_____

Socio-demographic profile of patients attending outpatient department of Psychiatry in a tertiary healthcare unit of Telangana state

Sangeeta Jairaj[1*], Neilofor Hussain[2], N Jagathi Devi[3], M Kavitha[4*]

[1]Associate professor of Community Medicine, GMC Nalgonda, Telangana, India
[2]Assistant professor of Psychiatry, GMC Nalgonda, Telangana, India
[3]Associate professor of Pharmacology, GMC Nalgonda, Telangana, India
[4]Associate professor of Pharmacology, GMC Nalgonda, Telangana, India

_____

Abstract

Background: Mental illnesses are a major source of morbidity across both developed & developing countries. They are an important health problem that refers to disorders of mood, thought, cognition, intelligence, personality, substance abuse and adjustment. **Material & Methods**: This is a retrospective descriptive study of socio-demographic factors of patients attending Psychiatry Outpatient department in Government General Hospital, GMC-Nalgonda, over a period of 6 months (from 1st June2020 to 31st November2020). **Results:** Data was analyzed after completion of 6 months. A total of 254 patients who attended the psychiatry op of GGH &GMH Nalgonda was analyzed. Nearly 64% of the study population belonged to the age group of 15 to 40 yrs, the most economically productive group. The chi sq test was done for males and females belonging to urban and rural areas. The p value (probability value) was found to be 0.01 and was significant for urban females. **Conclusion**: A total of 254 new patients visited the hospital in this period. We found that the mental disorders comprise a wide variety – mainly psychotic, mood disorders & neurotic disorders. They affect the most productive age groups, almost equally affect both the genders, with slight increase among females.
Keywords: mental illness, outpatient department (OPD), sociodemographic factors, tertiary health care, international classification of diseases (ICD), epidemiology, mental health care users (MHCUs), primary health care (PHC), Low income and middle-income countries (LAMICS). chi square test, p value (probability value)

Introduction

Mental illnesses are a major source of morbidity across both developed & developing countries. Mental illness affects all age groups. The global neglect of mental health is proven. Mental health issues are neglected in policy, planning & funding. In all countries there is a significant gap between the prevalence of mental disorders on one hand & the number of people receiving care & treatment on the other hand[1]. Mental disorders are an important cause of long-term morbidity, disability & poor quality of life. Various epidemiological surveys in Asia have indicated that there are 680 million people who are likely to succumb to psychiatric disorders. In terms of services there is less than one mental health professional per 1 lakh population whereas the desirable number is 3-4 psychiatrists per 1 lakh population. People with mental illness, in India often seek help from traditional healers.

There is an acute shortage of mental health professionals in developing countries. So mental health services are delivered through general hospitals and this is considered as the most viable strategy for increasing the access of underserved population to mental health care. There are limited mental health facilities in government set up. So, a vast population of the country 's mental health care is provided by private practitioners and hospitals.

_____

*Correspondence
Dr. M Kavitha
Associate professor of Pharmacology, GMC Nalgonda, Telangana, India
E-mail: mudavathkavitha@gmail.com

The World Health Organization noted that one in every four people are affected by mental disorder at some stage of life[2].

In low- and middle-income countries, the gap is more. The treatment gap for major depression in Africa is 67% compared with a 45% gap in Europe[3].

WHO global burden of disease study estimates that mental disorders are among the most burdensome in the world & their burden will increase. It is estimated that at any point in time in India, 3 to 5% of the population is suffering from serious mental diseases while another 10% of the population is suffering with minor mental illnesses[4].

It has been estimated that globally more than 400 million people have been affected by some kind of mental illness during their life time and majority of them residing in developing countries[5].

According to the reports of WHO2014, nearly 83 million people have been diagnosed with psychiatric disorders in united states of America. Depression is the commonest disorder among all the psychiatric disorders. The report of European region stated that 1out of 15 people suffer from major depression which is remarkably high and quite aiarming[6]. The life time prevalence of common mental disorders is about 30%according to the study of South Africa[7].

Psychiatric illnesses are commonly associated with a higher disability but rarely come to attention to a physician than any other physical illnesses. Six neuropsychiatric diseases like unipolar depressive disorders, alcohol use disorders, schizophrenia, bipolar affective disordered, Alzheimer's and other dementias, as also migraines have figured in the top 20 causes of disability in the world[8].

