Public Knowledge, Attitudes and Practices (KAP) Toward People with Mental Illness in KSA

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Abstract: **Background:** The view of people suffering from mental illness by different communities are important in understanding the level of knowledge that they have about mental illness and how the community deals with such people.
Objectives: To assess knowledge, attitudes and practices of the Saudi public toward mental illness and the mentally ill people in the community.**Methods:** A cross sectional, descriptive survey was conducted at primary healthcare centers in Al Baha – Saudi Arabia. `A convenient sampling method was used to recruit adult group of participants aged between 18 to 70 years. A valid and reliable questionnaire was used to collect data consists of three parts; sociodemographic data, knowledge questions about mental illness (n=16) and attitudes and practices of community members toward people with mental illness statements (n=9). **Results:** The study included 400 individuals. Females represent 73.5% of them. The age of more than one third of them (38.9%) ranged between 20 and 29 years whereas that of 25% ranged between 30 and 39 years. Overall, total mental illness knowledge score ranged between 36 and 65 (out of a possible maximum of 80) with a mean of 52.1 and standard deviation of 4.7. Female participants were more knowledgeable about mental illness than males (52.41±4.62 vs. 51.16±4.97), p=0.020. Total mental illness attitude and practice score ranged between 12 and 44 (out of a possible maximum of 45) with a mean of 29.1 and standard deviation of 4.9. Females were more likely than males to have higher attitude and practice score concerning mental illness (29.51±4.83 vs. 27.92±5.06), p=0.004. The highest attitude and practice score was reported among participants aged between 20 and 29 years (30.16±5.07) while the lowest score was observed among those aged 40-49 years (27.71±407), p=0.004. Regarding marital status, single participants had higher significant attitude and practice score than married ones (30.27±5.05 vs. 28.49±4.82), p=0.005. There was a statistically significant positive correlation between mental illness knowledge score and attitude/practice score (r=0.39, p<0.001).**Conclusion:** Knowledge regarding mental illness is deficient in many aspects. However, the attitude and practice of the participants towards mentally ill patients is encouraging in many points. There is a need to improve public knowledge about mental illness to minimize stigma towards mentally ill patients.

Key Words: Public Knowledge, Attitudes , Practices , Mental Illness , KSA.

INTRODUCTION

Mental disorders are considered as one of the major global burdens worldwide. Mental disorders defined in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) as "A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities".[1]

Globally, 450 million of people suffer from a mental or behavioral disorder. Nearly 1 million people commit suicide every year. Four of the six leading causes of disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder).[2]

The world Health Organization (WHO), 2001 defined mental health as "subjective well-being, perceived self- efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others".[3]

The reaction of people towards certain events such as death of a loved one is considered a natural response, not mental illness.[1]

The view of people suffering from mental illness by different communities are important in understanding the level of knowledge that they have about mental illness and how the community deals with such people. Elbur et al (2014) conducted a study in Saudi Arabia with the relatives of people with suffering from mental disorders revealed that the lack of awareness was common among relatives of people suffering from mental illnesses, and that their views were related to the causes of mental illnesses, and to stigma. They also, they had a negative beliefs and attitudes about the mentally ill persons and mental illnesses in general.[4]

The WHO has clarified in 2003 its report that the person with a mental disorder becomes a victim of human rights violations, stigma and discrimination in the community.[2] So, accordingly, the WHO held a Global Forum in 2007, which aimed to sending a message to all communities, families and individuals in every country that it is important to give a voice to this excluded group of the population to claim their rights and secure their participation in the community. Besides, increase the community knowledge about mental illness, increase their knowledge will reduce community negative attitude and enhance their practices towards mental illness patient.

WHO (2001) said that to provide adequate treatment and care to the mentally ill patients it is necessary to move the treatment of the mentally people from mental institutions to the community based.[3]

Salve et al (2014) indicated that the attitudes and cultural practices toward mental sufferings are majorly shaped by one's level of knowledge or ignorance about the subject matter.

