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Research Article

Study of Pathways and Barriers in Accessing Mental Health Services during Coronavirus Pandemic at PMCH Psychiatry OPD

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ABSTRACT
Aim: The aim of the present study was to understand the pathways to care among patients with psychiatric illnesses during the COVID 19 pandemic and the barriers to care among patients with psychiatric illnesses (both new and previously diagnosed) during the COVID 19 pandemic.
Methods: A cross-sectional, hospital-based, exploratory study was done on patients visiting the OPD of the Department of Psychiatry, Patna Medical College and Hospital, Patna. The study enrolled total of 50 diagnosed cases of new onset psychiatric illness and 50 previously diagnosed cases of psychiatric illness in the Department of Psychiatry at PMCH, Patna, as out-patients was recruited as subjects.
Results: In the study population, it was observed that maximum number of patients was in the newly diagnosed cases 18-28 years age group (50%) and previously diagnosed cases 18-28 years, age group (52%). On comparing both groups, significant difference was not found. (P. Value = 0.721). In newly diagnosed cases there were 34 (68%) male and 16 (32%) female and previously diagnosed cases had 32 (64%) male and 18 (36%) female subjects. In the study population, it was observed according to educational qualification maximum number of Illiterate patients were in the newly diagnosed cases18 (36%), Primary 3(6%), High school 5 (10%), Intermediate 14 (28%), Graduate 10 (20%) and previously diagnosed cases Illiterate 20 (40%), Primary 4 (8%), High school 6 (12%), Intermediate 12 (24%), Graduate 8 (16%). On comparing both groups, significant difference was found. (P. Value = 0.011).
Conclusion: There was no statistical difference on items in BACE-3 scale. The pathways study found that most of the patients first visited native/ religious faith healers before seeking specialist psychiatric care. This study will help to assess the effect of a stressful event such as COVID 19 pandemic on the difficulties faced in treatment seeking pattern of mental health of the population more so in an already diagnosed case of psychiatric illness.

Keywords: psychiatric illnesses, barriers, COVID 19 pandemic

INTRODUCTION

Severe acute respiratory syndrome corona virus 2 (SARSCoV-2), the seventh human corona virus, was discovered in Wuhan, Hubei province, China, during recent epidemic of pneumonia [1-2] SARS-CoV-2 as well SARS-CoV and Middle East respiratory syndrome corona virus (MERS-CoV) cause severe pneumonia with a fatality rate of 2.9%, 9.6% and 36%, respectively [3-5]

Other four human corona viruses, OC43, NL63, HKU1 and 229E, generally cause self-limited disease with mild symptoms [6] Genome's analysis and comparison of previously known coronavirus genomes indicate that SARS-CoV-2 presents unique features that distinguish it from other corona viruses: optimal affinity for angiotensin converting enzyme 2 (ACE2) receptor and a polybasic cleavage site at the S1/S2 spike junction that determines infectivity and host range [7-9] India has numerous diversities and cultures, which may affect the help-seeking behaviors of mentally ill patients and their families. [10]

The disease burden of non-communicable diseases is primarily comprised of mental illness. More than 450 million individuals worldwide, and this number is constantly rising, suffer from mental or psychosocial diseases, according to the World Health Organization

(WHO). [11-12] Pathways to care is a detailed and systematic description of sources of care used by patients before seeking help from mental health professionals and of the factors that modify it. [13] The pathway and the associated help-seeking behaviors help us identify the possible sources of delay in presentation. An understanding of how people seek help for mental disorders is essential for planning mental health services, coordinating psychiatric referrals, and enhancing the treatment-seeking attitude. [10] The most common pathways to mental health care in India are traditional healers, general hospitals, allopathic practitioners, and religious healers. These pathways create a delay in receiving psychiatric treatment in the first place, and it will also increase the course of the illness and severity of the illness. [12]