More than 85% of the world's population live in 153 low income and middle-income countries (LAMICS)[3]. Although country level information on mental health systems has recently become available, it still has substantial gaps and inconsistencies. The financial resources allocated by most of these countries is scarce. The man

_____

Jairaj S *et al*   International Journal of Health and Clinical Research, 2021; 4(16):256-260
www.ijhcr.com
256

power and infrastructure for mental health in these countries is grossly inadequate. Many LAMICS of Africa and South East Asia lack mental health policy and legislation to direct their mental health programs and services.

The WHO estimate of people with mental disorders to be about 450 million out of a total of 6 billion), with about 150 million suffering from depression ,25 million from schizophrenia, more than 90 million from alcohol drug used disorders[9]. The impact of this disorder are sever with approximately 1million people committing suicide annually. There is also an increase in co-morbidity of this different conditions[10,11]. The mental disorders thus form a wide variety of disorders among which many not acknowledged as ailment by many in the society. A lot of trouble is still caused to the sufferers. This affects the productivity of the individuals and to the nation .The people more affected by the disorders are in occupationally more active age group .Many of these disorders actually have good prognosis suggesting the need for early identification and prompt management of these illnesses.

According to the ministry of Family Welfare of India the life time prevalence of mental disorders is 12% and is likely to increase to almost 15% by the year 2020 [12].

In India little is known about the extent, severity and unmet need of treatment of mental disorders. The meta-analysis of available Indian studies carried out by Reddy & Chandrashekhar revealed the overall prevalence of mental disorders as 5.8% among the population[4]. A review analysis of 15 epidemiological studies by Ganguly on the prevalence of mental disorders in India estimated the national prevalence of all mental disorders as 70.5 per 1000 in the rural & 73 per 1000 in the urban population[13]

In India there are a very small number of qualified Psychiatrists, mostly concentrated in the metropolitan and urban areas, to deal with this huge problem further compounding the issue[14].

It is a general observation in India that a majority of patients with mental disorder never seek professional help, most of them utilize the help of unqualified medical practitioners, faith healers etc. The non-availability of mental health services, stigma, and superstition associated with mental disorders, coupled with the unwillingness or inability of families to care for their mentally ill relatives appear to be the main contributory factors[15]

This implies that the stigma of mental illness can be reduced by education and experience and an examination of attitudes towards mental illness should be included in medical training[16].

The etiological factors involved in the pathogenesis of the disease include genetic predisposition (60% concordance rate in monozygotic twins), family environment (presence of stressors and disease among other family members), viral infection (inconclusive proof) cerebral infections and neurotransmitter disturbance at any given point of time.[17-18].

Screening for psychiatric disorders in primary care can improve the detection rate and helps in preventing grave consequences of unrecognized and untreated psychiatric morbidity. The consequences of psychiatric morbidity such as depression when it is not identified and treated can be sever. These include suicide, loss of jobs and relationships and deterioration in physical health including higher risk of myocardial infarction. Early detection is important because it

would reduce not only the consequences but also unnecessary suffering for the patients[19]

We have taken up the study to know the extent of psychiatric disorders and types of psychiatric disorders in this area of Nalgonda district.

Aim of our study is to analyze the socio-demographic factors of patients attending Psychiatric OPD in tertiary healthcare unit.

Our **objective** is to assess the socio demographic factors of Psychiatric patients attending psychiatric OP in tertiary care hospital.

Material & methods
Study design
A retrospective descriptive study of socio-demographic factors of Psychiatric patients.

Place of study
Psychiatric Out patient department of Government General Hospital & Government Medical college Nalgonda.

Duration
6 months (from 1st June 2020 to 30 November 2020).

Selection criteria
All patients attending psychiatric out patient department of GGH & GMC Nalgonda

Procedure
The data was calculated for a period of 6 months from 1st June 2020 to 30th November 2020.Data regarding age, gender, marital status, occupation, education, family income was collected from the OP department records. The patients were classified according to modified Kuppu swamy's classification 2021[20] for their socioeconomic group. The socioeconomic groups being upper class, upper middle class, lower middle class, upper lower class and lower class. Data regarding their residence i.e., urban and rural was also collected from the outpatient records. Data regarding mental illness of the patient was collected from the records and was classified according to ICD 10[21] classification. The data was analyzed taking in to consideration the modified kuppu swamy's classification for socioeconomic status and ICD 10 classification for different illnesses. Different percentages were calculated according to ICD 10 classification. P Value was calculated for male and female, and rural and urban distribution.

