

Patients' Experience and Satisfaction with Psychosocial Intervention Clinic of Government Medical College and Hospital Chandigarh

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ABSTRACT

Background: Patient satisfaction with mental health services is increasingly being studied because it is a good predictor of quality in service delivery and individual healthcare. Patients who are satisfied with the effectiveness of interventions are more likely to comply with treatment and take advantage of services

Objectives: To assess the patient's experience and satisfaction with psychosocial intervention (PSI) clinic. To assess the unmet needs of the patients currently attending psychosocial intervention clinic. To assess the level of functioning of the patients attending psychosocial intervention clinic. To assess the quality of life of the patients attending psychosocial intervention clinic. **Materials & Methods:** The study sample includes 50 patients who have received at least 3 sessions from Psychosocial Intervention Clinic in the last 6 months. The study design was cross sectional. Instruments used in this study were socio-demographic and clinical data sheet, socio-demographic schedule for caregiver, patient satisfaction scale, psychosocial intervention needs checklist, global assessment of functioning, and World Health Organization quality of life-BREF. **Result:** Patients at the PSI clinic had diverse psychosocial needs, which were effectively addressed. They reported high satisfaction, particularly in trust and communication. Their functioning across various domains improved significantly, indicating positive outcomes from psychosocial intervention. **Conclusions:** The findings underline the pivotal role of psychosocial intervention in addressing the multifaceted needs of patients with mental illness. High satisfaction levels and improved functioning across domains reflect the positive impact of such interventions, emphasizing their importance in enhancing quality of life and overall well-being.

Keywords: Psychosocial intervention, needs, quality of life, occupational functioning.

INTRODUCTION

Mental health is a state of well-being enabling individuals to handle life's stressors, realize their capabilities, study, work effectively, and contribute to their community. It is essential for personal, social, and economic development and is a fundamental human right. Mental health goes beyond the absence of mental illness and exists on a complex continuum, experienced differently by individuals, with varying difficulties, suffering, and outcomes. Mental health problems include mental illnesses, psychosocial impairments, or conditions causing suffering, functional difficulties, or self-harm risk. People with mental health disorders often report poor psychological well-being (Saraceno, 2002).

Mental illness refers to cognitive, behavioural, or emotional deficits significantly impacting functioning, daily activities, and quality of life (QOL). QOL is defined as a person's overall life satisfaction and perception of living the life they want, emphasizing physical, emotional, and social well-being. The subjective appraisal of life satisfaction is central, though it can also be assessed objectively via income, education, and health status (Alemu et al., 2023). Patients with mental illness may need assistance in assessing their QOL due to symptoms and poor insight into their condition.

Psychosocial Interventions (PSI) are a key part of managing mental and substance abuse disorders. At the Department of Psychiatry, Government Medical College and Hospital, Chandigarh, a multidisciplinary team approach is employed, where psychiatric social work (PSW) plays a vital role in care, treatment, and

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rehabilitation. An OPD-based Psychosocial Intervention Clinic has functioned since 2016, alongside other PSI programs (Dangroo et al., 2020). Psychosocial interventions address psychological and social factors affecting mental health and can be applied in clinical, community, school, and workplace settings (Mathias et al., 2021).

Patient satisfaction is a reliable indicator of service quality and individual healthcare experience. Over the past two decades, studying patient satisfaction in health services has gained importance. Satisfied patients are more likely to adhere to treatment and utilize available resources effectively. High satisfaction improves patient engagement in mental health services (MHS) and supports recovery. However, satisfaction in mental health care is complex due to varied and multiple patient needs. It has become central to healthcare reforms aimed at improving system quality (Fortinet et al., 2018).

Psychosocial interventions tailor treatment to individual needs and circumstances, which fosters patients feeling understood and supported. Therapists provide empathy, creating a non-judgmental environment for patients to express thoughts and emotions. Empathy and emotional support significantly enhance patient satisfaction. Collaboration and shared decision-making further empower patients in their recovery process (Waldron & Turner, 2008).

A crucial aspect of psychosocial intervention is the role of family, friends, and support groups in creating a stable, supportive environment. These networks provide understanding, encouragement, and motivation for recovery. Relapse prevention strategies are embedded in psychosocial interventions, equipping patients with tools to identify triggers, manage them, develop coping strategies, and avoid relapse. These strategies enhance self-efficacy and empower patients to regain control over their lives (Priebe & Miglietta, 2019).

