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First Contact and Referral to Psychiatric Facility

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ASSOCIATION OF SOCIO-DEMOGRAPHIC FACTORS WITH FIRST CONTACT AND MODE OF REFERRAL TO TERTIARY CARE PSYCHIATRIC FACILITY IN ISLAMABAD

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ABSTRACT

Objective: To assess the association of socio-demographic factors with the first contact of patients and the modes of referral to a private tertiary care psychiatric facility in Islamabad, Pakistan.

Study Design: Cross sectional study.

Place and Duration of Study: Fauji Foundation Hospital, a private tertiary care psychiatric facility in Islamabad and the study period was from Jun to Dec 2016.

Methodology: Two hundred and forty six patients presenting to a psychiatric facility in Islamabad from June to Dec 2016 were made part of the sample. The age, gender, educational status, marital status, locality of residence, monthly family income, point of first contact and mode of referral to psychiatric service were recorded.

Results: Out of 246 patients (61.4% females and 38.6% males), the majority of patients (38.2%) consulted faith healers as their first contact for mental health care, followed by general practitioners (23.2%), medical specialists (14.6%) and traditional medical practitioners (14.2%). Only 9.8% patients reported to a psychiatrist directly. Local general practitioners were the primary source of referral to psychiatric services in majority of patients (40.7%). The educational status, monthly family income and locality of residence were significantly associated with the choice of first contact.

Conclusion: Strategies to improve pathways to mental health care must foster collaboration between key community-based providers and specialist mental health service providers, particularly in rural areas with low literacy and socio economic settings.

Keywords: First Contact, Mental Illness, Pathways to care, Referral.

INTRODUCTION

The World Health Organization (WHO) defines health as 'a complete state of physical, mental and social well being'. Health Belief Systems, essentially being a function of culture and psychosocial environment, strongly influence subjective experience of health, ill-health and treatment seeking behaviors[1].

When an individual becomes ill, a variety of factors come together to determine the response of the individual and his family to the illness. The patients along with their significant others may follow a process of treatment seeking determined by personal, psychosocial and cultural factors[2].

The availability and accessibility of health services is another variable that plays a role. Thus a chain of events is set up where a patient may contact a variety of service providers for consultation. This service provider may or may not be a qualified practitioner providing evidence based specialist care. In particular, there appears to be a lack of awareness regarding mental health issues in the general public. Thus many patients with mental health and psychosocial problems may not report directly to specialized services for treatment[1,2].

Pakistan is a low and middle income country with the majority of population being rural based; low literacy rates, socioeconomic constraints and cultural health belief models generally dictate that traditional practitioners and faith healers provide a convenient and affordable alternative to the expensive and often inaccessible modern health care. A research from Pakistan

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explored the pathway to care in absence of a well developed health care infrastructure. Naqvi (2009) described that a substantial amount of time is lost due to socio-cultural perspectives of treatment seeking in psychotic patients and their families[2]. If the conventional treatment options are ineffective, the patients might move along the pathway to care towards specialized medical health care professionals. A study of the pathway of care helps in analyzing the utilization of health services, identifying the sources of delay in receiving appropriate care, and to implement suitable remedial measures[3].

It has long been realized that non-orthodox medicine plays a significant role in delivery of health care in all countries, in some cases only one in four primary care patients with depressive symptoms were found to be receiving treatment from a GP or psychiatrist[4]. This is particularly relevant in low- and middle-income countries where there are greater possibilities for collaboration between Traditional/Complementary Medicine and Specialized health care in the management of persons with mental illness[5]. In a local research conducted in Lahore, the majority of Muslim psychiatric patients reported that they had sought diverse traditional healing methods, including Homeopathy, Naturopathy (Tibb), Islamic Faith Healing, and Sorcery, for their mental health disorders before reporting to specialized psychiatrists at tertiary care hospitals[6]. Mutual collaboration among faith healers and biomedical health care providers is dependent on education, regulation and shared responsibility[7].

