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Research Article

ECONOMIC BURDEN AND REASONS FOR DELAY IN FIRST PSYCHIATRIC CONSULTATION – AN OBSERVATIONAL STUDY

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ABSTRACT

It is estimated that in India about 25% population is suffering from severe mental illness and 10% have minor mental illnesses. In India, with its mix of rural and urban environment and cultural diversity, the proportion of the patients attending the psychiatric consultation, once the disorder is recognized is limited. Prevention of psychiatric disorders is complex due to its multifactorial etiology, such as genetic factors, life stressors, and neurochemical changes in the body. Though it is difficult to control all of these factors in order to prevent psychiatric disorders, the progression of the psychiatric illness can be interrupted by early identification and intervention. Early detection and intervention of the condition can shorten the duration of mental illness. Early treatment can also prevent complications and deterioration, i.e. severe disability, increased recurrence of episodic disorders, death due to suicide, and care giver burden. This study was conducted to detect the delay duration and various reasons for delay in first psychiatric consultation, in the patients attending the psychiatric out-patient department.

KEYWORDS: *First Psychiatric Consultation, Economic Burden, Multifactorial Etiology, Diagnosis and Duration of Delay, Traditional Healing.*

INTRODUCTION

India with a heterogeneous socio-demographic profile having a variety of cultural, religious, traditional beliefs and customs influences the health seeking behaviors of patients with mental illnesses. Relative shortage of trained mental health professionals, along with cultural factors has led to predominant involvement of traditional healers and non-psychiatric doctors in the care of mentally ill [1].

It is important to know why, how do people reach, and do not reach psychiatric services. An understanding of the way in which people seek care for mental disorders is important for planning mental health services, for the organization of training and for the organization of referrals to psychiatrists from other sources of health and social care [2]. Availability of psychiatric services do not guarantee those services being utilized by the population crucial to the utilization of psychiatric services and the attitude of the patients towards the illness in prevalent cases. The decision is to seek mental healthcare that may be determined or modified by clinical, demographic, attitudinal, cultural, social, geographic and economic factors. Many studies have shown that many people adapt different path ways, like approaching faith healers, traditional practitioners, before seeking a professional psychiatric care. People who have not previously received mental health services may be particularly reluctant to recognize their need for treatment and establish treatment contact [3]. Other factors like non availability of mental health professionals, stigma, superstitions associated with mental disorders, along with the unwillingness or inability of families to care for their mentally ill relatives appear to be contributing for the delay in specialist consultation [4]. This usually occurs due to prolonged burden on the care taker of the patient.

An understanding of the way people seek care for mental disorders is increasingly recognized as important for planning mental health services, provision of appropriate training and referral from other sectors of health and social care [5]. With this back ground we conducted a study to detect the delay duration and various reasons for delay in first psychiatric consultation, in the patients attending the psychiatric out-patient department [3].

Illness results in financial cost to patients. Among their economic cost of illness can be broadly divided into direct and indirect costs. Direct costs are those for which payments are

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made. A portion of direct cost is borne by health care services while patients and their caregivers or health insurance payments finance the rest. Cost of medicines constitutes a substantial portion of direct cost. In India almost three quarters of out of pocket expenditure was spent on purchasing medication. Transport costs, cost of nutritious food for the ill person, food and accommodation costs for accompanying person are other types of direct costs borne by patient.

Indirect costs are defined as the cost of productive time loss resulting from illness. This includes the cost of lost productivity in the patient as well in caregivers. We have considered the indirect cost as loss of pay during the entire course of illness, income which was lost to the family who usually acts as a caretaker for the patient. Household out of pocket expenditure has a significant effect on poverty in low and middle income countries with many poor resorting to borrowing and selling of assets to finance this cost [6].