Patient satisfaction and experience are globally accepted measures of health service performance and overall quality of care. Prioritizing patient experience in quality assessment ensures that services remain responsive, acceptable, and appropriate to patient needs (Webster et al., 2012). This approach ultimately supports improved adherence, better treatment outcomes, and continued patient engagement in mental health care.

OBJECTIVES

- To assess the patient's experience and satisfaction with psychosocial intervention clinic
- To assess the unmet needs of the patients currently attending psychosocial intervention clinic
- Level of functioning of the patients attending psychosocial intervention clinic
- To assess the quality of life of the patients attending psychosocial intervention clinic

MATERIAL AND METHODS

Research Design: The study was cross-sectional

Setting: Study was conducted at Psychosocial Intervention Clinic (PSI) at the Outpatient Department (OPD) of the Department of Psychiatry, Government Medical College & Hospital, Chandigarh.

Population: Any patient taking services from the Psychosocial Intervention Clinic and has received at least 3 sessions in last 6 months. Total 50 Consecutive participants were included.

Inclusion Criteria

- Patients diagnosed with any mental illness as per the ICD-10 (World Health Organization, 1993).
- Age between 18-60 years.
- Taking services from the Psychosocial Intervention clinic and has received at least 3 Sessions within 6 months.
- Clinically stable patients (clinical stability was defined as the absence or exacerbation of illness requiring an increase in dose by >50% in the last 3 month) (Lobana, A et al., 2002).

Exclusion criteria

- Patients having any significant and unstable physical illness or disability

TOOLS

1. **Socio-demographic and Clinical Data Sheet:** A semi-structured proforma recording patient registration number, age, sex, diagnosis, family history, caregiver details (age, sex, relationship, education, marital status, occupation, income, family size/type, domicile, religion), age of onset, illness and treatment duration, hospitalizations, side effects, and symptoms.
2. **Patient Satisfaction Scale (PAT-SAT):** Consists of 19 items across six domains – trust, communication, idea exploration, body language, active listening, and miscellaneous – rated on a 5-point Likert scale (strongly agree to strongly disagree). Easy to use without prior training, readable by low-education patients, translated into Hindi, and validated in Indian settings (Hansen et al., 2010).
3. **Psychosocial Intervention Needs Checklist:** Based on WHO framework and three tools: Camberwell Assessment of Need – Research (CAN-R) (Phelan & Slade, 1995), Supplementary Assessment of Need Scale (SNAS) (Neogi et al., 2016), and Screening Tool for Psychosocial Problems (STAPP) (Sahu et al., 2019). Identifies 18 areas of psychosocial dysfunction requiring intervention.
4. **Global Assessment of Functioning (GAF):** A 100-point scale divided into 10-point intervals describing symptoms and functioning, measuring overall psychological, social, and occupational functioning. Axis V of DSM-IV-TR (Spitzer, 1997).
5. **WHO Quality of Life-BREF (WHOQOL-BREF):** A 26-item, self-administered scale measuring physical health, psychological health, social relationships, and environment. Developed cross-culturally, available in Hindi and widely used for mental illness (WHOQOL Group, 1998).

Procedure: Firstly, ethical clearance was obtained from the institutional ethical committee. Subsequently, the list of patients attending the Psychosocial Intervention Clinic was scrutinized for inclusion in the study. Consent forms were presented in Hindi, English, or Punjabi, and then socio-demographic and clinical profiles were collected. Following this, participants underwent assessments using various scales, including the Patient Satisfaction Scale, Psychosocial Intervention Needs Checklist, Global Assessment of Functioning (GAF) scale, and World Health Organization Quality of Life-BREF.

Statistical Analysis: Statistical Package for the Social Sciences version sixteen (SPSS 16). Descriptive statistics mean and percentage were used.

