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ORIGINAL RESEARCH ARTICLE

PATHWAY TO CARE AMONG CLIENTS ATTENDING AT PSYCHIATRIC OPD OF A TEACHING HOSPITAL, BHARATPUR

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ABSTRACT

Background: Mental illnesses cause significant suffering around the world. A limited number of people with psychiatric problems seek treatment in healthcare facilities when their condition is severe only. Treatment by faith healers and unqualified medical practitioners is frequent which lead to the delay in proper treatment. The objective of the study was to identify the pathway to care among clients attending at Psychiatric Outpatient Department of Chitwan Medical College, Teaching Hospital, Bharatpur.

Methods: Descriptive cross-sectional design was used and 166 clients attending at psychiatric OPD of Chitwan Medical College, Teaching Hospital were selected by using non-probability, consecutive sampling technique. Data were collected from 11th August 2019 to 6th September 2019 through face to face interview method using structured interview schedule. Collected data were further analyzed in SPSS version 23 using descriptive and inferential statistics

Results: The finding of the study revealed that 54.2% of clients first visited faith healer for initial treatment and only 16.9% visited psychiatrist directly for the treatment. Similarly, 53.6% of clients visited other personnel than psychiatrist due to their cultural belief and 59.6% of the clients had adequate level of awareness towards mental illness. Significant association was found between status of pathway to care and client's sex, ethnic group and occupation.

Conclusions: It is concluded that mental illness clients first approached faith healer for their initial treatment due to their cultural belief. It is important that traditional healers and other treatment providers must be aware of and recognize the mental illnesses in order to treat mental patients early and refer to psychiatrist.

INTRODUCTION

Burden of mental disorders have remained alarmingly high around the world with significant impacts on health.[1] Nearly one billion individuals worldwide suffer from a mental illness, with more than 75% of those in low-income countries not getting treatment. Nearly three million individuals die each year as a result of substance abuse. Every 40 seconds, someone commits suicide. By the age of 14, around half of all mental health illnesses have begun.[2] Globally, people are suffering from mental, neurological, or psychosocial disorders, and this number is constantly growing.[3]

Mental illness affects all part of our society, irrespective of socio-economic status. There is a big gap in the need and provision of treatment of mental illness all over the world. Person with mental disorders suffer from severe emotional, behavioral and physical health problems due to lack of treatment.[1] In Nepal, the extent, suffering, and burden of disability and costs associated with mental disorders for people, families, and societies are startling. Multi-sectoral action plan for the prevention and control of non-communicable diseases (2014-2020) estimated the 18% of the NCDs burden is due to mental illness.[4]

Pathways to care refer to the sequence of contacts a sick person makes with services supplied by individuals or organizations, triggered by the distressed person's efforts, as well as those of his or her significant others, in seeking treatment for the disease. Patients' paths to care are influenced by socio cultural factors and health service variables such as the organization, availability, and accessibility of health services.[5]
Psychiatric services are limited in many regions of the world, particularly in developing countries including Nepal. Most patients choose psychiatric services as a last resort after consulting with a variety of non-psychiatric service providers, including faith healers.[6, 7] There is a lack of awareness in general population on mental health and proper care. Thus, non-medical service providers play a key role in the treatment pathway.[8]

Mental illness is an emerging health problem in Nepal. At present, there are limited psychiatrists in Nepal and among

them about 90% are providing services in major cities. People must travel a long distance to obtain psychiatrist services. The availability of mental health services in primary and tertiary health care remains weak. Evidence showed that the psychiatric patients first seek the help of various sources before attending a psychiatric health care service. Three fourth of people are seeking help from other health professionals due to easy access.[9, 10] Similarly, a large proportion of psychiatric patients usually do not attend any health facility due to lack of awareness regarding treatment services, the distance to be travelled, and due to the fear of the stigma associated with treatment.[11]

Mental health is one of the least prioritized areas in the health care sector of Nepal. There is single national psychiatric hospital running under Nepal Government in Kathmandu. The majority of the people are still unable to meet basic mental health services. The most challenging thing for people with mental illnesses is that they are not accepted by family members and society, and people living with mental problem often experience discrimination from own family and society. In most cases we can find mentally ill clients visiting other personnel rather than the psychiatrist and at last when they finally visit the psychiatrist their condition is usually very severe. So the researcher felt the importance of identifying the pathway to care for common mental illness.

METHODS

A descriptive cross-sectional study was carried out among the patients with mental illness who were attending at Psychiatric Outpatient Department of Chitwan Medical College Teaching Hospital (CMC-TH) from 11th August 2019 to 6th September 2019. The population of the study were those mentally ill patients who had been diagnosed with either one of the anxiety disorders, or Bipolar affective disorders (BPAD), or psychotic spectrum disease or unipolar depression by the psychiatrist. Patients aged 18 years and above and who had been diagnosed with mental illness within the past 5 years were included in the study, whereas patients who were critically ill or unable to communicate and not willing to participate were excluded from the study. Non-probability, consecutive sampling technique was used to select the sample for the study.

