RESEARCH ARTICLE

Turkish Journal of Psychiatry 2024;35(2):95–101

https://doi.org/10.5080/u26915

Referral Network Pathways of Care for Psychiatric Disorders in Kashmir – A Study from India

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ABSTRACT

Objective: Access to psychiatry services in Kashmir is challenging because of active enduring conflict, insecurity and a fundamental role played by the traditional health workers. We aimed to assess the main pathways to mental health services in Kashmir, India.

Methods: This cross-sectional hospital-based study was performed from March 2012 to June 2017 in the outpatient psychiatry department at a psychiatric disease hospital in Kashmir. A convenience sampling method was used to select newly referred patients to the services. A survey was developed to collect information on demographic data and the main pathways for patients when seeking care for mental disorders.

Results: A total of 518 patients were interviewed. About half of the respondents (48.8 %) attended clinical consultation from a general pathway like a physician or a neurologist, while 31.8% were visiting a psychiatrist for a significant psychiatric disorder. For some patients (17.8%), their initial pathway to mental health services is traditional healers.

Conclusion: The current study revealed different pathways to seeking psychiatric care in Kashmir India. Further studies are needed to address the treatment gap and ways to improve access to mental health services for the Kashmiri population.

Keywords: Psychiatric Disorders, Referral, Pathway, Conflict

INTRODUCTION

More than 450 million people across the globe are suffering from mental, psychosocial, and neurological problems (Sagar et al. 2020). In India, almost one in every seven Indians is suffering from some sort of mental distress. Specific to our region, it is estimated that 45% of Kashmir's adult population (1.8 million) were found to have some form of mental distress with a high prevalence of depression (41%), anxiety (26%), post-traumatic stress disorder (PTSD) (19%) (Housen et al. 2017). Another aspect to be considered is that there is a huge treatment gap for mental health disorders worldwide due to an inadequate response to the burden of mental illness. It is estimated that around two-thirds of mentally ill patients go untreated, especially in developing countries (World Health Organization 2013). Globally, psychiatrists remain a rare human resource with the global median number of psychiatrists remaining at approximately only one psychiatrist for every 100,000 population. High-income countries have approximately 120 times more psychiatrists than in low-income countries (World Health Organization 2021). India has spent 1.30% of the government's total expenditure on health, but the country has only 0.29 psychiatrists per 100,000 people. There is undeniably a shortfall in the quantity and quality of mental health services and their distribution in the country (World Health Organization 2017). India has 0.75 psychiatrists per 100,000 population (Singh Bhandari et al. 2020), as against the desirable number of anything above three psychiatrists per 100,000. Taking three psychiatrists per 100,000 population as the desired number, the study mentions that the number of psychiatrists required to reach the desired ratio in India is 36,000 and the country is currently short of 27,000 psychiatrists based on the current population (Garg et al. 2019).

Received: 20.09.2021, **Accepted:** 12.02.2022, **Available Online Date:** 04.03.2024

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There exists a mixed healthcare system in India, inclusive of the public healthcare system and the private healthcare system. Both public and private healthcare systems provide healthcare services to urban and rural India. Most of the private health care services are concentrated in urban areas, and they provide secondary and tertiary care level health services, including professional care for serious cases. The public health care system has been developed as a three-tier system based on the population norms and the kind of services provided includes preventive services, medical treatment, and health care. The three-tier include primary health care systems, including sub-centers and primary health centres. The secondary health care system includes community health centres, and sub-district hospitals, while the tertiary care level includes district hospitals, tertiary hospitals, and medical colleges (Aggarwal 2008). The pathways to care were defined as the path a psychiatric patient travels during his referral process to a mental health professional (MHP). Meanwhile, In Jammu and Kashmir, an integrated mental health system, a two-tier model centered in the public health care system from secondary to the tertiary level system has been gradually developed. Although this two-tier system only exists in a few big districts of the region, most districts in the region does not yet have any community mental health workers of any kind. Mental health institutes in the provinces or major districts constitute the top tier of the system and are responsible for enacting management guidelines and providing guidance and support to all mental health services in the region. The lower tier (town or district level) comprises mental health clinics in district hospitals which have still not been developed much. Over the years, the authorities have been trying to implement this model for the delivery of mental health services. In our region, there lies a disparity of cost between private and public healthcare institutions, and most of the population is financially unstable and dependent on out-of-pocket expenses.

