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Factors associated with treatment lag in mental health care

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Abstract

***Background**: Despite the substantial distress and impairment caused by mental disorders and the availability of effective therapies, unmet need for treatment of mental disorders remains a serious public health problem. Research has shown that there are long delays before patients seek treatment for their disorders. **Aim**: The study aimed to determine the duration and factors associated with treatment lag in patients coming to seek psychiatric treatment for the first time. **Method**: Patients who visited psychiatry out-patient clinic for the first time, with no prior psychiatric treatment in their life were taken as study sample (n=221). **Results**: The mean duration of treatment lag was found to be 30.36 months (range 1-300 months). Age, source of referral and past history of treatment from non-mental health professionals significantly affected the treatment lag in multivariate regression analysis. **Conclusion**: Treatment lag or delay was mostly related to potentially modifiable personal, socio-cultural and economic factors. Appropriate steps should be taken to modify these factors in order to meet the unmet need of mentally ill persons.*

***Key words**: treatment lag, mental illness*

Introduction

The early recognition and timely treatment of psychiatric disorders helps in reducing the suffering,prevents mental disabilities and makes interventions more cost-effective.[1] Despite the substantial distress and impairment caused by mental disorders and the availability of effective therapies, unmet need for treatment of mental disorders remains a serious public health problem.[2]

People who have not previously received mental health services may be particularly reluctant to recognize their need for treatment and establish treatment contact. Long lag periods between disorder onset and first professional-treatment contact remain an important source of unmet need for mental health care.[3] This widespread unmet need at a

time when clinical advances have made it possible to provide effective treatments for many psychiatric disorders underscores the importance of public health efforts to narrow gap in service delivery.[4]The adverse effects of treatment lag have been well documented. People who leave a disorder untreated tend to have a poorer outcome in the short as well as long term. Despite this, there is often a considerable time lag between the onset of psychiatric disorder and help-seeking. Many

people do not seek professional help at all.[1]

A number of illness-related characteristics, as well as socio-cultural factors have been identified as contributors to treatment delay,[4] which include a young age at onset of the disorder, insidious onset, negative symptoms, low social class, the attitudes and belief systems prevalent in a society, stigmatization of mental illness, poor psychosocial support, lower level of schooling, non-psychiatric attribution of mental symptoms, and a more pessimistic attitude to the successful treatment of mental disorders in general and for oneself in particular.

Little is known about patterns and correlates of initial treatment contacts, as help-seeking research has generally focused on recent service use among prevalent cases over relatively short time periods rather than on delays in initial treatment contact among incident cases over longer time periods. The few studies that have focused on the latter question have consistently shown that the vast majority of people with mental disorders eventually establish treatment contact. However, these studies have also shown that long delays are pervasive.[2,3] For example, an analysis of first treatment contact for depression in a nationally representative sample of people with a lifetime history of depression estimated that more than 80% eventually seek treatment, but the median delay is seven years.[3] The factors which are responsible for delay in treatment seeking might be different in different communities and different settings. The treatment lag, defined as the time between onset of disorder and obtaining care, appears to be universal.[5]

The present study aimed to assess the treatment lag in persons having psychiatric illness who seek treatment for the first time in their lifetime. It also assessed the major symptom that brought the patient to treatment at this stage.

Materials and Method

The study was conducted at the department of psychiatry, Government Medical College and Hospital (GMCH), Chandigarh, from April, 2010 to August, 2010. All the patients coming to the Psychiatry OPD for the first time were screened and those who had never sought psychiatric help before, were included. Patients were assessed using a structured proforma. It assessed the sociodemographic profile including age, sex, education, occupation, marital status, family income, locality, family type, distance from hospital, source of referral, total duration of symptoms, the presenting symptom that brought the patient to the treatment, family history of psychiatric illness, previous history of psychiatric and non psychiatric treatment and current diagnosis as per ICD 10.[6] Patients who had substance abuse and dependence (except nicotine) and persons with intellectual disability were excluded.

Written informed consent was taken from all the patients, and relatives wherever necessary. The study was approved by the Institutional Ethics committee.

Statistical analysis

Statistical analysis was carried out using Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, version 13.0). Descriptive statistics were calcuated. Proportions were compared using chi-square or fisher's exact test, whichever was applicable. To identify the effect of factors responsible for lag period, multivariate regression analysis was done.

