MENTAL HEALTH IN PRIMARY HEALTH CARE; A NEED ASSESSMENT STUDY

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ABSTRACT

Objectives: To identify various somatic symptoms among the selected patients and their families for underlying psychological problems and to identify the barriers faced by them in health seeking regarding such problems.
Study Design: Cross-sectional study.
Place and Duration of Study: This study was conducted in residential areas of Rawalpindi, over a period of six months, from Nov 2016 to Apr 2017.
Methodology: Three hundred and ten adult males along with the adult females of their families were selected using non-probability consecutive sampling The adults (above 18 years) were interviewed by trained nurses and public health assistants using structured validated questionnaire, Lahore Somatic inventory Scale after verbal informed consent The adults who were unwilling or already diagnosed with any psychiatric disorder were excluded. Data was entered and analyzed using SPSS 21.
Results: Among 310, 129 (41.9%) were males and 181 (58.4%) were females. The symptoms reported were recorded on three point Likert scale, 1 to 3. Top ten symptoms reported in descending order were lack of energy/ weakness 49 (15.8%), pain or tension in neck and shoulder 42 (13.5%), aches & pains 41 (13.2%), feeling tired 39 (12.6%), mostly aware of palpitations 29 (9.4%), head bursting 28 (9%), feeling wind or belching 18 (5.8%), pain in chest or heart 22 (7.1%), constipation 21 (6.8%), constriction around head 21 (6.8%). On exploring reasons for not contacting a psychologist or health facility, 110 (35.48%) said that they didn't know exactly whom to consult while 82 (26.45%) said that mental disorder is a stigma in our society and 74 (23.87%) were of the opinion that they were fearful of prolonged medication.
Conclusion: The most common psychosomatic symptoms identified were lack of energy or generalized weakness followed by aches and pains and feeling tired. Most of the participants didn't take help from a health specialist due to lack of awareness and stigmatized nature of illness.

Keywords: Health seeking behavior, Mental health, Primary health care.

INTRODUCTION

Neuropsychiatric disorders account for about 14% of the global burden of disease, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses[1]. This makes mental illness one of the largest contributors to the global burden of disease[2]. Mental health consumers are stigmatized and are discriminated against at the workplace, in health care and in communities[3].

The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis[1]. Of the non-communicable diseases, neuropsychiatric conditions contribute the most to overall burden more than either cardiovascular disease or cancer[1]. Neuropsychiatric conditions account for up to a quarter of all disability-adjusted life-years, and up to a third of those attributed to non-communicable diseases[1], Neuropsychiatric disorders are estimated to

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contribute 11.9% to the burden of disease according to World Health Organization regional Office for the Eastern Mediterranean Region. Same picture is in Pakistan where 180 million individuals in Pakistan are suffering from non-communicable diseases and amongst these the highest burden is of mental health disorders 27.8%, followed by 22.2% from high blood pressure, 17.8% from heart disease, 4.4% from diabetes[4]. In Pakistan, mental disorders account for more than 4% of the total disease burden, with the mental health burden higher among women. It is estimated that 24 million people in Pakistan are in need of psychiatric assistance[4].

There is a pressing need to scale up mental health services due to a substantial unmet need for mental health care. Integrating psychologists into primary health care can potentially deliver affordable mental health services to communities and help to close the treatment gap[5] Primary health care (PHC) Australia is one of the pioneers in integrating mental health into primary health care, and the mental health reforms in Australia may have some implications for Indonesia[5]. Integration of mental healthcare into the existing PHC system has been widely advocated; this approach is feasible in the developing countries since specialist psychiatric care has limited outreach. If mental disorders are regarded as a distinct health domain, with separate services and budgets, then investment in mental health is perceived to have an unaffordable opportunity cost. This concept is embodied in Social contract theory that denotes obligations on the part of the medical profession and its professionals are required by such a social contract. In psychiatry, this concerns the role of the psychiatrist as both a professional and as a member of society. The person with a mental disorder has the role of both patient and a member of society[6].

Though Pakistan is the first in WHO Eastern Mediterranean Region (EMRO) to have set up a National Programme for Mental Health (NPMH) in the year 1986. Pakistan is among 60% countries who have mental health policy[7]. However, Pakistan can still be categorized amongst 90% of the developing countries that do not have a mental health policy for adolescents and children; furthermore, until now, it could also be grouped with 27% of the same thatdid not have a system for mental health surveillance[8]. Only 0.4% of health care expenditures by the government health department are devoted to mental health. The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based, social insurance and private insurances[7].