Health care in India has inequality in mental health access and services. It is accessible to only those who can afford high-rated private hospitals or those who can easily access the hospital in their locality/district (Gater et al. 1991). In Kashmir, there is a lack of effective consultation and contact, putting a financial strain on the already precarious healthcare system. For the treatment of mentally ill patients, good inter-departmental coordination and referral are required (Gania et al. 2016). Furthermore, the problem is exacerbated by a significant knowledge gap in mental health literacy among the general public in emerging nations, particularly India. In poorer nations, where mental health facilities are already scarce, poor mental health literacy can take a toll on people and function as a barrier to the treatment and diagnosis of mental diseases (Saxena et al. 2007). In poor nations, both conventional and spiritual healers play an important part in the mental health care system (Mushtaq and Margoob 2006). There is a long tradition of spiritual and religious healing in Kashmir; people typically seek out these healers for treatment. Pir and Faqirs are a patient's earliest interactions with prior traumatic occurrences (Saldanha 2005). Pir and Faqirs are the spiritual and traditional healers in Kashmir. In light of the aforementioned causes, as well as a lack of or unequal distribution of available resources, Kashmir's mental health services are not adequately systematised to provide excellent mental health care to individuals suffering from any mental health disease.

The goal of our research was to discover what percentage of persons with mental illnesses get assistance, who they seek help from, and whether the time it takes to get therapy varies by problem.

Hence, with the objective to address this gap, we aimed to see the referral dimension of mental health disorders in order to get an insight into the mental health system in Kashmir

METHOD

Study Design

This cross-sectional hospital-based study was conducted from March 2012 to June 2017 in the outpatient psychiatry department at the psychiatric disease hospital of Kashmir. Psychiatric disease hospital Kashmir is open to patients from all over the districts. It has a reputed mental health service, with psychiatrists.

Sample Size

The pathways to care were defined as the path a psychiatric patient travels during his referral process to an MHP. Accounting for feasibility issues in the participating mental health care system and using previous experience with the pathways method (Gupta et al. 2021) which included at least 50 subjects per center, and a total of 518 patients was interviewed. (The SMHS hospital's community center and GPDH) were selected).

Sampling

Using the convenience sampling method, all of those who were newly referred to MHP and agreed to participate in this research were interviewed. Newly referred patients were defined as the general population with mental disorders who first visited the Department of Psychiatry, Psychiatric Disease Hospital Kashmir and had not sought care from mental health services during the previous year. Besides, the patients who were transferred from other departments within the department of psychiatry, psychiatric disease hospital Kashmir were excluded from the sample, as the purpose of this study is to investigate the referral system among the

different institutions of the two-tier health system in India. For subjects who were unable to answer the questions due to a diagnosis of severe mental illness, family members or relatives who had accompanied them to the hospital were interviewed; for respondents under 18 years old, their parents were interviewed.

Study Tool

We used structured questionnaires to collect data. The structured questionnaire was established in line with concepts of other pathway-to-care studies following the methodology of a WHO pathway study and its pathway encounter form. The other questionnaire was composed of sociodemographic and personal characteristics (Gater et al. 1991). The basic demographic and personal characteristics about gender, qualification, marital status were included in the information sheet.

Ethical Aspects

The research protocol was approved by the institutional review board (KU-2019). The informed written consent of the participants was obtained before each interview.

Statistical Analysis

Data was entered in a Microsoft Excel spreadsheet. Continuous variables were summarized as mean and standard deviation. Categorical variables were summarized as percentages. The chi-square test was used to test independence between two categorical variables. A p-value of less than 0.05 was considered statistically significant. All statistical analysis was done using SPSS 20.0.

