

Change in attitude and help-seeking pattern of caregivers and patients with mental disorders in the community - Recent findings from India

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ABSTRACT

Knowledge of factors related to patients' and primary caregivers' health-seeking behaviour is required for a complete early intervention for the management of mental illness. Previous research has found that men are more likely to seek care and that a considerable proportion of patients seek help from native healers before obtaining psychiatric help. The goal of this study was to see if there had been any changes in the paths to psychiatric care, as well as the socio-demographic characteristics that were linked to early help-seeking behaviour among patients with mental illnesses in metropolitan eastern India. **Method:** The researchers utilised a cross-sectional study design. A face-to-face interview was used to collect data using the WHO Encounter Form. Using a successive sample technique, patients with various diagnoses of mental illness undergoing Psychiatry outpatient therapy at a tertiary care medical college were included in the study. **Results:** In terms of gender, ladies (53.3%) were seen to use psychiatric services more than males (46.7%) from an urban or semi-urban background. For dissociative disorders, the median time from onset to first contact with a care provider was 0.1 years; 0.3 years for mood episodes; 0.6 years for anxiety disorders; one year for psychotic disorders; and seven years for Substance Use Disorders (SUD). However, interaction with current psychiatric services took an average of six months for dissociation; 3.5 years for mood disorders; three years for anxiety disorders; six years for psychotic disorders; and a maximum of seventeen years for SUD. Participants in the study who had a family history of mental illness sought care more quickly (OR = 4.3, 95 percent CI 1.19 to 7.11, $P = 0.03$). The fact that 73 percent of patients have a GP or mental health professional as their first point of contact for various mental diseases is good. Higher education status, urban background, dwelling closer to the mental health centre, and having a biological attribution model for psychological illness were the other clinical and demographic characteristics important for quicker paths to mental health treatment. **Conclusions:** In most cases of psychosis and SUD (substance use disorders), there is still a significant delay in receiving modern psychiatric therapy. The number of initial contacts with Native Healers has decreased. The majority of people said mental illness was caused by environmental or biological factors. Education and scientific information regarding mental health have aided the process of seeking treatment, and there should be a provision of training programmes for family physicians and community health professionals to facilitate the process of help-seeking behavior of psychiatric patients in the Indian subcontinent.

Keywords: Anxiety disorder, dissociative disorder, mental health, mood disorder, pathways to mental health care, psychosis

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Pathway to Mental Health Care

Many regions of the world, particularly LMICs (Low to Middle-Income Countries) like India, have limited mental health

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facilities, but even when they are available, a large number of patients prefer it to be the last choice. As a result, valuable time is lost that could have been used to identify and treat mental problems earlier, resulting in a better prognosis. The data from numerous research on the path to psychiatric care not only calls for an increase in the number of mental health services but also aids in identifying the social and cultural elements that influence help-seeking behaviour and should be addressed. The pathway is characterized as a series of interactions with individuals and organizations that are initiated by the distressed person's and his significant others' efforts to seek suitable assistance.^[1]

In the majority of cases, cross-sectional studies on the patterns of treatment-seeking behaviour for mental diseases in African nations such as Ethiopia and Nigeria indicated a considerable delay in modern psychiatric treatment-seeking behaviour. Traditional healers were often the first people to seek care for mental illness. These studies also revealed that interventions aimed at raising public awareness regarding the causes and treatment of mental illness could shorten the time it takes for people to seek treatment and enhance treatment outcomes.^[2,3] Further studies reveal that collaboration between orthodox and non-orthodox health services could make it easier for people with schizophrenia to get the therapy they need, reducing the amount of time they spend in untreated psychosis.

Another study in Nepal looked at the path to care for patients who had a manic episode and discovered that even among the educated, the concept of biological causes of mental illness is uncommon. Mental illnesses have been related to life difficulties, societal or family problems, and bad spirits. Sixty percent of patients went to an indigenous healer before seeing a doctor. Even when they resided in close proximity to health care services, 80 percent of the patients were brought after many weeks of illness. The data suggest that even in urban areas, people are unaware of psychiatric disease and have a strong faith in faith healers.^[4]

Older age, marital status, somatic complaints, anxiety, and depression were all linked to delayed paths to psychiatric care in Preston, according to a study. Suicidal ideation patients were seen within three days. They also discovered that establishing community teams resulted in a 22 percent rise in the number of patients seen, with neurotic illnesses seeing the most growth. In addition, shorter routes were linked to younger age and suicidal ideation.^[5]

Another research of mental treatment routes in a tertiary level general hospital in western India discovered that urban persons were more likely to be late for psychiatric consultations than rural people. In addition, despite contentment, relapse, cost, and distance may lead to the termination of psychiatric consultation. Traditional Healer consultation was determined to be the least satisfying, but 40 percent of new cases liked it. As a result, availability and reputation were prioritized over the conceptual framework.^[6]

