

Evaluation of Psychiatric Patient Health-Related Quality of Life and Drug Prescribing Assessment

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Abstract. This study explores how psychiatric medicines are being used and how they relate to the day-to-day wellbeing of patients attending the psychiatry department of a civil hospital. To understand this, various patient-related factors were considered, including age, gender, body weight, addiction history, level of education, occupation, and socioeconomic background. In addition, the type of psychiatric diagnosis and the pattern of prescribed medications were carefully reviewed. The core purpose of the study was to assess both the health-related quality of life of psychiatric patients and the appropriateness of the drug prescribing practices used in their treatment. This investigation was carried out over a span of 18 months in the Department of Psychiatry at Civil Hospital, Rajkot. Patients meeting the predefined inclusion criteria were systematically enrolled into the study. Each participant was then categorized according to their clinical diagnosis, age, body weight, gender, educational background, and socioeconomic status. Alongside this classification, their health-related quality of life was carefully evaluated to understand how these factors influenced their overall wellbeing. Information was gathered from a total of three hundred patients. Among them, one hundred eighty-five (61.62%) were women and one hundred fifteen (38.38%) were men. In terms of clinical diagnosis, schizophrenia emerged as the most common condition, affecting 45.48% of the study population, followed by anxiety disorders at 19.25%. Reflecting these patterns, antipsychotic medications were the most frequently prescribed (60%), with anxiolytic drugs also widely used, accounting for 40% of the prescriptions. This study provides a polaroid of how medicines are used in psychiatric care and how these treatments relate to patients' day-to-day wellbeing. To build this picture, a range of patient characteristics were examined, including age, gender, body weight, history of addiction, level of education, occupation, and socioeconomic background. In addition, the specific psychiatric diagnoses and the details of the prescribed drug regimens were carefully reviewed, allowing an integrated assessment of both drug utilization patterns and health-related quality of life in this population.

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1 Introduction

Psychiatric disorders are brain-based conditions that deeply reshape how individuals think, feel, and interact with the world. While every era has acknowledged these painful departures from mental wellness, the explanations have evolved dramatically—from ancient beliefs in demonic possession to modern understanding of neurochemical imbalances. [1,2] Today's diagnostic systems, such as the DSM-5, organize these conditions into distinct categories of behavioural and cognitive syndromes, each reflecting specific changes in brain function. Perhaps most tragically, those living with mental disorders carry a heavy burden: their lives are shortened by 10 to 15 years on average compared to the general population. [3]

Psychological disorders arise from a complex blend of factors that scientists are still working to fully understand. These disorders often result from an interplay between genetic vulnerability and life experiences, such as childhood adversity, chronic stress, medical illnesses, prenatal exposures, and disruptions in brain chemistry. [4,5] No single cause dominates; instead, each person's condition reflects a unique combination of inherited traits and environmental influences. To guide diagnosis and treatment worldwide, mental health professionals rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which classifies mental illnesses into categories based on symptoms and their impact on daily functioning. [4] Among these are anxiety disorders, marked by excessive fear and worry; mood disorders, which affect emotional regulation and energy; psychotic disorders, characterized by hallucinations and delusions; and neurodevelopmental disorders, which begin early in life due to differences in brain development. Importantly, while psychiatric conditions such as depression may come and go and often respond to therapy or medication, neurodevelopmental disorders like autism or ADHD are lifelong patterns requiring supportive approaches focused on adaptation and strengths. Understanding these differences is crucial for providing appropriate care tailored to everyone's needs. [6,7]

Health-related quality of life (HRQoL) captures something deeply personal yet scientifically vital: how patients truly experience their daily existence beyond clinical symptoms. This multidimensional concept weaves together the physical and emotional toll of symptoms, medication side effects, and functional abilities across life's many domains—ultimately reflecting one's sense of happiness and overall well-being. Unlike standard of living, which can be measured through income or housing, quality of life is inherently subjective, residing in the individual's perception of their own fulfilment and wellness. In mental health care, understanding HRQoL has become essential, as psychiatric conditions profoundly shape how people navigate relationships, work, and self-care. The present study seeks to illuminate these connections by examining prescription patterns of antipsychotic medications while exploring how various socioeconomic circumstances influence the quality of life among individuals living with psychiatric disorders. [8,9]

2 Materials and methods

Over a span of 18 months, an observational investigation was undertaken in the Department of Psychiatry at P.D.U. College, situated within the Civil Hospital campus in Rajkot, Gujarat, to systematically explore real-world prescribing practices and patient outcomes. The study received prior approval from the Institutional Ethics Committee for Human Research (approval no. ECR/259/Indt/GJ/2016/RR-21), ensuring that all procedures met established ethical standards for work involving human participants. A total of 300 individuals diagnosed with various psychiatric conditions were enrolled, allowing the

researchers to map patterns in antipsychotic and other psychotropic drug use across different diagnostic categories while simultaneously evaluating the extent to which these illnesses and their treatments impaired patients' health-related quality of life.

