Introduction

Pathway of care is defined as the sequence of contacts with individuals and organizations, initiated by the distressed person’s efforts and those of his significant others to seek appropriate help (Rogler and Cortes, 1993).

In other words, Pathway of care is an outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes. Thus the outcome of studies of the ‘pathway of care’ may support the development of care partnerships and empower patients and their care providers along with necessary modification in the existing health services. Pathway of Care can also be used as a tool to incorporate local and national guidelines into everyday practice.

Importance of the pathway of care

There has always been concern about early recognition and management of psychiatric disorders. This is even more important in the case of serious psychiatric disorders e.g. psychosis, where a delay in initiation of appropriate treatment, may lead to a poor outcome (Black et al., 2001, Altamura et al., 2001, Haas et al., 1998, McGorry et al., 1996, Waddington et al., 1995,)

Pathways of care of psychiatric patients in South Asia

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Abstract: Factors causing delay in initiation of appropriate treatment at the first instance vary from region to region depending upon socio-cultural profile, education, attitude of family/society towards mental illness, perceptions, myths, beliefs, stigma attached with psychiatric disorder, availability/accessibility of psychiatric services & previous experience of receiving psychiatric help. There is also a significant role of care providers in deciding the pathways to psychiatric care. Studies regarding help seeking behaviour and attitude toward mental illnesses and services which primarily determine the pathway of care have been carried out mainly in developed nations.

The authors discuss their view that awareness modifies the cultural myths regarding psychiatric disorders. Comparing two studies regarding help seeking behaviour, one done recently and another carried out three decades back at Lucknow, the authors conclude that even though India, like many other developing nations has made considerable progress with regard to mental health care provision, the faith healers are still the first care provider for the majority of psychiatric patients. This pathway then leads to local medical practitioner, general physician and then may be a psychiatrist. There are however, instances where care seekers might revert back to faith healers or may simultaneously be seeking help from modern as well as traditional methods of therapy.

Hence, active learning from the experiences of people requiring treatment for the first time is necessary to assist service providers to purposefully plan for more effective gate-ways or pathways to mental health services.

Key words: Pathway of Care, Help Seeking Behaviour
From the beginning of the journey, after the onset of psychosis, to the appropriate destination, the help seeking behaviour of an individual depends on many factors. Factors causing a delay in initiation of appropriate treatment in the first episode psychiatric disorders vary from region to region and depend on the:

- Socio-demographic and cultural profile
- Awareness and mental health literacy
- Attitude of family/society towards mental illness
- Myths/beliefs regarding causation and mode of treatment of mental illness
- Stigma attached with psychiatric disorders
- Experiences with previous health services
- Referral Patterns
- Availability/accessibility of psychiatric services

These factors also differ in the impact they have on deciding the pathway of care in different geographical regions. The care providers also play a significant role in this. The first care provider, is the most important, and gives direction to the pathway of care to seek further help (Lincoln et al., 1998).

Research on the ‘pathway of care’ provide relevant information regarding the individual’s health seeking and illness behaviour, and promote organized and efficient patient care based on the evidence based practice. Active learning from the experiences of people requiring treatment for the first time is likely to assist service providers and policy makers to purposefully plan for more effective gate-ways or pathways to psychiatric services.

Pathway of care also gives an idea about the time taken to reach a Psychiatric specialty and to commence effective treatment. This therefore determines the “Duration of Untreated Mental Illness” (DUMI). DUMI is functionally defined as the period between the onset of symptoms and the initiation of adequate treatment and is likely to vary considerably in patients depending on their help seeking pattern. This DUMI could be hypothesized as the single most important modifiable factor predicting prognosis of psychiatric disorder. Longer the duration of untreated serious psychiatric disorder poorer the prognosis. In the case of psychotic disorders, staying psychotic for prolonged duration will obviously influence social, occupational, and interpersonal functioning of the individual. Patients with longer duration of untreated psychosis also have poorer outcomes with respect to relapse rates, control of symptoms and remission rates (Black et al., 2001, Drake et al., 2000, Verdoux et al., 1998, Johnstone et al., 1986). Long duration of untreated psychosis is also associated with ineffective and demoralizing help-seeking and a variety of traumatic events, including high rates of involuntary hospital admissions (Johnstone et al., 1986) and poorer response to antipsychotic medications and poorer treatment outcome (Loebel et al., 1992). Empirical studies have shown that the duration of untreated psychosis (DUP) averages 1 to 2 years (McGlashan, 1999, Larsen et al., 1996, Beiser et al., 1993, Loebel et al., 1992). The average DUP is even more in developing nations, the reasons for which are yet to be explored from pathways of care studies.