In Post MDG era, the world is focusing on the neglected part of human health. Two targets of UN– SDGs are directly related to mental health[9]. The WHO mental health action plan also focuses on countries to provide comprehensive, integrated and responsive mental health and social care services in community-based settings[10]. WHO recommends countries to follow optimal mix of services pyramid framework for organization of mental health services[11]. In Pakistan, a national mental health plan was developed which aimed at working towards the adoption of a bio psychosocial model, a public health approach to health care by integrating mental health at all levels and ensuring participation of public representatives[7]. Due to the lack of research in general and lack of prevalence/incidence studies in particular, there was a missing link in the development of the policy. National studies in a few areas of mental health morbidity were yet to be planned, so there were no standard figures and estimates[7].

Pakistan is a setting where poverty, unemployment, illiteracy, malnutrition, gender biases and break-up of social support systems complex the stresses of urbanization and acculturation[8]. In the background of these problems, people in Pakistani culture with minor mental disorders frequently express their stress as somatic complaints; therefore, detection of mental health disorders at earliest opportunity would possibly decrease the morbidity and sufferings. There is a dire need of such a study to highlight the problem of mental health faced by masses so that the issue can be addressed at the grass root level.

The objectives of the study were to identify various somatic symptoms among the selected pateints and their families for underlying psychological problems and to identify the barriers faced by them in health seeking regarding such problems.

METHODOLOGY

It was a cross-sectional study, conducted in Residential areas, designated for soldiers in Rawalpindi over period of six months from 1st November 2016 to 30 April 2017. Using WHO sample size calculator, a sample size of 323 was calculated with prevalence of mental prob-lems as 66% (7), with 0.05 precision and alpha as 5%. Thirteen forms were discarded due to incomplete response. Total number of households in the community was one thousand, so every third household was approached using systematic random sampling. The adults (above 18 years) were interviewed by trained nurses and public health assistants using structured validated questionnaire, Lahore Somatic inventory Scale after verbal informed consent. The adults who were unwilling or already diagnosed with any psychiatric disorder were excluded. A structured questionnaire, Lahore Somatic inventory Scale[12] used is a validated tool adapted from Bradford somatic inventory (α=0.94), designed for Pakistani population to screen somatic symptoms as a clue to underlying psychiatric problems. Data was entered and analyzed using SPSS.21.

Categorical variables were analysed as frequencies & percentages. Continuous variables were computed as means and Standard deviations. The symptoms were recorded on three point Likert scale. (1→3) The symptoms reported were recorded on three point Likert scale. 1 to 3. 1 showed absence of symptom and 2 and 3 showed presence of symptom for less than 15 days or more than 15 days in previous month, respectively and mean scores of these symptoms were calculated. The difference in terms of gender and marital status was analyzed using independent sample t-test. A *p*-value ≤0.05 considered as significant.

RESULTS

Among 310, 129 (41.9%) were males and 181 (58.4%) were females. The mean age of respondents was 32.23 ± 8.9 years. Among these, 257 (82.9%) were married and 53 (17.1%) were unmarried.

Table-I: Symptoms reported by respondents.

Symptoms	Absent n (%)	Present (<15 days)	Absent (>15 days)
Headache	173 (55.8)	104 (33.5)	33 (10.7)
Fluttering In Stomach	210 (67.7)	83 (26.8)	17 (5.5)
Pain or Tension in neck n shoulder	144 (46.5)	124 (40)	42 (13.5)
Constriction around Head	222 (71.6)	67 (21.6)	21 (6.8)
Pain in Chest or Heart	221 (71.3)	67 (21.6)	22 (7.1)
Dry Mouth & throat	212 (68.4)	81 (26.1)	17 (5.5)
Lack of Energy/ Weakness	159 (51.3)	102 (32.9)	49 (15.8)
Sweating	230 (74.2)	64 (20.6)	16 (5.2)
Pressure on Chest	234 (75.5)	67 (21.6)	9 (2.9)
Choaking in Throat	230 (74.2)	59 (19)	20 (6.5)
Aches & pains	190 (61.3)	79 (25.5)	41 (13.2)
Aware of palpitations	209 (67.4)	71 (22.9)	29 (9.4)
Trembling or Shaking	236 (76.1)	62 (20)	12 (3.9)
Polyuria	193 (62.3)	100 (32.3)	17 (5.5)
head felt heavy?	185 (59.7)	108 (34.8)	16 (5.2)
Feeling Tired Mostly	173 (55.8)	98 (31.6)	39 (12.6)
Head Bursting Feeling	209 (67.4)	73 (23.5)	28 (9)
Constipation	226 (72.9)	63 (20.3)	21 (6.8)
Heart Sinking	230 (74.2)	66 (21.3)	14 (4.5)
Wind or belching	222 (71.6)	64 (20.6)	24 (7.7)
Cold Hand or Feet	234 (75.5)	58 (18.7)	18 (5.8)

Commonly reported somatic symptoms experienced for more than 15 days were lack of energy/weakness 49 (15.8%), pain or tension in neck and shoulder 42 (13.5%) aches & pains 41 (13.2%), feeling tired mostly 39 (12.6%). Least reported symptoms were pressure on chest 9 (2.9%), trembling or shaking 12 (3.9%). Table-I shows the proportions of all the symptoms.