According to the WHO about pathways to mental health care, the primary contacts of patients with mental illness for treatment can be native/religious healers, social workers, community workers, osteopaths, medical practitioners, and general hospitals. [14] In a delayed pathway, a patient with mental illness can go through any of these and finally reach psychiatric services. [15] Due to sociocultural viewpoints and a lack of knowledge about mental illness, most of the patients first consult a traditional and spiritual healer, which leads to a delay in proper psychiatric treatment. [16] Sociocultural factors appeared to influence the help-seeking behavior of patients with mental illness. Patients attending psychiatric outpatient services at a mental hospital were explicitly asked about various treatment facilities utilized by them before coming to the hospital. [17]

The aim of the present study was to understand the pathways to care among patients with psychiatric illnesses during the COVID 19 pandemic and the barriers to care among patients with psychiatric illnesses (both new and previously diagnosed) during the COVID 19 pandemic.

MATERIALS AND METHODS

A cross-sectional, hospital-based, exploratory study was done on patients visiting the OPD of the Department of Psychiatry, Patna Medical College and Hospital, Patna. The study enrolled total of 50 diagnosed cases of new onset psychiatric illness and 50 previously diagnosed cases of psychiatric illness in the Department of Psychiatry at PMCH, Patna, as out-patients was recruited as subjects.

Inclusion Criteria

1. Either sex, aged 18-60 years of age
2. Willing to provide written informed consent
3. Patients with no acute medical/ surgical emergency
4. Both new and previously diagnosed patients with psychiatric illnesses.

Exclusion Criteria

1. Not willing to provide consent
2. <18 & >60 years of age
3. Patients with organic brain disease

Tools of Assessment:

1. Socio-demographic data
2. ICD-10 classification of Mental and Behavioural Disorders
3. WHO Encounter Form for the pathway study
4. Barriers to Care Evaluation (BACE-3) scale

Procedure:

A written informed consent was taken for participation after explaining the purpose and design of the study. Prior to consent, the participants were informed that refusal to participate would not affect the course or further management adversely. Hundred patients with a total of 50 diagnosed cases of new onset psychiatric illness and 50 previously diagnosed cases of psychiatric illness occurring after covid 19 pandemic lockdown visiting the Psychiatric out Patient Department, Patna Medical College and Hospital, Patna were evaluated for the pathways and barriers to care.

The following baseline data was collected using a semi- structured proforma based on self-report from the patients; Socio-demographic data (age, sex, religion, education). The pathways to care data were collected using the adaptation from the encounter form used in the World Health Organization (WHO) Pathway Study. Appropriate statistical analysis using IBM SPSS was done. Chi square test was done to find the statistical significance between various groups/variables along with cross tabs. Ethical standards maintained throughout the study.

Ethical Aspects

1. The study was conducted at Patna Medical College & Hospital after permission from the college ethical committee.
2. Informed written consent was taken from each patient.

3. The study would not alter the treatment plan at any time.
4. Patient information would be kept confidential.
5. The patient would have the right to refuse to participate in the study and to withdraw from the study at any given time.

Statistical Analysis:

All the data were analyzed using SPSS package (Stata, version 26.0 SPSS INC, Chicago, IL, USA) for windows. The data were presented as descriptive statistics for continuous variables and percentage for categorical variables and was subjected Chi-square test, t test & Anova test. Other values were represented in number, proportions (%) and mean ± SD.

RESULTS

Table 1: Demographic data

Age in year	**Newly diagnosed cases (n=50)**		**Previously diagnosed cases (n=50)**		**P. value**
	Frequency	Percentage	Frequency	Percentage	
18 - 28	25	50%	26	52%	0.721
29 - 39	16	32%	16	32%	
40 - 50	7	14%	7	14%	
>50	2	4%	1	2%	
Total	50	100%	50	100%	
Mean±SD	30.38±10.68		29.52±10.45		
Gender	Frequency		Percentage	Frequency	Percentage
Male	34		68%	32	64%
Female	16		32%	18	36%
Marital status	Frequency	Percentage	Frequency	Percentage	P. value
Married	29	58%	26	52%	1.000
Unmarried	21	42%	24	48%	
Total	50	100%	50	100%	
Socio-economic status					
Lower	28	56%	27	54%	0.004
Upper lower	3	6%	2	4%	
Lower middle	18	36%	19	38%	
Upper middle	1	2%	2	4%	
Total	50	100%	50	100%	