This is significantly contributed to by the cultural stereotypes, myths, stories and other practices that affect one's behavior towards an issue of concern. Salve et al has also commented that if the attitudes and beliefs are expressed positively, they are expected to result in a supportive and inclusive behavior; otherwise, they may probably lead to avoidance, exclusion and discrimination of a person.[5]

Hunt (2003) stated that knowledge that the people gain by learning, practice and experience can formulate personal attitudes.[6]

Allport (1935) defined an attitude as "a mental and neural state of readiness, organized through experience, exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related".[7] Pickens (2005) defined Attitude as a collective construct of such as values, behaviors, beliefs, and stimulate, which include three main parts: an affect (a feeling), a cognition (a thought or belief), and a behavior (an action).[8] Studies conducted in Qatari and Indian communities reported that the participants had inadequate knowledge, and negative attitudes related to mental disorders, and they refused to accept the mentally ill people. Moreover, they tend to take discriminative actions towards them.[9, 10]

People in the community would have more awareness toward mental illness, and more acceptance of the mentally ill people in the community when they live and interact with them.[11] In contrast, people in the community who have only contact with mental illness. But not living and there is no relative relationship appear less positive attitudes toward mental illness.[12]

WHO (2000) stated that educating the public about a good practice toward the mentally ill people is an effective way in preventing negative attitudes toward mental illness.[13] Kaliyaperumal (2004) defined practices as "ways in which they demonstrate their knowledge and attitude through their actions".[14]

-Study rationale

It is very vital to study the knowledge, attitudes and practices of the public toward mental illness and the mentally ill people. The issue of knowledge, attitudes and practices of the public in Saudi Arabia toward mental illness and the mentally ill people remains unclear and ambiguous because of the lack of research studies addressing this important and crucial issue. The present study is aiming at addressing this issue and exploring the Saudi public knowledge, attitudes and practices toward mental illness and people suffering from mental illness. The research study will be conducted in the catchment area of Al Baha. It is hoped that the result of the study might increase awareness and improve attitudes toward mental illness and those who suffer from it. It is also hoped that the results of the proposed study would encourage stakeholders to initiate and design community programs specially designed to bridge the gap of knowledge, attitudes and acceptance of the mentally ill people.

-Study question:

What are the knowledge, attitude and practices of the public in the Saudi community towards people with mental disorders?

-Aim of the study:

The main aim of the study is to assess knowledge, attitudes and practices of the Saudi public toward mental illness and the mentally ill people in the community.

-Specific objectives

1. To assess knowledge of the Saudi public in Al Baha city regarding mental illness and the mentally ill people in the community.
2. To assess the attitudes and practices of the Saudi public in Al Baha city toward mental illness and the mentally ill people in the community.
3. To identify socio-demographic factors associated with to assess knowledge, attitudes and practices of the Saudi public in Al Baha city toward mental illness and the mentally ill people in the community.

LITERATURE REVIEW

Based on WHO Mental Health Atlas (2014) Worldwide, there was a decrease in the number of beds and the number of mental health hospitals between 2011 and 2014. This is accompanied by an increase of admission rates to mental hospitals, in the global median.[15]

Mentally ill patients and their families they are suffering from community view which is playing a major role in reducing patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. Mental health persons also, may vulnerable to community stigma. Stigma considered the most important obstacle lead to discrimination and abuse toward mentally ill persons.[16, 17]

A systematic review and meta-analysis study entitled evolution of public attitudes about mental illness, prepared by Schomerus, et al (2011). It`s objective was to explore whether the increase in knowledge about the biological correlates of mental disorders over the last decades. 16 studies were selected during the period 31 March 2011. Studies were selected based on that inquire on public attitudes, at least two occasions with identical methodology. Besides reports published in scientific journals or books, researcher includes also documents published online and grey literature, that is, reports not published in commercially available books or journals. The study reported that public understanding of the biological correlates of mental illness seems not to result in better social acceptance of persons with mental illness.[18]

Gibbons et al (2015) conducted a study in Australia to investigate mental health literacy in the community in addition to examine sex differences towards various aspects of mental illness. The study sample consisted 381 participants. Data was collected through an online questionnaire. The result indicated that sample appeared relatively proficient at correctly identifying mental illness, but males appear less knowledge in mental health literacy skills in comparing with females.[19]

Tzouvara and Papadopoulos (2014) conducted a cross-sectional study concerned with the stigma related to mental illness in the Greek culture. A questionnaire was the instrument that used to measure the types and level of stigma. A non-randomized snowball sampling was used because the number of Greek culture was inadequate. The sample included 111 of people living in England and Greece. The finding of the study indicated that Greek people are sympathetic towards the mentally ill person and at the same time they believe that patients need to stay under control in society. Work to minimize stigma toward mental illness, persons one of the most important recommendations of this study.[20]