RESULTS

Table 1: Socio-demographic Profile of the Patients (n=50)

Variable	Variable category	Mean $\pm$ SD/ f (%)
Age (18 – 60 years)		34.10 $\pm$ 1.02
Sex	Male	23 (46)
	Female	26 (52)
Marital Status	Single	14 (28)
	Married	33 (66)
	Widow	1 (2)
	Widower	1 (2)
	Divorced	1 (2)
	Separated	1 (2)
Education	Illiterate	2 (4)
	Primary	5 (10)
	Middle	3 (6)
	Matric	10 (20)
	Inter/Diploma	8 (16)

	Graduation	16 (32)
	Post Graduate	6 (12)
Occupation	Professional	7 (14)
	Semi professional	3 (6)
	Commercial shop owners	5 (10)
	Skilled/Semi-skilled/un-skilled worker	3 (6)
	House wife/house hold	20 (40)
	Unemployed/student	12 (24)
Family Income	0-10000	18 (36)
	10001- 20,000	18 (36)
	20,001-30,000	11 (22)
	30,001 & above	3 (6)
Religion	Hindu	35 (70)
	Islam	14 (28)
	Sikh	1 (2)
Family type	Nuclear	24 (48)
	Joint	25 (50)
	Extended	1 (2)
Locality	Urban	00 (00)
	Rural	28 (56)
	Semi urban	22 (44)
Permanent Resident	Punjab	21 (42)
	Haryana	7 (14)
	Chandigarh	16 (32)
	Himachal Pradesh	4 (8)
	Others	2 (4)
Language	Hindi	36 (72)
	Punjabi	4 (8)
	English	10 (20)

Table 1 summarizes the socio-demographic characteristics of the participants. The mean age was 34.10 ± 1.02 years. A slight majority were female (52%). Most were married (66%), and 28% were single. Regarding education, most participants were educated, with 32% graduates and 12% postgraduates. Occupationally, 40% were household workers, followed by 24% unemployed/students and 14% professionals. Monthly family income was below ₹10,000 for 36% of participants. Most belonged to the Hindu religion (70%), followed by Sikh (28%). Nearly half belonged to nuclear families (48%). The majority lived in rural areas (56%), with most residing in Punjab (42%) and Chandigarh (32%). Hindi (72%) was the most commonly spoken language.

Table 2 Socio-Demographic profile for Caregiver (n=50)

Variable	Variable category	Mean $\pm$ SD/ f (%)
Reliability of the information	Good	50 (100)
	Poor	00 (00)
	Doubtful	00 (00)
	Others	00 (00)

Relationship with Patient	Parents	20 (40)
	Spouse	26 (52)
	Sibling	2 (4)
	Offspring	2 (4)
Age	Age of caregiver	44.94± 13.12
Sex	Male	33 (66)
	Female	17 (34)
Marital Status	Married	44 (88)
	Unmarried	3 (6)
	Widow/Widower	3 (6)
	Divorced	00 (00)
	Separated	00 (00)
	Others	00 (00)
Education	Illiterate	4 (8)
	Primary	3 (6)
	Middle	2 (4)
	Matric	8 (16)
	Inter/Diploma	13 (26)
	Graduate	17 (34)
	Post Graduate	3 (6)
Occupation	Professional	36 (72)
	Semi-Professional	9 (18)
	Clerical/Shop owner/Farmer	9 (18)
	Skilled/Semi-skilled/un-skilled worker	2 (4)
	Housewife/household	15 (30)
	Retired	00 (00)
	Unemployed/Student	1 (2)
Language	Hindi	41 (82)
	Punjabi	5 (10)
	Urdu	00 (00)
	English	4 (8)

Table 2 shows the socio-demographic profile of caregivers included in the study. All caregivers provided good-quality information (100%). Most were spouses (52%) or parents (40%), while siblings (4%) and offspring (4%) formed the rest. The mean age was 44.94 ± 13.12 years. The majority were male (66%) and married (88%), with 6% unmarried and 6% widowed/widowers.

Regarding education, caregivers were mostly graduates (34%), followed by intermediate/diploma holders (26%), matric (16%), primary (6%), illiterate (8%), middle (4%), and postgraduates (6%). In terms of occupation, most were professionals (72%), followed by semi-professionals (18%), clerical/shop owners/farmers (18%), household workers (30%), and skilled/semi-skilled/unskilled workers (4%). The majority spoke Hindi (82%), followed by Punjabi (10%) and English (8%).

