

Knowledge, Attitude And Behaviour Towards Mental Illness Among Non-Psychiatric Clinicians In A Tertiary Care Teaching Hospital

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Abstract

Aim of the study- To assess the Knowledge, Attitude and Behaviour towards mental illness among non-psychiatric clinicians in a tertiary care teaching hospital and to test the primary hypothesis that doctors who hold more negative attitudes towards people with mental illness will have more discriminatory behaviours.

Material and Methods- This was a cross sectional study which was conducted on post graduate resident doctors and consultants of various medical faculties of Medical College, Baroda. Each participant was given MAKS (Mental Health Knowledge Schedule), MICA (Mental Illness Clinician's Attitude Scale) and RIBS (Reported and Intended Behaviour Scale) along with the socio demographic data sheet for age, sex, medical speciality, years of experience to be filled in their respective departments and two reminders were given for filling the data sheets at an interval of two days each. Those who did not return the data sheets after two reminders were considered dropouts.

Results- The study enrolled 200 participants out of which 147 were resident doctors and 53 were consultants. The mean score for MAKS, MICA-4 AND RIBS were 24 \pm 3, 46 \pm 9 and 15 \pm 3 respectively. Consultant doctors had a more negative attitude towards mental illness as compared to resident doctors. There was a negative correlation between MICA-4 score and RIBS score i.e. People with more negative attitude towards mental illness are likely to have less favourable intended behavior towards people with mental illness.

Conclusion- From this study we can conclude that a significant proportion of the doctors still lack knowledge about mental illnesses and still hold a negative attitude towards mental illness which demonstrates the need of mental health awareness programs aimed at doctors.

Keywords- Knowledge, attitude, behavior towards mental illness, Non-psychiatric clinicians, tertiary care teaching hospital.

Introduction

Psychiatry as a medical branch has often been stigmatized not only by the general public but often by the medical community as well. Also, this stigma is not limited to mental illnesses but also extends to the people dealing with persons with mental illnesses i.e. mental health professionals. Mental health professionals are thus both recipients of stigma and agents who can de-stigmatize psychiatry^[1]

A large number of patients visiting hospitals suffer from psychiatric illnesses and the first level of contact for most of them are non-psychiatric clinicians. Majority of these psychiatric illnesses go unrecognized leading to hardships, inconvenience and financial loss on the part of patients.

Psychiatric exposure of medical and paramedical staff during training is grossly inadequate which eventually leads to insufficient knowledge and misconceptions about psychiatric illnesses and their treatment.^[2-4] For effective health care to be

delivered, it is important that medical professionals are not obstructed by biased attitudes. The practice of psychiatry is often viewed as unscientific, imprecise and ineffective; consequently, physicians who hold these views tend to focus on physical symptoms and omit their focus on mental disorders and are less likely to refer patients to mental health professionals, which indicate their poor training or lack of awareness.

In India, because of limited number of psychiatrists and the stigma associated with mental illness, the patients with mental illness in medical and surgical settings are more likely to be seen by their primary clinician. Therefore, an adequate training in psychiatry at undergraduate level is crucial for diagnosis of mental illness in medical and surgical settings.

It is a common belief that as we go higher up in hierarchy of socio-economic status and education, the knowledge regarding mental illness increases and people are more likely to have a positive attitude towards mental illness. The purpose of this study is to assess the credibility of this belief among health professionals (non-Psychiatric clinicians) who have had training in Psychiatry during MBBS and believed to have a better understanding of mental illness than general population. Also, this study tends to assess their attitude towards mental illness and their willingness to seek help for them and their relatives if suffering from mental illness

Method

Study setting and design:

This is a cross sectional study conducted on post graduate resident doctors and consultants of various medical faculties of Medical College, Baroda.

Study population:

All consultants and post graduate resident doctors of various clinical branches of Medical College, Baroda College who gave written informed consent, were selected for the study. Those subjects

who were not willing to give informed written consent were excluded.

Tools used:

1) A semi structured self-report questionnaire including socio-demographic profile, medical speciality, post, year of residency, years of experience in the speciality, past history, family history, substance use.