Table-II: Relationship of gender & marital status with psychosomatic symptoms.

Variables	Categories	Mean ± SD scores	*p*-value
Gender	Male	25.20 ± 2.35	<0.001
	Female	32.8 ± 7.78	
Marital Status	Married	30.28 ± 7.47	<0.001
	Unmarried	26.5 4± 4.58	

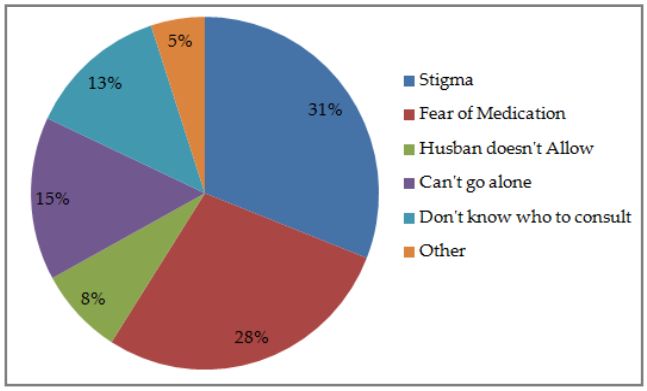

Figure: Reasons for not seeking care.

The psychosomatic symptoms were more frequently found among females. Marital status was also found to be significant determinant of being stressed as shown in table-II. Psychosomatic symptoms were found to be positively correlated with age of respondents (r=0.347, *p*<0.001, CI=0.249-0.460).

Though the symptoms are sufficient to highlight the problem of psychosomatic disorders but only 44 (14.2%) ever visited the health care facility / provider. The most common reason for not seeking care for mental illness were stigma attached to it and fear of medication reported by 82 (31%) and 74 (28%). Figure shows the reasons for not seeking medical care.

DISCUSSION

Mean score of the symptoms among our study participants were higher among females 32.8 ± 7.78 as compared to males 25.20 ± 2.35. These scores among females are much higher than the findings of a study[11-14] where scores of female inpatients were 11.83 ± 4.8. This indicated susceptibility of female gender to mental health problems who express their psychological problems as somatic symptoms.

Persistent pain was common among the respondents and was reported by 25.5% of them this is similar to a study conducted by WHO[13] where persistent pain was reported by 21.5% of the participants. Persons with persistent pain are more likely to have an anxiety or depressive disorder meeting ICD-10 diagnostic criteria. On further exploring about anatomical site it was found that headache among 33.5% and pain in chest by 21.6% which closely relates respectively to 45.2%, and 28.9% to the findings of same study. This shows a close resemblance in presentation among our respondents and the participants of that multicenter study.

When the participants inquired about the barriers perceived by them in seeking help from a mental health specialist, 31% told it to be a stigma while a study conducted at Australia[14] found that 23% of the participants were feeling embarrassed / shy in contacting a doctor which is comparable to our study. The findings were in line with a qualitative study among Blacks in England[15] and Asian American women[16] who consider stigma as one of the top reason for not able to assess or underutilize mental health services. It's a clear indication that mental disorders always pose difficulty in reporting to a health facility. Second top was 28% reporting fear of medication in our study while 21% in the same mentioned study[16-18] reported that their family, friends or the doctor might feel negative about them.

LIMITATION OF STUDY

The data was collected from a single center. More data can be collected from different regions to generalize results.

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RECOMMENDATION

There is a need to address mental health problems right at the primary level to minimize the increasing burden of this illness. In this regard, the role of psychologists' in PHC is vital for early screening of mental health disorders. Mental health Professionals should guide for quality care at PHC and continuous monitoring of the health programme.

CONCLUSION

The most common psychosomatic symptoms identified were lack of energy or generalized weakness followed by aches and pains and feeling tired. Most of the participants didn't take help from a health specialist due to lack of awareness and stigmatized nature of illness.

CONFLICT OF INTEREST

This study has no conflict of interest to be declared by any author.

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