RESEARCH PAPER

Cross Observational Study to Assess Prescription Patterns, Clinical Profiles, Quality of Life, and the Therapeutic Impact of Patient Counselling in Psychiatric Disorders

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ABSTRACT

Introduction

Psychiatric disorders represent a major global public health concern, contributing substantially to morbidity, disability, and diminished quality of life across all age groups. Mental and behavioural disorders form a significant share of the global disease burden, with depression, anxiety, schizophrenia, bipolar disorder, and substance use disorders being the most prevalent conditions.

Aims

The study aims to evaluate prescription patterns and clinical profiles of patients with psychiatric disorders, assess their quality of life, and determine the therapeutic impact of patient counselling on treatment outcomes in a cross-sectional observational setting.

Methods

This was a cross-sectional observational study conducted over a period of one and a half years in the Department of Psychiatry at Civil Hospital, Rajkot, Gujarat, a tertiary care government hospital serving a diverse urban and rural population.

Result

The study included 300 patients, predominantly aged 31–45 years, with a male preponderance, as males constituted a higher proportion than females among psychiatric outpatients.

Conclusion

The study highlights key demographic, clinical, and therapeutic trends among psychiatric outpatients, showing a predominance of males in the economically productive age group of 31–45 years. Depression and anxiety disorders accounted for over half of all diagnoses, emphasizing the significant burden of common mental disorders and the positive role of counselling in improving treatment outcomes.

Keywords: Psychiatric disorders, Prescription patterns, Clinical profile, Quality of life, Patient counselling, Cross-sectional observational study.

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INTRODUCTION

Psychiatric disorders constitute a major public health challenge worldwide, contributing significantly to morbidity, disability, and reduced quality of life across all age groups. According to global estimates, mental and behavioral disorders account for a substantial proportion of the overall disease burden, with depression, anxiety disorders, schizophrenia, bipolar affective disorder, and substance use disorders being among the most prevalent conditions [1]. In low- and middle-income countries, including India, the burden is further amplified by limited mental health resources, social stigma, delayed diagnosis, and poor treatment adherence [2]. These factors collectively result in suboptimal clinical outcomes and a diminished quality of life for affected individuals.

Pharmacotherapy remains a cornerstone in the management of most psychiatric disorders. Antidepressants, antipsychotics, mood stabilizers, anxiolytics, and adjunctive medications are commonly prescribed either as monotherapy or in combination, depending on the diagnosis, severity of illness, comorbid conditions, and patient-specific factors [3]. However, irrational prescribing practices, polypharmacy, inappropriate dosing, and

prolonged use of certain psychotropic drugs can increase the risk of adverse drug reactions, drug–drug interactions, and poor compliance [4]. Evaluating prescription patterns in psychiatric practice is therefore essential to assess rational drug use, adherence to standard treatment guidelines, and areas requiring therapeutic optimization.

In addition to pharmacological treatment, the clinical profile of patients—including sociodemographic characteristics, duration of illness, comorbid medical conditions, and severity of symptoms—plays a crucial role in determining treatment outcomes. Psychiatric disorders often follow a chronic and relapsing course, adversely affecting interpersonal relationships, occupational functioning, and social integration [5]. As a result, clinical improvement alone may not fully capture the overall well-being of patients. Quality of life (QoL) has emerged as an important multidimensional outcome measure that reflects physical health, psychological state, social relationships, and functional capacity [6]. Assessment of QoL in psychiatric patients provides valuable insights into the broader impact of the illness and the effectiveness of therapeutic interventions beyond symptom control.

Medication non-adherence is a common and persistent problem in psychiatric care, with reported rates ranging from 20% to 60%, depending on the disorder and treatment setting [7]. Factors contributing to poor adherence include lack of insight into illness, fear of side effects, complex drug regimens, inadequate patient–provider communication, and social stigma. Non-adherence is associated with relapse, rehospitalization, increased healthcare costs, and poor long-term prognosis. Addressing these challenges requires a holistic approach that integrates patient education and counseling into routine clinical practice.