Ethical approval was obtained from CMC Institutional Review Committee (CMC-IRC) (Reference no. CMC-IRC/076/077-057 dated August 06, 2019). The purpose of the study was explained to the patients, and informed consent was taken from each respondent prior to data collection. Data were collected by researcher themselves using structured interviews schedule and records reviews. After collecting data from patient, the information was confirmed by care provider. Data were collected at the OPD time in CMCTH from 9am to 4pm. All collected data were coded and organized before entry. Data were entered in Statistical Package for Social Sciences (SPSS) version 20 and analyzed by using descriptive statistics (frequency, percentage, median and interquartile range) to describe status of pathway to care and awareness towards mental illness. Inferential statistic (Chi-square test) was used to find out association between status of pathway to care with selected variables.

RESULTS

A total of 166 respondents were enrolled in this study. Median age of the respondents were 38 years; where minimum age was 18 years and maximum age was 78 years. More than half of the respondents (51.2%) were female, from urban area (77.7%) followed Hindu religion (82.0%), and belong to nuclear family (52.4%). Majority of the respondents (75.9%) were married and literate (84.9%). Similarly, 66.3% were employed and 85.5% reported that they had adequate annual family income to support their family. (Table 1) More than a quarter of respondents (33.7%) had a family history of mental illness and among them 57.1% had parental relationship with the respondents.

Table 1: Socio-demographic characteristics of the respondents (n=166)

Variables	Number (%)
Age (in years)	
<38	85 (51.2)
≥ 38	81 (48.8)
Median=38, IQR(Q_3-$Q_{1)}$=46-30years, Minimum=18year, Maximum=78year	
Sex	
Male	81 (48.8)
Female	85 (51.2)
Place	
Rural	37 (22.3)
Urban	129 (77.7)
Religion	
Hindu	136 (82.0)
Buddhist	15 (9.0)
Christian	15 (9.0)
Type of Family	
Nuclear	87 (52.4)
Joint	68 (41.0)
Extended	11 (6.6)
Marital Status	
Unmarried	29 (17.5)
Married	126 (75.9)
Divorced	4 (2.4)
Widow/ widower	7 (4.2)
Educational Status	
Illiterate	25 (15.1)
General literate	51 (30.7)
Basic education	32 (19.3)
Secondary education	49 (29.5)
Bachelor and above	9 (5.4)
Occupation	
Unemployed	56 (33.7)
Employed	110 (66.3)
Annual Family Income	
Adequate	142 (85.5)
Inadequate	24 (14.5)

Each quarter (25.9%) respondents were suffering from anxiety disorders and unipolar depression respectively. (Table 2) Majority of the respondents (63.3%) reported that they had initial symptoms between the age of 20 to 39 years. Similarly, first problem experienced by the respondents was depersonalization and derealization (37.4%). More than one third (36.7%) of the respondents reported that they first felt the need for help when they were not able to perform day to day activities and 54.3% found the initial change in their behavior themselves (Not shown in table).

Table 2: Respondents' final diagnosis (n=166)

Variables	Number (%)
Final Diagnosis	
BPAD	39 (23.5)
Psychotic spectrum disease	41 (24.7)
Unipolar depression	43 (25.9)
Anxiety disorder	43 (25.9)

More than half of the clients (59.6%) had adequate level of awareness towards mental illness where 40.4% had inadequate level of awareness towards mental illness. (Table 3). Likewise, 44% clients had a distance of less than one hour from their residence to psychiatric OPD, CMCTH and 61.5% visited first psychiatric consultation for treatment within a period of less than ten weeks after their psychiatric problem (Not shown in table).

Only 16.9 % respondents consulted a psychiatrist as the first contact, while 90 (54. 2 %) of the respondents first consulted with non medical service provider (traditional healers). Regarding factors responsible for visiting other than psychiatrist, 53.6% respondents were answered due to their cultural beliefs, stigma (8.7%), easy access (11.6%), lack of psychiatric service (10.9%) and belief as non psychiatric illness (15.2%). Similarly, nearly half (47.0%) of the respondents other family members initiated first contact for their initial problem. (Table 4)

Table 3: Respondents' level of awareness towards mental illness

Level of awareness	Number (%)
Adequate (≥ Median)	99 (59.6)
Inadequate (< Median)	67 (40.4)
Total	166 (100.0)

Median=11, IQR: Q3-Q1=12-10, minimum=3, maximum=15

Table 4: Respondents' status of the pathway to care (n=166)

Variables	Number (%)
First Contact Person	
Medical service provider (health person/physician)	48 (28.9)
Psychiatrist	28 (16.9)
Non- medical service provider (faith healer)	90 (54.2)
First Contact Initiated By	
Client self	40 (24.1)
Spouse	44 (26.5)
Other family members	78 (47.0)
Friends	4 (2.4)

There was a significant association between status of pathway to care with sex (p=.025), ethnic group (p=.003) and occupation (p=.041) of the respondents (Table 5).