Ethical consideration
Permission was taken from ethical committee of GGH & GMC Nalgonda. No ethical issues.

Analysis of data
This data is for the period of 6 months from 1st June 2020 to 30 November 2020. Data was entered in to Epi info software and analysis was done by following ICD 10 classification. No scales were used.

Table 1: Socio-demographic details

Age Distribution	Frequency	Percentage
<15-30 yrs.	106	42%
31-40 yrs.	56	22%
41-50 yrs.	37	14.5%
51-60 yrs.	37	14.5%
61-70 yrs.	9	3.5%
>70 yrs.	9	3.5%
Gender Distribution		
Male	119	46.8%
Female	135	53.2%
Total	254	100%

Jairaj S *et al*   International Journal of Health and Clinical Research, 2021; 4(16):256-260
www.ijhcr.com
257

Residence	Frequency	Percentage
Rural	104	41%
Urban	150	59%
Marital Status		
Married	174	68.5%
Single	61	24%
Widowed	18	7%
Divorced	1	0.4%

Table 2: Socio-economic status

Socio -economic status	Frequency	Percentage
Upper	2	0.8%
Upper Middle	7	2.8%
Lower Middle	50	19.7%
Upper Lower	195	76.7%
Lower	0	
Total	254	100%

Table 3: Diagnostic profile of patients

ICD classification	Frequency	Percentage
F00-F09	26	10.2%
F10-F19	22	8.7%
F20-F29	47	18.5%
F30-F39	69	27.1%
F40-F49	79	31.1%
F50-F59	4	1.6%
F60-F69	1	0.4%
F70-F79	5	2%
F80-F89	0	
F90-F98	1	0.4%
Total	254	100%

Table 4: Distribution according to sex

ICD classification	Male count	Male %	Female count	Female %
F00-F09	14	5.5%	12	4.7%
F10-F19	19	7.5%	3	1.2%
F20-F29	26	10.2%	21	8.3%
F30-F39	14	5.5%	55	21.7%
F40-F49	38	14.9%	41	16.1%
F50-F59	2	0.8%	2	0.8%
F60-F69	1	0.4%	0	
F70-F79	5	2%	0	
F80-F89	0		0	
F90-F98	0		1	0.4%
Total	119	46.8%	135	53.2%

Table 5: Distribution according to residence

ICD classification	Rural count	Rural %	Urban count	Urban %
F00-F09	18	7%	8	3.1%
F10-F19	16	6.2%	6	2.4%
F20-F29	32	12.6%	15	5.9%
F30-F39	14	5.5%	55	21.6%
F40-F49	20	7.8%	59	23.2%
F50-F59	0		4	1.6%
F60-F69	0		1	0.4%
F70-F79	5	1.9%	1	0.4%
F80-F89	0		0	
F90-F98	0		1	0.4%
Total	104	41%	150	59%

Results

The data was analyzed after completion of 6 months. A total of 254 patients who attended the Psychiatric OP of GGH & GMC Nalgonda was analyzed. Nearly 64% of the study population belonged to the age group of 15 to 40 years, the most economically productive. A total of 135 (53.2%) were females & 119 (46.8%) were males. A total of 150 (59%) belonged to urban area & 104(41%) belonged to rural area. A total of 174(68.5%) were married & 61(24%) were single & 18(7%) were widowed & only 1(0.4%) was divorced.

A total of 195 (76.7%) belonged to upper lower (class 4) class & 50(19.7%) belonged to lower middle class. A total of 7 (2.8%) belonged to upper middle class & 2 (0.8%) belonged to upper class

according to modified Kuppu swamy's classification 2021[20]. The diagnostic profile of the patients was as follows: 26 (10.2%) were in the group of F00-F09. Maximum patients were in the group F30-F39, 69 (27.1%) and F40-F49 is 79 (31.1%). P Value was calculated for males and females belonging to urban and rural areas. It was found that P Value was 0.01 and was significant for mental illnesses among urban females.