2) Mental Health Knowledge Schedule (MAKS)

The MAKS is a mental health knowledge related measure which comprises domains of relevant evidence -based knowledge in relation to stigma reduction. Part A comprises of six items covering stigma related mental health knowledge areas (help seeking, recognition, support, employment, treatment and recovery) and part B comprises of six items that enquires about classification of various conditions as mental illnesses. The total score is calculated so that higher score indicate greater knowledge.^[5]

3) Mental Illness: Clinician's Attitude Scale (MICA-4)

The MICA-2 scale was developed to assess medical student's, psychiatry resident's and psychiatrist's attitude including their view and knowledge of mental illness. MICA-4 scale was developed by adapting the MICA-2 items to apply to most health and social care professional groups. The scale has 16 items which are completed as a self-administered survey. MICA version's scores range between 16 and 96 and represent the sum of individual item scores. A high overall score indicates a more negative attitude.^[6]

4) Reported and Intended Behaviour Scale (RIBS)

The RIBS is a measure of mental health stigma related behavior, based on The Star Social Distance Scale. It is an 8 item scale containing four intended behavior items and 4 reported behavior items. Four intended behavior items assess the level of intended

future contact with people with mental health problems and four reported behavior items assess past or current contacts. The total score for each participant is calculated by adding together the response values for items 5-8. 'Don't know' is coded as neutral (3) for the purpose of determining a total score. As items 1-4 only calculate the prevalence of behaviours and respondents may or may not have engaged in those behaviours, they are not given a score value.^[7]

Data collection

All the consultants were approached individually in their respective departments after taking due permission from the Dean, Medical college, Baroda. They were briefly explained about the study in detail and all their queries were resolved. They were informed that participation in the study is completely voluntary and they can withdraw from the study at any given point of time and confidentiality will be maintained. After receiving written informed consent, they were requested to fill the socio demographic data sheet and the scales i.e. MAKS, MICA-4 and RIBS which were collected the next day. Those who could not fill the form by next day due to their busy schedule were given two reminders at an interval of two days each. Those who did not return the filled form after two reminders were considered as drop outs. Likewise, the resident doctors of each department were contacted during their free time which was inquired prior and were explained the purpose of the study and after receiving written informed consent, were asked to fill the data sheet during their leisure time. They were asked to handover the sheets to one particular resident doctor in each department from whom the sheets were collected after two days. Those who could not return the filled sheets after two days were sent two reminders telephonically at an interval of two days and those who did not return the filled forms after two reminders were considered as drop outs.

Analysis

Data was entered in MS Excel sheet and statistical analysis was carried out using Epi-info software. Descriptive statistics were done for clinical

variables. The response rate for various responses on MAKS, MICA-4 and RIBS were calculated. The mean scores for the three scales were calculated for the overall participants. Pearson correlation coefficient was applied.

Results

The study enrolled a total of 200 participants of S. S. G. Hospital and Medical College Baroda. Total 311 were approached, out of which 83 were consultants and 228 were Resident doctors.

Table 1 depicts the enrolment and participation

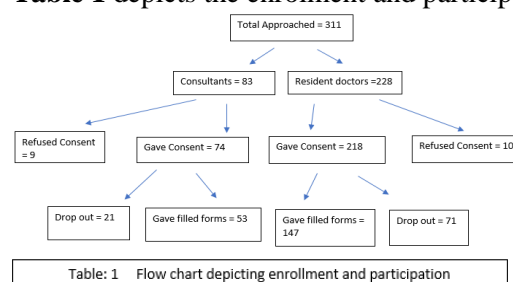


Table 2 depicts the study design

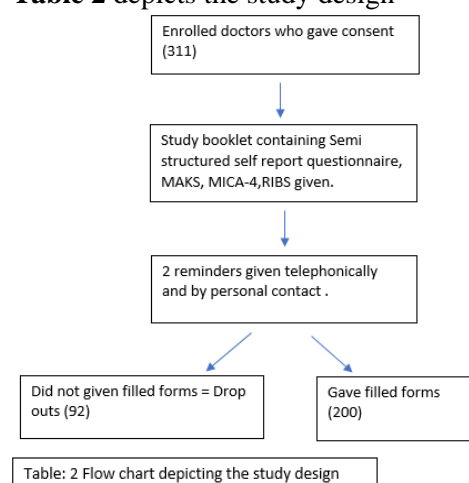


Table 3: Mean Score with Standard Deviation:

Scale	MAKS	MICA-4	RIBS
Score	24	46	15
Std Deviation	3	9	3

The mean score for MAKS for the overall study population (200) was 24 +/-3.

The mean for MICA-4 was 46 +/-9.

The mean for RIBS was 15 +/-3.