Hugo et al (2003) conducted a study in South African to investigate the knowledge and attitudes of the community members toward mental illness. Hugo, focused in his research on

the causes of illness and treatment options. A questionnaire survey performed to collect the data from 667 people of the general population through structured interviews. The result of this study elucidated that the stigma and lack of information related to mental illness present and effecting the preferred treatment modality and help seeking behavior. Based on the results researcher recommended that the importance of educating the community members about mental illnesses, their causes and treatment methods.[21]

In Qatar, which is close to the Kingdom of Saudi Arabia in the geographical location and environmental culture, study was conducted in primary health care center by Bener and Ghuloum (2011) to examine the ethnic differences in knowledge, attitude and practice towards mental illness. The sample randomly selected from visitors of primary health care centers. It included 3000 Qatari and non- Qatari Arabs adults. A questionnaire instrument was adapted by authors then tested for its reliability and validity. It demonstrated a high level of validity and high degree of reliability (kappa = 0.85). The study clarified that there is a significant number of Qatar (44.5%) than non-Qatari Arabs thought that the cause of mental illness was punishment from God and 35.1% of them believed that person is mentally retarded (40.5%) and psychiatric medication will cause addiction (61%).[10]

Descriptive study was done by Elbur et al (2013) in Taif city, Kingdom of Saudi Arabia. A targeted sample of the study was relatives of patients. 266 recruited to participate in the study. The researcher used face-to face interview method, semi-structured questionnaire as a tool to collect the data. Elbur found that (49.6%) of the participants believe that the major cause of mental illness was evil eye. while (47.4%) of them return cause to personal weakness. Elbur study included relatives of patients only and did not include the rest of the community members who do not have patients with mental illness; however, there was a lack of information about important issues related to mental illness.[4]

METHODS

Design:

The research study employed a cross sectional, descriptive survey design. This design was chosen because it is effective method to collect a large amount of data on a topic from a large population in a short time.

Setting:

The study was conducted at primary healthcare centers in Al Baha – Saudi Arabia. `

Sampling:

The proposed study employed a convenient sampling method to recruit participants. The sample was limited to adult group participants of an age range of 18 to 70 years of age. The minimum sample size was 380 males and females. The sample size was identified through the survey system program (Creative Research System, 2016).

Inclusion Criteria:

-Adult range of 18 to 70 years of age.

-Non-mentally ill persons.

Measures /Instruments:

The study instrument is an adapted questionnaire (Bener and Ghuloum, 2011).[10] The questionnaire consists of three parts. Part I: sociodemographic data, including gender, age, marital status, level of education developed by researcher. Part II includes knowledge questions about mental illness (n=16). The third part includes attitudes and practices of community members toward people with mental illness statements (n=9). The questionnaire was translated to Arabic Language by Bener and Ghuloum, 2011 in Qatar[10] and tested for validity and reliability as well as internal consistency. Permission to use the questionnaire was obtained through an e-mail communication.

The pilot-study, which includes (20) people was done to test the reliability of the questionnaire and to report the participants ' comments and noted the difficulties in which they experienced while answering the questionnaire. A questionnaire will be modified according to their answers. The final version of the adapted questionnaire will be used in the main study. To measure internal consistency of the questionnaire Cronbach's alpha was used.

Data collection:

The data was collected using the adapted Bener's questionnaire.[10] Ethical approval was obtained from the Ethics Committee. Subjects were recruited from waiting rooms at primary healthcare centers in Al Baha.

Data analysis and management:

The data were analyzed using the Statistical Package for Social Sciences (SPSS) version 26. Descriptive and inferential statistical techniques were employed to analyze the collected data. These techniques included (frequencies, percentages, mean and standard deviations). In addition to student t-test to compare means of two different groups and one-way analysis of variance (ANOVA) test was applied to compare means of more than two independent quantitative variables. Post-hoc least significance test (LSD) was applied to compare each individual two groups in case of significant ANOVA test. Pearson`s correlation test was applied to test for the linear relationship between normally distributed knowledge and attitude/practice scores. The significance level assigned for the analyses was at the $P<0.05$.

