Sir,

We are happy to receive critical appraisals and queries regarding our editorial article 'Pathway to psychiatric care' published in the Indian Journal of Psychiatry in the year 2011,[1] as it gives us crucial opportunity to further elaborate important unexplored issues regarding mental health in developing nations with particular reference to India. While drafting the above article, we did explore the reality about the existence of a pathway of care in developing nations, including India. It was clear that the government has been creating a structural hierarchical system of health care, which provides a pathway from first point of contact within the community to the tertiary level of specialty hospitals. Though the psychiatric facilities are not available in the beginning of these hierarchal health care systems, e.g., sub-center/primary health center (PHC), but they are able to make sound referrals of patients suffering from psychiatric disorders to the higher level of hierarchy where psychiatric facilities are available, e.g., district hospitals and specialty institutions. With increasing emphasis of government on rural hospitals, more and more specialists are available there. In fact, many state governments make it mandatory for medical doctors and post-graduates to work in rural areas after their education is over.

By applying the proposed definition of a pathway of care,[2] a patient getting in the contact with sub-center/PHC being referred to an appropriate place of psychiatric facility without delay will fulfill the concept of a pathway of care, i.e., entry at one point, which gives right directions for getting help at appropriate psychiatric facility significantly reduces the delay in the recognition and initiation of proper management, hence a better outcome. The so-called lacunae in the health care system of developing nations are that unlike gating system in well-developed western countries,[3,4] a patient suffering with any kind of illness (psychiatric or otherwise) of any severity is free to walk directly for consultation to higher hierarchal level of health care without need of a referral from lower level of hierarchal health care system. This does not mean that pathway does not exist but only that gating is absent. In one aspect, this is better and beneficial not only for psychiatric patients who can easily get help from a specialist health center at the time of emergency without losing the crucial time in getting the referral order from the place of first contact, i.e., sub-center/PHC but also for ease of access where many people still don’t use PHCs. Admittedly, this pathway of care where any person is free and permitted to directly consult a specialist, can get overburdened with those patients who do not need emergency care or specialist care and should have been easily managed at a lower level of health care. The way to approach an appropriate place of psychiatric care or other specialist care in developing nations is not always in a sequential manner of hierarchy of the health care system. Hence, the pathway, though not as well-structured or gated as in the West, does exist.

The writer[5] seems oblivious of the major attempts by the Government of India. However, our point was not about what the government does but about whether and how community avails itself of the services provided by the government.

For the past two decades, realizing the prevalence of severe psychiatric disorders (half of which do reside in the developing nations), the World Health Organization (WHO) and National Mental Health Program (NMHP) in India have been promoting the psychiatric services even at the lower hierarchal level, i.e., PHC for easy and early access within community.[8] Majority of developing nations, including India are implementing the WHO guidelines, for example, the Government of India has initiated the District Mental Health Program (DMHP) under the NMHP for remote and rapid access of psychiatric facility.[7]

Probably, the writer of the letter[5] has either missed or misunderstood many points. With the efforts of the government, psychiatric health care is now available even at the secondary levels, though it is underutilized. Globally, over 70% of person with mental illness receive no treatment from healthcare staff. The reason may be ignorant attitude of community about how to access assessment and treatment along with lack of knowledge about the features and treatability of mental illnesses.[8]

Though, It is true that mental health was not a priority about two decades back, because the morbidity/mortality of physical illnesses, especially infectious disease was much higher. However, as these scourges are effectively tackled (the highly successful Pulse Polio program, and directly observed treatment program for control of tuberculosis are cases in point), policy makers in India are approaching the mental illnesses as a priority.

About three to four decades back, the basic medical facilities were scarce in the periphery of the country. Patients suffering with mental illness as well as a variety of physical illnesses like epilepsy, chicken pox, measles, hemiparesis, etc. were taken to traditional healer practicing faith and religious healing. However, in the current scenario, when the psychiatric facilities are available over wider catchment area with better accessibility, the visits to traditional healers are avoidable as well as not advisable. This shows the age old held cultural beliefs justifying the explanatory models of causation of psychiatric disorder, which is contradictory
to the bio-psycho-social model of illness. The consequence is that there is help seeking behavior towards traditional healers rather than mental health professionals expected in the light of a biomedical model of psychiatric disorder.\(^9\)