Table 5: Association between the respondent's status of pathway to care and selected variables (n=166)

Variables	Status of Pathway			χ^2value	*p*-value
	Medical No. (%)	Non-medical No. (%)	Directly to psychiatrist No. (%)		
Age					
< 38 years	20 (23.5)	52 (61.2)	13 (15.3)	3.560	.169
≥ 38 years	28 (34.6)	38 (46.9)	15 (18.5)		
Sex					
Male	26 (32.1)	36(44.4)	19 (23.5)	7.413	.025
Female	22 (25.9)	54(63.5)	9 (10.6)		
Place					
Rural	13 (35.1)	19 (51.4)	5 (13.5)	1.027	.599
Urban	35 (27.1)	71 (69.1)	23 (17.8)		
Ethnic Group					
Brahmin/Chhetri	34 (35.1)	42 (43.3)	21 (21.6)	11.333	.003
Janjati/Dalit	14 (20.3)	48 (69.6)	7 (10.1)		
Type of Family					
Nuclear	27 (31.8)	45 (52.9)	13 (15.3)	0.797	.671
Joint	21 (25.9)	45 (55.6)	15 (18.5)		
Education					
Illiterate	6 (24.0)	16 (64.0)	3 (12.0)	9.285	.054
Literate	13 (25.5)	34 (66.7)	4 (7.8)		
Basic education and above	29 (32.2)	40 (44.4)	21 (23.3)		
Occupation					

Unemployed	11 (19.6)	38 (67.9)	7 (12.5)	6.369	.041
Employed	37 (50.9)	52 (47.3)	21 (19.9)		
Level of awareness					
Adequate	29 (29.3)	54 (54.5)	16 (16.2)	0.089	.956
Inadequate	19 (28.4)	36 (53.7)	12 (17.9)		

Significance level at 0.05

DISCUSSION

The findings of the study suggest that pathways to care for clients with mental disorders such as anxiety disorders, BPAD, psychotic spectrum disease or unipolar depression at CMC TH are diverse and the main care providers involved are non medical service provider; faith healer (54.2%) general practitioners (28.9%) and only 16.9% visited directly to a psychiatrist. This finding is similar to other different studies which showed that majority of the clients first contacted with faith healer.[11,12,9] Cultural belief was the major reason for visiting to faith healer for initial treatment. This study revealed that nearly half of the respondents (47.0%) had initiated first contact via their family members for their initial problem. This finding is consistent with the study conducted in Nepal revealed that more than half of the respondents (53.9%) were initiated by family members/ relatives for psychiatric consultation.[13] This might be because of the good support system in the family.

According to findings of the study, the median age of onset of illness was 33 years; majority of the patients (63.3%) belonged to the young age group (20 to 39 years). This finding is consistent with study conducted in India which revealed that most of the mental illness occurred in the age group of young age.[14] The fact that the majority of the respondents in this study are young may be due to the fact that this is the most economically productive age group; as a result, these patients have been brought for proper care. However, experts have previously found that psychotic illnesses manifest themselves more frequently in the relatively younger age group (<40 years).[15-17]

The finding of the study revealed that more than half of the respondents (59.6%) had adequate level of awareness towards mental illness. However the study conducted in Bangladesh showed that more than half of the respondents (56.28%) were not aware of any of mental health conditions.[18] This variation could be due to differences in geographical distribution, sample size and clients characteristics. In the study, majority of the respondents (61.5%) approached to psychiatric care within duration of less than ten weeks. This finding is consistent with the study conducted in Nepal which revealed that more than half of the respondents (57.6%) approached psychiatric care within ten weeks of onset of symptoms.[13] This is the positive finding and a good indicator of psychiatric service utilization among clients with mental problems.

In this study, sex of the respondents was significantly associated with status of pathway to care (p=.025). In contrast to this finding, the study conducted in Ghana[7] revealed that sex was not associated with pathway to care. This might be due to use of different tool or inclusion of different nature of clients.

The limitation of this study was that it was conducted at a Chitwan Medical College, teaching Hospital only thus study findings may not be generalization to other setting. The patient groups used in this study were heterogeneous and the pathway to care may have affected them. As severe mental disorders, which were less represented in this study, are the ones who are likely to reach mental health services as first contact. Despite of this, this study explore the mental illness patients' pathway to care which will be helpful for the further planning and implementation of the services to targeted group.

CONCLUSION

Based on finding, it can be concluded that most of the clients with mental illness first approach with faith healer for their initial treatment whereas only few clients directly visit to psychiatrist for their initial treatment. Pathways involving faith healers, health personnel and general physician took a longer time to reach the right psychiatric help. Deeply rooted cultural practice is a major influencing factor for not approaching psychiatrist for their initial treatment. So, there is need for implementing an efficient and effective referral process, the involvement of various service providers in the treatment pathway and the availability of services.

CONFLICT OF INTEREST: None

FINANCIAL DISCLOSURE: None

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