DUMI is a modifiable factor that could be reduced by early detection, educational and advertisement programs in the community and by modifications of hindering factors involved in psychiatric care pathways of patients. Evidence shows that reducing the duration of untreated psychosis in the first episode psychosis, gives rise to a good prognosis (Malla et al., 1999).

Pathway studies have investigated the roles of previous care providers and the time on the pathway (Linden et al., 2003, Gater et al., 1991). They help to monitor the effects of service development over time (Amaddeo et al., 2001, Harrison et al., 1997) and to promote easy and rapid access to health care, for a variety of psychiatric illnesses.
Determinants of “pathway of care”

Socio-demographic profile of community

In developing countries, the majority of the population still struggles for the basic needs of life. A significant percentage lives below the poverty line. Though literacy rates are more than 50%, the majority are literate up to primary school level. In this scenario, health insurance is a dream. In India, 70% of the population dwell in rural areas where medical services are minimal. Greater cohesion between family members, increased community tolerance and simple ways of life lead to easier accommodation of the patients with mental illness without treatment for years (Murthy, 2004, Thara et al., 1993).

An epidemiological survey in an urban population of South India showed that one third of patients with schizophrenia had received no treatment for many years (Padmavathi et al., 1998). In the study carried out at Lucknow by the authors, most of the patients belonged to a rural background and the percentage of patients who had not received treatment was even higher.

Availability and accessibility of psychiatric services

For enormous rural populations (up to 70% of the total population of most developing countries) modern psychiatry does not seem to exist (Farooq and Minhas, 2001). Many developing countries (including India and Pakistan) have now started providing services for the large populations (Goldberg, 1992, Goldberg, 1987), with the support of World Health Organization (WHO). Integration of mental health care with primary health care is also taking place in several developing countries (Cohen, 2001, Murthy, 2000). There is also a wide disparity in the type and numbers of the mental health workforce throughout the world. The median number of psychiatrists varies from 0.06 per 100000 population in low income countries to 9 per 100000 in high income countries (World Health Organization, 2001). In developing countries, where the number of specialist mental health professionals is very low in comparison to the actual demand, the provision of mental health services would remain a dream unless psychiatry is firmly rooted in primary health care (World Health Organization, 1975). Lauber and Ressler (2007) report that the most urgent problem of mental health care in Asia is the lack of personal and financial resources. Mental health concerns are a lower priority in Asia in comparison to physical health needs (Jacob, 2001).

Mental health literacy

Awareness about psychiatric disorders in general is poor and mental health literacy is low regardless of the population studied (Scott et al., 2002, Chen et al., 2000). Lack of knowledge about mental illness and its symptoms, as well as possible treatment approaches are negatively associated with health care use (Jorm, 2000).

What the public believes about mental illness, e.g. its aetiology, treatment and prognosis, and what the public considers to be the role of, and the effectiveness of, modern health services in managing mental illness would influence the health-seeking behaviour (Riedel-Heller et al., 2005, Lauber et al., 2005, Jorm et al., 2005, Angermeyer et al., 2005, Jorm, 2000).

In India, the major source of awareness about psychiatric disorders and psychiatric services in the community is the exposure to the patients suffering from a psychiatric disorder. It is not the role played by media advertisements, newspapers and various other agencies as in the Western countries (Jilani, 2009). On the other hand, Robert and Edwin (2006) in Baltimore County reported that the most common source of information was the newspaper. A study done in the UK reported that 32% of the respondents cited the media as their main source of information, 33% of respondents cited personal experience of someone with a mental disorder and a further 10% cited friends and relatives (Wolff et al., 1996). The public is still only vaguely aware of most types of psychiatric morbidity and the availability of effective treatments in developing countries. This is due to the lack of educational programmes and campaigns to raise awareness in the community.