Discussion

Increased prevalence of morbidity of 64% is seen in the younger age group. This trend was earlier demonstrated by many researchers from Asia – Khatri et al (Nepal) Kameshvell et al (India). Jaju et al (Oman)[22-24]Earlier studies have reported a strong association between gender & mental illness, with the female gender being the most prominent of the risk factors in certain psychiatrics disorders[25-27]. In our study sample also, there is a female gender prominence. As the study place was in town and accessible to the urban population, many were from urban areas. There is better awareness among the urban population.

Our study showed that the most commonly diagnosed mental disorders were neurotic, stress related and somatoform disorders (31.1%), followed by mood disorders (27.1%)

The studies by Kameshvell, Regmi et al[23] and Shrestha et al[28], neurotic or mood disorders were the main diagnostic group.

Soren et al[26] in a study conducted in Jharkhand India found affective psychosis (31.9%) as the main psychiatric problem followed by non-affective psychosis (18.8%), epilepsy (15.8%) & neurotic disorders (11.2%). In the study by Shrestha[28]63.7% of patients were suffering from psychosis, 18% neurosis & 6% from epilepsy.

The difference in the morbidity pattern maybe due to cultural factors and also the setup of study centers, that is whether it is conducted in mental hospitals, Psychiatric Outpatient of a General hospital or private clinic. Psychosis predominates in mental hospitals whereas a wide range including psychosis, mood disorders, neurosis, substance dependence and organic mental disorders occur in General hospital psychiatric unit.

One of the most significant finding of our study was good attendance for follow up. This maybe because of proper counselling and health education by our psychiatrist. This finding is in contrast to the study by Prosenjit Ghosh et al[26] where there were more dropouts for follow up.

The rates of psychiatric disorders fluctuate according to geographic, ethnic and socioeconomic status. However, it is widely agreed that psychotic disorders often affect young people who are in the midst of their most productive years of life[22]. Earlier studies have reported a strong association between gender and mental illness with the female gender being the most prominent of the risk fac tors in certain psychiatric disorders[29-30].

Current global epidemiological data consistently reports that up to 20% of children and adolescents suffer from a disabling mental illness that the suicide is the third leading cause of death among adolescents and that up to 50% of all mental disorders have their onset in adolescence. While the epidemiological data appears relatively uniform globally, the same is not true for policy and resources for care.

Awareness programs involving different cultural, occupational and social groups of the society will definitely be fruitful. Mental disorders are mostly stigmatized in our communities and this affect the overall care of mental health care users.

Now a days patients with psychiatric problems attending the general hospital are increasing. The hospital data of different researchers show that people prefer to visit general hospitals for treatment of mental disorders rather than mental hospitals. World Health Organization recommends that it is better to establish psychiatric units in general hospitals .Because of the requirement of many consultants liaison working with each other to come to a diagnosis shows that treatment in general hospital is better than psychiatric disorders treated in general hosp-itals get good care as compared to mental hospitals .

Limitation of the study

The limitation is we cannot apply the study results to the general population of Nalgonda as it is conducted in a hospital set up and not in the community.

Conclusion

We found that mental disorders comprise a spectrum of disorders which mainly consist of psychotic, mood & neurotic disorders. They affect the most productive age group, thus affecting the economic status of a person and the country as a whole. They are common in urban areas and female population. The awareness program in public about symptoms of mental disorders will definitely help in early diagnosis and prompt treatment.