RESULTS

A total of 518 patients participated in the study and most of them were females (68.7%), most of them were in the age group of 31-40 years (35.1%) followed by 24.3% among the 41-50 years age group (Table 1). The mean delay from the onset of the symptoms of the illness and its network pathway to reach a psychiatric physician is shown in Table 2. Most of the patients in our study were diagnosed to have a major depressive disorder (MDD) (26.64%), bipolar affective disorders (BPAD) (16.98%), obsessive-compulsive disorder (OCD) (16.02%), and schizophrenia (14.67%) respectively. It was observed that the mean period of illness was relatively less in possession disorder (5.6 weeks). Mental illnesses like BPAD, dissociation disorder, MDD, OCD, panic disorder and schizophrenia had a mean period of illness ranging from 6.12 to 6.80 weeks respectively. Illnesses like generalized anxiety disorder (GAD) and phobic disorders were found to have a mean period of illness comparatively greater than others, 7.33 and 8.08 weeks, respectively. In respect to the mean distance travelled, we found those having disorders like dissociation disorder, GAD, panic disorder and schizophrenia have travelled more than 60 km before attending to MHP. Moreover, the association between the type of mental illness and the mean period of illness was found to be statistically significant ($p<0.001$). The description of all the diagnosed studied participants has been enlisted in Table 3, describing the type of doctor and specialty they consulted for their ailment before consulting a psychiatrist. Most patients who were later diagnosed with MDD (26.64%) had either consulted a physician (5.79%), neurologist (4.05%) or faith healer (1.73%) before attending to an MHP. Many (2.50%) have also self-medicated themselves before arriving at a final diagnosis. Similarly, those diagnosed with BPAD (16.90%) had either visited faith healers (3.47%) or neurologists (27.02%) before coming to an MHP. Those with dissociation disorder (7.72%) had also attended to neurologists (3.86%) or faith healers (2.89%) before they reached an MHP. Patients with panic disorders (11.38%) had mostly reported to cardiologists (2.89%), followed by advised taken by local pharmacists (2.50%) to seek treatment for their mental ailment. The association between the mental disorder and the specialty consulted was found to be statistically significant.

Table 1. Age and gender characteristics of the studied population (n=518)

Trait	Sub-group	n	%
Gender	Female	356	68.72
	Male	162	31.27
Age in years	15-20	14	2.70
	21-30	151	29.15
	31-40	185	35.17
	41-50	126	24.32
	51-60	38	7.33
	61-70	4	0.77

DISCUSSION

The current study revealed some descriptive insight into the pathways of people with mental disorders in Kashmir. The findings reveal that most of the people with mental disorders who went to the public psychiatric facility had initially visited the non-psychiatric treatment centers as their first point of contact before visiting the formal public mental health service center. Although most of the patients had initially been to other non-psychiatric providers, the findings show that only a small percentage of patients with mental disorders (31.8%) initially took them directly to the formal psychiatric facility

Table 2. Distribution of type of mental disorder and first pathway contact with the mean delays from the onset to mental health professional (MHP)

Diagnosis	No of Patients n (%)	First contact n (%)	Second contact n (%)	Third contact n (%)	Fourth contact n (%)	Fifth contact n (%)	Mean Period (Months; (Mean±S.D.)	Mean Distance (SD/Kms; Mean±S.D.)	Sum of Squares (df)	F/ p-value
Overall mean	-	-	-	--	-	-	6.68±1.21	58.31±0.18	25.697 (6)	0.701/ 0.649
Phobic disorder	12(2.31)	2 (16.6)	7 (58.3)	1 (8.3)	1 (8.3)	1(8.3)	8.08±0.82	55.00±9.69		
BPAD	88(16.9)	32(36.3)	39(44.3)	10(11.3)	4(0.0)	3(0.0)	6.34±0.30	57.59±3.58		
Possession disorder	10(1.9)	1(10.0)	9(90.0)	0(0.0)	0(0.0)	0(0.0)	5.6±0.90	53.6±10.61		
Dissociation disorder	40(7.7)	3(7.5)	29(72.5)	3(7.5)	2(5.0)	3(7.5)	6.8±0.45	62.58±5.31		
GAD	12(2.3)	1(8.3)	10(83.3)	0(0.0)	1(8.3)	0(0.0)	7.33±0.82	61.16±9.69		
MDD	138(26.6)	23(16.6)	94(68.1)	5(3.6)	9(3.6)	7(5.0)	6.78±0.24	50.09±2.87		
OCD	83(16.0)	20(24.0)	51(61.4)	9(10.8)	2(2.4)	1(1.2)	6.53±0.31	48.75±3.68		
Panic Disorder	59(11.3)	4(6.7)	45(76.2)	1(1.6)	6(10.1)	3(5.0)	6.12±0.37	63.25±3.67		
Schizophrenia	76(14.6)	27(35.5)	38(50.0)	5(6.5)	5(6.5)	1(1.3)	6.48±0.33	61.74±3.85		
Total	518(100.0)	113(21.8)	322(62.1)	34(6.5)	30(5.7)	19(3.6)	-	-		