Table 3: Clinical profile of patient (n=50)

Variable	Variable category	Mean $\pm$ SD/ f (%)
Duration of illness	1-3 Months	1 (2)
	4-6 Months	10 (20)
	6- 12 Months	8 (16)
	1-2 Years	14 (28)
	2-5 Years	11 (22)
	10 Years	3 (6)
	More than 10 years	3 (6)
Duration of Treatment	1-3 Months	1 (2)
	4-6 Months	12 (24)
	6- 12 Months	7 (14)
	1-2 Years	13 (26)
	2-5 Years	11 (22)
	5-10Years	4 (8)
	More than 10 years	2 (4)
Referred From	Direct	48 (96)
	Relative	2 (4)
Age of onset	Abrupt	00 (00)
	Acute	00 (00)
	Sub-acute	00 (00)
	Insidious	50 (100)
Course of illness	Continues	8 (16)
	Episodic	30 (60)
	Remitted	12 (24)
Progress of illness	Improving	39 (78)
	Deteriorating	1 (2)
	Fluctuating	10 (20)
No of hospitalization		0.480 $\pm$ 1.19
Hospitalization in last one year		180 $\pm$ 560
Current ongoing Treatment	Yes	49 (98)
	No	1 (2)
> 50% Change in Medicine	Yes	00 (00)
	No	50 (100)
Family History of Psychiatric Illness	Yes	8 (16)
	No	42 (84)
Any Medico-Legal Issue's	Yes	2 (4)
	No	48 (98)
Diagnosis	F10-19	2 (4)
	F20-29	6 (12)
	F30-39	21 (42)

	F40-49	19 (36)
	F50-59	1 (2)
	F60-69	1 (2)

Table 3 shows the clinical details of patients. The percentage of the duration of illness was 1-3 months (2%), 4-6 months (20%) 6-12months (16%), 1-2 years (28%), 2-5 years (22%), 10 years (8%) and more than 10 years (6%). The percentage of the duration of illness treatment was 1-3 months (2%), and 4-6 months (24%).6-12 months (14%), 1-2 years (26%) 2-5 years (22%), 10 years (8%), and more than 10 years (4%). The patient was referred to direct (96%) and relative (4%). They all have an insidious onset. The course of illness of patients continued were (16%), episodic (60%), remitted (24%). Majority were progress of illness improved (78%), deteriorating (2%), and fluctuating (20%). The mean and standard deviation of the hospitalization was 0.480 ± 1.19 and the number of hospitalizations in one year was $.180 \pm 560$. Majority of the patients were on treatment (98%) They all didn't 50% change in medicine in the last 6 months and all were on psycho-social treatment. The majority of the family did not history of psychiatric illness (84%) and the history of psychiatric illness in the family (16%), any medico-legal issues in the family (2%). Diagnosed patients F10-19 (4%), F20-29 (12%), F30-39 (42%), F40-49 (36%), F50-59 (2%), and F60-69 (2%)

Table 4 Patient's Satisfaction (n=50)

Variable category	Mean $\pm$ SD/f (%)
Trust	12.84 $\pm$ 1.59
Communication	13.20 $\pm$ 1.86
Exploration of ideas/Options	8.86 $\pm$ 1.24
Body Language	8.48 $\pm$ 1.16
Active Listening	17.06 $\pm$ 2.57
Miscellaneous	21.56 $\pm$ 2.42

Table 4 shows that the mean of PAT-SAT scores in all 6 subcategories i.e. trust, communication, exploration of ideas, body language, active listening, and miscellaneous respectively, represents trust, 12.84 $\pm$ 1.59 communication, 13.20 $\pm$ 1.86 exploration of ideas, 8.86 $\pm$ 1.24, body language, 8.48 $\pm$ 1.16, active listening, 17.06 $\pm$ 2.57 and miscellaneous 21.56 $\pm$ 2.42.

Table 5 shows there were certain areas of high unmet psychotic symptoms (84%), crisis management (60%), stigma (54%), employment (52%), expressed emotion (52%), physical health (48%), flexible job timing(46%), conflicts (includes property & family) (38%), treatment compliance (36%), activities of daily living (34%), abuse, emotional/physical/sexual (34%), intimate relationships (32%), free treatment (30%), social support (26%), tax benefits (26%), medical reimbursement (26%), reservation in job (25%), daytime activities (22%), sexual expression (20%), travel concession(20%), alcohol(18%), company(18%), information on condition & treatment (18%), safety to self(16%), more time from clinicians (14%), drugs (14%), benefits(social assistance) (14%). childcare (12%), self-care (12%), religious/spiritual need (12%), Less unmet needs were reported in the areas of money management (10%), safety to others (10%), availability of finical recourses (10%), advanced directive (10%). Insurance (8%), certification (8%), looking after the home(6%), transport(6%), home visit (6%), basic education (4%), legal aid (4%), nominated representative(4%), food (2%), accommodation (2%).

