

Research Article

A COMPARATIVE STUDY OF PSYCHIATRIC PATIENTS RECEIVING TREATMENT IN TERTIARY CARE HOSPITAL AND PRIMARY HEALTH CARE CENTER

Dr. Vanapalli Vara Prasad^{1*}, Dr Surekaha Bodavula², Dr Vanapalli Katan³,

^{1*}Assistant Professor, Department of Psychiatry, Ranagaraya Medical College, Kakinada.

²MBBS, Civil Assistant Surgeon, Primary Health Centre, Peddada, Kakinada District

³MBBS, DPM Psychiatrist at Alcohol and Drug DeAddiction Centre, Government General Hospital, Kakinada.

Corresponding Author: Dr. Vanapalli Vara Prasad

Assistant Professor, Department of Psychiatry, Ranagaraya Medical College, Kakinada.

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Abstract

Introduction: Mental health disorders represent a significant and growing portion of the global burden of disease, affecting individuals across all demographics, socioeconomic backgrounds, and geographic regions. According to the World Health Organization (Resource: WHO Mental Health Report), psychiatric illnesses account for a substantial percentage of years lived with disability worldwide. Managing these conditions requires a stratified healthcare approach, ranging from primary community clinics to specialized tertiary care hospitals.

Materials and methods: It's a Case-Control study carried out for 1 year from April 2020 to march 2021 on subjects treated in Rangaraya Medical College, Kakinada. Details were collected after 3rd consecutive visit of all patients through a semi structured proforma that includes demographic details such as age, gender, education, marital status, area of domicile, socioeconomic status. Psychiatric diagnosis, IDEAS, PSQ-18 were the instruments applied by the consultant psychiatrists. International clinical harmonization Good

Clinical Practice (ICHGCP) were followed in this research. Written informed consent from patients were taken in their local language. Confidentiality of all the information obtained was maintained. No additional benefits were given to the participants in the study.

Results: The Patient satisfaction was found to be higher in PHCs 83.07 ± 8.72 compared to tertiary subjects 75.27 ± 9.51 ($p < 0.05$). Severe mental illness was higher 48.96% in PHCs as compared to tertiary care center common mental illness 23.36%. Subjects from tertiary care centres report higher GAF score (65%) higher among tertiary care subjects than their PHC counterparts (35%).

Conclusion: The patients receiving treatment in PHC's reported more satisfaction than those who receive treatment in tertiary care center. Higher disability scores on IDEAS in PHC's than tertiary Center due reporting of more cases of severe mental illness in PHC's. Married patients have shown higher satisfaction as compared to single/ Divorced/ Separated patients. Alcohol Dependence Syndrome

was found to be more in tertiary care hospital than in PHC's.

Key Words: Mental health disorders, World Health Organization, Patient satisfaction.

INTRODUCTION

Mental health disorders represent a significant and growing portion of the global burden of disease, affecting individuals across all demographics, socioeconomic backgrounds, and geographic regions. According to the World Health Organization (Resource: WHO Mental Health Report), psychiatric illnesses account for a substantial percentage of years lived with disability worldwide. Managing these conditions requires a stratified healthcare approach, ranging from primary community clinics to specialized tertiary care hospitals.¹ Tertiary care hospitals serve as the apex of the healthcare delivery system. These institutions are uniquely equipped with specialized psychiatric departments, advanced diagnostic tools, multidisciplinary teams (including psychiatrists, clinical psychologists, and psychiatric social workers), and intensive inpatient and outpatient infrastructure.² Consequently, the patient population seeking treatment at a tertiary facility is highly diverse, often encompassing individuals with severe, chronic, treatment-resistant, or co-morbid psychiatric conditions that cannot be adequately managed at primary or secondary levels.³

Within a tertiary care setting, psychiatric patients present with a wide spectrum of disorders, primarily categorized into major psychiatric disorders (such as Schizophrenia, Bipolar Affective Disorder, and Major Depressive Disorder) and minor

psychiatric or neurotic disorders (such as generalized anxiety, panic disorders, and somatoform disorders). The clinical presentation, treatment adherence, socio-demographic profiles, and overall outcomes of these patients vary significantly based on numerous variables. These variables include age, gender, socioeconomic status, geographical background (rural vs. urban), duration of illness, and the specific modality of treatment received (pharmacotherapy, psychotherapy, or combination therapy).⁴

Patient satisfaction helps in evaluating quality of care, and an indicator of weaknesses in the service. Its affected by many factors like patients demographic, diagnosis treatment, chronicity of diseases and size of the hospital, and it varies for different clinical conditions as well as in demographic groups.⁵ On this Background the present study was conducted with the following Hypothesis There will be no difference in patient satisfaction for treatment across tertiary care centres and primary health centres.