In the study population, it was observed that maximum number of patients was in the newly diagnosed cases 18-28 years age group (50%) and previously diagnosed cases 18-28 years, age group (52%). On comparing both groups, significant difference was not found. (P. Value = 0.721). In newly diagnosed cases there were 34 (68%) male and 16 (32%) female and previously diagnosed cases had 32 (64%) male and 18 (36%) female subjects. In the study population, it was observed according to their Marital status maximum number of Married patients were in the newly diagnosed cases29 (58%), Unmarried 21(42%) and previously diagnosed cases Married 26 (52%), Unmarried 24(48%). On comparing both groups, significant difference was not found. (P. Value = 0.1.000). In the study population, it was observed according to socioeconomic status maximum number of lower socioeconomic status patients were in the newly diagnosed cases28 (56%), Upper lower 3(6%), Lower middle 18 (36%), Upper middle 1 (2%) and previously diagnosed cases lower socioeconomic status patients 27 (54%), Upper lower 2(4%), Lower middle 19 (38%), Upper middle 2 (4%). On comparing both groups, significant difference was found. (P. Value = 0.004).

Table 2: Distribution of patients according to their educational qualification and occupation

Educational qualification	**Newly diagnosed cases (n=50)**		**Previously diagnosed cases (n=50)**		**P. value**
	Frequency	Percentage	Frequency	Percentage	
Illiterate	18	36%	20	40%	0.011

Primary	3	6%	4	8%	
High School	5	10%	6	12%	
Intermediate	14	28%	12	24%	
Graduate	10	20%	8	16%	
Total	50	100%	50	100%	
Occupation	Frequency	Percentage	Frequency	Percentage	P. value
Unskilled	19	38%	24	48%	0.001
Semi-skilled	5	10%	1	2%	
Skilled	3	6%	1	2%	
Professional	3	6%	2	4%	
Student	15	30%	17	34%	
Unemployed	5	10%	5	10%	
Total	50	100%	50	100%	

In the study population, it was observed according to educational qualification maximum number of Illiterate patients were in the newly diagnosed cases18 (36%), Primary 3(6%), High school 5 (10%), Intermediate 14 (28%), Graduate 10 (20%) and previously diagnosed cases Illiterate 20 (40%), Primary 4 (8%), High school 6 (12%), Intermediate 12 (24%), Graduate 8 (16%). On comparing both groups, significant difference was found. (P. Value = 0.011). In the study population, it was observed according to their occupation maximum number of Unskilledpatients were in the newly diagnosed cases5 (10%), student 15 (30%), Professional 3 (6%), skilled 3 (6%), Semi-skilled 5 (10%), Unskilled 19(38%) and previously diagnosed cases Unskilled 5 (10%), student 17(34%), Professional 2 (4%), skilled 1 (2%), Semi-skilled 1 (2%), Unskilled 24 (48%) On comparing both groups, significant difference was found. (P. Value = 0.001).

Table 3: Distribution of seeking symptom

No. of Prior visit	**Newly diagnosed cases (n=50)**		**Previously diagnosed cases (n=50)**	
	Frequency	Percentage	Frequency	Percentage
F 40 – F 44 (Anxiety symptoms like nervousness, tremor, sweating and palpitation)	11	22%	8	16%
F 30 – F 34 (Mood symptoms like low mood, loss of interest decreased sleep, Elevated mood, Increased energy etc.)	20	40%	12	24%
F 42 (OCD)	4	8%	6	12%
F 20 – F 29 (Psychotic symptoms like abusive and aggressive behaviour, irrelevant talk etc.)	8	16%	23	46%
F 51 (Sleep problems like decreased sleep etc.)	2	4%	0	0%
F 10 – F 19 (Substance use opioid, bodyache, restlessness etc.)	4	8%	0	0%
F 45 Somatoform disorder symptoms like pain in different body parts, restlessness etc.	1	2%	1	2%