The usual burden on the patients and their family is not only limited to cost but also effects the family, marital life, education and work hold of the patients and the care givers. Due to increased duration of illness the burden gets increased more when compared to other disorders. The social stigma and religious beliefs play a very crucial role in the diagnosis of the patient. Now a days there is a gradual increase of psychiatry diseases due to increased exposure to alcoholism, smoking and intake of illegal drugs. Not only social habits but also due to increased stressors in job, increased costs of household needs & decrease in the value of a person and relationships are adding flavor to the increase in rate of psychiatry disorders.

Stigma:

A strong feeling of disapproval that most people in a society have about something, especially when this is unfair. Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease [31]. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. Although research has gone far to understand the impact of the disease, it has only recently begun to explain stigma in mental illness [32]. Much work yet needs to be done to fully understand the breadth and scope of prejudice against people with mental illness. Fortunately, social psychologists and sociologists have been studying phenomena related to stigma in other minority groups for several decades. Comparing and contrasting the definitions of public stigma and self-stigma [33].

The impact of stigma is twofold, as outlined in Table 5. Public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness turn against themselves [34].

Both public and self-stigma may be understood in terms of three components:

- Stereotype
- Prejudice and
- Discrimination.

Social psychologists view stereotypes as especially efficient, social knowledge structures that are learned by most members of a social group [35].

Public Stigma:

Several themes describe misconceptions about mental illness and corresponding stigmatizing attitudes. Media analyses of film and print have identified three types of people with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should be marveled; or they are responsible for their illness because they have weak character. Results of two independent factor analyses of the survey responses of more than 2000 English and American citizens parallel these findings [36].

a. Fear and exclusion: persons with severe mental illness are feared and, therefore, be kept out of most communities;

b. Authoritarianism: persons with severe mental illness are irresponsible, so life decisions should be made by others;

c. Benevolence: persons with severe mental illness are childlike and need to be cared for [37].

Although stigmatizing attitudes are not limited to mental illness, the public seems to disapprove persons with psychiatric disabilities significantly more than persons with related condition [38].

Strategies for Changing Public Stigma:

Strategies that change public stigma have been grouped into three approaches:

a) Protest,
b) Education and
c) Contact

Groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages. To the media: STOP reporting inaccurate representations of mental illness. To the public: STOP believing negative views about mental illness [40]. Protest is a reactive strategy; it attempts to diminish negative attitudes about mental illness, but fails to promote more positive attitudes that are supported by facts [41]. Education provides information so that the public can make more informed decisions about mental illness. This approach to changing stigma has been most thoroughly examined by investigators [42]. Research, for example, has suggested that persons who evince a better understanding of mental illness are less likely to endorse stigma and discrimination [43].

Stigma is further diminished when members of the general public meet persons with mental illness who are able to hold down jobs or live as good neighbors in the community [44]. Research has shown an inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma [45].

Self Stigma:

One might think that people with psychiatric disability, living in a society that widely endorses stigmatizing ideas, will internalize these ideas and believe that they are less valued because of their psychiatric disorder [46]. Self-esteem suffers, as does confidence in one's future Important factors that affect a situational response to stigma include collective representations that are primed in that situation, the person's perception of the legitimacy of stigma in the situation, and the person's identification with the larger group of individuals with mental illness [47]. This model has eventual implications for ways in which persons with mental illness might cope with self-stigma

as well as identification of policies that promote environments in which stigma festers [48].

Aim:

- To study the trajectories
- assess the economic burden
- Reason for delay in first psychiatric consultation.

Objectives:

The objectives of the study are as following:

- The reason for delay in first psychiatric consultation.
- To study economic burdens through direct and indirect costs.

Study Place:

- This study was conducted in the outpatient department of Psychiatry clinics which are located in Guntur city of Guntur District.

Study Design:

- It's a Prospective Observational Study.