BPAD= Bipolar affective disorder; GAD= Generalized anxiety disorder; MDD=Major depressive disorder; OCD= obsessive-compulsive disorder; S.D. = Standard deviation. $p < 0.05$ is considered significant at 95% confidence interval.

Table 3. Cross-tabulation of disease characteristics and place patients first sought psychiatric treatment

Particulars	Phobic Disorder	BPAD	Possession Disorder	Dissociative disorder	GAD	MDD	OCD	Panic disorder	Schizophrenia	χ^2 (df)	p-value	Total
Psychiatrists	2(1.7)	32(28.3)	1(0.8)	3(2.6)	1(0.8)	23(20.3)	20(17.6)	4(3.5)	27(23.8)	36.606(8)	<0.001*	113(21.8)
Physician	2 (4.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	25(51.0)	14(28.5)	6(12.2)	2(4.0)	45.560 (8)	<0.001*	49(9.4)
Surgeon	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	3(20.0)	6()	6(40.0)	0(0.0)	23.997(8)	0.002*	15((2.8)
Cardiologist	0(0.0)	0(0.0)	0(0.0)	5(14.2)	5(14.2)	3(8.5)	7(20.0)	13(37.1)	2(5.7)	74.181(8)	<0.001*	35(6.7)
ENT Specialist	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(7.6)	10(76.9)	1(7.6)	0(0.0)	1(7.6)	30.588(8)	<0.001*	13(2.5)
Neurologist	0(0.0)	19(23.4)	0(0.0)	20(24.6)	0(0.0)	21(25.9)	6(7.4)	0(0.0)	15(18.5)	62.909(8)	<0.001*	81(15.6)
Endocrinologist	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	10(71.4)	0(0.0)	4(28.5)	0(0.0)	27.409(8)	<0.001*	14(2.7)
Local Medical Shop	2(4.4)	9(20.0)	0(0.0)	0(0.0)	0(0.0)	8(17.7)	5(11.1)	9(20.0)	12(26.6)	26.099(8)	<0.001*	45(8.6)
Self-Medication	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	12(92.3)	0(0.0)	1(7.6)	0(0.0)	32.826(8)	<0.001*	13(2.5)
Non-allopathic treatment	1(5.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	5(25.0)	5(25.0)	4(20.0)	5(25.0)	16.776(8)	0.03*	20(3.8)
Gastroenterology	5(17.8)	6(21.4)	0(0.0)	0(0.0)	4(14.2)	4(14.2)	5(17.8)	0(0.0)	4(21.2)	102.992(8)	<0.001*	28(5.4)
Pulmonologist	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(7.6)	5(38.4)	2(15.3)	5(38.4)	0(0.0)	25.208(8)	<0.001*	13(2.5)
Faith healer	0(0.0)	22(27.8)	9 (11.3)	12(15.1)	0(0.0)	9(11.3)	12(15.1)	7(8.8)	8(10.1)	81.778(8)	<0.001*	79(15.2)
Total	12(2.3)	88(16.9)	10(1.9)	40(7.7)	12(2.3)	138(26.6)	83(16.0)	59(11.3)	76(14.6)	-	-	518(100)

BPAD= Bipolar affective disorder; GAD= Generalised anxiety disorder; MDD=Major depressive disorder; OCD= obsessive-compulsive disorder; ENT Specialist= ear nose and throat. *$p < 0.05$ is considered significant at 95% confidence interval.

for treatment, which totally contradicts with similar studies conducted all in other parts of the globe (Appiah-Poku et al. 2004, Ngoma et al. 2003). Mental disorders constitute 5.6% of the total disease burden in India. Only 10 % of mental disorders in India are receiving treatment (Hashimoto et al. 2015). The primary care in India is provided by the National Mental Health Program, and India was the first country among developing countries to deliver primary mental health care through community-based mental health care (Venkatesh et al. 2015). The mental health services in Kashmir are primarily limited to two hospitals in Srinagar (GMC Srinagar and SKIMS Hospital), though the National Mental Health Plan and the district mental health program were started in many districts of Kashmir. The district mental health program (DMHP) has been started in various districts of India. The DMHP was started in July 2008 (Shoib et al. 2021a, Shoib et al. 2021b, Shoib and Yasir Arafat 2020).