In the study population, it was observed according to their seeking system of F 40 – F 44(Anxiety symptoms like nervousness, tremor, sweating and palpitation) in the newly diagnosed cases 11 (22%), F 30 – F 34 (Mood symptoms like low mood, loss of interest decreased sleep, Elevated mood, Increased energy etc.) 20 (40%), F 42 (OCD) , 4 (8%), F 20 – F 29 (Psychotic symptoms like abusive and aggressive behaviour, irrelevant talk etc.)

8 (16%), F 51(Sleep problems like decreased sleep etc.) 2(4%), F 10 – F 19(Substance use opioid, bodyache, restlessness etc.) 4 (8%), F 45Somatoform disorder symptoms like pain in different body parts, restlessness etc. 1 (2%) and previously diagnosed cases seeking system of F 40 – F 44(Anxiety symptoms like nervousness, tremor, sweating and palpitation) in the newly diagnosed cases 8 (16%), F 30 – F 34 (Mood symptoms like low mood, loss of interest decreased sleep, Elevated mood, Increased energy etc.) 12 (24%), F 42 (OCD) , 6 (12%), F 20 – F 29 (Psychotic symptoms like abusive and aggressive behavior, irrelevant talk etc.) 23 (46%), F 51(Sleep problems like decreased sleep etc.) 2(4%), F 10 – F 19(Substance use opioid, bodyache, restlessness etc.) 0 (0%), F 45 Somatoform disorder symptoms like pain in different body parts, restlessness etc. 1 (2%).

Table 4: Treatment offered in first visit

	Newly diagnosed cases (n=50)		**Previously diagnosed cases (n=50)**		**P. value**
	Frequency	Percentage	Frequency	Percentage	
No treatment given	24	48%	0	0%	0.850
Not known	8	16%	16	32%	
Psychotropics	14	28%	20	40%	
Religious ceremony	4	8%	13	26%	
Homeopathic medicine	0	0%	1	2%	
Total	50	100%	50	100%	

In the study population, it was observed according to their treatment offered in first visit no treatment given in the newly diagnosed cases24 (48%), Not known8 (16%), Psychotropics 14 (28%), Religious ceremony 4 (8%), Homeopathic medicine 0 (0%) and previously diagnosed cases no treatment given 0 (0%), Not known 16(32%), Psychotropics 20 (40%), Religious ceremony 13 (26%), Homeopathic medicine 1(2%). On comparing both groups, significant difference was not found. (P. Value = 0.850).

Table 5: Treatment offered in last visit

	Newly diagnosed cases (n=50)		**Previously diagnosed cases (n=50)**		**P. Value**
	Frequency	Percentage	Frequency	Percentage	
No treatment given	24	48%	0	0%	0.531
Not known	2	4%	0	0%	
Psychotropics	17	34%	47	94%	
Religious ceremony	7	14%	3	6%	
Homeopathic medicine	0	0%	0	0%	
Total	50	100%	50	100%	

In the study population, it was observed according to their treatment offered in last visit no treatment given in the newly diagnosed cases24 (48%), Not known 2 (4%), Psychotropics 17 (34%), Religious ceremony 7 (14%), Homeopathic medicine 0(0%) and previously diagnosed cases no treatment given 0 (0%), Not known 0(0%), Psychotropics 47 (94%), Religious ceremony 3 (6%), Homeopathic medicine 0(0%). On comparing both groups, significant difference was not found. (P. Value = 0.531).