Research is required to clearly delineate the boundaries of such collaboration and to test its effectiveness in producing improved patient outcomes. The present research was conceptualized to assess the pathways to mental health care in a private tertiary care psychiatric facility in Islamabad. The association of socio demographic and clinical characteristics of the study participants was also determined in relation to the pathway to care in mental health settings. An understanding of the research findings will provide an insight into the psychosocial determinants of treatment seeking; that will inform effective strategies for improving utiliza-tion of specialist mental health services.

METHODOLOGY

This was a cross sectional study to assess association in which consecutive sampling was used to invite all adult patients, male and female, presenting to Fauji Foundation Hospital, a private tertiary care psychiatric facility in Islamabad; who were making their first contact with the study centre during the study period (June to December 2016). Patients who had attended any other specialty psychiatric health facility in the past 01 year were excluded because such cases might have a recall bias regarding their pathway to care based on their past utilization of psychiatric services. We also did not include patients who were unable to give appropriately detailed account due to severe psychiatric illness, and where reliable informant was not available to provide collateral information. After applying inclusion and exclusion criteria, a total of 246 patients were finally included in the study.

Approval was obtained from the institute's ethics review board. All study participants were informed about the study and its objectives to explore the pathways to mental health care in a private tertiary care psychiatric facility in Islamabad. After written informed consent was obtained from each participant, each individual was assigned a serial reference number and all data was subsequently handled in total anonymity and confidentiality.

The relevant socio demographic details including the age, gender, educational status, marital status, locality of residence, monthly family income, point of first contact and mode of referral to psychiatric services of all participants were entered in a specially designed data collection form. The clinical diagnosis was also recorded for each study participant after detailed psychiatric interview by qualified psychiatrist.

The data was entered and analyzed using SPSS version 20.0. The variables in this study included: Age, gender, educational status, marital

status, socioeconomic status (monthly family income), locality, point of first contact in health seeking and mode of referral to psychiatric services. Descriptive statistics (mean, standard deviation, and percentages) were used for summarizing the study variables. For categorical variables, the association was tested using the chi square test and a *p*-value of <0.05 was considered statistically significant.

RESULTS

The total number of study participants was 246. The mean age was 35.65 ± 11.96 years with a range of 16 to 61 years. Of all, 151 (61.4%) were females and 95 (38.6%) were males.

Table-I: Socio-demographic characteristics of study participants (n=246).

Variable	Frequency	Percentage(%)
Age (in years)		
16-29	83	33.7
30-49	129	52.5
>50	34	13.8
Gender		
Male	95	38.6
Female	151	61.4
Educational level		
No formal education	44	17.9
Primary education	90	36.6
Secondary education	51	20.7
Tertiary education	61	24.8
Marital Status		
Unmarried	76	30.9
Married	119	48.4
Widowed/Divorced	51	20.7
Locality of Residence		
Rural	142	57.7
Urban	104	42.3
Monthly Family income (in PKR)		
<15K	86	35.0
15-30K	102	41.5
>30K	58	23.5
Clinical Diagnosis		
Depressive disorder	95	38.6
Bipolar affective disorder	50	20.3
Schizophrenia	47	19.1
Anxiety disorder	54	22.0

Out of the total sample of 246 patients, 94 (38.2%) consulted faith healers as their first contact for mental health care. The rest included 57 (23.2%) patients going to general practitioners, 36 (14.6%) who sought out medical specialists and 35 (14.2%) who presented to traditional medical practitioners for their first consultation. Only 24 (9.8%) patients reported to a psychiatrist directly.

Local general practitioners were the primary source of referral to psychiatric services in majority of patients (40.7%) followed by medical/other specialist (29.7%) and self/family (19.5%). The educational status, monthly family income and locality of residence were significantly associated with the choice of first contact; patients from rural background with no formal education and low monthly income were more likely to seek care from faith healers.