Ethical considerations

Before conducting the study, an ethical approval was obtained from the Research Ethics Committee. Informed consent was given to participants before they take part in the investigation. An explanation of all the following points was done for participants in order to be fully aware of the research before they agree; the benefits and risks of the study, the title and the aim of the study, participants' selection, duration of the study and confidentiality of research. Then, there were free to take part in this study: All the processes of this research have done in an ethical and legal framework.

The researcher clarified to all persons that they are volunteering to participate in this study and have a full decision to participate in the study and in the case if they do not agree to participate this will not affect them.

RESULTS

The study included 400 individuals. Table 1 summarizes their sociodemographic characteristics. Females represent 73.5% of them. The age of more than one third of them (38.9%) ranged between 20 and 29 years whereas that of 25% ranged between 30 and 39 years. Most of them (61.4%) were married and university graduated (58.2%).

Table 1: Sociodemographic characteristics of the participants (n=400)

	Frequency	Percentage
Gender		
Male	**106**	**26.5**
Female	**294**	**73.5**
Age (years)		
20-29	**156**	**38.9**
30-39	**100**	**25.0**
40-49	**93**	**23.3**
50-59	**39**	**9.8**
≥60	**12**	**3.0**
Marital status		
Single	**131**	**32.8**
Married	**246**	**61.4**
Divorced	**14**	**3.5**
Widowed	**9**	**2.3**
Educational level		
Primary school	**13**	**3.3**
Intermediate school	**16**	**4.0**
Secondary school	**103**	**25.7**
University	**233**	**58.2**
Postgraduate	**33**	**88**

-Knowledge about mental illness

Most of the participants either strongly agreed or agreed that traumatic event or shock can be a cause of mental illness (93.8%), substance misuse like alcohol or drugs could result in mental illness (86.8%), people with mental illness can be successfully treated using psychotherapy (84%), mental illness is due to possession by evil spirits (83%), people with mental illness can live in community (76.3%) and stress in daily life lead to mental illness (72.3%). On the other hand, only 11% and 9.3% either strongly agreed or agreed that traditional healers can treat mental illness or people with mental illness are mentally retarded, respectively while14.8% either strongly agreed or agreed that mental illness can be punishment from God.

Overall, total mental illness knowledge score ranged between 36 and 65 (out of a possible maximum of 80) with a mean of 52.1 and standard deviation of 4.7. It was normally distributed as shown by insignificant Shapiro-wilk test. Figure 1

Female participants were more knowledgeable about mental illness than males (52.41±4.62 vs. 51.16±4.97), p=0.020. Other studied factors such as age, marital status and educational level were not significantly associated with knowledge about mental illness as shown in Table 3.

Table 2: Response of the participants to knowledge questions about mental illness

	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)
Do you think substance misuse like alcohol or drugs could result in mental illness?	223 (55.8)	124 (31.0)	33 (8.3)	11 (2.8)	9 (2.3)
Do you think mental illness is due to possession by evil spirits?	106 (26.5)	226 (56.5)	43 (10.8)	20 (5.0)	5 (1.3)
Do you think poverty can be the cause of mental illness?	39 (9.8)	145 (36.3)	92 (23.0)	107 (26.8)	17 (4.3)
Do you think brain disease can be the cause of mental illness?	45 (11.3)	147 (36.8)	146 (36.5)	56 (14.0)	6 (1.5)
Do you think mental illness can be punishment from God?	8 (2.0)	51 (12.8)	106 (26.5)	123 (30.8)	112 (28.0)
Do you think traumatic event or shock can be a cause of mental illness?	158 (39.5)	217 (54.3)	17 (4.3)	3 (0.8)	5 (1.3)
Do you think stress in daily life lead to mental illness? 9	76 (19.0)	213 (53.3)	49 (12.3)	56 (14.0)	6 (1.5)
Do you think genetic inheritance may be the cause of mental illness?	49 (12.3)	120 (30.0)	130 (32.5)	76 (19.0)	25 (6.3)
Do you think people with mental illness are mentally retarded?	5 (1.3)	32 (8.0)	75 (18.8)	198 (49.5)	90 (22.5)
Do you think people with mental illness can live in community?	63 (15.8)	242 (60.5)	65 (16.3)	24 (6.0)	6 (1.5)
Do you think people with mental illness can work in regular jobs?	35 (8.8)	164 (41.0)	111 (27.8)	69 (17.3)	21 (5.3)
Do you think traditional healers can treat mental illness?	6 (1.5)	38 (9.5)	103 (25.8)	167 (41.8)	86 (21.5)
Do you think people with mental illness can be successfully treated with medication?	64 (16.0)	202 (50.5)	90 (22.5)	33 (8.3)	11 (2.8)
Do you think people with mental illness ca be successfully treated using Psychotherapy?	104 (26.0)	232 (58.0)	53 (13.3)	10 (2.5)	1 (0.3)
Do you think psychiatric medication will cause addiction?	62 (15.5)	148 (37.0)	128 (32.0)	55 (13.8)	7 (1.8)
Do you think people with mental illness are dangerous?	29 (7.2)	129 (32.3)	111 (27.8)	109 (27.3)	22 (5.5)