In this study, adults over 18 who were living with psychiatric conditions and seeking care either as outpatients or as inpatients in the psychiatric ward were invited to participate—provided they gave their informed consent. Those who chose not to take part, along with pregnant women (who were excluded for safety and ethical reasons), were respectfully left out of the research. For every participant who joined, a carefully designed data collection form captured their personal and clinical story: basic demographics, medical and psychiatric history, specific diagnosis, and the treatment plan prescribed by their care team. To understand how these illnesses and treatments affected their daily well-being, the study used the Short Form-12 (SF-12) questionnaire—a trusted tool that measures health-related quality of life from the patient's own perspective. [10]

3 Statistical Analysis

In this study, all quantitative data were presented as percentages or means with standard deviations to clearly convey central tendencies and variability. Categorical data were summarized by medians and analysed using appropriate non-parametric tests, such as the independent t-test, to account for data distribution characteristics. Visual aids, including graphs, were employed to enhance comprehension and interpretation of the results. Statistical significance was determined at a p-value threshold of ≤ 0.05 , ensuring robust evaluation of the findings.

4 Results

During the span of the study a total of 300 patient were enrolled. The cohort was predominantly female (61.62%), with males comprising the remaining 38.38%. Age distribution revealed that most participants fell within the 26–40 years age group (54.2%), followed by the 41–60 years group (25.8%) and the 18–25 years group (20%). Comorbidity assessment identified that 30.15% of patients (n=40) presented with hypertension and/or diabetes mellitus alongside depression. Additionally, 15.10% (n=30) reported a history of suicidal ideation, while 20.18% (n=28) had a positive family history of psychiatric illness, often accompanied by family trauma. Substance use analysis showed that 32.24% were addicted to tobacco, 23.18% to alcohol, and 10.29% had other addictions including smoking, tea, or coffee. A notable 34.29% reported no addictive behaviours. Educational attainment varied considerably: 36.25% had completed primary education, 25.12% had achieved higher education, and 18.6% were illiterate. Regarding occupation, farming was most prevalent (32.10%, n=45), followed by elementary occupations such as clerical work (25.80%, n=38). The remaining 20.3% were engaged in other occupations.

The medical diagnosis of the patients revealed a range of psychiatric disorders. Among these, schizophrenia was the most observed condition, followed by anxiety disorders, bipolar disorder, and alcohol use disorder. Other psychiatric illnesses identified in smaller proportions included mania, intellectual disability, nicotine use disorder, and obsessive-compulsive disorder, which collectively represented a minor portion of the total sample. Overall, the number of female patients exceeded that of males, and schizophrenia was predominantly diagnosed among female participants.

Quality of life (QoL) was assessed using the SF-12 questionnaire. The overall mean Physical Component Summary (PCS) score was 33.98, while the mean Mental Component Summary (MCS) score was 36.56. Statistical analysis demonstrated a significant correlation between PCS and MCS scores ($P < 0.05$). The mean PCS and MCS scores among female patients were 33.99 ± 6.40 and 36.18 ± 7.43 , respectively. When compared across subgroups, variations in QoL were noted with respect to age, tobacco and alcohol addiction, educational status, and occupation. Patients engaged in farming or unemployed individuals exhibited notable differences in both PCS and MCS values, as summarized in Table 1.

Table 1: Demographics and Socio-Economic Factors with Short Form-12

Factors	N	%	PCS		MCS	
Demographics						
Gender						
M	115	38.38	34.30 ± 6.55	0.9662	35.99 ± 7.64	0.896
F	185	61.62	33.99 ± 6.40		36.18 ± 7.43	
Age						
18-25	60	20	34.18 ± 6.44	0.9983	36.09 ± 7.50	0.9949
26-40	163	54.2	33.99 ± 6.48		36.47 ± 7.21	
41-60	77	25.8	34.55 ± 6.30		35.94 ± 7.54	
Social History						
Addiction						
Tobacco	97	32.24	34.19 ± 6.68	0.9985	36.62 ± 7.65	0.9945
Alcohol	70	23.18	34.29 ± 6.36		36.07 ± 7.86	
Other Addiction	31	10.29	34.82 ± 6.41		35.85 ± 7.53	
No Addiction	103	34.29	34.47 ± 6.30		35.91 ± 7.50	
Education						
Primary	109	36.25	34.04 ± 6.46	0.995	36.11 ± 7.43	0.9945
Secondary	75	25.12	34.12 ± 6.46		35.90 ± 7.59	
Illiterate	56	18.6	34.40 ± 6.51		36.40 ± 7.14	
Others	60	20.03	33.61 ± 6.22		36.09 ± 7.43	
Occupation						
Agriculture	74	24.72	34.03 ± 6.48	0.9778	36.62 ± 7.67	0.9742
Elementary	58	19.35	34.45 ± 6.16		36.01 ± 7.58	
Unemployed	75	24.83	34.03 ± 6.55		36.07 ± 7.15	
Others	93	31.1	34.29 ± 6.26		35.50 ± 7.56	
Schizophrenia	136	45.48	33.98 ± 6.53	0.9909	36.56 ± 7.55	0.998
Anxiety	58	19.25	34.06 ± 6.50		36.45 ± 7.70	
Alcohol Use Disorder	19	6.37	33.69 ± 6.47		35.77 ± 7.20	