Results

A total of 221 patients were included in the study. The socio-demographic profile of the patients is shown in Table 1. Most common diagnosis was depression (165, 74.7%). Other affective disorders viz. mania, bipolar disorder

and dysthymia were seen in six (2.6%) patients. Neurotic, stress related and somatoform disorders were found in 36 (16.3%) patients. These disorders included phobias, panic disorder, dissociative disorder, somatization disorder, hypochondriasis, dhat syndrome, adjustment disorder, psychogenic headache, unspecified anxiety and OCD. Ten patients were diagnosed to have a psychotic disorder (psychosis NOS = 5, schizophrenia = 4, ATPD = 1). Two patients had migraine, one had dementia and one had organic brain syndrome.

Table-1: Socio-demographic profile (N=221)

	Variable	n	%
Age	<30 yrs	87	39.4
	30 - 50 yrs	102	46.2
	>50 years	32	14.5
Gender	Male	99	44.8
	Female	122	55.2
Formal	<10 yrs	134	60.6
Education	≥ 10 yrs	87	39.4
Marital status	Single	50	22.6
	Married	153	69.2
	Divorced	2	0.9
	Widow/er	11	5.0
	Separated	5	2.3
Occupation	Unemployed	32	14.5
	Govt job	16	7.2
	Private job	42	19.0
	Student	44	19.9
	Labourer	28	12.7
	Housewife	44	19.9
	Retired	15	6.8
	Agriculture	32	14.5
Income	0 – 3500	40	18.1
(INR)	3501–7000	42	19.0
	7–10,000	12	5.4
	> 10,000	127	57.5
Family	Nuclear	153	69.2
	Joint	68	30.8
Locality	Rural	81	36.7
	Urban	140	63.3
Distance from	0 – 20 km	126	57.0
Hospital	21 – 40 km	36	16.3
	41 – 80 km	20	9.0
	> 80 km	39	17.6

Table 2 shows the psychiatric profile of the patients. The mean treatment lag in the study was 30.36 (range 1–300) months. Nearly half (49.3%) patients had a history of seeking a non-psychiatric treatment in any form.

Multivariate regression was conducted with treatment lag as the dependent variable and a total of 15 socio-demographic and clinical variables as independent variables. The detailed results are shown in table 3. The significant ($p<0.05$) variables were as follows: Age, Source of referral and Past history of non-psychiatric treatment.

Table 2: Psychiatric profile (N=221)

	Variable	n	%
Source of	Self	65	29.4
referral	Friends of family	29	13.1
	Other patients	9	4.1
	Other OPDs or general practitioners	118	53.4
Presenting	Headache	39	17.6
symptom	Anxiety	39	17.6
	Bodyaches	22	10.0
	Tension	11	5.0
	Sleep loss	23	10.4
	Sadness	12	5.4
	Ghabrahat	11	5.0
	Others	64	28.9
Family	Present	16	7.2
history	Absent	205	92.8
Past history	Present	109	49.3
of non-psychiatric treatment	Absent	112	50.7
Illness duration	< 1 mth	30	13.6
	1 – 6 mths	69	31.2
	7 – 12 mths	29	13.1
	1 – 2 yrs	30	13.6
	2 – 3 yrs	13	5.9
	3 – 4 yrs	14	6.3
	4 – 5 yrs	7	3.2
	5 – 10 yrs	19	8.6
	> 10 yrs	10	4.9

Table 3: Multivariate regression analysis

	B	SEB	β	t	p	95% CI	
						Lower	Upper
Age	5.813	2.833	0.164	2.052	0.041*	.228	11.398
Sex	3.069	8.118	0.031	0.378	0.706	–12.936	19.075
Education	4.171	2.409	0.155	1.731	0.085	–.579	8.920
Occupation	0.557	2.191	0.021	0.254	0.800	–3.762	4.876
Marital status	6.233	4.371	0.113	1.426	0.155	–2.386	14.852
Monthly Income	1.400	3.227	0.035	0.434	0.665	–4.963	7.763
Family type	–3.342	7.595	–0.031	–0.440	0.660	–18.316	11.632
Locality	–10.154	8.861	–0.100	–1.146	0.253	–27.624	7.316
Religion	–10.824	6.923	–0.112	–1.564	0.119	–24.473	2.824
Distance from hospital	–3.528	3.159	–0.084	–1.117	0.265	–9.756	2.700
Source of referral	–3.453	1.598	–0.163	–2.161	0.032*	–6.603	–0.303
Presenting symptom	–0.608	0.501	–0.084	–1.214	0.226	–1.595	0.380
Family history	13.087	12.998	0.069	1.007	0.315	–12.539	38.713
Past non-psy treatment	–21.531	7.254	–0.220	–2.968	0.003**	–35.832	–7.229
Diagnosis	0.864	0.682	0.087	1.268	0.206	–0.480	2.208

Analysis was done with treatment lag as dependent variable

Discussion

The present study showed that the duration of treatment lag was significantly affected by age, source of referral and treatment of psychiatric disorders by non-mental health professional in the past.