MATERIALS AND METHODS

It's a Case-Control study carried out for 1 year from April 2020 to March 2021 on subjects treated in Rangaraya Medical College, Kakinada.

Details were collected after 3rd consecutive visit of all patients through a semi structured proforma that includes demographic details such as age, gender, education, marital status, area of domicile, socioeconomic status. Psychiatric diagnosis, IDEAS, PSQ-18 were the instruments applied by the consultant psychiatrists. International clinical harmonization Good Clinical

Practice (ICHGCP) were followed in this research. Written informed consent from patients were taken in their local language. Confidentiality of all the information obtained was maintained. No additional benefits were given to the participants in the study.

Instruments used: IDEAS – Indian Disability Evaluation and Assessment Scale for measuring and quantifying disability in mental disorders. Information were gathered from the patients, and their family members. It has satisfactory face, content, criterion validity, and internal consistency. It has been widely used for research purposes, satisfactorily.

PSQ 18-Patient Satisfaction Questionnaire 18-Short form is an items scale tapping information on seven dimensions of satisfaction with medical care such as general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor and accessibility and convenience. Good internal consistency, reliability, validity was reported and has been adapted for use in primary care outpatients setting.

Participants and Sample size - 51 Cases and 53 Controls from Rangaraya Medical College were recruited after taking consent.

Inclusion criteria: The inclusion criteria were patients with any mental illness (severe mental illnesses - Schizophrenia, severe depression with psychotic symptoms, common mental illness - depression without psychotic symptoms, anxiety disorders) and willing to give informed consent, age above 12 years, based on clinical interviews conducted by a consultant psychiatrist.

Exclusion criteria: The exclusion criteria were any degree of Intellectual disability, epilepsy, cognitive deficits and those who do not give consent.

Statistical analysis: By using SPSS following were analysed Frequencies, percentages, mean, Standard deviation, Standard error of mean with $p < 0.05$ was considered significantly, independent t-test and ANOVA were used.

RESULTS

Both the groups were age and sex matched, male population was 65%. PHC population had people who never had formal education and hadn't gone to school (38.2%) compared to the cases visiting tertiary center (23%). Only 8% of the cases in PHC had completed degree compared to 18% in tertiary center cases

Variables	Cases N (%)	Controls N (%)
Gender		
Male	18 (35.29)	20 (36.45)
Female	33 (64.71)	33 (62.62)
Education		
Not gone to school	20 (38.20)	11 (21.90)
1-10 std	24 (47.06)	29 (54.29)

10 std and above	7 (14.70)	12 (23.81)
Age group		
14-18	2 (2.94)	2(2.80)
19-60	41 (81.37)	44 (83.23)
60 and above	8 (15.69)	8 (14.95)
Marital status		
Never married	7 (12.87)	8 (15.24)
Married	39 (78.22)	41 (78.10)
Divorced / Widow/separated	5 (8.91)	4(6.66)
Religion		
Hindu	45 (90.1)	33 (62.86)
Muslim	2 (3.96)	16 (31.43)
Christian	3 (5.94)	3 (5.71)

Table 1: Demographic profiles

Mental illness	Cases N (%)	Controls N (%)	Significance
Severe mental illness	24 (47.0)	12 (22.4)	0.001
Common mental illness	26 (51.0)	38 (71.0)	
ADS	01 (02.0)	04 (6.6)	