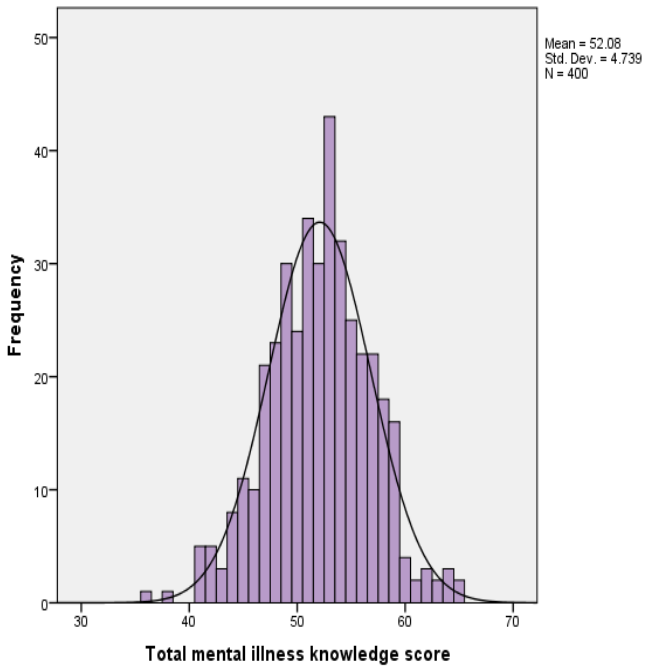

Figure 1: Total mental illness knowledge score among the participants.

Table 3: Factors associated with knowledge of the participants about mental illness

	Mental illness knowledge score mean±SD	p-value
Gender		
Male (n=106)	**51.16±4.97**	
Female (n=294)	**52.41±4.62**	**0.020**
Age (years)		
20-29 (n=156)	**52.10±4.61**	
30-39 (n=100)	**52.47±4.45**	
40-49 (n=93)	**51.46±4.74**	
50-59 (n=39)	**52.77±5.78**	
≥60 (n=12)	**51.08±5.18**	**0.462**
Marital status		
Single (n=131)	**52.54±4.61**	
Married (n=246)	**51.99±4.62**	
Divorced (n=14)	**51.07±5.05**	
Widowed (n=9)	**49.44±8.17**	**0.191**
Educational level		
Primary school (n=13)	**49.77±8.78**	
Intermediate school (n=16)	**51.75±5.86**	
Secondary school (n=103)	**51.91±4.61**	
University (n=233)	**52.03±4.33**	
Postgraduate (n=35)	**53.91±4.89**	**0.072**

-Attitude and practice questions regarding mental illness

More than half of the participants either strongly agreed or agreed that they are willing to maintain a friendship with someone with mental illness (61.3%) and they would visit psychiatrist if they have emotional problem (52.4%). On the other hand, most of them either strongly disagreed or disagreed that they are ashamed to mention someone in their family has mental illness (74.5%), they are afraid to have a conversation with someone with mental illness (56.7%), and they are disturbed to work in their workplace with someone who has mental illness (53%). However, 48.6% of them are not willing to share a room with someone who has mental illness. Table 4

Overall, total mental illness attitude and practice score ranged between 12 and 44 (out of a possible maximum of 45) with a mean of 29.1 and standard deviation of 4.9. It was normally distributed as shown by insignificant Shapiro-wilk test. Figure 2

Females were more likely than males to have higher attitude and practice score concerning mental illness (29.51±4.83 vs. 27.92±5.06), p=0.004. The highest attitude and practice score was reported among participants aged between 20 and 29 years (30.16±5.07) while the lowest score was observed among those aged 40-49 years (27.71±407), p=0.004. Regarding marital status, single participants had higher significant attitude and practice score than married ones (30.27±5.05 vs. 28.49±4.82), p=0.005.