It was seen that patients who were less than 30 years of age came for treatment earlier than other age group patients. This could be attributed to the fact that illness occurring at a younger age leads to more disability and disturbance in daily life activities than that occurring at the later age. It is also possible that mental disorders occurring at a younger age are taken more seriously as these might lead to disruption in study as well as social consequences, thus affecting matrimonial prospects. Also, at a young age, persons are under the control of their parents and are more receptive to their advice.

Those patients who came for treatment themselves after feeling the need to see a psychiatrist, read about the mental disorders and their treatment from the internet or were brought by their family members came for treatment earlier. Patients who had been going to either non mental health professionals or alternative methods of treatment came for treatment later than those who did not go anywhere. The delay in seeking treatment in these persons could be due to partial relief from treatment or false hope of recovery. This finding has also been reported in an earlier study that compared two groups and found that the group seeking treatment from non mental health professionals came later than those who did not seek any treatment earlier.[1] This implies that training of the general practitioners and primary care physicians is necessary to bridge the unmet need in mental health care. Not all the patients come to psychiatrists even after advised by their doctors. The stigma associated with mental disorders as well as shortage of mental health professional might be responsible for this. So, better training of other specialist doctors and primary health care physicians is a must. The National Mental Health Programme (NMHP) also emphasizes on integration of mental health into primary health care. The District Mental Health Programme

(DMHP) scheme funded by Ministry of Health, Govt of India also aimed to strengthen the Primary Health Care through training of doctors and other paramedical staff.

Another concern is the number of persons seeking help from traditional healers, which include faith healers, religious healers, diviners, herbalists, *tantriks, ojhas* and many others. Up to 70% of mentally ill persons go to faith healers for treatment at some point.[7] This also increases the treatment lag as these patients do not come for psychiatric treatment. A study has even found that traditional healers have some understanding of mental illnesses.[8] Considering the role that traditional healers have played in societies since ancient times and the fact that majority of patient and families have trust in their healing abilities, it might not be possible to stop patients form going to traditional healers for treatment. Keeping this in view, some countries have even advocate to integrate traditional healers into health care systems.[7] Educating traditional healers about the common mental illnesses and their treatment and appropriate referral may result in decreasing the duration of treatment lag.

It has been observed that the factors that lead to a delay in seeking treatment are potentially modifiable. Some of these factors are education, socio economic status, stigma associated with the illness, knowledge and attitudes to mental disorders and treatment, other than psychiatric attribution of symptoms, pessimistic attitude towards the treatment and outcome of mental disorders.

Most of these factors can be modified through mental health education programmes. Screening for mental disorders at community level and large-scale public education programs hold promise for hastening the awareness, detection, and treatment of mental disorders. Additional efforts are needed to train non-health care professionals to recognize individuals with mental disorders, especially severe disorders in need of emergent care, and also timely referrals to appropriate health care professionals for disorders that are even less in severity as the chances of progressing to severe illness and outcome like suicide can be a serious issue. It is likely that a combination of such interventions will be required to make meaningful progress in shortening the high-risk period of untreated mental disorders. Further research into treatment delay and the factors associated with it, in a wider national framework, is clearly warranted.

The World Health Organization(WHO) has also taken up the issue of treatment gap and lag seriously. WHO has laid down ten recommendations,[5] which include integration of mental health care with primary health care, ready availability of psychotropic drugs, shifting of care away from institutions and towards community facilities, public education about mental health, involvement of families, communities and consumers in advocacy, policy-making and forming self-help groups, establishment of national mental health programmes, improving the training of mental health professionals in community work, establishing and enhancing links with other governmental and nongovernment agencies, monitoring the mental health systems using quality indicators and providing more support for research.

This study has a few limitations like relying on patient's recall. The comorbid diagnosis was not assessed, and only the primary diagnosis was focused upon. Also, the severity of disorders and patient's knowledge and attitudes towards mental disorders was not assessed.The treatment lag is a major reason for the unmet need seen in psychiatric disorders. Most of the lag can be attributed to reasons that can be potentially modified. Major efforts are needed at all the

levels to meet this important, but unmet need.

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