Jilani & Trivedi (2009) report that majority (70%) of patients and their family members lack the proper knowledge from where to and how to seek proper help for behavioural problems. They did not know whether specialist (psychiatrist) help
is needed. In this study, the majority of the sample belonged to the rural population with low educational status and lower socio-economic class. People from such a background usually do not have a good understanding about basic health services. They may also not know whether psychiatric treatment is provided by the same health services which usually provide care for physical problems or whether is it provided in a different setup. This may be due to the fact that in most of the developing countries, as in India, mental health services are not integrated (partially or completely) with general health services (Cohen, 2001, Murthy, 2000). A similar view has been put forwarded by Jorm, (2000), who reported that many members of the public cannot correctly recognize mental disorders and do not understand psychiatric terms.

**Stigma of mental illness**

Stigma significantly affects the help seeking behaviour of an individual, both in developing and developed nations. Comparable to Western countries, there is a widespread tendency to stigmatize and discriminate people with mental illness in the developing world. Stigma experienced from family members is pervasive.

Social disapproval and devaluation of families with mentally ill individuals are an important concern. It holds true that patients with mental illnesses are stigmatized and suffer adverse consequences particularly with regards to marriage, marital separation and divorce (Lauber and Rossler, 2007), increased social isolation, limited life chances, and decreased access to treatment (Rosenfield, 1997, Fink and Tasman, 1992, Link, 1982). They also have poorer social functioning as assessed by housing and employment status (Corrigan, 1998). Those with the stigma of mental illness also encounter a significant barrier to obtaining general medical care (Liggins and Hatcher, 2005), failure to seek or inordinate delay in seeking appropriate care (Jacob, 2001) and recovery from mental illness (Corrigan et al., 2003).

Stigma is one of the reasons due to which many seek help from traditional healers as the prime service provider.

**Concept and explanatory models about causation of mental illness**

Depression, anxiety and unexplained somatic symptoms are not considered as mental illness in many societies. The varying cultural models of illness (Kleinman, 1980) attributes such conditions to life events, fate, supernatural causes and physical diseases and therefore reduces actual demand for mental health care.

Belief about causation of psychiatric disorder determines help seeking behaviour (Zafar et al., 2008). Therefore, a belief regarding supernatural causation of illness will promote help seeking from traditional means and biological causation about psychiatric disorder will favour help seeking behaviour from a professional (Jorm, 2000).

A recent study from South India reported that the majority of patients (70%) with schizophrenia consider spiritual and mystical factors as the cause of their predicament. The most common spiritual and mystical factors are black magic, evil spirits, conflicts among relatives and relationship difficulties (Saravanan et al., 2007).

Studies from both India and Malaysia reveal that belief by psychiatric patients in supernatural, spiritual, mystical and social causal model are associated with greater use of traditional healers and poorer compliance with medication (Saravanan et al., 2007, Razali et al., 1996). Similarly a study by Sheikh and Furnham (2000) reported that culturally determined causal beliefs of mental illness contribute to attitudes towards seeking professional help for psychological problems for Asians.

In many of the developing Asian countries mental disorders are commonly considered ‘nonmedical diseases’ that are caused by an invisible, abstract element and supernatural forces. Thus, they are thought to be the domain not of doctors, but of traditional healers (Razali et al., 1996, Thong et al., 1992, Trivedi and Sethi, 1979). Another reason to seek help from faith healers and traditional healers is that the religious healers are present in greater numbers and it is easier and cheaper to seek help from them (Kurihara et al., 2006, Trivedi and Sethi, 1979) than seeking help from modern allopathic treatment centers.
On the contrary, the belief in supernatural causation is uncommon in the West (Brändli, 1999, Angermeyer and Matschinger, 1999). A study by Wahass and Kent (1997) reported that those living in Saudi Arabia were most likely to believe that hallucinations are caused by Satan or are due to magic and hence the most effective mode of treatment would be religious assistance than British people who are more likely to believe the cause as schizophrenia or brain damage and hence need medication and psychological therapies.

**Referral patterns**

Communication between different types of care providers is rare at an individual or institutional level. In a study carried out by Jilani & Trivedi (2009), only a quarter of patients of the total sample were referred to psychiatrists by previous care providers with a major role played by general medical practitioners and the least by faith healers.

The point of concern is that in developing countries, the majority of patients do seek help from faith healers or local practitioners including quacks, but very few patients are referred to psychiatric services by them (Jilani, 2009, Kurihara et al., 2006).