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Table 6: Showing the frequency and percentage of various Perceived barriers to access to care on Newly diagnosed BACE-3 Scale

Items	Not at all		A little		Quite a lot		A lot	
	Freq	%	Freq	%	Freq	%	Freq	%
1. Being unsure where to go to get professional care.	25	50%	10	20%	11	22%	4	8%
2. Wanting to solve the problem on my own	29	58%	17	34%	4	8%	0	0%
3. Concern that I might be seen as weak for having a mental health problem	48	96%	2	4%	0	0%	0	0%
4. Fear of being put in hospital against my will.	43	86%	4	8%	3	6%	0	0%
5. Concern that it might harm my chances when applying for jobs*.	7	14%	2	4%		4%	1	2 %
6. Problems with transport or travelling to appointments.	18	36%	19	38%	9	18%	4	8%
7. Thinking the problem would get better by itself.	27	54%	20	40%	3	6%	0	0%
8. Concern about what my family might think, say, do or feel.	44	88%	5	10%	1	2%	0	0%
9. Feeling embarrassed or ashamed.	43	86%	5	10%	2	4%	0	0%
10. Preferring to get alternative forms of care (e.g.traditional/religious healing or alternative/complementary therapies).	38	76%	9	18%	3	6%	0	0%
11. Not being able to afford the financial cost involved.	24	48%	21	42%	4	8%	1	2%
12. Concern that I might be seen as 'crazy'.	47	94%	3	6%	0	0%	0	0%
13. Thinking that professional care probably would not help	49	98%	1	2%	0	0%	0	0%
14. Concern that I might be seen as a bad parent*.	24	48%	1	2%	0	0%	0	0%
15. Professionals from my own ethnic or cultural group not being available.	50	100%	0	0%		0%	0	0%
16. Being too unwell to ask for help.	42	84%	6	12%		4%	0	0%
17. Concern that peoples I know might find out.	49	98%	1	2%		0%	0	0%
18. Dislike of talking about my feelings, emotions or thoughts.	44	88%	5	10%		2%	0	0%
19. Concern that people might not take me seriously if they found out I was having professional care.	44	88%	5	10%	1	2%	0	0%
20. Concerns about the treatments Available (e.g., medication side effects).	45	90%	3	6%	2	4%	0	0%

21. Not wanting a mental health problem to be on my medical records.	49	98%	1	2%	0	0%	0	0%
22. Having had previous bad experiences with professional care for mental health	50	100%	0	0%	0	0%	0	0%
23. Preferring to get help from family or friends.	45	90%	5	10%	0	0%	0	0%
24. Concern that my children may be taken into care or that I may lose access or custody without my agreement*.	25	50%	0	0%	0	0%	0	0 %
25. Thinking I did not have a problem.	38	76%	8	16%	3	6%	1	2%
26. Concern about what my friends might think, say or do	47	94%	2	4%	1	2%	0	0%
27. Difficulty taking time off work.	47	94%	3	6%	0	0%	0	0%
28. Concern about what people at work might think, say or do*	20	40%	1	2%	0	0%	0	0 %
29. Having problems with childcare while I receive professional care*	28	56%	0	0%	0	0%	0	0 %
30. Having no one who could help me get professional care.	50	100%	0	0%	0	0%	0	0%