Table: 5 Unmet Psychosocial Intervention Needs

Variable	Yes	No
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Basic	Food & Accommodation	02 (04)	48 (96)
	Daytime Activities	11 (22)	39 (78)
Health	Physical health	24 (48)	26 (52)
	Psychotic symptoms	42 (84)	8 (16)
	Treatment compliance	18 (36)	32 (64)
	More time from clinicians	07 (14)	43 (86)
	Crisis management	30 (60)	20 (40)
	Psychological distress	42 (84)	16 (32)
	Safety to others	05 (10)	45 (90)
	Safety to self	08 (16)	42 (84)
	Alcohol	09 (18)	41 (82)
	Drugs	07 (14)	43 (86)
	Abuse (emotional/physical/sexual)	17 (34)	33 (66)
Social	Company	09 (18)	41 (82)
	Intimate relationships	16 (32)	34 (68)
	Social support	13 (26)	37 (74)
	Sexual expression	10 (20)	40 (80)
	Self-help (SHG, club, society)	00 (00)	50 (100)
	Religious/spiritual need	06 (12)	44 (88)
	Caregivers stress help	28 (56)	22 (44)
	Expressed emotion	26 (52)	24 (48)
	Stigma	27 (54)	23 (46)
	Conflicts (includes property & family)	19 (38)	31 (62)
Functioning	Looking after the home & Childcare	03 (06)	47 (94)
	Self-care	06 (12)	44 (88)
	Basic education	02 (04)	48 (96)
	Money management	05 (10)	45 (90)
	Availability of financial resources	05 (10)	45 (90)
	Activities of Daily Living	17 (34)	33 (66)
	Flexible job timing	23 (46)	27 (54)
	Vocational training	22 (44)	28 (56)
	Employment	26 (52)	24 (48)
Service	Information on Condition & Treatment	09 (18)	41 (82)
	Telephone & Transport	03 (06)	47 (94)
	Insurance	04 (08)	46 (92)
	Benefits (social assistance)	07 (14)	43 (86)
	Certification	04 (08)	46 (92)
	Reservation in job	25 (50)	25 (50)
	Tax benefits	13 (26)	37 (74)
	Travel concession	10 (20)	40 (80)
	Free treatment	15 (30)	35 (70)
	Medical reimbursement	13 (26)	37 (74)
	Legal aid	02 (04)	48 (96)

	Nominated representative	02 (04)	48 (96)
	Home Visit	03 (06)	47 (94)
	Advanced Directive	05 (10)	45 (90)

Table 6 Global assessment of functioning Scale of sample (n=50)

Variable	Category Variable	Mean $\pm$ SD/ f (%)
GAF	Global Assessment of Functioning	80.22 $\pm$ 8.15

Table 6 shows the GAF scale ranking a patient from zero to a hundred and all patient Mean & SD scores was 80.22 $\pm$ 8.15 which is adequate.

Table-7 Patient's Quality of Life (n=50)

Quality of Life	Mean $\pm$ SD/f (%)
How would you rate your quality of life	3.42 $\pm$ 1.01
How satisfied are you with your health	3.18 $\pm$ 849
Physical	12.16 $\pm$ 1.94
Psychological	11.64 $\pm$ 2.25
Social	12.10 $\pm$ 2.92
Environmental	12.79 $\pm$ 1.97
Total score	55.29 $\pm$ 10.93

Table 7 shows that the mean of WHO-QOL-BREF scores in all domains i.e. Rate of quality of life, satisfaction with health, physical, psychological, social, and environmental represents scores of rate of quality of life 3.42 $\pm$ 1.01, satisfaction with health 3.18 $\pm$ 849 physical 12.16 $\pm$ 1.94, psychological 11.64 $\pm$ 2.25, social 12.10 $\pm$ 2.92 and environmental 12.79 $\pm$ 1.97 indicates all the domains have an adequate quality of life.