There is also no gateway system in developing countries. Anyone can walk in and out through any health service without the need of any referral from previous care providers. This gives rise to a directionless help seeking behaviour. The gate keepers (the first care providers) with whom a patient first consults and are generally referred to a psychiatrist in developed nations are mostly general medical practitioners. In the majority of developing countries the first care providers are usually local practitioners (qualified Ayurvedic, Unani or quacks), general practitioners (qualified Allopathic Medical Practitioners), faith or traditional healers (Jilani, 2009, Kurihara et al., 2006, Pradhan et al., 2001, Chadda et al., 2001), and they make minimal or no referrals to psychiatrists.

**Pathway of care studies from South Asian and other developing countries**

The urgent need to explore the pathways of care and help seeking behaviour was felt after the model of psychiatric pathways put up in 1980 by Goldberg & Huxley (1980). Published literature in English, especially from South Asia and other developing countries have been reviewed.

**Studies from India**

A multi-center study by Pradhan et al (2001) aimed at finding out the pattern of first care givers of the first contact mentally ill patients at five centers in India, representing different parts of the country: Eastern part represented by Ranchi; Southern by Kerala, Western by Mumbai and Northern by Chandigarh and Delhi. Although these areas have many dissimilar socio-cultural practices, there were similarities in the selected sample so far as the age and sex were concerned. Sample sizes at different centers were a total of 384 subjects (IHBAS, Delhi-43; PGIMER, Chandigarh-65; CIP, Ranchi-76; JIH, Mumbai-100 and SHH, Kerala-100). Concerning first caregivers, 34.1% had chosen the psychiatrists, 29.4% the general practitioners and 26% had chosen faith healers and exorcists. In general psychiatrists were the preferred primary caregivers followed by other allopathic doctors and faith healers.

In term of socio-demographic profiles, no significant difference between male and female respondents regarding their choice of first caregivers for mental health problems was reported. Respondents from rural areas preferred psychiatrists much readily than their urban counterparts (p=0.006). However, the respondents from the urban areas preferred to visit doctors other than psychiatrists as first caregivers (p=0.001). Choice for the first caregiver was not influenced by gender differences, literacy status and family type.

Among all five centers, a distinct finding from Kerala was reported that 74% of the people had directly come to the psychiatrist as their first contact. This could be attributed to the higher literacy status and mental health awareness in the state as a whole.
Paradoxically the patients presenting with somatic symptoms mostly sought psychiatric consultations as compared to those having psychic symptoms (p<0.001). On the contrary patients presenting with psychic symptoms mostly sought allopathic doctors other than psychiatrists as their first caregivers (p<0.001).

A study titled “Help seeking behaviour of psychiatric patients before seeking care at a mental hospital at Delhi by Chadda et al (2001) reported that Psychiatrists were the first doctors to be consulted by the majority (57.7%) of the patients for their mental illness followed by faith healers (29.5%), alternative systems of medicine (1.3%), and physicians (11.5%).

The common reasons for visiting faith healers were easy accessibility, trustworthiness, belief in supernatural causation of mental disorder and recommendations of relatives and friends. The reasons for visiting the mental hospital either as a first choice or subsequently were recommendations by significant others (96%), lack of response to other systems of medicines (41%), availability of low cost treatment (35.9%), previous contact of an acquaintance with the hospital (15.4%), seeking second opinion about the illness (19%) and seeking hospitalized treatment (10%). Other health care facilities were primarily used because of easy accessibility and availability.

A study by Jilani & Trivedi (2009) reported that at the onset of first episode psychosis, the majority of patients and their family members (67.55% of the total sample of 151) were not aware about psychiatric disorders. The majority of patients sought first help from faith healers (60.26%) followed by local practitioners (20.53%), psychiatrist (13.25%) and General medical practitioners (5.96%). However, a significantly higher number of those patients and family members who were aware preferred help from the psychiatrist (p=0.002) and a significantly higher number of those who were unaware from faith healers (p=0.03).

During 'pathway of care’, 151 patients with ‘FENAP’ made a total of 1089 consultations with different types of care providers, including psychiatrists, general practitioners, local practitioners and faith healers. The majority of the consultations (94.55%) were made with non-psychiatrist care providers, and only 6.29% contacts were made with psychiatrists. Among non-psychiatrist care providers, 64.25% consultations were with faith healers, 23.51% consultations were with local practitioners, and 12.24% consultations were with general medical practitioners. The average number of contacts made with different types of care providers during pathways of care by patients with FENAP was 7.21.