The number of patients visiting the local chemist shop (8.8%) or taking medicine of their own (2.7%) was also observed. This can be explained due to poor mental health literacy which takes a huge toll on people and acts as a barrier to the treatment and diagnosis of mental disorders in developing countries, where mental health services are already limited (Mushtaq and Margoob 2006).

There are various reasons which are obstacles to delivering mental health services in India. Stigma, scarcity of medical facilities, socio-economic factors, and poor mental health literacy are important factors that hinder the delivery of mental health services. Mental health Stigma is one of the main challenges for delivering mental health services. There is an unmet need to reduce the stigma associated with mental illness, which will improve the delivery of mental health services (Appiah-Poku et al. 2004).

In, Kashmir mental health systems are not fully systematized to provide ideal mental health services to patients suffering from any mental health problems due to either non-existence or unequal distribution of available resources. Therefore, patients chose an accessible pathway according to local convenience and affordability. The number of patients who consulted the non-psychiatric pathway was higher than the patients who consulted the specialist path (48.8% vs 31.8%). Even though less than half of the patients in this study had initially sought care from non-psychiatric providers such as faith-based religious or traditional healers, we know that conventional and spiritual healers play an essential role in the mental health care pathway in developing countries. Studies in other parts of India have reverberated the same finding, and similar observations were made from other parts of the world where religious healers and herbalists were the first points of contact for some patients before they eventually went to the public psychiatric hospital (Girma and Tesfaye 2011). Our study found that only 31.8% were referred to a psychiatrist on the first contact. This shows the need for proper education regarding mental illness and focuses on reducing the stigma associated with mental health illness.

Furthermore, 17.1% of patients with mental health disorders had their first contact with faith healers. The appointment to faith healers is common across the country, and the rate in this study is similar to that of earlier studies which show a range of 30-80% chance of visiting faith healers. Conventional and spiritual healers play an essential role in the mental health care pathway in developing countries (Jalal et al. 2020, Khoso et al. 2018). In Kashmir, there is a long history of faith healers. People usually go to these healers, especially for treatment. Pir and Faqirs are the first contacts of a patient with trauma. Patients who have mental illness usually seek faith healers and are the first contact with patients as 56% of psychiatric patients attribute mental illness to ghosts, evil spirits, and other invisible forces. Faith healers have special gifted powers to control these evil powers through prayers and rituals (Sethi and Trivedi 1979, Village and Revd 2005).

In developing countries, patients with mental illness are in direct contact with mental health services and this exact same protocol is also followed in Kashmir. The situation is worsened by the fact that primary health care professionals in India are not adequately trained for diagnosing and treating mental disorders as rightly mentioned by Yildiz et al. (2003) in their study in which they stressed the need for training of general physicians in mental health problems for effective diagnosis at the primary care level. Also Ayranci and Yenilmez (2002) stated some factors responsible for low rates of psychiatric disorders being diagnosed and treated in primary care settings as following: physicians under-recognizing mental disorders despite being educated on the subject, mental screening scales not being used, patients being unaware of their diseases and providing insufficient information to physicians about mental symptoms, and co-occurrence of psychiatric disorders. The Ministry of Health and Family Welfare (MOHFW) is the authority responsible for health and mental health services. Resources are distributed to the states through the state health societies and subsequently to the district health societies. There are separate governances for hospital and primary care services − hospital services being under the Directorate of Health Services, Kashmir and Health, and the Health and Medical Education Department, respectively. Hence, primary mental health services that were introduced later than the hospital services have become separately governed under the private sector. The involvement of private organizations in the delivery of mental health care has been small, largely due to the prohibition of the old stigma associated with mental health issues. These are in the form of private specialist services and local non-governmental organizations (NGOs). Several NGOs, which involved professionals, consumers, and careers, have been established since a decade ago. Interestingly, there

