The
Central African
Journal
of
Medicine

THE CENTRAL AFRICAN

JOURNAL OF MEDICINE

ORIGINAL ARTICLES

Pathways to psychiatric care in Harare, Zimbabwe

A P REELER

SUMMARY

A study was carried out on the pathways to psychiatric care in Harare, Zimbabwe. Encounter forms were completed on 48 patients admitted to psychiatric beds. Analysis indicated that there was a by-pass of primary care facilities, with a significant number presenting directly to tertiary care facilities. here were lengthy delays before seeking care, but delays while receiving care were moderate.

The sample as a whole was composed of major disorders, displaying severe symptoms, and there was a suggestion that some patients become more disturbed along the pathway. As a whole, the sample is very different to samples screened from primary care settings, and the consequences of this are discussed.

INTRODUCTION

Epidemiological studies in recent years have indicated that psychological disorders are common both in community and primary care samples. It has also been observed that very few patients with psychological disorders ever receive specialist psychiatric care.[1]

Correspondence:
Department of Psychiatry
School of Medicine
University of Zimbabwe
P.O. Box A178
Avondale
Harare, Zimbabwe

This work suggests that only severe or chronic disorders receive such specialist attention, and, furthermore, that many psychological disorders receive no attention at all.

The Western studies have been complemented by studies in other parts of the world, and the African studies suggest direct comparability with the Western studies.[2, 3] In Zimbabwe, the studies, which have been mainly carried out on primary care populations, conform to these general findings.[4, 5]

Goldberg and Huxley have earlier proposed a Filter Model for psychiatric care, which describes the pathways to psychiatric care for patients suffering from psychological disorders.[1]

This model assumed that cases receiving specialist psychiatric care were the residue of a progressive filtering process, but it was also recognised that some patients may reach psychiatric services by other than the established pathways.[6]

Studies of patients in specialist psychiatric settings are therefore likely to represent a somewhat skewed sample, and this limits the generality of such studies.

It is also important to the development of effective mental health services that the referral network to such services is well-understood, and it was with this aim that the World Health Organisation has proposed a programme of research to improve the quality of mental health services.

This programme envisaged a series of complementary studies, several of which were seen as necessary. One study, the "100 patients study", was aimed at understanding the prevalence of psychological disorder in primary care settings, and such, studies have been conducted in Zimbabwe.[4, 5, 7]

The second study involved the investigation of referral networks, the "pathways to psychiatric care", as well as the calculation of annual inception

rates for psychological disorders. Gater and Goldberg, as mentioned above, have conducted such a study for the psychiatric service for South Manchester.[6] This study provides and interesting comparison, since the South Manchester and Harare mental health services are both embedded in a filter model service model, with a stress on a primary care base.

The present paper reports upon an attempt to investigate the pathways to care in Harare, Zimbabwe.

MATERIALS AND METHODS

All patients referred to the psychiatric services in Harare during the period 1st June to 1st July 1989, were to be assessed. All patients who were returning for treatment or had sought care during the previous years were to be excluded, but all patients beginning a new episode of care were to be included.

A series of meetings were held with the psychiatric staff in the two units involved (Harare Psychiatric Unit and Ward 12), and the purpose of the exercise was explained. The units involved provide psychiatric services, inpatient and outpatient, to the metropolitan area of Harare, as well as operating as a referral service to the outlying Provincial Medical services. In practice, the catchment area for the psychiatric service covers a large proportion of the northern area of Zimbabwe.

Instruments: A specially prepared encounter form, provided by the World Health Organisation, was used to record various details of the patients. The psychiatric staff were instructed in the use of the form, which took about fifteen minutes to complete.

The encounter form is divided into seven sections, each recording various items of information about the patients. Basic information on the Centre and mental health professionals is recorded. Demographic information about the patient is also recorded, including age, gender, marital status, social position and past history of psychological disorder. The remaining five sections relate to the pathway to care, and detailed information about various carers, types of problems presented, kinds of treatment offered, and the times of various events (onset of disorder, journey to care, time taken in referral, etc.) were recorded.

The study protocol, devised by the World Health Organisation, also required specific ICD-10 diagnoses, but this was dispensed with in the present study. The rationale here was that the psychiatrists had been attempting to follow DSM-III guidelines, and it was felt that it was better to allow staff to express their diagnoses in their most usual form. In practice, the diagnoses that were assigned were of an informal nature, and no record was kept of the system being utilised in making the diagnoses.