Bipolar Disorder	33	10.9	34.00 ± 6.69		35.45 ± 7.35	
Others	54	18	34.01 ± 6.85		36.24 ± 7.42	

In the present study, lorazepam emerged as the most frequently prescribed medication, followed by trihexyphenidyl, fluoxetine, olanzapine, diazepam, and clonazepam. Among the antipsychotic category, atypical antipsychotics such as olanzapine, clozapine, amisulpride, risperidone, quetiapine, aripiprazole, ziprasidone, and paliperidone were predominantly prescribed, whereas typical antipsychotic agents including haloperidol, chlorpromazine, and fluphenazine were used less frequently. The distribution of these prescriptions is represented in Table 2 and Fig. 1.

In addition to psychotropic drugs, a substantial proportion of patients were also prescribed adjuvant medications. Multivitamins were the most common (55.50%, n=70), followed by proton pump inhibitors (n=55), analgesics (n=38), laxatives (n=34), and antibiotics (n=21). Most antipsychotic medications were indicated for the management of schizophrenia, followed by bipolar affective disorder, as illustrated in Fig. 1.

Table 2: Prescribed Medications

Drug name	(N)	Drug Percentage (%) proportion
Antipsychotic Agents		
Atypical antipsychotic Drug:	180	60%
olanzapine		
clozapine		
amisulpride		
risperidone		
quetiapine		
aripiprazole		
ziprasidone		
paliperidone		
Typical antipsychotic Drug:	130	43.33%
haloperidol		
chlorpromazine		
fluphenazine		
Anti-Depressants – SSRIs		

citalopram	65	21.9%
fluoxetine	80	26.7%
sertraline	50	16.5%
paroxetine	40	13.33%
Anxiolytics Drugs		
benzodiazepine	25	8.33%
lorazepam	120	40%
diazepam	50	16.8%
clonazepam	30	10%
Anticholinergic Drug		
trihexiphenidyl	110	36.7%

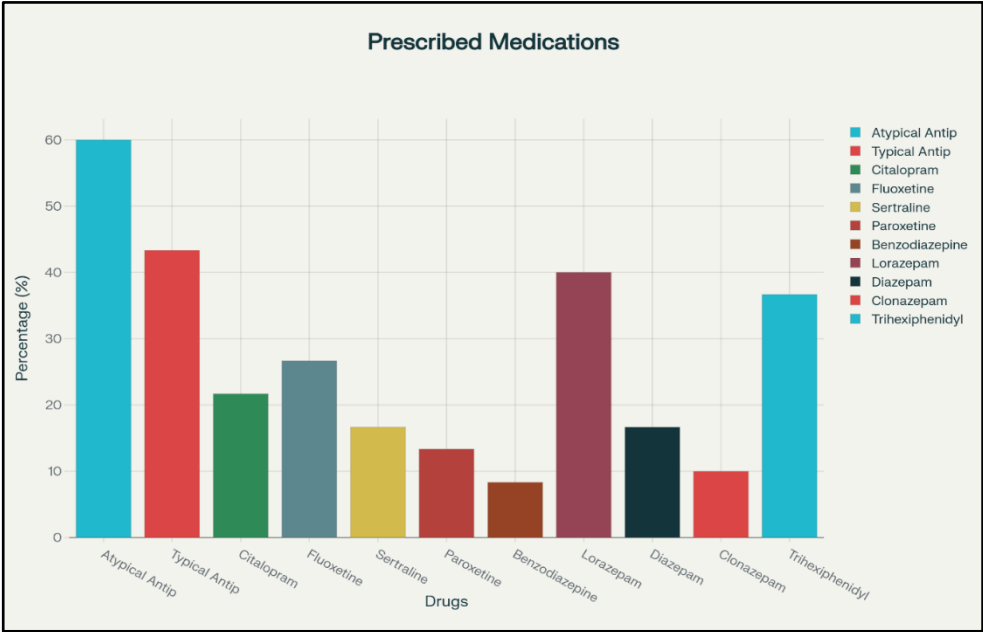


Fig. 1 Prescribed Medications in Psychiatric Patients.