Correlation between MICA-4 and RIBS for Consultants:

Correlation Coefficient: -0.228381

Hence, we conclude that there is a negative correlation between MICA-4 and RIBS.

Correlation between MICA-4 and RIBS for Residents:

Correlation Coefficient: -0.09097

Hence, we conclude that there is a negative correlation between MICA-4 and RIBS.

We conclude that people with more negative attitude towards mental illness are likely to have less favourable intended behaviour towards people with mental illness.

Knowledge regarding mental illness (MAKS)

The mean score of the population was 24 +/- 3.

The majority of respondents agreed that people with a severe mental illness (SMI) can fully recover (78.5%), medication was effective for treating mental illness (90.2%) , psychotherapy can be an effective treatment for people with mental illness (95%) and they knew what advice they would give a friend who may be suffering with mental illness (96.6%).

68% believed that most people with a mental health problem want to have paid employment while only 22% people believed that most people with a mental problem go to a healthcare professional for help.

In addition, majority of the respondents could identify most of the mental disorders whereas 52.1 % believed that stress was a mental disorder and 50% believed that grief was a mental disorder.

Attitude towards people with mental illness (MICA-4)

The mean score was 46 +/- 9.

54 % agreed that they just learn about mental health when needed, and would not bother reading additional material on it, 32.8 % believed that People with a severe mental illness can never recover enough to have a good quality of life , 65.8 % agreed that Working in the mental health field is just as respectable as other fields of health and social care , 26.1 % agreed that If they had a mental illness , they would never admit this to their friends because of fear of being treated differently.42.8 %

believed that People with a severe mental illness are dangerous and 65.4 % believed Health/Social care staff know more about the lives of people treated for a mental illness than do family members or friends.26.6 % agreed that If they had a mental illness, they would never admit this to their colleagues for fear of being treated differently.

29.2 % believed that Being a health/social care professional in the area of mental health is not like being a real health/social care professional.63 % agreed that If a senior colleague instructed them to treat people with a mental illness in a disrespectful manner, they would not follow their instruction. Only 34.5 % agreed that they feel as comfortable talking to a person with a mental illness as they do talking to a person with a physical illness.69.5 % believed that It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed. A small percentage of 16.6 % believed that the public does not need to be protected from people with a severe mental illness. 33% believed that If a person with a mental illness complained of physical symptoms (eg chest pain) they would attribute it to their mental illness. 59% agreed that General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist. 27.2 % agreed that they would use the term 'crazy' , 'nutter' , 'mad' etc. to describe to colleagues people with a mental illness who they have seen in my work and 72.4 % agreed that If a colleague told them they had a mental illness, they would still want to work with them.

Reported and intended behavior:

The mean score of the population on RIBS was 15 +/- 3.

15.10 % of the population agreed that they are living or have ever lived with someone with a mental illness while 9.50 % reported of working or having worked before with someone with a mental illness. 13.30 % reported of having a neighbor with a mental illness and 9.50 % reported that they currently have or have had a friend with a mental illness.

There was some discriminatory behavior portrayed by the clinicians as only half of the population (55.4%) agreed that they would be willing to live with someone with a mental illness, 68.6% intended to work with someone with a mental illness in the future, 66.5 % were willing to live nearby someone with a mental illness whereas majority of the population (86%) were willing to be friends with someone with a mental illness which shows a favourable behavior.

Discussion

Knowledge about mental illness:

The mean score of the population was 24 ± 3 . The score in our study was higher than what was found in a study done in China to assess the level of stigma in community mental health staff where the mean score for MAKS was 16.8 ± 5.39 .^[8]

These findings are similar with those found among the mental health workers and primary health care nurses who could correctly identify the case vignettes given to them of severe mental illness.^[9,10]

In comparison to the public, it appears that the clinicians could identify mental illnesses more than the general public. For example, in a sample from the South African community, only 31% could correctly identify the typical mental illnesses from vignettes.^[11] This difference could be due to the education content that the clinicians receive or perhaps more exposure to people living with mental illness.

Among the respondents, 52.1% of the respondents falsely identified stress as mental illness. This finding is comparable to the findings in England (58.4%- 56.8%) in a study that was done as an evaluation from 2009 to 2012 among the general population.^[12]

Stress is mainly reported to be a cause for mental illness in a number of studies.^[13] This implies that non-psychiatric clinicians may still need some additional training on the types of mental disorders

and factors that may predispose an individual to mental illness.