RESULTS

Encounter forms were completed upon 67 patients in all, but complete data was only available upon 488 patients. All of these patients were admitted to psychiatric beds. Nineteen patients were excluded from the study, mainly because the encounter forms were incomplete in most respects. It appears that busy staff were unable to complete these forms when clerking the patients, and subsequent examination of patient notes did not remedy the deficit. The settings in which these patients were seen are indicated below in Table I.

Table I: Settings where patients seen.

Setting	Number
Psychiatric OPD, Mental Hospital	11
Admission to psychiatric ward	18
Medical ward	19

As can be seen, the settings were restricted to central hospital facilities, and therefore represents a selected sample, from a potentially wider source of settings. No data was available for outpatient contacts or contacts with other mental health professionals, such as clinical psychologists. This omission resulted in the inability to calculate incidence rates, but did, nonetheless, allow the pathways to be investigated.

The sample itself appears little different from samples screened from primary patients. However, as can be seen from Table II below, there are some differences. There is a large proportion of single men, which is different to samples screened from primary care clinics, where there tends to be parity in the distribution of sexes, with perhaps a slight tendency towards a preponderance of women.[4,5]

Table II: Demographic characteristics of sample.

AGE:	
Mean	28,2 years
S.D.	9,4 years
GENDER:	
Male	33
Female	15
MARITAL:	
Single	23
Married	15
Married (apart)	7
Widowed	0
Divorced	3
SOCIAL POSITION:	
Above average	3
Average	37
Below average	8
PAST HISTORY OF PSYCHOLOGICAL DISORDER:	
In survey area	36
Outside survey area	12
SUGGESTION FOR CARE:	
Patient	2
Previous care	12
Family/others	34

A pathway was also carried our, with the routes to specialist mental health care being described (see Figure I below), and mean delays in weeks on the pathways were also calculated (see Figure II). These latter values are somewhat misleading since the numbers of patients using some of the routes is very small (n=2 in some cases).

As can be seen from Figure I, many patients initially consult a traditional healing system, and thereafter proceed through a variety of routes in an indirect fashion. Few of these patients are directly referred to Western-style health facilities. A sizeable percentage by-pass primary care facilities altogether, and present directly to tertiary care facilities.

These findings, taken together, describe the very different picture to a comparable study from the West, where the majority of patients will initially consult a general practitioner.[6] The number of pathways used in Zimbabwe is smaller than in the South Manchester study, which probably reflects the health position in Zimbabwe with relatively underdeveloped services, and also a relative paucity in the variety of health service options.

Figure II describes the delays experienced by patients using the various pathways. As can be seen,

the shortest delays are those inpatients identified to the police, and this seems to be associated with "bad" behaviour. Generally, there is a lengthy period between onset of symptoms and contact with a carer, but thereafter the delays would seem moderate. Even those patients who initially consult traditional healers do not experience great delays before seeing mental health professionals (MHPs). Here, the police would seem to provide the longest delays in referring on patients, and this may be due to complications over misdemeanours, crimes and often access to transport.

Overall, as can be seen from Figures I and II, the pathways show a clear by-pass of primary care facilities with most presenting directly to tertiary care. This figure is higher if the routes involving the police and traditional healers are included.

Problems presented: The majority of patients (74 pc) presented with problems that may be considered to be severe: psychotic symptoms, disturbed behaviour and violence. There are few patients who present with minor disorders, and surprisingly, only a small percentage who present with somatic symptoms. This last is surprising since somatic symptoms appear very frequently in cases prescriptively screened from primary care samples.[4,5]

As can be seen from Table III below, the longest delays are experienced before patients seek care. The delays before seeking care are quite variable, whilst the delays between seeking care and seeing an MHP are moderate. This latter delay can be inferred from the difference between Total Delay and Delay Before Care.

The most marked change seems to be the increase of violence amongst patients. However, the changes do not alter the finding that psychotic symptoms, disturbed behaviour and violence account for over 70 pc of the presenting problems. This bolsters the conclusions of earlier African studies and reviews, that only the most severe cases (and usually only psychosis) receive the attention of mental health professionals.