Duration of Study:

The study is performed for duration of 6 MONTHS from NOVEMBER 2016-APRIL 2017

Sources of Data:

The patients were divided according to their pathway of consultation, reasons for delay, economic burdens and were interviewed using a questionnaire form which contains

1. Socio demographic variables
2. Patterns of previous consultation
3. Reason for delay
4. Cost of medication used to assess the patients attending psychiatric outpatient department

Study Criteria:

Inclusion Criteria:

- Availability of reliable informant.
- Patients or attendants who are willing to participate in the study.

Exclusion Criteria:

- Those who are unable to recollect the reasons for delay.
- People who are not willing to participate in the study.

Tools:

1. The results are analyzed by using SPSS 16 software.

2. A semi prepared questionnaire form is prepared based on the ICD -10 guidelines and it was attached in the annexure for reference.

RESULTS

The total subjects included in the study are 190 patients, out of them 88 subjects are suffering from schizophrenia, 38 subjects are suffering with depression, 53 are suffering from generalized anxiety disorder, 6 subjects are suffering from alcohol dependent syndrome, 3 subjects are suffering from obsessive compulsive disorder, 2 subjects are suffering from bipolar disorder.

The diagnosis was carried out by the neuropsychiatrist at the research area.

Using the SPSS software, the results are obtained in the form of graphs and bar diagrams.

Table No. 1: Relation between Gender and Diagnosis

Diagnosis	Gender		Total
	Male	Female	
Schizophrenia	4	46	**88**
Depression	1	25	**38**
GAD	2	27	**53**
ADS	5	1	**6**
OCD	3	0	**3**
Bipolar Disorder	1	1	**2**
Total	**9**	**10**	**190**

In our study, the patients with schizophrenia were mostly included when compared to other psychiatry disorders. The schizophrenic patients were about 22% males and 24% females. Out of all, the patients with anxiety disorder included 14% males and 14% females.

Table No. 2: Relations between Age and Diagnosis

Diagnosis	AGE					
	1-20	21-30	31-40	41-50	Above 50	Total
Schizophrenia	8	33	15	16	16	88
Depression	2	4	8	3	21	38
GAD	2	10	10	11	20	53
ADS	0	0	2	2	2	6
OCD	0	1	1	0	1	3
Bipolar Disorder	0	2	0	0	0	2
Total	1	50	36	32	60	190

In our study mostly the people affected with psychiatry diseases were above 50yrs age group (32%) and then between age group 21-30 included 26%. In general anxiety disorders the number of affected people increased with age. Out of 190 patients, the number of people with bipolar disorder included only 2 within age group 21-30.

Table No. 3: Relation between Diagnosis and reason for Delay

Diagnosis	Reasons for Delay							Total
	No delay	Ignorance of Illness treated by other Physicians/ Traditional Healers	Stigma	Thinkingthat Disorder is self Limiting	Patient refusal	Lack of Care Givers	Financial Problems	
Schizophrenia	20	18	6	20	14	7	3	88
Depression	11	4	6	6	1	9	2	38
GAD	2	8	8	13	4	8	1	53
ADS	1	1	0	1	1	0	1	6
OCD	0	0	0	1	0	0	1	3
Bipolar Disorder	0	0	0	0	1	0	1	2
Total	44	30	20	41	21	24	9	190

Out of 190 patients 23% have no delay in their diagnosis of the disorder and the remaining patients had delay in their diagnosis with reasons like ignorance of illness treated by other physicians/traditional healers (15.7%), stigma (10.5%), thinking that disorder is self limiting (21.5%), patient refusal (11%), lack of care givers (12.6%), financial problems (0.04%).

Table No. 4: Relation between Diagnosis and Locality

Diagnosis	Locality		Total
	Urban	Rural	
Schizophrenia	38	50	88
Depression	17	21	38
GAD	18	35	53
ADS	2	4	6
OCD	2	1	3
Bipolar Disorder	2	0	2
Total	79	111	190

The patients included in our study are mostly from rural background. Among 190 patients 41.5% are urban population and the remaining 58.4% are from rural population.