Most of the participants believed that medication for mental illness and psychotherapy are effective and believed that the people living with mental illness could fully recover. Similarly, several researchers have documented that mental health and primary care workers believe that medication and psychotherapy are effective in managing mental illness.^[9,10]

Attitude towards mental illness:

The mean score of MICA-4 in our population was 46 ± 9 .

The score was less as compared to what was found in a study that assessed level of stigma among community mental health staff in China which was 51.69 ± 6.94 which indicates more positive attitude of non-psychiatric clinicians included in our study.^[8]

Also, a study that assessed attitude of medical students towards mentally ill patients in Egypt using MICA-2 found a mean score of 50.7 ± 7.8 indicating a more negative attitude of medical students as compared to non-psychiatric clinicians in our study.^[14]

Ye Rong et. al. researched attitude towards depression among medical students and their result showed that the mean score was 43.51 for MICA.^[15]

Some encouraging findings in our study were that 54 % agreed that they just learn about mental health when needed, and would not bother reading additional material on it, 65.8 % agreed that Working in the mental health field is just as respectable as other fields of health and social care, and 65.4 % believed Health/Social care staff know more about the lives of people treated for a mental illness than do family members or friends, 63 % agreed that If a senior colleague instructed them to treat people with a mental illness in a disrespectful manner, they would not follow their instruction and 69.5 % believed that It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed, 72.4 % agreed that If a colleague

told them they had a mental illness, they would still want to work with them.

These findings are indicative of a positive attitude towards Mentally ill and are comparable to the positive findings of a study which assessed stigmatizing attitude of healthcare professionals towards psychiatry and patients with mental health problems and found a modest positive attitude towards psychiatry in three groups. GPs scored significantly higher than the FPs and the latter scored significantly higher than the MHCs on all factors of MICA.^[16]

Negative attitude towards mental illness became apparent as 32.8 % believed that People with a severe mental illness can never recover enough to have a good quality of life, 42.8 % believed that People with a severe mental illness are dangerous, Only 34.5 % agreed that they feel as comfortable talking to a person with a mental illness as they do talking to a person with a physical illness, a small percentage of 16.6 % believed that the public does not need to be protected from people with a severe mental illness.

These findings are comparable to those found in a study where more than half of the medical students did not feel comfortable to even talk to psychiatric patients.^[17]

Another study got a similar findings where in a general hospital in Hong Kong among health workers reported that they believed that the patients diagnosed with mental illness cannot decide on their treatment plans and they were considered to be dangerous compared to others.^[18]

In our study negative attitude was also seen in other areas where 26.1 % agreed that If they had a mental illness, they would never admit this to their friends because of fear of being treated differently. 26.6 % agreed that If they had a mental illness, they would never admit this to their colleagues for fear of being treated differently, 33% believed that If a person with a mental illness complained of physical symptoms (eg chest pain) they would attribute it to their mental illness. 59% agreed that General practitioners should not be expected to complete a thorough assessment for people with psychiatric

symptoms because they can be referred to a psychiatrist.

A somewhat contrasting results were found in a study where majority of the non-psychiatric healthcare professionals showed a desire to know more about the psychiatric illnesses and their treatment in their patients.^[19]

These responses highlight the stigma and discrimination present towards psychiatric disorder, within the medical community itself. These findings are similar to those found in previous studies done on similar lines.^[20,21,22,23]

Behavior towards individuals with mental illness:

The mean score of the population on RIBS was 15 +/- 3.

Our mean score for RIBS was similar to the finding in a study done by Henderson et al. to evaluate the impact on the general population of England's time to change program and their result showed that the mean score for RIBS and MAKs were 14.5 and 21.2 respectively which is comparable to our study.^[24] The score in our study was higher than what was found in a study in China that assessed the level of stigma in community mental health staff where the mean score for RIBS was 11.97.^[8]

Contrary to the findings in our study, in Kenya, the primary health workers were not willing and others were not comfortable to admit people with mental illness in the general facilities.^[21] These views were also found among primary health care workers in Nigeria, Brazil and Switzerland.^[9,21]

In a study that examined physicians' attitude towards people diagnosed with schizophrenia in Turkey, more than 70% were not willing to a person diagnosed with schizophrenia as a neighbour.^[25]