In other words, this indicates the lack of knowledge of the biomedical model of psychiatric disorder among general population and that the cultural beliefs are so strong that cultural explanatory model of psychiatric disorders predominates over the biomedical model.\(^10\) Studies in the recent time\(^11,12\) reveal that majority of persons with psychiatric patients though do first seek help from faith healers rather medical professionals, including psychiatrist, but the referrals by them to psychiatric services are negligible. Furthermore, the ways of practice by faith healers are unethical and inhuman, which also significantly delay the proper management.\(^13\) No doubt, the same story is repeated in the present society and often makes news headlines. This was the point that we had made in our article, which is probably not well understood by the letter’s writer.\(^5\)

At the same time, it is very important to take into the consideration the community views regarding mental health for making the policies by policy makers so that culturally sensitive and locally acceptable health care is provided with modern medicine.\(^14\) Hence the government and stakeholders must be aware of the sensitive cultural issues regarding psychiatric disorders before making policies and the general public must be aware about psychiatric facility along with scientific knowledge about the biomedical explanatory model of psychiatric disorder believing that like other illnesses psychiatric disorders do have biological causation.

With background of such facts, pathway of care must be promoted in our country as the basic requirement of the structural hierarchal health care system do exist; and following a favorable pathway to care will have easy access without delay in initiation of management with consequent avoidance of many foreseeable adverse outcomes.

**EXPLANATIONS TO THE CRITICAL POINTS**

1. We\(^1\) have used the term awareness denoting a certain level of knowledge (definitely there is no structured scale to measure it) about the nature of psychiatric disorders among the general population. This does not mean knowing scientific terminology, e.g., labeling a behavior abnormality as psychotic disorder or schizophrenia but refer to the perceptual capacity of the community to categorize such behavior as an illness. The awareness definitely extends to cover knowledge about medical facilities for treatment of such behavioral problems with biomedical causation.

We know from various governmental initiatives that policy makers do have this awareness on the part of the policy makers (Government and stakeholders) denote the knowledge about the actual burden of psychiatric disorder in communities, its morbidity and the attitudes of community dwellers towards that particular illness, e.g., communities perception about the etiology of that particular illness which significantly modifies the help seeking behavior.\(^15\)

Taking into account of all these, the government of India has taken many important initiatives in the form of advertisement about treatment of psychiatric disorders through electronic media, along with establishment of NMHP about three decade back in the year 1982. This approach is to decentralize the mental health care in community using public health infrastructure and other resources by implemented DMHP in all states of India. At present, there are 125 functional DMHP sites in India. The government of India has planned to extend DMHP to all districts of India as part of 11th Five Year Plan.\(^16,17\) The main objective is to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population. Hence, there is no question that government is not taking any initiative forcing the mentally ill patient to seek help from traditional healers. Though, lack of services could be one factor in delay of proper treatment but hardly could it be a factor encouraging the patient attending faith healers as help seeking behavior basically depends upon the causative explanatory model of psychiatric disorder.\(^15\)

Most of mentally ill people do contact faith/traditional healers either as their first health provider or during the course of illness at one point of time or another during the period of exacerbations of illness but most patients do not get cured by faith healers as stated by Kapur 1979\(^18\) in the present time.\(^19,20\)

2. India like any other Asian Countries has many faith healers, quacks, spirituo-religious healers practicing in both rural and urban area even as psychiatric health care is being increasingly made available there. It is wrong to say that lack of medical facility in the rural areas forces the patients to seek help from the traditional health providers rather than their cultural belief among many others. PHC have penetrated to the deepest interiors of the country and doctors there who practice evidence-based medicine, though not skilled in diagnosing and treating psychiatric disorders, are none-the-less much better first contacts and when approached to provide first care and proper referrals.

Just to enlighten, I am making a brief review about the PHC in India. Each PHC is equipped with at least one medical doctor, a health worker, a vehicle and other necessary facilities, including those required performing small surgical intervention. A PHC acts as a referral unit for 6 sub-centers. It also has 4-6 beds
for patients. The activities of PHCs involve curative, preventive, primitive and Family Welfare Services. There are 23236 PHCs functioning as on September 2005 in our country.\cite{21}