Table No. 5: Relation between Diagnosis and Family History of Psychiatric Illness

Diagnosis	Family History Of Psychiatric Illness		Total
	Present	Absent	
Schizophrenia	22	66	88
Depression	9	29	38
GAD	13	40	53
ADS	3	3	6
OCD	0	3	3
Bipolar Disorder	1	1	2
Total	48	142	190

In consideration with the family history, there were about 74.7% without any family history of psychiatry disorders and the remaining 25.2% patients had family history.

Table No. 6: Relation between Diagnosis and Educational Status

Diagnosis	Education				Total
	Primar	Secondary	Graduation	Illiterat	
Schizophrenia	19	26	19	24	88
Depression	8	8	4	18	38
GAD	12	8	5	28	53
ADS	0	4	1	1	6
OCD	2	1	0	0	3
Bipolar Disorder	0	1	0	1	2
Total	41	48	29	72	190

In our study population we have found that 37.8% were completely illiterate and in the rest 46.8% were at least minimally educated. About 15.2% were graduated in different fields.

Table No. 7: Relation between Diagnosis and Family type

Diagnosis	Family type			Total
	NUCLEAR	JOINT	SINGLE	
Schizophrenia	44	3	8	88
Depression	23	11	4	38
GAD	34	16	3	53
ADS	5	1	0	6
OCD	3	0	0	3
Bipolar Disorder	0	2	0	2
Total	**109**	**66**	**15**	190

The psychiatric disorders observed more in the subjects of nuclear family (57.36%) than in joint family (34.73%) and single (7.897%).

Table No. 8: Relation between Diagnosis and Economic status

Diagnosis	Economic status			Total
	Poor	Middle class	Upper	
Schizophrenia	40	46	2	88
Depression	17	21	0	38
GAD	25	27	1	53
ADS	2	3	1	6
OCD	2	1	0	3
Bipolar Disorder	1	1	0	2
Total	87	99	4	190

In our study population, middle (52.1%) and lower (45.7%) class people were most effected whereas the upper class (2.1%) was the least effected one.

Table No. 9: Relation between Diagnosis and Duration of Delay

Diagnosis	Duration of Delay					Total
	No Delay	1-30 Days	2-6 Months	7 Months- 1 Year	More than 1 Year	
Schizophrenia	21	12	24	2	29	88
Depression	9	6	7	3	13	38
GAD	10	1	15	1	26	53
ADS	4	1	0	0	1	6
OCD	1	0	0	0	2	3
Bipolar Disorder	0	0	2	0	0	2
Total	**45**	**20**	**48**	**6**	**71**	190

In our study population the duration of delay observed in first psychiatric consultation was 76.843% where as no delay in 23.157%.

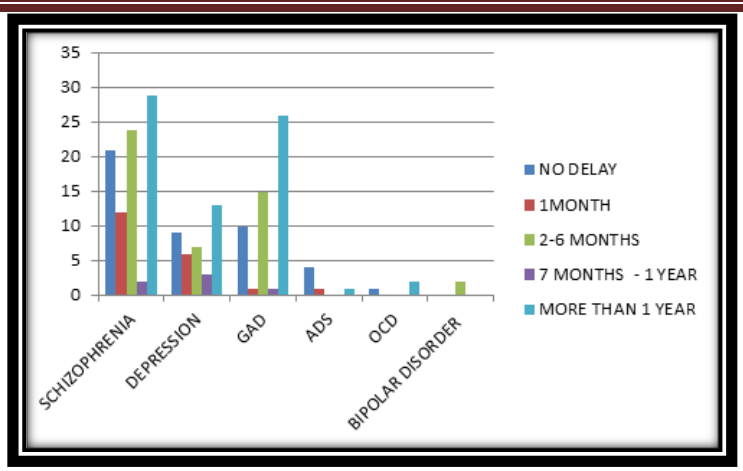

Fig. 1: Relation between Diagnosis and Duration of Delay

Table No. 10: Relation between Diagnosis and Traditional Healing Outcome

Diagnosis	Traditional Healing Outcome			
	Recovere	Improved	No Change	Worsened
Schizophrenia	1	1	27	6
Depression	0	0	10	2
GAD	0	0	20	4
ADS	0	0	3	0
OCD	0	0	2	0
Bipolar Disorder	0	0	1	1
Total	1	1	63	13