References

1. Kohn R, Saxena S, Levav I, et al. The treatment gap in mental health care. Bull World Organ 2004;82(11):858-866.
2. WHO. Mental health: New understanding, New hope: World Health Report 2001. Geneva: World Health Organization. 2001:09-24.
3. Jacob ks Sharanp,Mirza I , et al Mental health system in countries; where are we now?Lancet 2007;370(9592);1061-1077.
4. National Institute of Health and sssFamily Welfare. National Mental Health Program. New Delhi: NIHFW; 2005. Accessible from: http:www.mihfw.orgndcnihfw/html/Programmes/NationalMentalHealth.htm. Last accessed om 2007 Jul 12.
5. WHO Depression factsheet N369(online) oct2014. Citedjune 2015 available from URL http/www.who,int/media centre /factsheet/fs369(en) .
6. WHO /Europe[online] European health report 2014 [cited 2015] Available at URI;{http//www euro who int /en/health-topics/… mental health /data- and- statistics}
7. Herman AAstein DJ,Seedat Setal.the South African stress and health(SASH) study;12 month and lifetime prevalence of common mental disorders S.Africa Med j 2009;9(5);339-344.
8. Murray CJL,Lopez AD Mortality by cause for eight regions of the world;Global burden of disease study. Lancet. 1997;349;1269 -76x
9. World Health Organization-Investing in mental health 2003
10. World Health Organization. Quality improvement for Mental Health Geneva; World Health Organization 2003.
11. Reddy MV, Chandrasekar CR. Prevalence of mental and behavioral disorders in India: A meta-analysis. India J Psychiatry. 1998;40:149-57.
12. Ganguli HC. Epidemiological findings on prevalence of mental disorders in India. India J Psychiatry. 2000;42:14-20.
13. Government of India. Mental Health: All Indian Perspective, 1946-2003. New Delhi: Directorate General of Health Services. 2004:4-17.
14. Rogler LH, Cortes DE. Help-seeking pathways: A unifying concept in mental care Am J Psychiatr. 1993;150:554-61.
15. Royal College of Psychiatrists, Royal College of Physicians, British Medical Association. Stigmatization within the Medical Profession. Council Report CR91. Royal College of Psychiatrists: London; 2001.
16. Africa B, Schwartz RS. Schizophrenic Disorders. In: Howard H Goldman (Editor). Review of General Psychiatry. New York Appleton & Lange; 1995.
17. Kasyc M, Norquist GS. Schizophrenia Epidemiology. In: Kaplan HI, Sadock BJ, editors. Comprehensive Text nook of Psychiatry. Philadelphia: Williams & Wilkins. 1995:908.
18. Statistical Package for Social Sciences. SPSS version 10.0. USA:SPPS incorporate;2007
19. Ruzzana Zam Zam,Manium Thambu et al .International journal of mental health systems 3. Article No 13(2009)
20. Saleem SM.JanSS.Modified Kuppuswamy socioeconomic scale updated for the year 2021. Indian J Forensic Community Med 2021;8(1);1-3..

21. World Health Organization. The ICD-10 Classification of Mental and Behavioral disorders (Tenth Revision): Diagnostic Criteria for Research. Geneva; 1992
22. Khattri JB, Gidar ST, Thapa P, et al. Socio-demographic characteristics and diagnostic profile of patients attending psychiatric OPD of a private hospital in western region of Nepal. Nepal J Med Sci 2012;1(1):15-18.
23. Kameshvell, Rajin S, Raj Kumar P. Morbidity pattern among patients attending a private psychiatric clinic – A cross sectional study. Sch J App Med Sci 2016;4(9D):3462-3466.
24. Jaju S, Al-Adawi S, Al-Kharusi H, et al. Prevalence and age of – onset distributions of DSM IV Mental disorders and their severity among school going Omani adolescents and youth: WMH CIDI findings. Child Adol Psych Ment Health 2009; 3(1):29.
25. Soren S, Bhutto ZA Kumari P, et al. A socio-demographic study of patients attending DMHP, Dumka. Eastern J Psychiatry 2008;11:9-13.
26. Prosenjit Ghosh,Anshuman Gogoi. Sociodemographic and clinical Profile of Patients Attending a Private Psychiatry Clinic in Assam, India. Ind J Priv Psychiatry 2019;12(2):52-57

27. Regmi SK, Khalid A, Nepal MK, et al. A study of socio-demographic characteristics and diagnostic profile in psychiatric outpatients of TUTH. Nepalese Journal of Psychiatry 1999; 1(1):26-33.
28. Shrestha NM, A prospective analysis of 300 cases attending outpatient's clinic in Mental Hospital. In: Proceedings if the Workshop on National Mental Health Planning, Kathmandu; 1987. 00. 47-73.
29. Rosenfield S. gender and mental health do women have more psychopathology, men more or both the same land why ? in horwitz AV shield TL ed A Hand book for the study of mental health; social contexts, Theories and systems New York , NY US; Cambridge university press; 1999. Pp348-360
30. Bagadia VN Ayyar KS Lakdawala PD   et al .Psychiatric morbidity among patients attending medical outpatient department .Ind J Psychiat 1986;28(2);139 .

Jairaj S *et al*   International Journal of Health and Clinical Research, 2021; 4(16):256-260
www.ijhcr.com
260