In the study population, showed that on newly diagnosed cases "Being unsure where to go to get professional care" was perceived as a barrier to access to care by most patients accounting for 25(50%) not at all, 10(20%) a little, 11 (22%) quite a lot 4(8%) a lot. "Wanting to solve the problem on my own" as a barrier while "Thinking the problem would get better by itself" was also perceived as a barrier 29(58%) not at all, 17(34%) a little, 4(8%) quite a lot. "Concern that I might be seen as weak for having a mental health problem" as a barrier was also perceived 48(96%) not at all, 2(4%) a little." Fear of being put in hospital against me will" was also perceived 43(86%) not at all, 4(8%) a little 3 (6%) quite a lot. "Concern that it might harm my chances when applying for jobs" was perceived 7(14%) not at all, 2(4%) a little, 2 (4%) quite a lot 1(2%) a lot. "Problems with transport or travelling to appointments" was perceived 18(36%) not at all, 19(38%) a little, 9 (18%) quite a lot 4(8%) a lot. "Thinking the problem would get better by itself" was perceived 27(54%) not at all, 20(40%) a little, 3 (6%) quite a lot 0(0%) a lot. "Concern about what my family might think, say, do or feel" was perceived 44(88%) not at all, 5(10%) a little, 1 (2%) quite a lot 0(0%) a lot. "Feeling embarrassed or ashamed" was perceived 43(86%) not at all, 5(10%) a little, 2 (4%) quite a lot 0(0%) a lot. "Preferring to get alternative forms of care (e.g. traditional/religious healing or alternative/complementary therapies" was perceived 38(76%) not at all, 9(18%) a little, 3 (6%) quite a lot 0(0%) a lot. "Not being able to afford the financial cost involved" was perceived 24(48%) not at all, 21(42%) a little, 4 (8%) quite a lot 1(2%) a lot. "Concern that I might be seen as 'crazy'. was perceived 47(94%) not at all, 3(6%) a little, 0 (0%) quite a lot 0(0%) a lot. "Thinking that professional care probably would not help" was perceived 49(98%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Concern that I might be seen as a bad parent" was perceived 24(48%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Professionals from my own ethnic or cultural group not being available" was perceived 50(100%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Being too unwell to ask for help" was perceived 42(84%) not at all, 6(12%) a little, 2 (4%) quite a lot 0(0%) a lot. "Concern that peoples I know might find out" was perceived 49(98%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Dislike of talking about my feelings, emotions or thoughts" " was perceived 44(88%) not at all, 5(10%) a little, 1 (2%) quite a lot 0(0%) a lot. "Concern that people might not take me

seriously if they found out I was having professional care" was perceived 44(88%) not at all, 5(10%) a little, 1 (2%) quite a lot 0(0%) a lot. "Concerns about the treatments Available (e.g., medication side effects" was perceived 45(90%) not at all, 3(6%) a little, 2 (4%) quite a lot 0(0%) a lot. "Not wanting a mental health problem to be on my medical records" was perceived 49(98%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Having had previous bad experiences with professional care for mental health" was perceived 50(100%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Preferring to get help from family or friends" was perceived 45(90%) not at all, 5(10%) a little, 0 (0%) quite a lot 0(0%) a lot. "Concern that my children may be taken into care or that I may lose access or custody without my agreement" was perceived 25(50%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Thinking I did not have a problem" was perceived 38(76%) not at all, 8(16%) a little, 3 (6%) quite a lot 1(2%) a lot. "Concern about what my friends might think, say or do" was perceived 47(94%) not at all, 2(4%) a little, 1 (2%) quite a lot 0(0%) a lot. "Difficulty taking time off work" was perceived 47(94%) not at all, 3(6%) a little, 0 (0%) quite a lot 0(0%) a lot. "Concern about what people at work might think, say or do" was perceived 20(40%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Having problems with childcare while I receive professional care" was perceived 28(56%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Having no one who could help me get professional care" was perceived 50(100%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot.

DISCUSSION

Originating in Wuhan (Hubei, China) on 31 December 2019, a total of 27 cases of pneumonia of unknown etiology led to a global viral pandemic (SARS-CoV-2).[18] The exponential and global increase in the rate of infections and the first deaths were the triggers for the World Health Organization (WHO) to declare a pandemic on 11 March 2020. It has affected the population worldwide, with more than 110 million confirmed cases and more than 2.5 million deaths[19] at its peak. As of September 2021, this epidemiological crisis continues with about 219 million accumulated cases and 4.55 million accumulated deaths. Yet, around 5760 million vaccine doses have been administered and 2370 million citizens have been immunized, or 30.7% of the worldwide population.[20]