Table IV shows the analysis for the diagnosis assigned to these patients. As mentioned above, these diagnoses are informal and cannot be taken as accurate. It should also be noted that three cases w~~ HIV positive, but no prevalence can be es' since not all cases were prescriptively scre their HIV status. As can be seen from bot

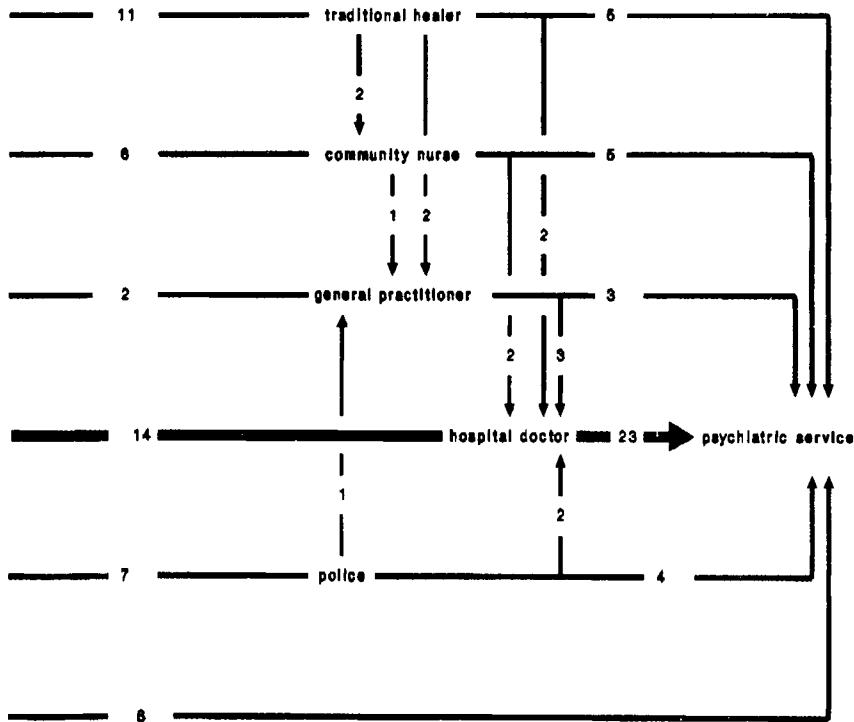*Figure I: Pathways to psychiatric care: Frequency of patients using various pathways.*

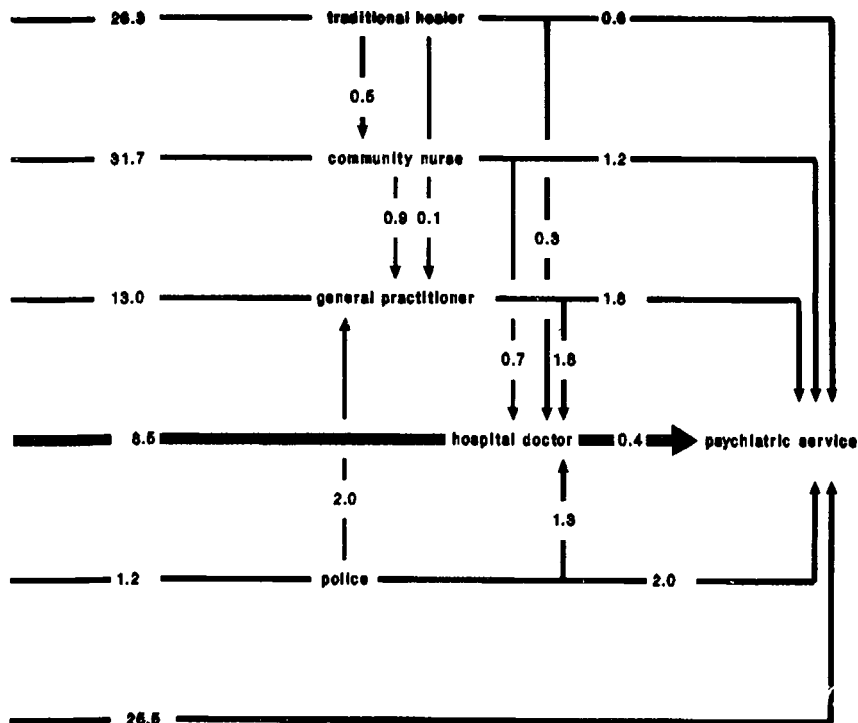*Figure II: Delays on pathways: Mean values in weeks.*

Table III: Problems presented and their delays.