This difference may be due to the different life styles in the different countries whereby those who are outgoing interact more with the neighbours and would care about their psychological distresses and those who are introverts would not mind about their neighbour. Generally, any situations that require

close proximity with people living with mental illness such as working with or nearby, being in a relationship or being a neighbor bring out stigmatizing reactions.^[26] These discriminating behaviors may affect the self-esteem of the people with mental illness and this affects their attitude and increases their level of dependence on the family members and the community and may limit their access to timely services.^[27,28]

The discriminatory behaviors may be due to the misinformation or inadequate knowledge among non-psychiatric clinicians. This affects their confidence and they may feel that they do not have enough skills to take care of people admitted with mental illness.^[29]

Correlation between attitude towards mental illness and intended behavior towards people with mental illness

We found a negative correlation between MICA-4 and RIBS for both, Consultants (Correlation Coefficient: -0.228381) as well as Residents (Correlation Coefficient: -0.09097)

This is similar to the findings in a study done in China among the community mental health staff to assess their level of stigma where they found a negative correlation between the MICA score and RIBS ($r = -0.43$).^[8]

Hence, we conclude that there is a negative correlation between MICA-4 and RIBS. i.e., People with more negative attitude towards mental illness are likely to have less favourable intended behavior towards people with mental illness.

Conclusion

In this study we surveyed a total 200 doctors of various clinical branches of S.S.G. Hospital. Out of these subjects, 53 were consultants and 147 were resident doctors. The subjects were given MAKs, MICA-4 AND RIBS to be filled which are the scales for Knowledge, Attitude and Behavior respectively.

In this study, we found that the mean score for MAKs was 24 ± 3 , the mean for MICA-4 was 46 ± 9 and that for RIBS was 15 ± 3 .

The majority of respondents agreed that people with a severe mental illness (SMI) can fully recover (78.5%), medication was effective for treating mental illness (90.2%), psychotherapy can be an effective treatment for people with mental illness (95%) and they knew what advice they would give a friend who may be suffering with mental illness (96.6%). 68% believed that most people with a mental health problem want to have paid employment while only 22% people believed that most people with a mental problem go to a healthcare professional for help. In addition, majority of the respondents could identify most of the mental disorders whereas 52.1% believed that stress was a mental disorder and 50% believed that grief was a mental disorder.

There was some positive attitude seen in the clinicians as a significant proportion (65.8%) agreed that Working in the mental health field is just as respectable as other fields of health and social care, 69.5% believed that It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed, 72.4% agreed that If a colleague told them they had a mental illness, they would still want to work with them.

A significant proportion of clinicians also showed a negative attitude with 42.8% who believed that People with a severe mental illness are dangerous, only 34.5% agreeing that they feel as comfortable talking to a person with a mental illness as they do talking to a person with a physical illness. Nearly one fourth of the population reported that they would not admit regarding their mental illness to their friends or colleagues for fear of being treated differently and 33% believed that If a person with a mental illness complained of physical symptoms (ex. chest pain) they would attribute it to their mental illness and 59% agreed that General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.

There was some discriminatory behavior portrayed by the clinicians as only half of the population (55.4%) agreed that they would be willing to live with someone with a mental illness, 68.6% intended to work with someone with a mental illness in the future, 66.5 % were willing to live nearby someone with a mental illness whereas majority of the population (86%) were willing to be friends with someone with a mental illness which shows a favorable behavior.

This study demonstrate the need for mental illness educational programs aimed at clinicians as well as increased exposure to Psychiatry during undergraduate training for providing basic information and thus demystifying mental illness since significant proportions of the doctors still lack knowledge about mental illnesses and still hold a negative attitude towards mental illness. A better understanding of mental disorders among medical staff would allay fear and mistrust about mentally ill people in the medical community as well as lessen stigmatization towards such persons.

Limitations

There are some limitations of the study:

- First, the study sample size was small reducing the power of the study. However, extensive effort was made to ensure that majority of the clinicians working in the facility were included.
- Also, since the study was a cross-sectional design, it cannot be used to make inference about causality.
- Furthermore, in this small study it was not possible to explore more factors which could have predicted stigma in this group.
- There may be reporting bias because the participants were being asked about the behavior which would have been better done with observation. There may be self-reporting bias.

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Ethical approval

The proposal of the study was submitted to the IECHR (Institutional Ethics Committee for Human Research). Permission of IECHR of Medical College and S.S.G. Hospital Baroda was given on 15/02/2018.

Competing interests

The authors declare that they have no competing interests.