It was observed that maximum number of patients were in the newly diagnosed cases 18-28 years age group (50%) and previously diagnosed cases 18-28 years, age group (52%). On comparing both group, significant difference was not found. (P. Value = 0.721). AM Ruscio et al[21] also found similar results with the mean age. In another study the Mean age whole sample was 20.6 years which is consistent with the results in this study. The present study newly diagnosed cases there were 34 (68%) male and 16 (32%) female and previously diagnosed cases had 32 (64%) male and 18 (36%) female subjects.In another similar study 96 subjects (55 women, 41 men which is almost consistent with the present study. This study was similar to Poyraz et al.[22] According to their Marital status maximum number of Married patients were in the newly diagnosed cases 29 (58%), Unmarried 21(42%) and previously diagnosed cases Married 26 (52%), Unmarried 24(48%). On comparing both groups, significant difference was not found. (P. Value = 0.1.000). AM Ruscio et al[21] also found similar results with the marital status. it was observed according to educational qualification maximum number of Illiterate patients were in the newly diagnosed cases18 (36%), Primary 3(6%), High school 5 (10%), Intermediate 14 (28%), Graduate 10 (20%) and previously diagnosed cases Illiterate 20 (40%), Primary 4 (8%), High school 6 (12%), Intermediate 12 (24%), Graduate 8 (16%). On comparing both group, significant difference was found. (P. Value = 0.011). This study was similar to Pérez-Vigil et al.[23]

It was observed according to their seeking system of F 40 – F 44(Anxiety symptoms like nervousness, tremor, sweating and palpitation) in the newly diagnosed cases 11 (22%), F 30 – F 34 (Mood symptoms like low mood, loss of interest decreased sleep, Elevated mood, Increased energy etc.) 20 (40%), F 42 (OCD) , 4 (8%), F 20 – F 29 (Psychotic symptoms like abusive and aggressive behaviour, irrelevant talk etc.) 8 (16%), F 51(Sleep problems like decreased sleep etc.) 2(4%), F 10 – F 19(Substance use opioid, bodyache, restlessness etc.) 4 (8%), F 45 Somatoform disorder symptoms like pain in different body parts, restlessness etc. 1 (2%) and previously diagnosed cases seeking system of F 40 – F 44

(Anxiety symptoms like nervousness, tremor, sweating and palpitation) in the newly diagnosed cases 8 (16%), F 30 – F 34 (Mood symptoms like low mood, loss of interest decreased sleep, Elevated mood, Increased energy etc.) 12 (24%), F 42 (OCD) , 6 (12%), F 20 – F 29 (Psychotic symptoms like abusive and aggressive behaviour, irrelevant talk etc.) 23 (46%), F 51(Sleep problems like decreased sleep etc.) 2(4%), F 10 – F 19(Substance use opioid, bodyache, restlessness etc.) 0 (0%), F 45 Somatoform disorder symptoms like pain in different body parts, restlessness etc. 1 (2%). This data is similar to Sulaberidze L et al.[24] It was observed according to their how long ago first visited in the newly diagnosed cases, 0-6 months 14 (28%), 6 month-1 year, 8 (16%), 1 year-2 years, 5 (10%), 2 years-5 years 0 (0%), 5 years-10 years 0(0%), >10 years, 0(0%), no prior visit, 23(46%) and previously diagnosed cases according to their how long ago first visited in 0-6 months 3 (6%), 6 month-1 year, 4 (8%), 1 year-2 years, 5 (10%), 2 years-5 years 22 (44%), 5 years-10 years 10(20%), >10 years, 6(12%), no prior visit , 0(0%). On comparing both groups, significant difference was not found. (P. Value = 0.091). This data is similar to (WHO (World Health Organization). (2005).[25]