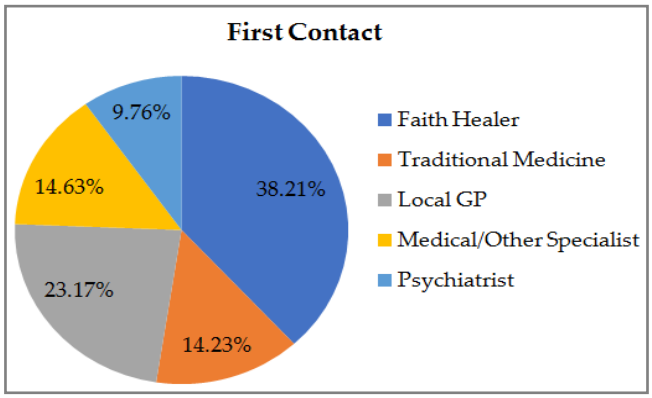

Figure: First point of contact for mental health care.

DISCUSSION

In Pakistan, faith healers and traditional medical practitioners are an easily accessible and culturally accepted source of treatment for various psychiatric disorders. Our findings highlighted the role of faith healers as first contact for mental health care, and the majority of patients (38.2%) reported seeking help from faith healers at the start of their treatment.

Previous studies of patients consulting providers of Traditional medicine in low- and middle-income countries provide a similar perspective where these patients appear to have high rates of psychiatric disorders. However the clinical diagnoses were varied depending on the methods employed and the disorders examined[5].

A local research conducted in Lahore explored the variety of traditional healing practices available for Muslim psychiatric patients who had now presented to tertiary care psychiatric hospitals in Lahore[7]. Out of 87 adult psychiatric patients (38% male and 62% females) included in the study, the majority reported that they had sought diverse traditional healing methods, including Homeopathy, Naturopathy (Tibb), Islamic Faith Healing, and Sorcery, for their mental health disorders before reporting to specialized psychiatrists at tertiary care hospitals.

While conducting a study of attendees at native faith healers in Rural Pakistan, Saeed et al found an overall rate of DSM-III-R diagnoses of 61% using the Psychiatric Assessment Schedule[8]. Similarly high rates of traditional faith healing practices were reported by a study in Cairo, Egypt, where the authors investigated the pattern of consulting traditional healers among 350 patients diagnosed with bipolar affective disorder. In all, 40.8% sought traditional healers as their first point of contact[9].

Another research with concordant findings assessed nonpsychiatric treatments and traditional and folklore management of psychiatric disorders in Minia Governorate, Egypt. The majority of the patients (86.8%) were treated by non psychiatric medical and traditional services before they sought psychiatric care[10].

The popularity of faith healers as first choice for psychiatric patients is also evident from a study where majority of patients with mental disorders in Bangladesh were also found to have first consulted native practitioners[11]. In a Nigerian study, nearly 76% of the population used traditional/ faith healers as their first treatment option[12]. This finding may be explained on account of the fact that a general belief in supernatural forces as the cause of mental

Table-II: Association of socio-demographic characteristics and first point of contact in pathway to care.