Table 4: Response of the participants to attitude and practice questions regarding mental illness

	Strongly agree N (%)	Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly disagree N (%)
Would you visit psychiatrist if you have emotional problem?	**46 (11.5)**	**164 (40.9)**	**74 (18.5)**	**81 (20.3)**	**35 (8.8)**
Would you visit a healer if you have emotional problem?	**32 (8.0)**	**142 (35.5)**	**67 (16.8)**	**113 (28.2)**	**46 (11.5)**
Are you afraid to have a conversation with someone with mental illness?	**20 (5.0)**	**82 (20.5)**	**71 (17.8)**	**154 (38.4)**	**73 (18.3)**
Are you willing to maintain a friendship with someone with mental illness?	**69 (17.3)**	**176 (44.0)**	**108 (27.0)**	**37 (9.3)**	**10 (2.5)**
Do you think that marriage can treat mental illness?	**15 (3.8)**	**64 (16.0)**	**138 (34.5)**	**115 (28.7)**	**68 (17.0)**
Are you willing to share a room with someone who has mental illness?	**16 (4.0)**	**76 (19.0)**	**114 (28.5)**	**127 (31.8)**	**67 (16.8)**
Are you ashamed to mention someone in your family who has mental illness?	**10 (2.5)**	**40 (10.0)**	**52 (13.0)**	**183 (45.8)**	**115 (28.7)**
Are you disturbed to work in your workplace with someone who has mental illness?	**16 (4.0)**	**73 (18.3)**	**99 (24.7)**	**159 (39.7)**	**53 (13.3)**
Are you afraid of someone with mental illness who is staying next door?	**25 (6.3)**	**90 (22.5)**	**109 (27.2)**	**117 (29.2)**	**59 (14.8)**

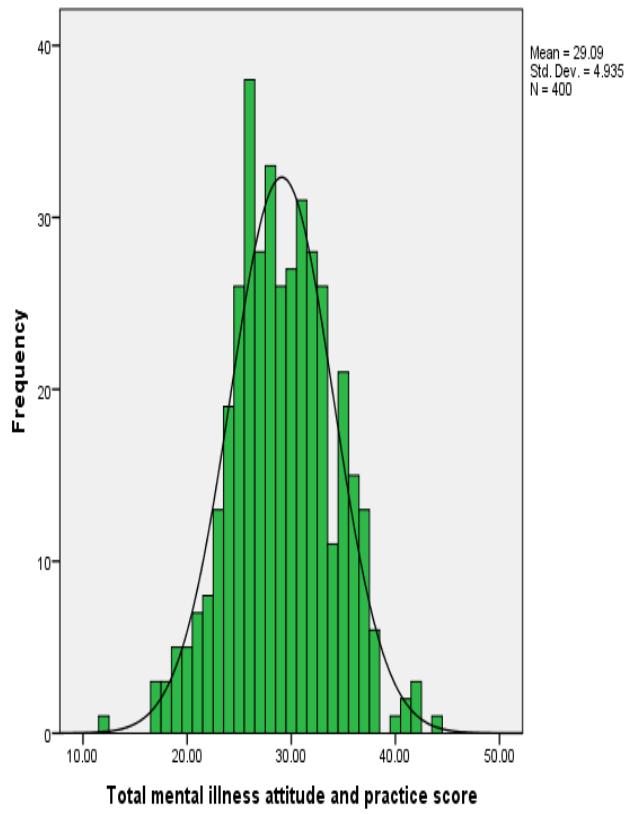

Figure 2: Total mental illness attitude and practice score among the participants.