According to our study 41.04% have visited traditional healers (33.15 had no improvement, 6.31% subjects had worsened their condition, only 0.52% had improved the psychiatric condition,51% had recovered) whereas 58.94% subjects have not visited traditional healers at all.

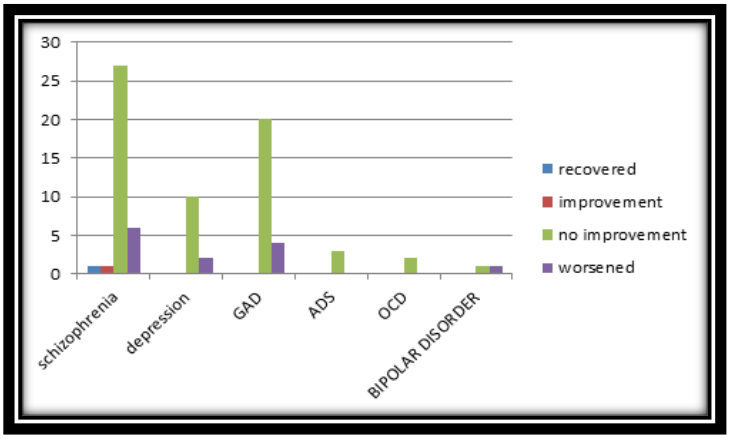

Fig. 2: Relation between Diagnosis and Traditional Healing Outcome

Table No. 11: Relation between Diagnosis and RMPS/other Specialists Outcome

Diagnosis	RMPS / Other Specialist Outcome		
	Improved	No Change	Worsened
Schizophrenia	9	46	5
Depression	2	22	2
GAD	6	29	3
ADS	0	3	0

OCD	0	1	0
Bipolar Disorder	0	2	0
Total	17	103	9

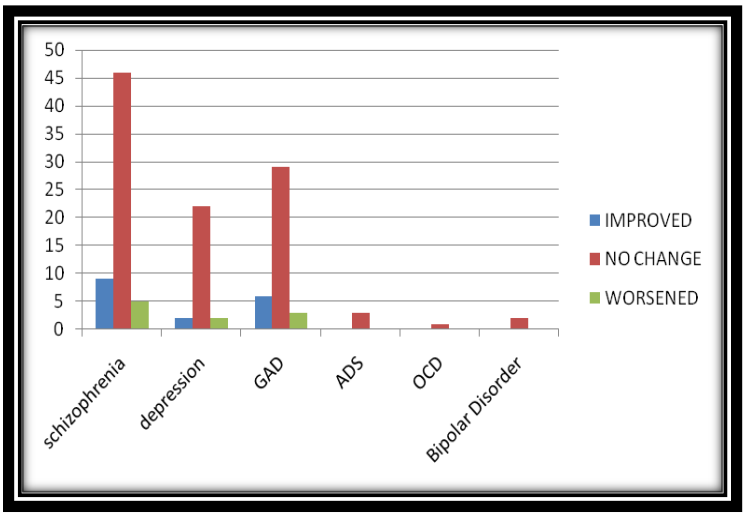

Fig. 3: Relation between Diagnosis and RMPS/Other Specialists Outcome

Table No. 12: Relation between Diagnosis and Psychiatric Outcome

Diagnosis	Psychiatric Outcome			Total
	Recovere	Improved	No Change	
Schizophrenia	20	55	13	88
Depression	10	27	1	38
GAD	23	30	0	53
ADS	3	3	0	6
OCD	0	3	0	3
Bipolar Disorder	0	2	0	2
Total	56	120	14	190