DISCUSSION

The present study aimed to assess patients' experience and satisfaction with psychosocial intervention clinics. It employed a cross-sectional design involving 50 participants aged 18–60 years diagnosed with mental illness according to ICD-10 criteria and clinically stable (absence of exacerbation requiring a >50% dose increase in the last three months). Standardized tools used included the Patient Satisfaction Scale, Psychosocial Intervention Needs Checklist, Global Assessment of Functioning (GAF), and WHOQOL-BREF. Written informed consent was obtained from both patients and caregivers, and socio-demographic and clinical variables were recorded using a specially designed proforma. Patient satisfaction with mental health services has gained prominence as it reflects service quality and individual experience, influencing treatment adherence and service utilization. Although many studies have explored satisfaction with

psychiatric services, satisfaction related to psychosocial interventions remains underexplored, making this study significant. Regarding clinical details, the duration of mental illness varied, with 20% having illness for 4–6 months, 16% for 6–12 months, 28% for 1–2 years, 22% for 2–5 years, and 6% for over 10 years. Treatment duration ranged similarly, and the majority (96%) of patients were directly referred for treatment. The age of onset was insidious, and 78% showed progressive improvement (Zarit & Femia, 2008). Furthermore, 98% continued treatment without interruption, and all patients maintained the same medication. The predominant diagnoses were mood affective disorder (42%) and neurotic, stress-related, and somatoform disorders (36%), consistent with Dutta, V et al. (2021). All caregivers reported good relationships with the patients, similar to Singh, S et al. (2020), with the majority being spouses (52%) and parents (40%). Most caregivers were male (66%), married (88%), and well-educated, with 34% being graduates, aligning with Gupta et al. (2022). The majority were professionals and spoke Hindi. The study revealed high patient satisfaction with psychosocial intervention, as scores in all domains were above average and near maximum. The highest scores were observed in “trust, communication,” and miscellaneous categories, aligning with Murphy et al. (2012). Other dimensions, such as concept exploration, body language, and active listening, also scored highly. These findings are consistent with Singh (2019), which assessed patient satisfaction in psychiatric outpatient care, and Wiersma (2006), where psychosocial interventions provided high satisfaction and acceptability, reflected in high participation rates. The study further assessed unmet psychosocial needs using a standardized checklist. High unmet needs were reported in psychotic symptoms (84%), crisis management (60%), stigma (54%), employment (52%), expressed emotion (52%), physical health (48%), flexible job timing (46%), and conflicts (38%), consistent with Pathare et al. (2018), which highlighted deficits in health and social services. Singh et al. (2016) similarly reported persistent psychosocial unmet needs in the same settings. The study reinforced that stigma is the greatest barrier to accessing assistance, as supported by Crowe & Lyness (2014), where negative perceptions of mental illness led to more unmet needs and poorer attitudes toward medication. In assessing global functioning, the majority of patients had high GAF scores, representing good psychological, social, and occupational functioning. These findings align with Moos et al. (2002) and Alexandratos et al. (2012), which provided evidence of significant improvement in social functioning due to multi-component structured psychosocial intervention. To assess quality of life (QOL), the WHOQOL-BREF was used, covering physical, psychological, social, and environmental domains. A higher mean score indicated a better QOL. In this study, 40% of patients had illness durations exceeding five years, adversely affecting the physical and psychological health domains of QOL. These findings align with Evans et al. (2017), who noted that longer illness duration negatively impacts QOL in severe mental illness. Moreover, stigma perceived by patients with severe mental illness was associated with lower self-esteem and self-efficacy, impairing the social domain of QOL, as similarly reported by Bhowmick, I et al. (2021). That study also showed significant QOL improvement after psychosocial intervention over six months. Overall, the present study supports existing literature indicating that patients with severe, chronic mental illness exhibit poorer QOL compared to the general population, but structured psychosocial interventions can significantly improve treatment satisfaction, functioning, and quality of life.

CONCLUSION

Patients attending the Psychosocial Intervention (PSI) clinic communicated a substantial number of psychosocial intervention needs, all of which were effectively addressed within the intervention framework. The prevalent unmet needs included psychotic symptoms, crisis management, stigma, employment, expressed emotion, physical health, flexible job timing, conflicts (including property and

family matters), treatment compliance, activities of daily living, abuse, and emotional/physical/sexual concerns.

A comprehensive evaluation of patients' satisfaction covered various categories, revealing the highest scores in "trust" and "communication," as well as miscellaneous aspects. The majority of patients express a high level of satisfaction. Furthermore, a significant majority of patients demonstrated high scores in the Global Assessment of Functioning across multiple domains, including occupational, social, schooling, and daily activities which indicate positive functioning in occupational, social, schooling, and daily activities domains.

Patients who underwent psychosocial intervention at the PSI clinic demonstrated a predominantly positive impact on their quality of life. The results highlight a significant correlation between psychosocial intervention and favourable patient outcomes, indicating an overall improvement in functioning among individuals with mental illness.

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Ethical Clearance: Taken

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