

Pathways to mental healthcare in high-income and low-income countries

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Understanding the way in which people seek care for mental disorders is important for planning services, training and referral mechanisms. Pathways to care fall broadly into three categories: via primary care physicians; via native healers; and via patient choice (patients can have direct access to mental health professionals). The pattern and nature of access to service in low-income countries are different from those in high-income countries.

Pathways to care can be defined as the contacts made during the period between onset of illness and the initiation of treatment (Rogler & Cortes, 1993). Pathway studies have been used to investigate how people use services (including time on the pathway) and the role of carers. These studies can provide information regarding the way health

services perform in relation to mental healthcare (Gater *et al.*, 2005): how primary and general healthcare services are used; whether people with mental disorders seek help outside the formal healthcare services; where and when they get treatment, and what treatment they get; whether care is delayed; the variation in and duration of pathways; who initiates the care seeking.

Pathway studies can also be used to help monitor the effects of service developments over time and to compare different services. If repeated, they can allow a comparison of service functioning to be made over time. The pathways method provides detailed service utilisation data, which can map the dynamic consequences of changes in service organisation and provision. It may be used to operationalise the measurement of service accessibility (Amaddeo *et al.*, 2001). Moreover, the pattern of care-seeking of psychiatric patients is important for service and policy issues (Giasuddin *et al.*, 2012).

International comparison of pathways to psychiatric care

The pattern and nature of access to service in low-income countries are different from those in high-income countries. However, factors other than resources may determine the receipt of care for mental disorders (Gureje & Lasebikan, 2006). These factors include: knowledge about the aetiology of the mental illness; negative attitudes to mental illness in the community; lack of awareness that the impairment is a medical problem and that there is an effective intervention for it; belief in a supernatural causation of mental illness; and fear of stigma (Gureje & Lasebikan, 2006). In contrast to findings from the high-income world, where general practitioners (GPs) and mental health professionals are central in pathways to psychiatric care, studies from Africa have found that GPs play a less prominent role, as other help providers, such as traditional healers, are more important in this regard (Temmingh & Oosthuizen, 2008).

In one European study, a large majority of patients with mental disorders were referred directly by their GP and hospital doctors; non-medical sources of referral were minimal – 2% in Manchester and 10% in Eastern Europe. Traditional healers did not play a major role (Gater *et al.*, 2005). A series of studies from Africa have examined pathways to care for psychiatric patients. Studies from Nigeria (Aghukwa, 2012), Ethiopia (Girma & Tesfaye, 2011) and South Africa have found significant delays in treatment in patients with psychiatric disorders, where traditional healers were the predominant first contact. In Arab countries (Sayed *et al.*, 1999; Al-Adawi *et al.*, 2002; Salem *et al.*, 2009) the majority of patients with mental disorders try home remedies and family help and consult traditional healers (faith healers, diviners and herbalists) before seeking any biomedical doctor's help or Western treatment.

Pathway studies have demonstrated that pathways to psychiatric care follow three patterns (Fujisawa *et al.*, 2008).

- The first is dominated by the role of primary care physicians. Most patients first contact their GP, who refers them to mental health professionals; thus, GPs act as gatekeepers to psychiatric services. This pattern is typically seen in western and eastern European countries; the UK and Australia are examples.
- The second pattern is seen in Bali (Indonesia), India, Harare (Zimbabwe), Nigeria, Saudi Arabia and the United Arab Emirates (UAE), where native healers play an important role.
- The third pattern is seen in Ankara (Turkey), Lower Silesia (Poland) and Verona (Italy), where patients are allowed to see any carer of their choice and are likely to have direct access to mental health professionals. In Japan, patients are allowed to access any medical facilities of their choice, and patients with psychiatric problems prefer to see physicians in general

hospitals rather than private practitioners (Fujisawa *et al.*, 2008). This is in contrast to countries in which people are supposed to see GPs before they are seen by specialists.

Direct access to mental health professionals has both advantages and disadvantages. In the Goldberg & Huxley model (Huxley, 1996), GPs are expected to function as gatekeepers, and to refer only patients with more severe illness to higher levels of specialisation. Direct access may lead to the wasteful use of the time of highly specialised professionals, as GPs are able to treat milder forms of illness. Such an arrangement would thus increase the cost of care. On the other hand, direct access to mental health professionals may shorten the period between the onset of symptoms and the patient's arrival at mental health services for those who have milder symptoms at the beginning of their illness but who do not recover as well when treated by GPs. People with severe illnesses pass more easily through the filters to secondary professional care than do people with common mental disorders (Huxley, 1996).

Help-seeking behaviour in many Asian countries such as India (Campion & Bhugra, 1997); Bangladesh (Giasuddin *et al.*, 2012), Cambodia (Coton *et al.*, 2008), Malaysia (Phang *et al.*, 2010; Razali & Najib, 2000), Indonesia (Kurihara *et al.*, 2006) and Singapore (Chong *et al.*, 2007) is not different from that in Arab and African countries, where they follow the second pattern: native healers play an important role. Duration of the untreated illness was longer in African, Arab and Asian studies than that reported in studies done in the West. The decision to consult a particular healing specialist is often taken by the family or carer. A traditional healer was consulted first because of the deep-seated belief in supernatural causation of the mental illness and trustworthiness of faith healers; this is a reflection of cultural beliefs relating to help-seeking (Chadda *et al.*, 2001).

The attitudes and beliefs of family in Asian, African and Arab societies are likely to be crucial in the pathways to care. A common view is that 'modern' (i.e. Western) treatments are effective in curing medical (physical) illness, but are powerless against black magic or supernatural causes; in particular, psychiatrists do not have the expertise to deal with supernatural powers (Razali *et al.*, 2008). Witchcraft, charming and possession by evil spirits are regarded as common causes of illness and are the most common explanations of mental illness offered by traditional healers to their patients. Deep-seated cultural beliefs among patients and their families are a major barrier to the receipt of modern psychiatric care. People generally recognise that medical care is useful, but still believe that it does not deal with the core problem, which is spiritual.

Factors that influence the help-seeking

Help-seeking is a dynamic process determined by certain social, demographic, sociocultural and psychological factors and clinical conditions

(Madianos *et al*, 1993). These factors influence the interpretation of psychopathological symptoms, the formation of concepts and stereotypes regarding the effectiveness of psychiatry, coping mechanisms and, finally, the decision to visit a traditional healer, physician or psychiatrist. A low level of education was found to determine directly the formation of negative attitudes to psychopathological symptoms and the use of mental health services (Madianou *et al*, 1986; Madianos *et al*, 1987). There is evidence that help-seeking for psychiatric disorders depends on the perception of illness and attitudes to treatment (Huxley, 1996). Urbanisation is associated with more frequent use of mental health services. When the ratio of psychiatrists to population is high, the individual more often turns to a psychiatrist (Shapiro *et al*, 1984). Symptom definition, severity of symptoms and patient response to treatment have been found to predict help-seeking behaviour (Madianos *et al*, 1993).

Conclusion

Understanding the way in which people seek care for mental disorders is increasingly recognised as important for planning mental health services, as well as for the provision of appropriate training and referral mechanisms between health and social care sectors.

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