Variable	Faith-Healer n(%)	Traditional Medical Practitioner n(%)	Local General Practitioner n(%)	Medical/Other Specialists n(%)	Psychiatrists n(%)	$\chi 2$	*p*-value
Age (in years)							
16-29	33 (39.8)	12 (14.5)	12 (14.5)	18 (21.7)	8 (9.6)	12.32	0.138
30-49	50 (38.8)	19 (14.7)	35 (27.1)	11 (8.5)	14 (10.9)		
>50	11 (32.4)	4 (11.8)	10 (29.4)	7 (20.6)	2 (5.9)		
Gender							
Male	34 (35.8)	10 (10.5)	27 (28.4)	14 (14.7)	10 (10.5)	3.64	0.453
Female	60 (39.7)	25 (16.6)	30 (19.9)	22 (14.6)	14 (9.3)		
Educational level							
No formal education	16 (36.4)	7 (15.9)	13 (29.5)	5 (11.4)	3 (6.8)	24.91	0.015
Primary education	38 (42.2)	16 (17.8)	20 (22.2)	12 (13.3)	4 (4.4)		
Secondary education	20 (39.2)	8 (15.7)	12 (23.5)	9 (17.6)	2 (3.9)		
Tertiary education	20 (32.8)	4 (6.6)	12 (19.7)	10 (16.4)	15 (24.6)		
Marital Status							
Unmarried	35 (46.1)	11 (14.5)	9 (11.8)	12 (15.8)	9 (11.8)	10.69	0.220
Married	41 (34.5)	15 (12.6)	37 (31.1)	16 (13.4)	10 (8.4)		
Widowed/Divorced	18 (35.3)	9 (17.6)	11 (21.6)	8 (15.7)	5 (9.8)		
Locality of residence							
Rural	57 (40.1)	28 (19.7)	39 (27.5)	8 (5.6)	10 (7.0)	31.24	<0.001
Urban	37 (35.6)	7 (6.7)	18 (17.3)	28 (26.9)	14 (13.5)		
Monthly Family Income (in PKR)							
<15K	39 (45.3)	19 (22.1)	17 (19.8)	7 (8.1)	4 (4.7)	66.81	<0.001
15-30K	41 (40.2)	15 (14.7)	33 (32.4)	9 (8.8)	4 (3.9)		
>30K	14 (24.1)	1 (1.7)	7 (12.1)	20 (34.5)	16 (27.6)		

disorders is highly prevalent in the traditional Nigerian society. Only 6% of the participants presented first to a psychiatrist. This is close to our result of around 9.8% patients reported to a psychiatrist directly. The scarcity of professional psychiatric services in most parts of both developing countries may play a role here.

A recent systematic review also identified stigma related to mental health disorders as a factor leading to patients avoiding help seeking in general, resulting in delays in consulting a GP or psychiatrist[13]. However in a research including an urban section of multiethnic Asian population in Singapore, authors reported that 15.7% of the patients with mental illnesses had sought help from psychiatric healthcare providers from the onset of illness[14]. The better educational profile of patient population in this study along with easier access to psychiatric services in urban area may have contributed to these results.

In addition to traditional and faith based practitioners, our results highlighted that local general medical professionals significantly contributed to primary care of psychiatric patents. 23.2% patients consulted a general practitioner initially while medical specialists were the first choice of 14.6% patients.

An international review of mental health services similarly emphasized the role of primary care in resource constrained countries. The supply of psychiatrists in developing countries is much smaller than that in the developed world (typically below 0.4/100,000 versus 9-25/100,000). This invariably leads to primary care bearing the burden of mental health care provision for virtually all forms of disorders[15,16].

In an Indian study, Physicians (with degree/diploma in Medicine) were the most common first sources of help (30.2%), with general practitioners (MBBS) being the second most common (25.8%), and Psychiatrists at third place (15.6%). Each person had on average consulted more than three carers before coming to study hospital. It should be noted that the majority of these patients had urban background, thus perhaps being more amenable to accepting medically trained professionals in accessible clinics and hospitals[17].

In our study, Local general practitioners were found to be the primary source of referral to psychiatric services in majority of patients (40.7%).

Previously researchers have pointed out GPs as the gate-keepers to specialized health care. However, the challenges of constructive collaboration among biomedical and traditional health care providers leading to suboptimal health outcomes in patient care have also been highlighted in previous literature[18].

A systematic review to synthesize qualitative and quantitative research about primary mental health care in Brazil reported that primary care professionals had a limited capacity to identify and treat mental health problems, and the continuity of care between primary and specialized care remained fragile[19]. Another study explored the feasibility of a liaison psychiatry service for frequent attendees in primary care, and reported high levels of patient satisfaction when psychiatric services were integrated in primary care[20].

Our study did not identify age or gender difference as being statistically significant factors in accessing mental health care. This is similar to a cross-sectional study conducted at a psychiatric hospital in Ghana involving 107 patients. The authors reported that nearly 48% of patients initially consulted non-psychiatric treatment centers (faith-based, traditional healers and general medical practitioners) as their first point of contact for treatment of mental disorders. Similar to our research, the authors did not report any significant association between pathways to care and the age or gender of the participant[21].