has been a significant rise in the efforts in mental health advocacy by individuals and groups of consumers using social media as a platform. Efforts to form coalitions at the national level and to involve as many stakeholders as possible in the national planning of services delivery have just been revived recently. Mutual collaboration with services from other governmental agencies (NGO), and private and NGO's, are potential outlets for mental health service delivery in the future. Mental health services in Kashmir are still largely based on those inside mental institutions. Efforts have been made to expand services beyond the mental hospitals through decentralization to move services to the general hospitals for many years, and the incorporation of mental health care into the primary health programs. Services currently available in the system can be categorized into three levels − the mental hospitals, the general hospitals, and the primary health centers, as well as specialist services. Being in a state of conflict with limited resources, the main focus had been providing services to the people seeking treatment in those settings. However there is a need to provide coordinated, comprehensive mental health care to cater to the different groups of people with varying levels of mental health needs through within and from outside the health organization. These would include adequate mental health promotion and mental illness prevention activities, services for early detection, and treatment of common mental illnesses and services that provide adequate treatment and aftercare for people with serious mental illnesses. For this purpose, looking at the needs of the population for mental health services is important so that services would be more needs-led and fair.

The study gives us insight into the delay at the beginning of proper psychiatric treatment in people who visit faith healers or other specialties for treatment. The study advocates for improving mental health literacy, reducing the stigma associated with mental illness, enhancing the knowledge regarding psychiatric illness and its management, and guaranteeing good quality management compliance. There is a need for an overall haul of the medical health care system and to develop innovative programs to improve mental health literacy.

Study limitations: The study was conducted at a single location, thus there is a possibility of section bias in the study. . Our study had a limited number of patients which is one of the major limitations of our study. Further, there are chances of recall bias as the study provides and asks the patients about the retrospective pathway.

CONCLUSION

The current study revealed different pathways to seek psychiatric care in Kashmir India that included a direct pathway to a public psychiatric hospital, a direct pathway to a non-psychiatric general medical practitioner; and a direct pathway to the faith-based or traditional healing centres. Even though the latter points of contact (religious prayer camps, traditional healers or general hospitals) are a preference for most individuals as the initial place to seek mental health treatment. The presence of those smaller number of patients at the public psychiatric facility indicates that there is a need to educate people and eventually a transition to the more formal psychiatric treatment facility for mental health services in Kashmir division is required. The public mental health authorities in Kashmir need to recognize that it is important to increase funding to incorporate these faith-based and traditional healers as well as expand psychiatric care at the general medical health facilities as part of the mental health continuum of care. Doing so will enable people with mental disorders to access mental health treatment regardless of which door they initially choose to access mental health care.

REFERENCES

Aggarwal AK (2008) Strengthening Health Care System in India : Is Privatization the Only Answer ? Indian J Community Med 33: 69–70.

Appiah-Poku J, Laugharne R, Mensah E et al (2004) Previous help sought by patients presenting to mental health services in Kumasi, Ghana. Soc Psychiatry Psychiatr Epidemiol 39: 208–11.

Ayranci U, Yenilmez C (2002) Evaluation of mental health services in primary health care settings in the city centre of Eskişehir. Turk Psikiyatri Derg 13: 115–24.

Gania AM, Ahmad Suhaff A, Ahmad Hakak B et al (2016) Pattern of sychiatric morbidity among referred patients to the department of psychiatry in super speciality hospital of Kashmir. J Evol Med Dent Sci 5: 5695–700.

Garg K, Kumar CN, Chandra PS (2019) Number of psychiatrists in India: Baby steps forward, but a long way to go. Indian J Psychiatry 61: 104–5.

Gater R, de Almeida e Sousa B, Barrientos G et al (1991) The pathways to psychiatric care: a cross-cultural study. Psychol Med 21: 761–74.

Girma E, Tesfaye M (2011) Patterns of treatment seeking behavior for mental illnesses in Southwest Ethiopia: a hospital based study. BMC Psychiatry 11: 138.

