacted faith healers as the primary helping agency. Although, the ancient wisdom may have some role in the treatment of mental disorders, there is a need for generating awareness in the psychiatric patients in India to get professional help. The traditional healers, while dealing with psychiatric patients, often hide their inability to understand and treat these disorders and attribute them to supernatural causes, further enhancing the misbeliefs of these patients [4]. A study on the Indian indigenous healers observed that relatively more healers than doctors revealed their diagnoses to the patient; and that the healers, when they did diagnose, did so in terms of 'tick', and 'evil' and treatment was largely with ashes, mullets, and holy water. Psychiatric patients used to go through different traditional and faith healers, including indigenous methods of exorcism, before arriving to proper care. This caused a delay in presentation, which was largely attributable to the stigma associated with such illnesses, which in turn, led to suffering, and affected the outcome. An established fact that in a majority of psychiatric illnesses, (including schizophrenia, affective disorders) early diagnosis and treatment can significantly improve the outcome and prognosis, have noted that there is a longer delay on pathways involving native healers [5]. There are a few limitations to consider in this study including a relatively small sample size, the absence of a standardized questionnaire for diagnosis, and the lack of correlation with the severity of illness. Additionally, it is a single-centre study that included all psychiatric illnesses, and the sample size for each individual disease was small, making it difficult to generalize the data to the larger population.

CONCLUSION

The study found that the majority of patients attending the mental hospital suffered from severe mental illnesses and belonged to the female gender, lower socio-economic class, and was with a low educational status. Faith healers were the most commonly sought primary helping agency among the study subjects. Pathways involving faith healers and traditional healers took a longer time to reach the right psychiatric help. In the pathway of care, the fact that faith healers and traditional healers were the primary helping agency sought by patients is concerning as it has resulted in a delay in accessing psychiatric help. The results of this study emphasize the need for increasing awareness of available mental health services and improving the organization of primary mental health care. It is crucial to strengthen the linkages between mental health services and primary care, while also improving mental health training for general practitioners and traditional healers. Finally, there is a need to actively identify cases in the community and improve access to specialist services to ensure that patients receive timely and appropriate care. The need for incorporating an efficient and effective referral mechanism, the role of various service providers in the pathway of care, and the availability of services should be kept in mind when designing any mental health program in India.

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