Patient counseling is a structured process aimed at improving patients' understanding of their illness, prescribed medications, expected benefits, potential side effects, and the importance of adherence [8]. Effective counseling can empower patients to actively participate in their treatment, enhance medication compliance, reduce anxiety related to therapy, and improve overall treatment satisfaction. In psychiatric disorders, counseling assumes even greater importance due to the chronic nature of illness and the frequent need for long-term pharmacotherapy. Evidence suggests that patient-centered counselling interventions can lead to better clinical outcomes and significant improvements in quality of life [9].

Despite the recognized importance of rational prescribing and patient counselling, there is limited real-world data assessing prescription patterns, clinical profiles, quality of life, and the therapeutic impact of counselling in psychiatric patients, particularly in tertiary care and hospital-based settings. Cross observational studies provide an effective means of evaluating current practices and identifying gaps in care delivery [10]. Such studies can generate evidence to support rational drug use, strengthen counselling strategies, and inform policy decisions aimed at improving mental healthcare services.

Materials and Methods

Study Design: This study was conducted as a cross-sectional observational study.

Study Place: The study was carried out in the **Department of Psychiatry, Civil Hospital, Rajkot, Gujarat**, a tertiary care government hospital catering to a large and diverse patient population from both urban and rural areas.

Study Duration: The duration of the study was **one year and six months**, during which data collection, patient assessment, counselling intervention, and outcome evaluation were systematically performed.

Study Population

The study population consisted of patients attending the psychiatry outpatient department (OPD) and those admitted to the psychiatry inpatient department (IPD) of Civil Hospital, Rajkot.

Sample Size: A total of **300 patients** diagnosed with psychiatric disorders were included in the study based on predefined inclusion and exclusion criteria.

Inclusion Criteria

- Patients aged **18 years and above**.
- Patients of either gender diagnosed with psychiatric disorders as per **ICD-10/DSM-5 criteria**.
- Patients receiving at least one psychotropic medication.
- Patients willing to participate and providing informed consent.

Exclusion Criteria

- Patients with severe cognitive impairment or acute psychotic agitation preventing effective communication.
- Patients with serious medical or neurological illnesses interfering with psychiatric assessment.
- Pregnant and lactating women.
- Patients unwilling to participate in the study.

Statistical Analysis:

Data were entered into Excel and subsequently analyzed using SPSS and GraphPad Prism. Continuous variables were summarized as means with standard deviations, while categorical variables were presented as counts and percentages. Comparisons between independent groups were performed using two-sample t-tests, and paired t-tests were applied for correlated (paired) data. Categorical data were compared using chi-square tests, with Fisher's exact test applied when

expected cell counts were small. A p-value of ≤ 0.05 was considered statistically significant.

TABLE

Table 1: Demographic Distribution of Study Participants (N = 300)

Variable	Category	Number (n)	Percentage (%)
Age (years)	18–30	92	30.7
	31–45	118	39.3
	>45	90	30.0
Gender	Male	176	58.7
	Female	124	41.3

Table 2: Distribution of Psychiatric Disorders

Diagnosis	Number (n)	Percentage (%)
Depression	98	32.7
Anxiety Disorders	74	24.7
Schizophrenia	56	18.7
Bipolar Disorder	42	14.0
Others	30	10.0

Table 3: Prescription Pattern of Psychotropic Drugs

Drug Class	Patients (n)	Percentage (%)
Antidepressants	164	54.7
Antipsychotics	128	42.7
Mood Stabilizers	76	25.3
Anxiolytics	110	36.7
Polypharmacy (>2 drugs)	182	60.7

Table 4: Quality of Life Scores Before and After Counselling

QoL Assessment	Mean Score ± SD	p-value
Before Counselling	48.6 ± 6.4	—
After Counselling	56.9 ± 7.1	**<0.001**