Gupta AK, Grover S, Thapaliya S et al (2021) Pathways to care and supernatural beliefs among patients with psychotic disorders in Nepal. Middle East Curr Psychiatry 28: 61.

Hashimoto N, Fujisawa D, Giasuddin NA et al (2015) Pathways to mental health care in Bangladesh, India, Japan, Mongolia, and Nepal. Asia Pac J Public Health 27: NP1847-57.

Housen T, Lenglet A, Ariti C et al (2017) Prevalence of anxiety, depression and post-traumatic stress disorder in the Kashmir Valley. BMJ Glob Health 2: e000419.

Mushtaq H, Margoob M (2006) Pir, Faqir and psychotherapist: Their role in psychosocial intervention of Trauma; JK Practitioner 13 (Suppl.1): S89.

Jalal A, Premnath A, Suni MS et al (2020) Delay and treatment factors of psychiatric treatment among patients seeking faith healers. Kerala J Psychiatry 33: 42–51.

Khoso A, Soomro RA, Quraishy AM et al (2018) An insight into frequency and predictors leading psychiatric patients to visit faith healers : A hospital-based cross-sectional survey , Karachi , Pakistan. Int J Soc Psychiatry 64: 217–24.

Ngoma MC, Prince M, Mann A (2003) Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. Br J Psychiatry 183: 349-55.

Sagar R, Dandona R, Gururaj G et al (2020) The burden of mental disorders across the states of India : the Global Burden of Disease Study 1990 – 2017. Lancet Psychiatry 7: 148-61

Saldanha D (2005) Mental Health: An Indian perspective 1946-2003. Med J Armed Forces India 61: 205.

Saxena S, Thornicroft G, Knapp M et al (2007) Resources for mental health: scarcity, inequity, and inefficiency. Lancet 370: 878-89.

Sethi BB, Trivedi JK (1979) Socio-demographic variables and manifestation of ill-health of patients who attended traditional healers clinic. Indian J Psychiatry 21(1).

Shoib S, Arafat SM, Saleem SM (2021) Development of mental health services in Kashmir. Ind Psychiatry J 30: 361-3

Shoib S, Chandradasa M, Saleem SM et al (2021) Psychiatry in Kashmir: a call for action. Lancet Psychiatry 8: 1031–2.

Shoib S, Arafat SM (2020) Mental health in Kashmir: conflict to COVID-19. Public Health 187: 65–6.

Singh Bhandari S, Joseph SJ, Udayasankaran JG et al (2020) Telepsychiatry: A feasible means to bridge the demand–supply gaps in mental health services during and after the COVID-19 pandemic: preliminary experiences from Sikkim state of India. Indian J Psychol Med 42: 500–2.

Venkatesh BT, Andrews T, Mayya SS et al (2015) Perception of stigma toward mental illness in South India. J Family Med Prim Care 4: 449–53.

Village A, Revd T (2005) Dimensions of belief about miraculous healing. Ment Health Relig Cult 8: 97–107.

World Health Organization (2013) Comprehensive Mental Health Action Plan 2013-2030. Available from: https://www.who.int/publications/i/item/9789240031029 [Accessed: 2021 Dec 27].

World Health Organization (2017) Mental Health ATLAS 2017 Member State Report (India) [Internet]. https://www.who.int/mental_health/evidence/atlas/profiles-2017/IND.pdf?ua=1. 2018 Jan. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response/?gad_source=1&gclid=CjwKCAiAt5euBhB9EiwAdkXWO4oLDC_AhzObVR2m5BC5N5vclaFQSriI8LLbZW1VEELCGZJ3kD3jIRoC-PYQAvD_BwE [[updated 30 August 2021; cited 10/02/2024].

World Health Organization (2021) Mental health atlas 2020. p. 516. Available at: https://www.who.int/publications/i/item/9789240036703 (Accessed: 26 January 2022).

Yildiz M, Emin Onder M, Tural U et al (2003) Birinci basamak sağlik hizmetlerinde calişan pratisyen hekimlerin psikotik bozukluklar ve tedavisine yönelik tutumlari [General practitioners' attitudes towards psychotic disorders and their treatment in the primary health care system]. Turk Psikiyatri Derg 14: 106-15.