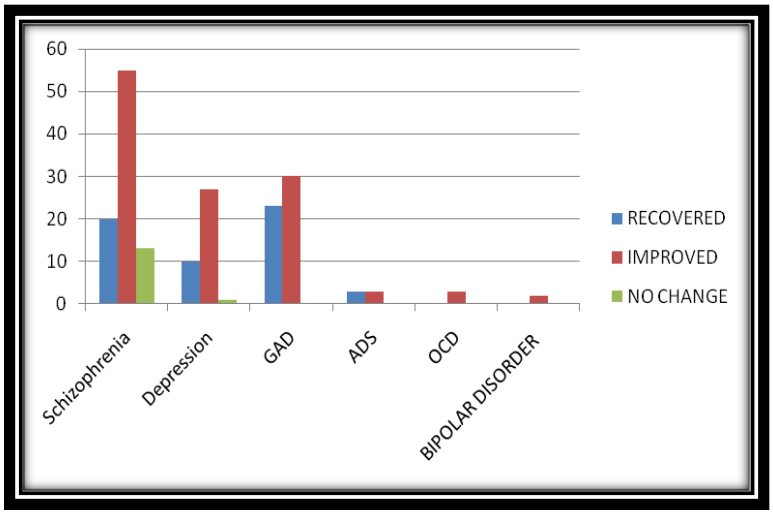

Fig. 4: Relation between Diagnosis and Psychiatric outcome

Table No. 13: Relation between Diagnosis and Path of Consultation

Diagnosis Schizophrenia	Path of Consultation						Total
	Traditional Healers to Psychiatrist	Traditional Healers to RMPS/PMPS/ others to Psychiatrist	RMPS / Specialist to Psychiatrist	RMPS/Specialist/ others to Traditional Healers to Psychiatrist	Others to Psychiatrist	Directly to Psychiatrist	
Schizophrenia	7	22	39	3	5	12	88
Depression	1	12	11	1	3	10	38
GAD	5	16	15	2	8	7	53
ADS	0	1	3	1	0	1	6
OCD	1	1	0	0	0	1	3
Bipolar Disorder	1	1	0	0	0	0	2
Total	15	53	68	7	16	31	190

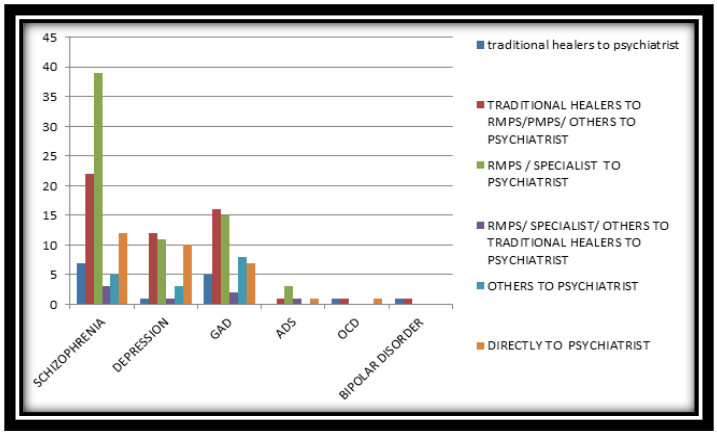

Fig. 5: Relation between Diagnosis and Path of Consultation

Table No. 14: Relation between Diagnosis and Direct cost

Diagnosis	Direct Cost			Total
	Rs1 to 1,000	Rs1,001 to 10,000	Rs.10,001 to 50,000	
Schizophrenia	37	51	0	88
Depression	16	21	1	38
GAD	23	30	0	53
ADS	3	3	0	6
OCD	2	1	0	3
Bipolar Disorder	0	2	0	2
Total	81	108	1	190