The various beliefs in the family members regarding psychiatric problems of the patients and reasons for not seeking or discontinuing treatment from care providers from time to time during pathway of care were as follows: 'Lack of knowledge of where and how to seek proper help for such kind of behavioural problems. They did not know that specialist (psychiatrist) help was needed 72.85% (n=110); concerns of stigma' 68.21%, (n=103); depending upon severity of illness, when severe they took the treatment, when it subsided, they left the treatment 67.55% (n=102); and belief that symptoms will resolve on its own as it is due to supernatural phenomenon and needs faith healing 66.23% (n=100), considered that patient was dramatizing/feigning 45.03% (n=68), lack of resources 52.98% (n=80). These myths and beliefs acting as barriers to seeking help were significantly less among those who were aware about psychiatric disorders (p<0.5) at or prior to onset of psychosis, emphasizing the fact that awareness and mental health literacy do have profound effects over cultural myths and beliefs. The authors had conducted a study on traditional healers at Lucknow back in 1975-76 and to our surprise in the last 35 years; there has been little change in health seeking behaviour of psychiatric patients. However, there has been tremendous progress in the technical know-how in the country. The present study therefore emphasizes the relevance of traditional healers and the need to incorporate them for a community based approach. In both the above studies, the majority of patients were from rural backgrounds with low socio-economic status, where old cultural beliefs in the context of religious activity do predominate than in people
from urban areas with average to higher socio-economic status.

This study reported a poor referral pattern of the total patients, the greater proportion (39.74%) were recommended to seek help from the study center by a group of persons, denoted as ‘Social Workers, Paramedical Staff, Police and other Person Knowing This Institution’; followed by referrals from the ‘previous care provider’ (29.80%). The other sources of referral were through ‘family members of other psychiatric patient’ (17.88%), and self-referral (12.58%). Of all the patients (n=45) referred by care providers, a majority (n=22) were referred by general medical practitioners, followed by local practitioners (n=19), psychiatrists (n=03), and faith healers (n=01). In general, the majority of patients had consulted faith healers.

In contrast, a study from south Manchester by Gater and Goldberg (1991) of 250 patients newly referred to the mental illness services of South Manchester, almost two-thirds were referred directly by their General Practitioners and a further third were referred by hospital doctors. Non-medical sources of referral accounted for only 2% of new cases.

**Studies from South Asian and other Developing countries**

A study from Cambodia by Coton et al (2008) “The Healthcare-Seeking Behaviour of Schizophrenic Patients” reported that out of 104 patients with schizophrenia, 56.7% began the help seeking with traditional medicine; 22.1% with allopathic and psychiatric treatment, and 20.2% with religious medicine. Thus 77.3% of patients did not first seek treatment with the psychiatrist because they did not know it was a mental problem or because they did not know mental health services existed. The only factor which significantly influenced the help seeking behaviour was patient’s level of education. In Cambodia, traditional and religious medicines are the first pathway to mental healthcare when patient and caregiver decide to seek help due to psychotic symptoms.

A multicenter study titled ‘The Health Care Seeking Behaviour of Schizophrenic Patients’ from 6 region of five Asian countries including China, Japan, South Korea, Malaysia and the Philippines, by Bou-Yong et al (1995) reported the help seeking pattern of 1061 patients with schizophrenia. In most of the centers, though help seeking behaviour was more oriented towards psychiatric health care, other types of managements were also sought frequently. Most Japanese subjects sought care in allopathic medicine, while subjects from Hunan, Sichuan and Korea alternated between allopathic medicine and magico-religious therapies or traditional herbal medicine. In the Philippines and Malaysia, the majority of the subjects sought magico-religious therapies first, and then later sought psychiatric care. The choice of psychiatric care was mostly influenced by the decision maker's knowledge and interpretation of the patient's illness. In determining the choice of management among various types of non-psychiatric management, cost, location and societal attitudes played substantial roles as were knowledge and interpretation.