Another investigation of the pathway of care among psychiatric patients at a mental health facility in central India discovered that a large proportion of psychiatric patients do not attend any health facility due to a lack of awareness about treatment services, the distance, and the stigma associated with treatment. Prior to entering a psychiatric health centre, psychiatric patients seek support from a variety of sources. The study concluded that while developing a mental health programme, it is important to consider the path taken by these patients.^[7]

A cross-sectional study of help-seeking behaviour of patients visiting a mental hospital in Delhi found that the majority of patients (57.7%) went straight to psychiatrists, with only about 30% choosing religious faith healers as their first choice, indicating minor positive changes in societal perceptions of psychiatric illnesses. Trust, ease of availability and accessibility, recommendations from significant individuals, and belief in the supernatural origin of sickness were all key sociocultural variables in deciding on a certain facility.^[8]

Another descriptive research of patients with serious mental problems in Puducherry, South India, found that roughly one-third (34.7%) went to traditional healers as their first point of contact, while nearly half of the individuals saw psychiatrists directly. Significant delays between each point of contact have been documented, particularly in the case of individuals with schizophrenia and Bipolar Disorder.^[9]

According to a cross-sectional survey conducted in 14 locations across Nepal, the majority of patients with serious mental diseases first visited with faith healers (49%) before seeing medical doctors (13%) or psychiatrists (28%). The initial psychiatric consultation took an average of three weeks. Epilepsy had the greatest time between commencement of illness and psychiatric care, followed by neurotic illness and psychotic illness.^[10]

Methods

Using a successive sampling strategy, patients with mental and behavioural issues who visited the outpatient Department of Psychiatry at a Tertiary care Medical college were included in the study. Both in-patient and outpatient departments were involved in the research. After getting approval from the institutional ethics committee, the study was carried out. The research lasted two years, from December 2018 to December 2020.

- (i) A semi-structured interview to obtain a socio-demographic profile, which includes variables such as age, gender, marital status, education, family information, occupation, income, residence, distance from the hospital, family history of mental illness, family attitude toward mental illness, expenses incurred on the way to mental health care, and so on.
- (ii) Encounter form developed by the WHO (1987)^[11] for pathway study. It begins with basic information about the patient, such as name, date, first visit to a mental health facility, the first symptom experienced by the patient, when it occurred, and the diagnosis. The decision to seek care

first, who was first seen, when and who made first contact, and the first symptoms and treatment are all included in the following section of the form. It also contains the same information regarding the first referral, the second referral, and the third referral. The encounter form has already been utilised in studies on mental care pathways in China, Southwest Ethiopia, Japan, Bangladesh, and Jaipur, among other countries (Rajasthan, India).

After obtaining proper informed consent, patients with mental diseases and their caregivers were questioned for demographic data and details provided in the WHO Encounter Form. A semi-structured interview was used to gather information. Only participants who gave proper informed consent were included in the study, and they had the option to refuse or withdraw their participation at any moment. The client's respect and confidentiality were protected.

Results

A total of 120 patients who visited a multi-speciality hospital's psychiatry department were interviewed. The majority of the patients ($n = 96$, 80%) were between the ages of 20 and 50, with a female predominance ($n = 64$, 53%).

Twenty-five (75%) of the 33 (27.5%) patients who had a family history of mental illness sought help within two years of the commencement of their disease. Those with a family history of psychiatric disease were more likely than those without a family history to seek specialist mental health care [Table 1]. (OR 4.37; $P = 0.02$)

Only 8% ($n = 9$) felt mental illness was caused by witchcraft or supernatural powers, while the majority ($n = 111$, 92%) used a bio-psycho-social model of attribution [Table 1].

Table 1: Depicting the socio-demographic, clinical and care-pathway variables of the study population

Variables	P with an odds ratio
Gender	
Male ($n=56$)	OR=0.91, $P=0.62$
Female ($n=64$)	
Education	
Graduates ($n=52$)	OR=0.86, $P=0.45$
Undergraduates ($n=68$)	
Background	
Rural ($n=28$ (23%))	OR 1.73, $P=0.05$
Urban ($n=92$ (77%))	
Distance from MHC	
<20 km ($n=92$ (77%))	OR 2.17, $P=0.04$
>20 km ($n=28$ (23%))	
F/h Psychiatric illness	
33 (27.5%)	OR 4.37, $P=0.02$
Point of First Contact	
Medical Practitioners ($n=52$, 43%)	
General Hospital ($n=20$, 17%)	
Psychiatrists ($n=28$, 23%)	
Native Healers ($n=20$, 17%)	

Patients with psychotic illnesses ($n = 15$, 12.5%) sought help after an average of 18 months from the onset of the disease, but only after a 6-year wait for psychiatric care. Patients with mood and anxiety disorders ($n = 85$, 70.8%) had the shortest pathway (about three and a half years), whereas somatoform and dissociative disorders ($n = 20$, 16.6%) had the longest (approximately six years).