Problem	No. of patients presenting problem		Mean delay in weeks for patients presenting problem to first carer	
	First carer	MHP (psychiatrist)	Delay before care (in weeks)	Total delay (in weeks)
Violence	12	13	8.0	14.2
Psychotic symptoms	11	12	15.2	18.9
Disturbed behaviour	12	8	10.4	11.6
Somatic symptoms	9	3	1.6	2.7
Depression	3	4	53.3	56.4
Organic symptoms	1	1	3.0	5.0
Substance abuse	1	1	7.9	11.5

Table IV: Diagnosis given and their delays

Diagnosis	No of patients presenting problems	Mean delay in weeks for patients presenting problem	
		Delay before care (in weeks)	Total delay (in weeks)
Schizophrenia	23	16.2	20.4
Affective disorder	7	16.6	18.4
Personality disorder	6*	0.7	10.3
Organic disorder	4	1.0	4.4
Substance abuse	5	5.6	9.8
Neurosis	3	49.6	50.5

(includes 3 cases identified as HIV positive)

and Table IV, there is a trend towards greater delays being associated with minor disorders, which again is supported by the studies indicating poor detection of minor disorders by primary care workers.[7, 8]

DISCUSSION

Taken as a whole, these results are interesting and complement the general picture emerging from epidemiological investigations of psychological disorders in Zimbabwe. The skew in the sample is clear: it is confined to admissions to psychiatric wards, and provides no information on other contacts with the psychiatric services.

Accepting these limitations, what can we conclude from these findings? The most obvious conclusion is that patients with severe disorders tend to by-pass primary care facilities.

As could be seen from Figures I and II, a large proportion of patients present directly to tertiary care, either to the psychiatric service itself or to a hospital doctor.

An equally significant proportion of patients consult traditional healers, but, interestingly, these consultations do not seem to be associated with undue delays before receiving specialist mental health care. Primary care facilities are rarely used, which is in marked contrast to the comparable study from the West.[6] However, once contact has been made with a care-giver, the delays while receiving care seem little different for the various routes. The lengthiest delays

all take place prior to the decision to consult, and this may well be a factor in the severity of the disorders seen.

The delays while receiving care are all moderate, with the somewhat surprising trend towards shortest delays being experienced on the traditional healer route. This finding suggests that we should pay closer attention to the role that traditional healers play in the health system, and, obviously, to the role they play in psychological disorders. The present study does not support the frequently expressed view that traditional healers have an obtrusive effect on major disorders, but the role of traditional healers requires more investigation than at present. The point was make earlier.[2]

There is also the suggestion that delays while receiving care may lead to further deterioration in the condition of patients. This is suggested by the increased number of problems of violence reported by mental health professionals. Twenty-five percent of patients showed problems of violence to the first carer, and this proportion had increased to 38 pc by the time the patients had seen mental health professionals. This raises the difficulty of whether violence should be seen as an index of severity or as a consequence of the failure of care. This finding too would seem to require more attention in the future.

The differences in the delays experienced by sufferers of "major" and "minor" disorders is clear, but perhaps unremarkable, when placed against the general epidemiological background. As was indicated above, African and Zimbabwean studies have shown very low rates of detection of minor disorders by primary care workers.

It has also been noted, in one study, that few cases of psychosis (severe cases) are missed by this same group.[9] Thus, the lack of representation by minor disorders is not surprising. What is interesting is the manner in which severe cases by-pass primary care workers altogether, and, together, these two findings suggest that primary care has little current utility for patients suffering from severe psychological disorders. The need for primary care workers to learn detection skills is thus crucial, and this may not be an enormous problem to solve, as recent studies have demonstrated.[7, 9]

This by-passing of primary care, and indeed of all the 'filters of care" is not trivial, however, and has important implications both for service delivery and research. As far as service delivery goes, the use of the psychiatric services as the point of entry for care may result in patients with physical illness, that presents in psychological form, receiving inappropriate care. The presence of three patients who were HIV positive, and were diagnosed as suffering from Personality disorders, lends support to this view.

In view of the HIV epidemic, the relationship between HIV status and psychopathology needs careful examination. It will be important to determine whether the HIV status of patients, such as those indicated above, is materially related of their admission, or merely represents an epiphenomenal relationship. It will be important to understand the impact of high rates of HIV infection on psychiatric morbidity, since there are reports of psychotic-like reactions in HIV infected persons.