A study by Kurihara et al (2006) from Bali regarding help seeking pattern of 54 patients with a variety of mental illness reported that the pathway to psychiatric care was dominated by traditional healers (faith healers). The first source of treatment chosen by the subjects was traditional healers (n=42: 78%), general practitioners (n=4: 7%), hospital doctors (n=3: 6%), and community health centers (n=3: 6%), with two subjects (4%) visiting the mental hospital directly. Of the patients, 47 (87%) consulted a healer before visiting the mental hospital. Consultation with the healers was associated with treatment delay. The worrying point was that although access to both general practitioners and community health centers is readily available in the community, the majority of subjects chose traditional healers as the first option. Also the majority of care providers consulted just prior to reaching the mental hospital were traditional healers (n=36, 67%) followed by community health centers (n=9, 17%) and general practitioners (n=7, 13%). Of the 137 traditional healers on the pathway, only 11 (8%) recommended that the subjects go to a mental hospital. Of the 47 subjects, who visited the traditional healers at least once, 14 (29.8%) evaluated the treatment effect as much improved by at least one traditional healer on the pathway.
The pathway included 137 traditional healers, 14 community health centers, eight hospital doctors, and eight general practitioners. Of the 54 subjects, 47 (87%) sought help from traditional healers, and of these, 36 (67%) visited multiple healers. The mean number of traditional healers visited by the 47 subjects was 2.9 (range 1–7). Subjects without psychotic symptoms tended to evaluate the treatment effect as much improved more often than psychotic subjects. They concluded that traditional healers function not only as a barrier to reaching psychiatric care, but as either an effective provider of care or a decision-making support for seeking help from psychiatric care for some mental patients in Bali. The knowledge and recognition of psychological disorders by the traditional healers were crucial for early treatment intervention for psychiatric patients.

A study from Pakistan by Naqvi et al (2009), revealed that in the pathway to care for patients with first episode psychosis, psychiatrists were most commonly approached as the initial care provider followed by faith healers, who were visited by 15% of the patients. Around 5% of the participants visited general practitioners and the emergency department each, while rest visited teachers, social workers, psychologists and other caregivers for help. The authors argue that psychiatrist were approached on priority basis either because of a poorly developed primary care health system or as the majority of patients were educated.

In Japan, for patients with any psychiatric disorder, there are three dominant pathways, as the: Direct Pathway (contacting the mental health professional as first care provider), the Pathway via General Hospitals, and the Pathway via Private Practitioners (Fujisawa et al., 2008).

Myths are not confined to mental illnesses. One study from north India by Rai and Kishore (2009) reported that the most common myth about diabetes is that it is caused by eating sugars. Others myths identified were, diabetes can only occur in old age, soaking feet in water can help control blood sugar, diabetes is a result of past sins and is cured by spiritual treatment. Myths were significantly more common in females, non-diabetics and the less educated group.

Recently a study regarding health services utilization in general from Pakistan by Qidwai et al (2002) reported that of the 387 patients with a variety of illnesses mainly physical, 383 (99%), 141 (36.4%), 88 (22.7%) and 45 (11.6%) of the respondents had used services of allopath, homeopath, Hakim (Unani) and spiritual healers respectively. The worrying findings was that still 379 (98%), 259 (67%), 174 (45%) and 249 (64.4%) of patients were willing to consult allopath, homeopaths, hakims and spiritual healers again respectively.

A study from Africa (Ethiopia-a developing nation) by Bekele et al (2009) reported that of the total patients (1044) at the commencement of new episodes of neuropsychiatric disorders, 41% directly consulted a psychiatrist. The rest of the patients sought care from up to four different care providers before arriving at the psychiatric hospital. A proportion (30.9%) of patients had sought care from priests, holy water or church. The median delay between onset of illness and arrival at the psychiatric hospital was 38 weeks. The longest delays before arriving at the mental hospital were associated with having no formal education, unemployment and diagnoses of epilepsy and physical conditions.

Pathway of care and help seeking behaviour of Asian countries in comparison to Western countries

South Asian people living in the western countries are at greater likelihood of consulting with a general practitioner (Commander et al., 1997), though they more commonly fail to have their condition recognized in primary care compared with native born white people (Bhui et al., 2003, Odell et al., 1997, Wilson and MacCarthy, 1994). The reason of more consultation by South Asian people with general practitioners is that they more often incorporate physical symptoms and idioms into the presentation of their psychological distress than whites (Nazroo et al., 2002). Hence they are less likely to be referred onto specialist psychiatric services than their white counterparts (Commander et al., 1997). This indicates the effect of culture on the presentation of psychiatric disorders (eg. more somatization of depressive and
anxiety symptoms in South Asians simulating physical disorders than in whites).