One more issue raised by our learned friend\cite{5} is about to respect the cultural explanatory model of illness and help seeking behavior. We\cite{1} hope not to confuse ‘respect’ with ‘acceptance as valid’. Not all the explanatory models and consequent help seeking behavior could be acceptable, e.g., accepting witchcraft as the causative model of schizophrenia will certainly deprive the patient of proper health care and adversely affect the prognosis. We cannot condone unscientific and harmful practices in the name of medical pluralism. However, we do agree that there is a need to respect the cultural based explanations of communities as direct denial will definitely weaken the trust over the medical health professional. A gradual approach of making population aware of and accepting the biomedical model of explanations in view of scientific evidences could be tried. To repeat, patients are not forced to seek help from traditional healers due to lack of treatment services but may seek help because of other reasons, e.g., due to a lack of awareness about effectiveness of modern treatment services; the cultural explanatory model of psychiatric disorder and the fear of the stigma associated with modern psychiatric explanatory models and consequent help seeking.

3. The pathway of care doesn’t exist in India the way it exists in western developed nations. This doesn’t mean that it doesn’t exist at all. Surely, there are ill-defined pathways and issues associated with it. We were discussing how this pathway can be made clearer so that proper psychiatric health care is available to the masses.

It is true in many aspects that a medical facility in India is free to walk-in and walk-out clinics without need of referral. This is helpful until the entire health care structure is well-organized. But this too is changing. Many tertiary institutions (e.g., Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow; All India Institute of Medical Sciences, New Delhi) in India have made a strict policy to admit only referrals from other medical facilities. Even though no clear-cut pathways always operate from rural to urban or from primary to secondary or tertiary care, there is no health card or national health number, but patients from one health facility are regularly being referred to higher center. This is very common practice everywhere.

Therefore, denying the use of terms like referral pattern or the direct access to psychiatric services or even pathway to health care is derogatory to developing nations. The letter writer’s\cite{5} objection to even usage of the term pathways of care in India is most unfortunate.

4. One of the valuable comment made by the letter writer\cite{5} is that ‘contrary to the false expectation of the authors, there is no agenda in community mental health program (referring to DMHP) of India. But the fact is that the DMHP does includes mental health advocacy to mitigate cultural myth and superstition about mental illness as one could easily abstract the apparent meaning of its component ‘Public education in the mental health to increase awareness and reduce stigma’.\cite{7} If one will think in concrete manner then the meaning would be different.

Yes, with pride, Indian rural people do survive on social support systems, as rightly pointed out by the letter writer,\cite{5} but they survive not because of the so-called traditional care but in spite of it.

5. The letter writer\cite{5} has written straight way that authors have blamed faith healing as if they (faith healers) are standing on the way of pathway of care. This would have been a very sound thought provoking comment if it would have been a voice of a psychiatrist practicing in developing country being aware of grass root reality there. Going a step ahead, the letter writer has truly pointed out that faith healers are predominantly the first help provider,\cite{23-25} and hence has emphasized there potential role in providing mental health. But important point is that what kind of help they can provide except for an early referral and to some extent involvement in non-psychopharmacological management. If one would advocate for faith healer roles in making diagnosis and prescribing pharmacological treatment, then I think no responsible person of developing countries would be agreed. I humbly invite the letter writer to ask any person with enough experience of practicing psychiatry in India and they will tell you about the limitations and at times harmful nature of faith healing practices.

6. To the point no. 6, we have detailed initiatives about Pathway of Care in India earlier while describing PHC structure.

7. There is shortage of mental health professionals in developing nations. Naturally they may be overburdened. Realizing this truth in developing nations, the WHO advocates even involvement of person practicing alternative medicines including traditional healers into the care process for early referrals to psychiatric services. This indirectly indicates the importance of even traditional healers and the respect to them being advocated by WHO. There is no question of our\cite{1} underestimating or passing a judgment on faith-healers. Though, many of their practices do indeed pose threat to the well-being of the persons suffering from mental illnesses. Hence their involvement is a tricky issue as they cannot be bound by legal guidelines, they are not a significant source of referrals and their treatment modalities are often in conflict with evidence based medicine.

Contrary to the letter writer’s\cite{5} view, we\cite{1} cannot condone
unscientific and harmful practices in the name of medical pluralism. There are almost no referrals from faith healers to psychiatric care, (the same applies to other medical referrals). Just because they are common, faith healing practices do not become scientific. Let them also be judged by the same rigorous scientific criteria as are applied to the discipline of psychiatry and not merely a few studies that vaguely hint at possible benefits.

Let us not criticize the faith healers, but we must question their practices. More importantly, as we were trying to say in our guest editorial, let us look at various issues around the pathways of care in developing countries including India. We thank the letter-writer for a stimulating discussion.