Table 5: Factors associated with attitude and practice of the participants regarding mental illness

	Mental illness attitude and practice score mean±SD	p-value
Gender		
Male (n=106)	**27.92±5.06**	
Female (n=294)	**29.51±4.83**	**0.004***
Age (years)		
20-29 (n=156)	**30.16±5.07ŧ⊩**	
30-39 (n=100)	**28.81±5.35ŧ**	
40-49 (n=93)	**27.71±407ŧ**	
50-59 (n=39)	**28.90±4.56**	
≥60 (n=12)	**28.92±4.46**	**0.004****
Marital status		
Single (n=131)	**30.27±5.05‡**	
Married (n=246)	**28.49±4.82‡**	
Divorced (n=14)	**29.86±3.63**	
Widowed (n=9)	**27.33±5.32**	**0.005****
Educational level		
Primary school (n=13)	**27.00±5.46**	
Intermediate school (n=16)	**29.63±4.44**	
Secondary school (n=103)	**29.80±4.72**	
University (n=233)	**28.94±5.03**	
Postgraduate (n=35)	**28.60±4.82**	**0.268****

*Student t-test **ANOVA test
ŧPost hoc LSD test, p=0.031
⊩ Post hoc LSD test, p<0.001
‡ Post hoc LSD test, p=0.001

Correlation between knowledge and attitude/practice scores

There was a statistically significant positive correlation between mental illness knowledge score and attitude/practice score (r=0.39, p<0.001). Figure 3

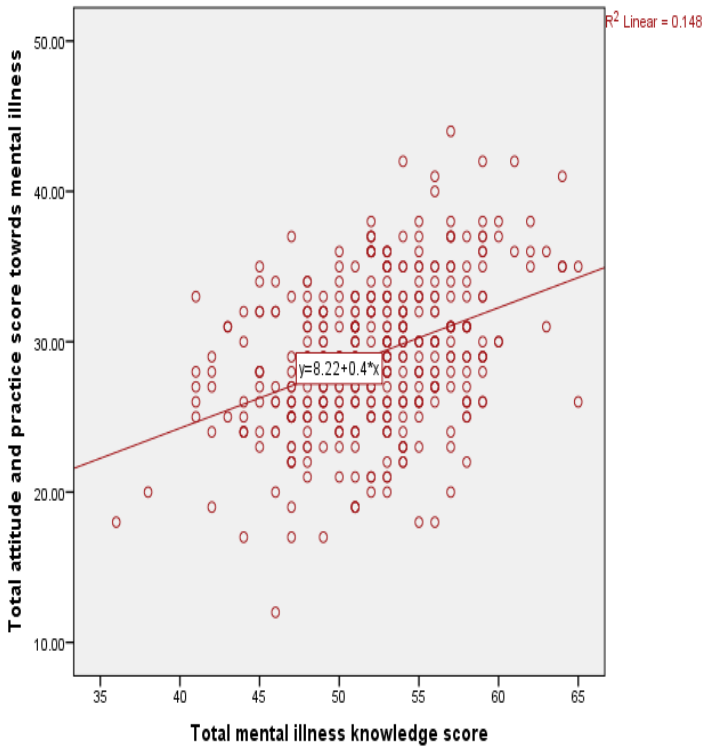

Figure 3: Correlation between mental illness knowledge score and attitude and practice score towards mental illness among the participants.

DISCUSSION

Despite the availability of the mental disorders treatment, there is a reported underutilization of such treatment as a result of stigma and discrimination created by the general public towards mental illness.[22] The current study aims to assess knowledge, attitudes and practices of the Saudi public in Al-Baha city toward mental illness and the mentally ill people in the community. Results of this study are expected to provide baseline data about the knowledge, attitudes and practices of general public regarding mental health. Also, the results will give an idea about the perceived barriers to the conduction of further programmes to improve the situation. Additionally, this study fills a gap in the literature as there are no similar studies that explore the knowledge, attitude and practice regarding mental health and mentally ill patients in our Region and even in the whole Kingdom of Saudi Arabia, up to our knowledge.

In the present study, most of the participants could recognize that traumatic event or shock can be a cause of mental illness, substance misuse like alcohol or drugs could result in mental illness, people with mental illness can be successfully treated using psychotherapy, people with mental illness can live in community and stress in daily life lead to mental illness. However, also most of them believed that mental illness is due to possession by evil spirits. Findings of this study is better that those observed in a similar older study carried out in Qatar where a considerable proportion of people considered mental illness is a punishment from God and also considered mentally ill patients as mentally retarded and psychiatric medication will cause addiction.[10] In Taif city, Kingdom of Saudi Arabia, almost half of studied people believed that the major cause of mental illness is evil eye and also considered the cause of mental illness is personal weakness. However, this study included relatives of patients only and did not include the rest of the community members who do not have patients with mental illness; however, there was a lack of information about important issues related to mental illness.[4]