Our research findings indicated that the educational status of patients was significantly associated with the choice of first contact. Patients with no formal education were more likely to seek help from faith healers. This is similar to a study conducted among visitors to faith healing settings in Riyadh, Saudi Arabia.

Results indicated most of the visitors to the faith healers were young adults with only primary level of education, and people with higher educational levels were more likely to seek medical help instead of a faith healing treatment[22].

Comparable findings were also reported by the authors of a study carried out in Egypt that reported a positive correlation between low educational level and traditional healers' consultation. The individuals with little or no formal education were more likely to consult traditional healers[9]. Another study in Nigeria also found that participants with more than six years of education used psychiatric services as the first treatment option. Those who had cleared primary education also presented to psychiatric services earlier than patients with no formal education[12].

Patients with lower education may have negative attitudes towards psychiatrists and psychotropic medication, thus producing larger treatment gaps in this particular group. This was reported by an exploratory survey in India where the majority of uneducated patients preferred consulting faith healers for their mental health issues[23].

Similarly, a recent study conducted to identify barriers to mental health services utilization in Sudan using a mixed methods assessment included 103 patient carers and six psychiatric consultants who shared their experiences. The authors concluded that overall, 80% of patients who had only primary or no education resorted to other types of treatments before coming to the psychiatric hospital compared to 62.2% of those with higher education (secondary, university, and post graduate studies). However the difference was not statistically significant[24].

In contrast to our research, there have been few reported instances of highly educated patients preferring spiritual help seeking. In the following cross-sectional study conducted at an established Islamic spiritual healing centre in Malaysia with 357 respondents, higher education level was found to be significantly correlated with help seeking at this centre[25]. The authors attributed this to a more threatening view of the illness and supernatural attributions that appeared commonly among the sample population.

Our findings demonstrated that patients from rural background were more likely to seek care from faith healers. In Nigeria, participants living in the rural areas were significantly more likely to have used traditional healers as their first treatment option compared with patients living in the urban areas who were more likely to have used psychiatric services[12].

CONCLUSION

Community based health providers are first point of contact for the majority of population. Strategies to improve pathways to mental health care must aim to foster collaboration between key community-based providers and specialist mental health services, particularly in rural areas with low literacy and socio economic settings.

CONFLICT OF INTEREST

This study has no conflict of interest to be declared by any author.

REFERENCES

1. Üstün J. Re-defining 'Health'. Bulletin of the World Health Organization 2005; 83(11): 802-10.
2. Naqvi HA, Hussain S, Zaman M, Islam M. Pathways to care: duration of untreated psychosis from Karachi, Pakistan. PLoS One 2009; 4(10): e7409-13.
3. Burns JK, Tomita A. Traditional and religious healers in the pathway to care for people with mental disorders in Africa: a systematic review and meta-analysis. Social Psychiatr Psychiatric Epidemiol 2015; 50(6): 867-77.
4. Chin WY, Chan KTY, Lam CLK et al. Help seeking intentions and subsequent 12 month mental health service use in Chinese primary care patients with depressive symptoms. Br Med J Open 2015; 5(1): e006730.
5. Gureje O, Nortje G, Makanjuola V, Oladeji B, Seedat S, Jenkins R. The role of global traditional and complementary systems of medicine in treating mental health problems. Lancet Psychiatr 2015; 2(2): 168-77.
6. Farooqi YN. Traditional healing practices sought by Muslim psychiatric patients in Lahore, Pakistan. Int J Disability Develop Edu 2006; 53(1): 401–15.
7. Van der Watt ASJ, Nortje G, Kola L, Appiah-Poku J, Othieno C, Harris B et al. Collaboration between biomedical and complementary and alternative care providers: barriers and pathways. Qual Health Res 2017; 27(14): 2177-88.
8. Saeed K, Gater R, Hussain A, Mubbashar M. The prevalence, classification and treatment of mental disorders among attenders of native faith healers in rural Pakistan. Soc Psychiatr Psychol Epidemiol 2000; 35(2): 480-85.