Table 2: Distribution of patients

Treatment	Cases	Controls
Single drug	51.9%	48%
Multiple drug	47%	53%

Table 3: Drug treatments

PSQ-18 questions	Case (N-51) Mean	Control (N-53) Mean	p value
General satisfaction	09.25±1.33	08.63±1.29	0.001
Technical quality	18.52±2.40	17.18±2.63	0.001
Inter personal manner	9.42±1.15	8.74±1.31	0.001
Communication	9.56±0.95	8.92±1.09	0.001
Finance	8.56±2.07	8.08±1.92	0.087
Time spent with doctor	9.29±1.30	8.17±1.59	0.001

Accessibility/ convenience	17.92±2.61	16.07±2.85	0.001
Total	83.07±8.72	75.27±9.51	0.001

Table 4: Patient satisfaction

PSQ - 18 was used to assess patient satisfaction. Assessed across domains that included general satisfaction, technical quality, interpersonal manner, communication, finance, time spent with the doctor, accessibility and convenience.

DISCUSSION

In the study conducted by Shalini Ahuja et al, in a district of Madhya Pradesh have opined it needs continued inputs into the DMHP covering and identified nine different indicators domains such as need for treatment, utilization of care, quality of care and financial risk protection to measure a district's health system performance for mental health. Even though crucial to be reported, indicators on suicide rates and attempts, daily stock-out rates of medicines and re hospitalization need a robust system in place which in this case is provided by a functional district mental health programme and research projects.⁶

As they have found additional advantages of community based interventions, small, clean mental hospitals could avoid long stay and promote good turnover. Mental hospitals in the vicinity of 100 km could promote easy accessibility and acceptability. When inpatient services are made available at the primary care level, the patients would obtain full advantage of the treatment, patients would seek help at an early date, Relapses could be better prevented, and treatment gap could be abridged. Thus, community interventions like DMHP play a more vital role. In our study its shown like married

persons has better Patient Satisfaction scores which is in accordance with Hall et al study.⁷

In a Rosenheck R et al study has shown the strongest and most consistent predictors of satisfaction were older age and better self-reported health. As in our study it has shown in cases satisfaction in all age groups as compared with controls. In a Holikatt PC et al study shows schizophrenia were least satisfied, whereas patients with major depression had highest satisfaction with services. As in our study patients from cases were in decreasing patterns of ADS, common mental illness and then Severe mental illness but in controls it follows decreasing order ADS, severe mental illness, common mental illness.⁸

There was a difference in satisfaction levels among the demographic and clinical groups regarding various components of satisfaction. Patient satisfaction in psychiatry is a complex issue with various influencing factors. It is essential to study this further, as it has potential to improve clinical care. Effective training programmes are required to develop mental health skills of primary health care staff as per World Health Organization. Lack of Proper training programmes for primary care physicians in India are criticized as 'never properly trained'.⁹

Studies from India have reported that primary health care professionals are often inadequately trained, reluctant or unable to detect, diagnose or manage common mental

disorders. Continuous Mental health education for primary care physicians is more likely to improve the quality of mental health care.³⁸ Development of care for mental illness at Primary care centres is the way out for reaching the needy population. Implement on community mental health through established primary care centers. Providing community-based services for greater numbers of people with schizophrenia in low and middle income countries is an urgent public health priority. Primary aim is making mental health care accessible to all by setting up psychiatric services in peripheral areas, training primary health care personnel and involving the community in promotion of mental health care. Decentralisation of psychiatric services and integration with general health care is the felt need of the country and is required not only in rural areas but semi-urban areas and suburbs of cities.¹⁰

CONCLUSION

The Major conclusion from this study is that there is higher global disability scores, IDEAS in cases than controls due to more of severe mental illness in PHC's. PHC treatment team is being able to cater more individuals with severe mental illness compared to tertiary care. However, more the number of patients with severe illness would have contributed to higher scores in IDEAS. Tertiary centres cater more for minor mental illness and thus lesser disability. ADS is more in tertiary care hospital than PHC's possibly due to availability of services for general medical condition, medical complications of alcohol and also owing to psychiatric references from the medical team. Possibility of more

holistic treatment being available at tertiary hospital than in PHC cannot be undermined. The Global Assessment of Functioning scores are higher in controls than cases due to more of minor mental illness in controls.

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