Overall, the average total mental illness knowledge score was 52.1 out of a possible maximum of 80, which considered moderate. In a similar study carried out in Qatar,[10] insufficient mental health knowledge was observed among both Qataris and non-Qatari Arabs. Also, in India, the level of knowledge about mental illnesses was very low, particularly among people from rural areas.[23] Some other authors reported that even among healthcare professionals, insufficient knowledge regarding mental health affected almost one third of nurses.[24, 25] Comparison between these studies, including the present one is not practical as a result of different characteristics of the participants, using different tools to assess knowledge about mental illness and carrying out studies at different times.

Female participants were more knowledgeable about mental illness than males in the present study. The same has been observed by Gibbons et al (2015)[19] and Sawadogo et al (2020).[24]

In the present study, social acceptance of mentally ill persons was reported by a considerable proportion of the participants as more than half of them are willing to maintain a friendship with someone with mental illness, not ashamed to mention someone in their family has mental illness, not afraid to have a conversation with someone with mental illness, and not disturbed to work in their workplace with someone who has mental illness. This community-acceptance was also observed in similar Indian[23] and South African[21] studies which observed that most of the public agreed that mental illness is similar like other illnesses and can be managed by proper therapy and involvement in the community. Tzouvara and Papadopoulos (2014) observed that Greek people are sympathetic towards the mentally ill person and at the same time they believe that patients need to stay under control in society.[20] However, some authors reported that about 40.2% and 33.3% of population in Indian rural and urban area, respectively believed that mental illness is untreatable and unwilling to marry a person recovered from mental illness.[26] In the present study, almost two-thirds of the participants believed that mental illnesses can be treated with medicine successfully. This is coincide with what has been reported by Basu R, et al (2017).[23] In Qatar, negative attitudes towards mental ill people were observed among nationals and non-nationals, although most of them stated that they would visit psychiatrists for their emotional problems.[10] On the other hand, a considerable proportion of people in the present study would not visit psychiatrist if they have emotional problem.

It has been reported that implementing educational activities and events for general public could have a vital role in improving their knowledge about mental illness and consequently their attitude and practice regarding mentally ill patients.[24]

The current study revealed a positive correlation between mental illness knowledge score and attitude/practice score. The same has been observed in South Africa as it has been reported that the stigma and lack of information related to mental illness prevail and affecting the preferred treatment modality and help seeking behavior.[21] Kato TA, et al (2013) reported that poor knowledge and lack of clinical practice with patients lead to negative attitudes and stigmatization towards people with mental illness.[27] However, a systematic review and meta-analysis study carried out by Schomerus, et al (2011) revealed public understanding of the biological correlates of mental illness seems not to result in better social acceptance of persons with mental illness.[18]

Few limitations of the present study should be addressed. The cross-sectional design with its inherited limitations concerning the temporal relation between independent and dependent variables is considered a limitation. Using a convenience non-probability sample could impact the generalizability of findings. Finally, in the current study we did not focus on a particular mental illness but we considered mental illness as a whole. Despite those limitations, this study could have public health importance in addressing this important issue in our community.

CONCLUSION:

Knowledge of adults attending primary healthcare centers in Al Baha–Saudi Arabia regarding mental illness is deficient in many aspects, particularly `considering mental illness occurred due to possession by evil spirits, poverty can be the cause of mental illness, people with mental illness are dangerous and psychiatric medication will cause addiction. Females were more knowledgeable than males regarding mental illness. However, the attitude and practice of the participants towards mentally ill patients is encouraging in many points such as acceptance to work, make conversation and maintain a friendship with them. However, negative attitude was observed concerning sharing rooms. Positive attitude was more observed among females, younger and single participants. There was an association between having higher knowledge about mental illness and expressing positive attitude towards mentally ill patients.

RECOMMENDATIONS

Based on the results of the present study, the following are recommended:

-Increase the awareness and knowledge of the community regarding mental illness through mass media and educational activities at primary care centers.

-Correcting misconception regarding mental illness through pamphlets distributed on primary care centers attendees to minimize stigma towards mentally ill patients in the community.

-Further longitudinal study including a random population-based sample is recommended for full understand of the situation in our community

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