9. Assad T, Okasha T, Ramy H, Goueli T, El-Shinnawy H, Nasr M, et al. Role of traditional healers in the pathway to care of patients with bipolar disorder in Egypt. Intl J Social Psychol 2015; 61(6): 583-90.
10. Kamal AM, AbdElhameed MA, Siddik MT. A study on nonpsychiatric management of psychiatric patients in Minia governorate, Egypt. Egypt J Psychiatr 2013; 34(1): 128-33.
11. Giasuddin NA, Chowdhury NF, Hashimoto N, Fujisawa D, Waheed S. Pathways to psychiatric care in Bangladesh. Soc Psychiatry Psychiatr Epidemiol 2012; 47(1): 129-36.
12. Odinka PC, Oche M, Ndukuba AC, Muomah RC, Osika MU, Bakare MO et al. The Socio-demographic Characteristics and Patterns of Help-Seeking among Patients with Schizophrenia in South-east Nigeria. J Health Care Poor Underserved 2014; 25(1): 180-91.
13. Schnyder N, Panczak R, Groth N, Schultze-Lutter F. Association between mental health related stigma and active help seeking: Systematic review and meta analysis. Br J Psychiatr 2017; 210(4): 261-68.
14. Chong SA, Abdin E, Vaingankar JA, Kwok KW, Subramaniam M. Where do people with mental disorders in Singapore go to for help? Ann Acad Med Singapore 2012; 41(1): 154-60.
15. Goldberg D, Mubbashar M, Mubbashar S. Development in mental health services - a world view. Int Rev Psychiatr 2000; 12(1): 240-8.
16. Goldberg D. Psychiatry and primary care. World Psychiatry 2003; 2(3): 153–57.
17. Gupta SK. Web model of pathways to psychiatric care for Indian setting. Intl J Health Allied Sci 2012; 1(4): 293-96.
18. Thirthalli J, Zhou L, Kumar K, Gao J, Vaid H, Liu H et al. Traditional, complementary and alternative medicine approaches to mental health care and psychological well being in India and China. Lancet Psychiatr 2016; 3(7): 660-72.
19. Amaral CE, Onoko-Campos R, Santos de Oliveira PR, Pereira MB, Ricci EC, Pequeno ML et al. Systematic review of pathways to mental health care in Brazil: narrative synthesis of quantitative and qualitative studies. Int J Mental Health Sys 2018; 12(1): 65-70.
20. Bestall J, Siddiqi N, Heywood-Everett S, Freeman C, Carder P, James M et al. New models of care: a liaison psychiatry service for medically unexplained symptoms and frequent attenders in primary care. Br J Psych Bulletin 2017; 41(6): 340-44.
21. Ibrahim A, Hor S, Bahar OS, Dwomoh D, McKay MM, Esena RK et al. Pathways to psychiatric care for mental disorders: a retrospective study of patients seeking mental health services at a public psychiatric facility in Ghana. Int J Ment Health Syst 2016; 10(1): 63-72.
22. Alosaimi FD, Alshehri Y, Alfraih I, Alghamdi A, Aldahash S, Alkhuzayem H, et al. Prevalence of psychiatric disorders among visitors to faith healers in Saudi Arabia. Pak J Med Sci 2014; 30(5): 1077-82.
23. Zieger A, Mungee A, Schomerus G, Ta TMT, Weyers A, Boge K et al. Attitudes towards psychiatrists and psychotropic medication: A survey from five metropolitan cities in India. Indian J Psychiatr 2017; 59(3): 341-46.
24. Ali SH, Agyapong V. Barriers to mental health service utilisation in Sudan - perspectives of carers and psychiatrists. BMC Health Services Res 2016; 16(2): 31-40.
25. Hasanah K, Abdullah A, Saini SM, Sharip S, Shaharom MH. Psychiatric morbidities among attenders of an islamic spiritual healing centre in Malaysia. Mental Health, Religion & Culture 2016; 19 (7): 742-51.