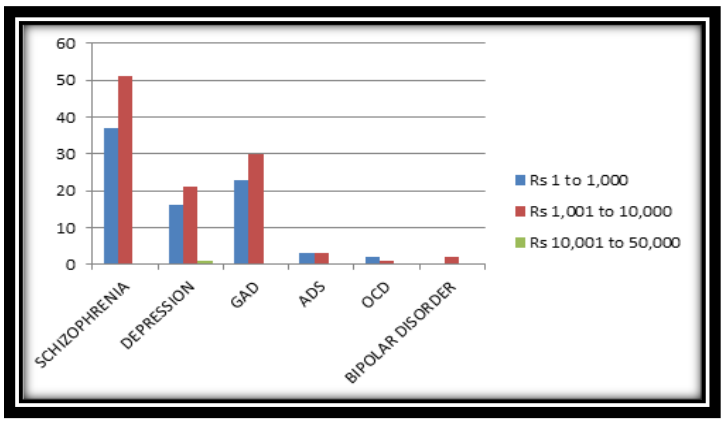

Fig. 6: Relation between Diagnosis and Direct cost

In the study population we have considered

- About 56.84% have spent between Rs 1001-10,000 directly (direct cost).
- About 42.63% have spent Rs 1-1000 directly.
- About 0.52% have spent Rs10001 -50,000 directly.

Table No. 15: Relation between Diagnosis and Indirect cost

Diagnosis	Indirect Cost					Total
	Nil	Rs1 to 1,000	Rs1,001 to 10,000	Rs.10,001 to 50,000	50,000 above	
Schizophrenia	11	39	30	4	4	88
Depression	9	16	11	2	0	38
GAD	10	27	13	2	1	53
ADS	1	2	2	1	0	6
OCD	0	1	1	0	1	3
Bipolar Disorder	0	1	1	0	0	2
Total	31	86	58	9	6	190

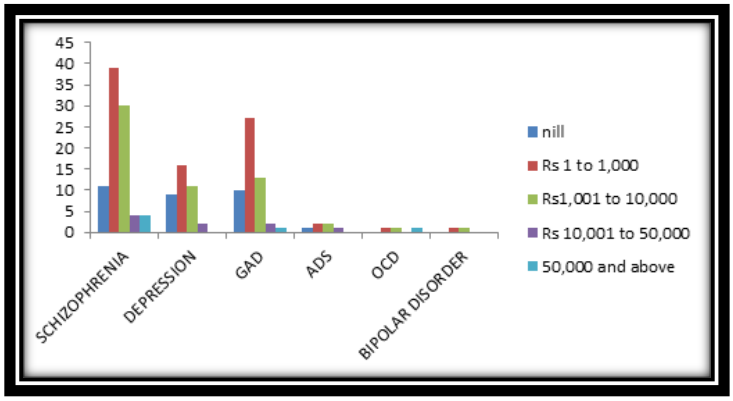

Fig. 7: Relation between Diagnosis and Indirect cost

In the study population we have considered

- About 30.52% have spent Rs 1001-10000 indirectly.
- About 4.73% have spent Rs10001 -50000 indirectly.
- About 45.2% have spent Rs1-1000 indirectly.
- About 3.15% have spent Rs 50000 and above indirectly.
- About 16.3% have not spent any money indirectly.

DISCUSSION AND CONCLUSION

This study was an attempt to assess the trajectories, economic burden and reason for delay in first psychiatric consultation.

The study was carried out in 190 subjects, where all of them or psychiatric patients.

The results observed are as following:

In the taken sample size and subjects the prevalence of psychiatric disorders was greater in female subjects than in male subjects that is 52.63% in females and 47.36% in males (p=0.103).