In patients diagnosed with schizophrenia, trihexyphenidyl was the most frequently prescribed medication (30.9%), followed by lorazepam (28.9%), amisulpride, olanzapine, risperidone, fluoxetine, and citalopram. For those with bipolar disorder, lorazepam was the most prescribed drug (35%), followed by olanzapine (25%), trihexyphenidyl (18%), risperidone, fluoxetine, and amisulpride. Among patients with anxiety disorders, lorazepam accounted for the highest prescription rate (48.9%), followed by citalopram (35.05%), while other drugs such as olanzapine, risperidone, fluoxetine, haloperidol, and trihexyphenidyl were used less frequently.

5 Discussion

In this study of 300 adults receiving psychiatric care paints a portrait of a predominantly female cohort navigating severe mental illness during their prime working years. Most participants—61.62%—fell between 26 and 40 years old, with a mean age of 33.99 ± 6.48 years, aligning closely with prior reports from comparable settings. Medical comorbidities like hypertension and diabetes were uncommon, yet psychosocial adversity ran deep: several patients disclosed past suicidal ideation and family trauma. Substance use was nearly ubiquitous, with tobacco leading, followed by alcohol and other agents; remarkably, 34.29% reported no addiction history at all. The rural footprint shaped livelihoods, as farming-related work predominated, trailed by clerical and manual labour occupations—a pattern echoing *Koshy B. et al.* [11] Education levels varied, with most having completed primary schooling, some secondary, and a few remaining illiterate.

Quality-of-life assessment revealed a striking paradox: SF-12 physical component impairment significantly outpaced mental component impairment. This likely reflects the reality of welfare settings where patients manage daily activities independently amid caretaker shortages, compounded by psychiatric symptoms that hinder physical functioning.

Schizophrenia dominated diagnostic profiles, followed by bipolar disorder and anxiety disorders—findings that mirror *Lahon K et al.* [12], who also noted peak antipsychotic prescribing among adults aged 21–40 years, particularly for women. Treatment patterns reflected contemporary practice: atypical antipsychotics predominated, with olanzapine and risperidone leading the pack, while haloperidol remained the most prescribed typical agent. Adjunctive classes included benzodiazepines, SSRIs (citalopram and fluoxetine most common), multivitamins, anticholinergics, and symptom-targeted medications like pantoprazole, laxatives, and antibiotics. Disease-specific prescribing showed nuanced strategies: schizophrenia management frequently combined trihexyphenidyl, lorazepam, and amisulpride; anxiety treatment leaned on lorazepam and citalopram; bipolar disorder care featured lorazepam and olanzapine; and alcohol use disorder protocols employed lorazepam, olanzapine, and risperidone.

Perhaps most surprisingly, HRQoL did not differ significantly across gender, age, addiction status, education, or occupation. Rather than suggesting absence of disparity, this indicates psychiatric illness exerts a uniformly devastating impact across all socioeconomic strata—a sobering reminder that in this context, the disease itself is the great equalizer.

6 Limitations

This study's insights emerge from a specific context that shapes their interpretation. Conducted at a single tertiary care hospital in western India, the findings reflect the realities of that setting and may not extend to urban centres, primary care clinics, or other regions with different resource configurations and population characteristics. The reliance on caretaker responses—essential for capturing functional status and treatment adherence in this psychiatric cohort—introduced gaps where caretakers were unavailable or unable to participate, potentially skewing the data toward patients with more engaged support systems. Future research spanning multiple sites, longer durations, and larger cohorts would strengthen the evidence base and clarify how these findings translate across India's diverse mental health landscape.

7 Conclusion

This study offers a window into real-world psychiatric care, mapping medication patterns and quality-of-life burdens among patients seeking help at a tertiary hospital. The data reveal a patient population that is predominantly female, middle-aged, and educated at least through primary school, with a notable proportion free from addiction. Schizophrenia emerged as the most common diagnosis, while lorazepam, trihexyphenidyl, olanzapine, and risperidone anchored the pharmacologic response. Quality-of-life assessment uncovered a critical imbalance: although both physical and mental components were impaired, the physical domain suffered more severely, creating tangible obstacles to daily functioning. Surprisingly, the urban setting appeared to blunt the influence of socioeconomic and demographic factors—gender, age, education, and occupation did not significantly modify outcomes. This suggests that in this context, the illness itself, rather than social position, drives the burden of disease, highlighting the need for interventions that prioritize functional restoration alongside symptom control.

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9 Conflict of interest

The authors declare that there is no conflict of interest.

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