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REFERENCES

1. Trivedi JK, Jilani AQ. Pathway of psychiatric care. Indian J Psychiatry 2011;53:97-8.
2. Rogler LH, Cortes DE. Help-seeking pathways: A unifying concept in mental health care. Am J Psychiatry 1993;150:554-61.
3. Goldberg D., Huxley P. Introduction. Mental illness in the Community: The Pathway to Psychiatric Care. London: Tavistock Publications; 1980: 4-5.
4. Gater R, Goldberg D. Pathways to psychiatric care in South Manchester. Br J Psychiatry 1991;159:90-6.
5. Chowdhury AN. Pathway to psychiatric care (PPC) and cultural myth. Indian J Psychiatry 2012;182:11.
6. Mental Health Policy and Service Provision. The World Health Report 2001. Mental Health: New Understanding, New Hope. http://www.who.int/whr/2001/chapter4/en/index1.html [Last Accessed on 2012 December 08].
7. Components of District mental health Programme. Ministry of Health and Family Welfare, Government of India. Available from: http://www.niifhw.org/NDC/DocumentationServices/NationalHealthProgramme/NATIONALMENTALHEALTHPROGRAMME.html. [Last accessed on 2012 December 8].
8. Thornicroft G. Stigma and discrimination limit access to mental health care. Epidemiol Psychiatr Soc 2008;17:14-9.
9. Joel D, Sathyaseelan M, Jayakaran R, Vijayakumar C, Muthurathnam S, Jacob KS. A biomedical educational intervention to change explanatory models of psychosis among community health workers in South India. Indian J Psychiatry 2006;48:138-42.
10. Kermode M, Bowan K, Arole S, Joag K, Jorm AF. Community beliefs about treatments and outcomes of mental disorders: A mental health literacy survey in a rural area of Maharashtra, India. Public Health 2009; 123:476-83.
11. Lahariya C, Singhal S, Gupta S, Mishra A. Pathway of care among psychiatric patients attending a mental health institution in central India. Indian J Psychiatry 2010;52:333-8.
12. Jilani AQ, Trivedi JK, Dalal PK, Sinha PK, Dhyani M. Pathway of care in first episode non affective psychosis. Thesis submitted in department of psychiatry. Lucknow, India: CSMMU; 2009.
13. Trivedi JK, Sethi BB. Healing practices in psychiatric patients. Indian J Psychiatry 1980;22:111-6.
14. Shankar BR, Saravanan B, Jacob KS. Explanatory models of common mental disorders among traditional healers and their patients in rural south India. Int J Soc Psychiatry 2006;52:221-33.
15. Padmavati R, Thara R, Corin E. A qualitative study of religious practices by chronic mentally ill and their caregivers in South India. Int J Soc Psychiatry 2005;51:139-49.
16. Murthy RS. Mental health initiatives in India (1947–2010). The Natl Med J India 2011;24:98-107.
17. Sinha SK, Kaur J. National mental health programme: Manpower development scheme of eleventh five-year plan. Indian J Psychiatry 2011;53:281-5.
18. Kapur RL. The role of traditional healers in mental health care in rural India. Soc Sci Med Anthropol 1979;13 B:27-31.
19. Mishra N, Nagpal SS, Chadda RK, Sood M. Help-seeking behavior of patients with mental health problems visiting a tertiary care center in North India. Indian J Psychiatry 2011;53:234-8.
20. Saleem MO, Saleh B, Yousuf S, Sabri S. Help-seeking behaviour of patients attending the psychiatric service in a sample of United Arab Emirates population. Int J Soc Psychiatry 2009;55:141-8.
21. Primary Health Centre, Government of India. Available from: http://india.gov.in/citizen/health/health.php?id=79. [Last accessed on 2012 December 8].
22. Chadda RK, Agarwal V, Singh MC, Raheja D. Help seeking behaviour of psychiatric patients before seeking care at a mental hospital. Int J Soc Psychiatry 2001;47:71-8.
23. Campion J, Bhugra D. Experiences of religious healing in psychiatric patients in South India. Soc Psychiatry Psychiatr Epidemiol 1997; 32:215-21.
24. Phang CK, Marhani M, Salina AA. Prevalence and experience of contact with traditional healers among patients with first-episode psychosis in hospital Kuala Lumpur. MJP online 2010; 19 (2).