Discussion

The primary objective of the study was to examine if there had been any recent changes in the path of care that individuals with mental illnesses take when seeking help, as well as to figure out what factors influence that process.

In our study, the majority of the population (66%) had first contacted a medical practitioner, 17% had contacted a mental health professional, and only 17% had contacted native healers, which is similar to the findings of a study from New Delhi, India, which found that only 8% of patients contacted traditional healers as their first point of contact.^[7,12] However, prior studies from Gwalior, Jaipur, and Ranchi found that traditional healers were the initial point of contact in 69%, 40%, and 61% of instances, respectively, and that less than 10% of people sought a psychiatrist as the first aid.^[1,7,13,14] Research from Nepal found that the majority of patients with severe mental problems first met with religious healers (49%), then with medical doctors (13%) or psychiatrists (28%).^[10] This shows a variation in the help-seeking behaviour of the individuals and a variable reliance on traditional healers. This reveals a wide range of individuals' help-seeking behaviour as well as a varying dependence on traditional healers. The main cause of the disparity could be cultural or regional factors influencing the level and kind of use of existing healthcare facilities, as well as knowledge and understanding of mental diseases.^[10] In some parts of India, culturally recognised traditional practices such as temple healing are permitted, while they may not be in other places.^[9]

In the current study, females accounted for 53.3% of the psychiatric population, while males accounted for 46.7%. Females who sought psychiatric help were also found to be more likely to be literate, married, and employed. This is in contrast to earlier Indian investigations, which showed a male-biased distribution.^[7,15-18] The higher male presentation was related to gender prejudice in society, where a male member's disease is viewed more seriously than a female member's. However, our research found a shift in gender representation in psychiatric settings, which could be due to a rise in female literacy, socioeconomic level, and awareness.

A comparison of the help-seeking behaviour of 43% of graduates and 57% of undergraduates found that education level had no influence on help-seeking behaviour. The majority of the subjects were educated, and the most chosen career route was that of a medical practitioner, according to our observations. This finding is consistent with previous research, which found that patients from urban, literate, and higher socioeconomic class families chose private practitioners or general hospital psychiatric

settings for treatment. This could be related to the stigma associated with mental diseases as well as psychiatric facilities.^[7]

Those who lived within 20 kilometres (77%, $n = 92$) of a mental health centre were more likely to seek help than those who lived further away, according to the current study. Previous research from neighbouring countries such as Nepal^[4] found that 80 percent of patients with manic disorders were brought after many weeks of sickness, even though they lived close to health care resources. As a result, in the urban setting, a shift in the assistance-seeking pattern may be seen, with a majority of people living near mental health care facilities seeking help early.

Patients from rural areas accounted for 23% of the total, while patients from sub-urban areas accounted for 47%, and patients from urban areas accounted for 36%. This is in stark contrast to prior studies, in which a majority of patients were from lower socioeconomic backgrounds and came from rural areas. Patients from urban, literate, and higher socioeconomic class families preferred to seek therapy from private practitioners or general hospital psychiatric settings, according to the study. This could be related to the stigma associated with mental diseases as well as psychiatric facilities.^[7,10] And need to have regular training programmes for family physicians and community health professionals to facilitate the help-seeking behavior of psychiatric patients and timely referrals in the Indian subcontinent.

Only 8% ($n = 9$) believed mental illness was caused by witchcraft or supernatural powers, while the majority ($n = 111$, 92%) used a bio-psycho-social model of attribution. When compared to prior studies that indicated mental illness was linked to evil spirits, life pressures, social conflicts, and other self-explanatory magico-religious attribution models of mental illness,^[1,4] this conclusion is highly encouraging.

Conclusions, Implication and Future Directions

With an increase in female representation in the distribution, a significant change in help-seeking behaviour, and an attribution model of sickness, indicating greater awareness, this study provides intriguing insights into the current pathway to care model. Even while there is still a delay in obtaining psychiatric care, particularly in the case of psychosis and substance use disorders, there has been a decrease in the frequency of initial contact with native healers.

The majority of people said mental illness was caused by environmental or biological factors. As a result, community-level education and scientific awareness about mental health-related concerns would make the process of seeking treatment easier. Because primary care physicians and practitioners are the community's first point of contact, they should be trained to be receptive and competent in the first management of psychiatric disorders and referral of serious mental illnesses such as psychotic disorders, severe mood disorders with suicidal attempts,

and other complex conditions with comorbidities to specialized mental health care centers or postgraduate psychiatry department of nearest medical college. This could result in a shorter period of untreated sickness, improving the prognosis.

School education programme, mental health awareness campaigns in the underprivileged areas, and employment of more mental health professionals at districts and community levels, as well as more training of professional and paraprofessional regarding psychiatric disorders, would make a paradigm shift in care-seeking pathways of our society.

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Conflicts of interest

There are no conflicts of interest.

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