Table 5: Medication Adherence Before and After Counselling

Adherence Status	Before Counselling n (%)	After Counselling n (%)	p-value
Good Adherence	124 (41.3)	208 (69.3)	**<0.001**
Poor Adherence	176 (58.7)	92 (30.7)	

Figure 1: Prescription Pattern of Psychotropic Drugs

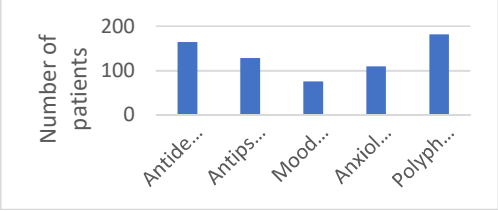
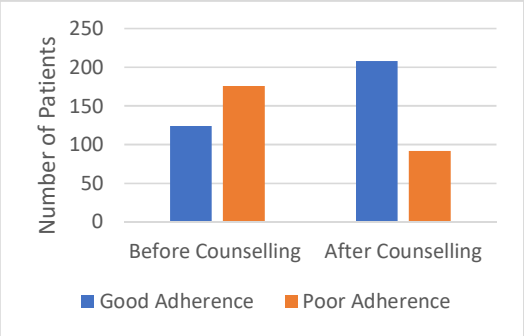


Figure 2: Medication Adherence Before and After Counselling



A total of 300 patients were included in the study. The demographic profile showed that the majority of participants belonged to the 31–45 years age group (39.3%), followed by 18–30 years (30.7%) and those above 45 years (30.0%). Males constituted a higher proportion of the study population (58.7%) compared to females (41.3%), indicating a male predominance among patients attending the psychiatric outpatient services.

Regarding the distribution of psychiatric disorders, depression was the most commonly diagnosed condition, observed in 98 patients (32.7%). Anxiety disorders were the second most frequent diagnosis, affecting 74 patients (24.7%). Schizophrenia accounted for 18.7% of cases, while bipolar disorder was diagnosed in 14.0% of patients. Other psychiatric conditions, including substance use disorders and miscellaneous diagnoses, constituted 10.0% of the study population.

Analysis of prescription patterns revealed that antidepressants were the most frequently prescribed class of psychotropic drugs, used in 54.7% of patients. Antipsychotics were prescribed to 42.7% of patients, reflecting their substantial use in psychotic and mood disorders. Anxiolytics were prescribed in 36.7% of cases, while mood stabilizers were used in 25.3% of patients. Notably, polypharmacy, defined as the use of more than two psychotropic drugs, was observed in 60.7% of patients, indicating a high prevalence of multiple drug use in psychiatric management.

Evaluation of quality of life (QoL) scores demonstrated a significant improvement following counselling. The mean QoL score increased from 48.6 ± 6.4 before counselling to 56.9 ± 7.1 after counselling, and this improvement was statistically highly significant ($p < 0.001$).

Similarly, medication adherence showed a marked improvement after counselling. Prior to counselling, good adherence was observed in only 41.3% of patients, while 58.7% exhibited poor adherence. After counselling, the proportion of patients with good adherence increased significantly to 69.3%, with a corresponding reduction in poor adherence to 30.7%. This change was statistically significant ($p < 0.001$),

highlighting the positive impact of counselling on treatment adherence.

DISCUSSION

The present study provides a comprehensive overview of the demographic characteristics, diagnostic profile, prescription patterns, and the impact of counselling on quality of life and medication adherence among psychiatric outpatients. The findings highlight several clinically relevant trends that are consistent with existing literature while also emphasizing the importance of psychosocial interventions alongside pharmacotherapy.

In this study, the majority of patients belonged to the economically productive age group of 31–45 years, followed closely by younger adults aged 18–30 years. This distribution is in agreement with previous studies reporting a higher burden of psychiatric morbidity in early and middle adulthood, a period often associated with occupational stress, family responsibilities, and social pressures [11,12]. The male predominance observed in the present study is similar to findings from several Indian hospital-based studies, which report higher male attendance in psychiatric outpatient departments. This may reflect gender-based differences in health-seeking behavior, sociocultural factors, and greater access of males to healthcare facilities, rather than a true difference in disease prevalence [13].