The issue of HIV infection is not trivial, for as Goldberg and Huxley have commented, psychiatric services rarely reject cases, and thus the probability of accepting false positives remains very high.[1] There remains the very real possibility of overburdened psychiatric services accepting cases that they perhaps should not. Where no filter exists between community and psychiatric care, a possible solution is to require all admissions to be admitted to general hospital beds before referral to the psychiatric wards.

For research, the finding has different implications. The sample for many African studies has been too frequently drawn from patients under the care of mental health professional. For example, Lamont's impressions of Zimbabwean psychopathology were based upon a similar population to that being presently reported.[10] Earlier, Carothers had done the same for East African populations,[11] with the erroneous conclusion that neurosis was uncommon in Africans. Clearly, their conclusions can only be seen as descriptive of severe cases who receive specialist psychiatric care. They have no applicability for the remaining morbid population. This point has been made earlier.[3, 12]

For this reason, it is important that studies of psychopathology focus on both primary and tertiary care, with perhaps an emphasis upon primary care, as Michael Shepherd has argued.[13] The filtering process that determines access to specialist psychiatric care needs to be clearly understood, and the study of the pathways to psychiatric care is a useful method for

deriving this understanding. The present study, with its shortcomings, provides a beginning to such understanding.

CONCLUSIONS

An examination of the pathways to psychiatric care in Harare, Zimbabwe, reveals a picture somewhat different to that of a British pathway. The results suggest that there are long delays between the onset of symptoms and the seeking of care. The routes to care indicate a by-pass of primary care, and the use of psychiatric services, as the initial point of entry to care for a significant number of patients. Severity of symptoms would seem to be the major factor behind seeking care, and major illness would seem to be more common than minor illness. Furthermore, minor illness would seem to occasion lengthier delays, both before and after seeking care, and some cases of physical illness appeared to attract diagnosis of minor illness. The use of traditional healers does not seem to led to delays in receiving specialist mental health care, which may be reassuring for those who assume that traditional healers have a detrimental effect upon psychological disorders. It may equally indicate that traditional healers were ineffective or even noxious. The role of traditional healers generally requires more attention that it does at present.

Overall, the study of pathways to care seems to provide a useful epidemiological tool. It indicates possible sampling difficulties, and may also indicate ways in which service delivery may be rendered more efficient. However, the omission of outpatient contacts is a methodological limitation, and limits the confidence we can have in these conclusions.

REFERENCES

1. Goldberg, D P, Huxley P H: Mental illness in the community, London: Tavistock, 1980

2. Reeler, A P: Psychological disorders in Africa III: Service delivery, Cent Afr J Med, 1987; 33:37–42.

3. Reeler, A P: Psychological disorders in primary care and the development of clinical services: An African perspective, The Psychologist, 1991; 4:349–353.

4. Reeler A P, Williams H, Todd C H: Psychopathology in primary care patients: A four-year study in rural and urban settings in Zimbabwe (submitted for publication), 1990.

5. Hall, A, Williams H: Hidden psychiatric morbidity Part I: Study of prevalence in an outpatient population at Bindura Provincial Hospital, Cent Afr J Med, 1987(a); 33:239–245.

6. Gater R, Goldberg D P: Pathways to psychiatric care in South Manchester, Brit J Psychiat, 1988; 373–382.

7. Hall A, Williams H: Hidden psychiatric morbidity Part II: Training health care workers in detection: A pre- and post-study at Karanda Mission Hospital, Cent Afr J Med, 1988(a); 33:255–258.

8. Diop B, Colignon R, Gueye M, Harding T W: Diagnosis and symptoms of mental disorder in a rural area of Senegal, Afr J Med Sci, 1982; 11:95–103.

9. Williams H, Reeler A P: Teaching Zimbabwean medical students on awareness of hidden psychological disorder in an urban outpatient setting, Trop Doct, 1989; 19:52–54.

10. Lamont A: African psychiatric in Mashonaland, Cent Afr J Med, 1979; 25:120–126.

11. Carothers J C: A study of mental derangement in Africans and an attempt to explain its peculiarities, more especially in relation to the African attitude to life, Psychiat. J Operation Stat Interpers Relat, 1946; 47–86.

12. Reeler A P: Psychological disorders in Africa I: Issues of prevalence, Cent Afr J Med, 1986; 32:298–303.

13. Shepherd M, Wilkinson G: Primary care as the middle ground for psychiatric epidemiology, Psychol Med, 1988; 18:263–267.

Institute of
Development Studies