The result showed that on newly diagnosed cases "Being unsure where to go to get professional care" was perceived as a barrier to access to care by most patients accounting for 25(50%) not at all, 10(20%) a little, 11 (22%) quite a lot 4(8%) a lot. "Wanting to solve the problem on my own" as a barrier while "Thinking the problem would get better by itself" was also perceived as a barrier 29(58%) not at all, 17(34%) a little, 4(8%) quite a lot. "Concern that I might be seen as weak for having a mental health problem" as a barrier was also perceived 48(96%) not at all, 2(4%) a little. " Fear of being put in hospital against me will" was also perceived 43(86%) not at all, 4(8%) a little 3 (6%) quite a lot. "Concern that it might harm my chances when applying for jobs" was perceived 7(14%) not at all, 2(4%) a little, 2 (4%) quite a lot 1(2%) a lot. "Problems with transport or travelling to appointments" was perceived 18(36%) not at all, 19(38%) a little, 9 (18%) quite a lot 4(8%) a lot. "Thinking the problem would get better by itself" was perceived 27(54%) not at all, 20(40%) a little, 3 (6%) quite a lot 0(0%) a lot. "Concern about what my family might think, say, do or feel" was perceived 44(88%) not at all, 5(10%) a little, 1 (2%) quite a lot 0(0%) a lot. "Feeling embarrassed or ashamed" was perceived 43(86%) not at all, 5(10%) a little, 2 (4%) quite a lot 0(0%) a lot. "Preferring to get alternative forms of care (e.g. traditional/religious healing or alternative/complementary therapies" was perceived 38(76%) not at all, 9(18%) a little, 3 (6%) quite a lot 0(0%) a lot. "Not being able to afford the financial cost involved" was perceived 24(48%) not at all, 21(42%) a little, 4 (8%) quite a lot 1(2%) a lot. "Concern that I might be seen as 'crazy' was perceived 47(94%) not at all, 3(6%) a little, 0 (0%) quite a lot 0(0%) a lot. "Thinking that professional care probably would not help" was perceived 49(98%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Concern that I might be seen as a bad parent" was perceived 24(48%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Professionals from my own ethnic or cultural group not being available" was perceived 50(100%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Being too unwell to ask for help" was perceived 42(84%) not at all, 6(12%) a little, 2 (4%) quite a lot 0(0%) a lot. "Concern that peoples I know might find out" was perceived 49(98%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Dislike of talking about my feelings, emotions or thoughts" was perceived 44(88%) not at all, 5(10%) a little, 1 (2%) quite a lot 0(0%) a lot. "Concern that people might not take me seriously if they found out I was having professional care" was perceived 44(88%) not at all, 5(10%) a little, 1 (2%) quite a lot 0(0%) a lot. "Concerns about the treatments Available (e.g., medication side effects" was perceived 45(90%) not at all, 3(6%) a little, 2 (4%) quite a lot 0(0%) a lot. "Not wanting a mental health problem to be on my medical records" was perceived 49(98%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Having had previous bad experiences with professional care for mental health" was perceived 50(100%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Preferring to get help from family or friends" was perceived 45(90%) not at all, 5(10%) a little, 0 (0%) quite a lot 0(0%) a lot. "Concern that my children may be taken into care or that I may lose access or custody without my agreement" was perceived 25(50%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Thinking I did not have a problem" was perceived 38(76%) not at all, 8(16%) a little, 3 (6%) quite a lot 1(2%) a lot. "Concern about what my friends might think, say or do" was perceived 47(94%) not at all,

2(4%) a little, 1 (2%) quite a lot 0(0%) a lot. "Difficulty taking time off work" was perceived 47(94%) not at all, 3(6%) a little, 0 (0%) quite a lot 0(0%) a lot. "Concern about what people at work might think, say or do" was perceived 20(40%) not at all, 1(2%) a little, 0 (0%) quite a lot 0(0%) a lot. "Having problems with childcare while I receive professional care" was perceived 28(56%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. "Having no one who could help me get professional care" was perceived 50(100%) not at all, 0(0%) a little, 0 (0%) quite a lot 0(0%) a lot. This result is similar to Sarah Clement et al.[26]

CONCLUSION

The study highlights significant barriers and pathways to mental health care during the COVID-19 pandemic, revealing that many patients initially sought help from native or religious healers before accessing specialist psychiatric services. Key barriers included financial constraints, stigma, and a preference for self-reliance or alternative treatments. Despite the pandemic's challenges, no significant statistical differences were found in demographic factors between newly diagnosed and previously diagnosed patients, though educational and occupational disparities were noted. These findings underscore the need for targeted interventions to improve mental health literacy, reduce stigma, and enhance accessibility to professional care, particularly during crises. The study provides valuable insights for policymakers to design more effective mental health services tailored to the needs of vulnerable populations.

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