South Asian people may have a different understanding about what is primarily the matter with them and attribute their problems to different underlying causes. Their appreciation of mental health problems appears to be closely tied with expectations regarding social role functioning (Belliappa, 1991). Lay and traditional healers potentially offer a more acceptable alternative for south Asian people in contrast to their white counterparts who may be more receptive to western models of psychiatric care (Bhui, 1999).

Recent studies regarding help seeking behaviour of ethnic South Asian minorities and the main stream regarding help seeking behaviour for depressive and anxiety disorder report no differences. This is partially due to improved skills in recognition of somatic complaints underlying neurotic disorders by general practitioners and efficient referrals to the specialist, or the fading away of traditional cultural beliefs of South Asians in the presence of western culture and environment, or easily available health services in western countries (Commander et al., 2004, Bhui et al., 2001).

A larger multicenter (eight centers) study by Richard et al (2005) from Eastern Europe regarding pathways to psychiatric care reveals results different to the findings of studies from developing nations mentioned above. There were 50 new patients at each center. The most frequent diagnoses in all centers combined were mood and neurotic disorders (23% each), followed by schizophrenia (16%), other psychotic disorders (15%) and mental disorders due to substance misuse (11%). Major pathways included general practitioners, direct access and hospital doctors, and not traditional or alternative health system involving religious healers. The suggestion to first seek care most often came from family or friends, who first suggested psychiatric care, indicating good mental health literacy in family members and the community. In all centers combined, 87% first sought care from a doctor, usually a general practitioner (40%) or by directly accessing the psychiatric services (33%), and less frequently from a hospital doctor (14%).

In developed countries, after the onset of illness, majority of the patients prefer to seek help from a primary health center or a family physician, who usually refers the patients to a psychiatrist if necessary, and gives proper advice about treatment. Thus their pathways are more likely to be linear and desirable. In developing countries, patients are free to seek help from any health agency including native healers or from tertiary level medical institutions without a referral.

The following reasons necessitate the need to follow a desirable pathway of care in developing countries. First, for enormous rural populations (up to 70% of the total population of most developing countries) modern psychiatry does not seem to exist (Farooq and Minhas, 2001). In fact, it can be argued that in the majority of developing countries mental health care is being provided by the community without following any structured pathways involving continuous care by psychiatric services in the community.

Undesirable cultural beliefs and myths, result in further underutilization of available services leading to a circuitous, tedious and complicated pathway of care. This could be removed by integrating mental health to primary health centers as now occurring in several developing countries (Cohen, 2001, Murthy, 2000) with the support of World Health Organization (WHO), and also by increasing psychiatric services in the form of District Mental Health Program (DMHP), which is an approach to decentralize mental health care in the community using the public health infrastructure and other resources.

The emphasis should also be on creating awareness in the community about mental health, training primary health care workers in recognition and early care of common psychiatric disorders and the integration of mental health services with other disciplines in primary care.

To reduce the cultural myths and beliefs there is a need to highlight scientific based facts about causation of psychiatric disorders which may dilute superstitious belief over a period of time. The general public should be informed through the media, pamphlets, book chapters at school levels etc. about common signs and symptoms, causation, and appropriate places and
professionals for management of common psychiatric disorders. The significant non psychiatrist care providers, could be trained and involved in mental health planning for early and sound referral in view of shortage of psychiatrists in developing countries.

Conclusions

Due to differences in design of various studies and lack of a standard protocol and tools to assess the pathway of care, it is difficult to compare these studies. But still, it is very clear that in developing countries:

- Awareness and mental health literacy is low
- Referral pattern is poor
- Belief in the supernatural causation of illness is common
- The major pathway of psychiatric care involves non-psychiatrist professionals especially faith healers and local physicians

There is urgent need for:

- Educational programs to raise awareness and mental health literacy
- Increment of psychiatric services and their integration with main stream health services
- Implementation of a robust referral system
- Establishment of strong working relationships between traditional and modern health-care providers

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