Depression emerged as the most common psychiatric diagnosis, followed by anxiety disorders. This pattern aligns with global and national epidemiological data identifying depressive and anxiety disorders as the leading contributors to the overall burden of mental illness [14]. The relatively high proportion of patients with schizophrenia and bipolar disorder indicates that tertiary care centers continue to manage a substantial number of patients with severe mental illnesses, often requiring long-term pharmacological treatment and regular follow-up [15]. The presence of other psychiatric conditions, including substance use disorders, further underscores the heterogeneous nature of patients attending psychiatric services.

The prescription pattern analysis revealed that antidepressants were the most commonly prescribed psychotropic drugs, reflecting the high prevalence of depressive and anxiety disorders in the study population. Similar trends have been reported in other prescription pattern studies conducted in psychiatric outpatient settings [16]. Antipsychotics were the second most frequently prescribed drug class, corresponding to the significant proportion of patients diagnosed with schizophrenia and bipolar disorder. The use of anxiolytics and mood stabilizers was also substantial, indicating their role as adjuncts in managing comorbid anxiety, mood instability, and acute symptom exacerbations.

A noteworthy finding of this study was the high prevalence of polypharmacy, observed in over 60% of patients. While polypharmacy is sometimes necessary for managing complex psychiatric conditions, it raises concerns regarding increased risk of adverse drug reactions, drug–drug interactions, higher treatment costs, and reduced medication adherence [17]. This finding highlights the need for regular prescription audits and rational use of psychotropic medications in clinical practice.

One of the most significant outcomes of the present study was the improvement in quality of life scores following counselling. The statistically significant increase in mean QoL scores after counselling emphasizes the positive role of psychoeducation and supportive counselling in psychiatric care. Counselling helps patients gain better insight into their illness, develop coping strategies, and improve social and occupational functioning, which collectively contribute to enhanced quality of life [18].

Similarly, medication adherence showed a marked and statistically significant improvement after counselling. Poor adherence is a well-recognized challenge in psychiatric practice and is associated with relapse, rehospitalization, and poor long-term outcomes [19]. The substantial increase in good adherence following counselling in this study reinforces the importance of patient education, addressing misconceptions about medications, and involving patients in shared decision-making. These findings are consistent with previous studies demonstrating that structured counselling and psychoeducation significantly improve adherence and treatment outcomes [20].

Overall, the findings of the present study underscore the importance of a holistic approach to psychiatric management, combining rational pharmacotherapy with counselling and psychosocial interventions. Such an integrated approach not only improves clinical outcomes but also enhances quality of life and treatment adherence, ultimately leading to better long-term prognosis for patients with psychiatric disorders.

CONCLUSION

the present study provides valuable insights into the demographic, clinical, and therapeutic patterns among patients attending psychiatric outpatient services and highlights the critical role of counselling in improving treatment outcomes. The predominance of patients in the economically productive age group and the higher representation of males reflect important trends in psychiatric morbidity and health-seeking behavior. Depression and anxiety disorders emerged as the most common diagnoses, indicating a substantial burden of common mental disorders in routine clinical

practice. The prescription pattern showed extensive use of antidepressants and antipsychotics, with a notable prevalence of polypharmacy, emphasizing the need for rational prescribing and regular prescription audits to minimize adverse effects and enhance treatment safety. Importantly, counselling interventions demonstrated a significant positive impact on quality of life and medication adherence. By improving insight, addressing misconceptions, and reducing fears related to treatment, counselling enhanced compliance and overall well-being. These findings strongly support the integration of structured counselling with pharmacological management to achieve holistic, patient-centered care and better long-term outcomes in psychiatric disorders.

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