Considering the age factors/the prevalence of psychiatric disorders was more in age group of above 50 years subjects that is 51.57%, which was followed by the subjects of age group 21-30 years (26.3%) which again followed by 31-40 years (18.94%) and 16.84% in 41-50 years subjects and least prevalence was seen in 1-20 years age group which was 6.315% (p=0.016).

The prevalence of psychiatric disorders was more in rural regions with a percent of 58.42% compared to urban region with 41.57%.

The prevalence of psychiatric disorder was more in unmarried with 47.89%,than in married (31.052%) widow (134.684%) and separated (7.308%) (p=0.044).

The psychiatric disorders observed more in the subjects of nuclear family (57.36%) than in joint family (34.73%) and single (7.897%) (p=0.318).

There are more number of unemployed (59.495) subjects of psychiatric disorders, than employed (40.52%) subjects (p=0.043).

The duration of delay observed in first psychiatric consultation was76.843% whereas no delay in 23.157% subjects. Coming to duration of delay in first psychiatric consultation of patients, the duration of delay was observed as follows:

- Delay more than 1 year was observed in 37.368% subjects.

- Delay more than 2-6 months was observed in 25.263% subjects.
- Delay was not observed in 23.157% of subjects.
- Delay between 1-30 days was observed in 10.52% of subjects.
- Delay between 7 months -1 year was observed in 3.152% subjects (p=0.110).

The reason for delay in first psychiatric consultation was due to ignorance of illness treated by other specialists in 21.578% of subjects. 15.789% due to subjects thinking that disorder is self limithing.12.63% subjects had no care takers.10.526% subjects due to stigma.10.526% subjects due to patient refusal.5.263% subjects due to financial problems. Whereas delay was not observed in 23.1575 of subjects (p=0.087%).

The study was also conducted on all subjects for traversing the trajectories of consultation to psychiatric by the subjects.

- About 35.789% of subjects had consulted RMPs, specialist, others before consulting psychiatrist.
- About 27.89% had consulted traditional healers then RMP's, specialist, others before consulting psychiatrist.
- Whereas about 16.315% subjects have directly consulted psychiatrist.
- And 8.4210% from others to psychiatrist.
- About 7.894% from traditional healers to psychiatrist and RMP's, specialist, others to traditional healers to psychiatrist was 3.684% (p=0.364).

The therapeutic outcome at traditional healer's consultation by subjects was as follows:

- 33.15% subjects had no improvement in psychiatric condition.
- 6.31% subjects had worsened the psychiatric condition.
- 0.52% subjects had improved the psychiatric condition.
- 0.51% subjects had recovered the psychiatric condition.
- Whereas 58.94% subjects have not visited traditional healers at all (p=0.820).

Therapeutic outcome for subjects who consulted RMPs/specialists are as follows:

- 54.21% subjects had no change in psychiatric condition.
- 8.94% subjects had improvement in psychiatric condition.
- 4.21% subjects had worsened there psychiatric condition.
- Whereas 32.10% of subjects had not visited RMPs or specialist.(p=0.926)

Therapeutic outcome for subjects who consulted psychiatrist are as follows:

- 63.157% subjects had improved psychiatric condition.
- 29.47% subjects had recovered the psychiatric condition.
- 7.365 subjects had no change in psychiatric condition.

The study was also conducted to know the expenditure of psychiatric treatment. Further it is divided into direct cost (cost of medication, cost of consultation and cost of investigation) and indirect cost (cost of traditional healers, RMPs, specialist, ayurvedic or others).

- About 56.84% subjects have spent between Rs 1001-10,000 directly (direct cost).
- About 42.63% subjects have spent Rs 1-1000 directly.
- About 0.525 subjects have spent Rs10001 -50,000 directly.
- About 30.52% have spent Rs 1001-10000 indirectly.
- About 4.73% have spent Rs10001 -50000 indirectly.
- About 45.2% have spent Rs1-1000 indirectly.
- About 3.15% have spent Rs 50000 and above indirectly.
- About 16.3% have not spent any money indirectly.

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