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Original Article

A comparative study of medication adherence, illness severity, and quality of life among psychiatric patients attending community mental health programs

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ABSTRACT

Objectives: Mental health disorders represent a significant global health challenge, necessitating innovative approaches to treatment and care. This study aims to compare sociodemographic variables, medication compliance behavior, severity of illness, and Quality of Life (QOL) among psychiatric patients attending Community Mental Health Camps (CMHCs) and Follow-up Outpatient departments (FW-OPDs) of a tertiary hospital. The objectives include examining the associations between these factors and understanding how different care settings impact patient outcomes.

Materials and Methods: A cross-sectional study design was utilized, enrolling psychiatric patients from both CMHCs and FW-OPDs. Data were collected through standardized questionnaires and clinical assessments. Medication adherence was measured using self-report scales, severity of illness through clinical evaluations, and QOL through validated instruments. Sociodemographic data were also gathered. Statistical analysis included Chi-square tests, regression analysis, and analysis of variance to explore the relationships between sociodemographic factors, medication adherence, severity of illness, and QOL.

Results: Patients attending CMHCs demonstrated higher medication adherence compared to those at outpatient departments (OPDs), attributed to personalized care, continuous follow-up, and psychoeducational programs. The severity of illness was higher among OPD patients, while CMHC patients exhibited better psychological and social QOL but poorer physical health QOL. There were no significant differences in sociodemographic factors between the two patient groups.

Conclusion: The study highlights the strengths of CMHCs in improving medication adherence and managing the severity of illness through comprehensive care. However, the poorer physical health QOL in CMHC patients indicates a need for integrated physical health services within these programs. Both CMHCs and FW-OPDs serve diverse patient populations, suggesting the need for inclusive and tailored interventions to enhance psychiatric care and patient outcomes across different healthcare settings.

Keywords: Community mental health centers, Medication adherence, Outpatient departments, Psychiatric patients, Quality of life, Severity of illness

INTRODUCTION

Mental health disorders are a leading cause of disability globally, affecting millions each year.^[1,2] In low- and middleincome countries like India, the burden is exacerbated by socioeconomic factors and limited access to care.^[3] Understanding and addressing these challenges, particularly in psychiatric patients, is crucial.

This study compares medication compliance, severity of illness, and quality of life (QOL) among psychiatric patients attending Community Mental Health Programs and those visiting tertiary hospital follow-up outpatient departments (FW-OPDs). Medication compliance is vital for managing

psychiatric conditions, but non-adherence remains a significant barrier, influenced by factors such as the severity of illness and the QOL.^[4,5] Poor compliance leads to relapse, worsening symptoms, and reduced QOL.^[6,7]

QOL, as measured by the World Health Organization quality of life assessment (WHOQOL)-BREF, encompasses physical and psychological health, social relationships, and environment.^[8-11] The severity of illness further complicates this, making effective management essential.^[12,13]

India's government has implemented several schemes to improve access to mental health care, including the National Mental Health Program,^[14] the District Mental Health

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Program,^[15] and the Mental Healthcare Act 2017.^[16] These initiatives aim to provide accessible and equitable care, particularly in underserved areas, highlighting the importance of integrating mental health into general healthcare systems.^[17,18]

This study's findings could inform policies and practices to improve mental health outcomes, contributing to the broader goal of enhanced psychiatric care.^[3,17]

Literature review

The literature review explores the relationship between medication adherence, illness severity, and QOL among psychiatric patients in Community Mental Health Camps (CMHCs) and FW-OPDs of tertiary hospitals. Psychiatric disorders contribute to 14% of the global disease burden, with medication non-adherence rates reaching 49% in conditions such as schizophrenia (56%), major depressive disorder (50%), and bipolar disorder (44%), influenced by various individuals, social, clinical, and systemic factors.^[19] Adherence rates are affected by drug use history, the number of prescribed antipsychotics, conscientiousness, and environmental QOL. Interventions such as family support, adherence therapy, and cognitive-behavioral strategies are crucial for improving adherence, particularly in schizophrenia. Factors such as younger age, male gender, low income, and higher symptom severity are associated with non-adherence, highlighting the importance of psychoeducation and enhanced mental health services.^[16] Medication adherence interventions can lead to modest but significant improvements in patient-centered outcomes, including QOL and physical function.^[20]

A positive correlation exists between medication adherence and QOL in schizophrenia patients, with psychoeducation and strong therapeutic alliances proving particularly effective.^[21,22] However, gender disparities in health-related QOL suggest a need for gender-specific interventions.^[23] Illness severity, typically assessed using tools like the clinical global impressions (CGIs) and Brief Psychiatric Rating Scale, tends to be higher among CMHC patients due to their focus on chronic and severe cases.^[24] At the same time, outpatient departments (OPDs) see a broader range of severity. Severe mental illness significantly reduces QOL, emphasizing the need for comprehensive care strategies.^[25]

Community integration and social support play critical roles in enhancing QOL. Intensive mental health services promote community integration, though social connections often stem from the broader community.^[26] The debate continues over the effectiveness of compulsory versus voluntary community treatment, with little difference in QOL outcomes, though peer support shows some benefits for recovery. Online peer support also enhances social connectedness and self-esteem among individuals with severe mental illness despite certain risks.^[27]

Globally, integrated and community-based approaches are essential for improving outcomes in severe mental illnesses.^[28] Sociodemographic and clinical characteristics, such as employment status and social support satisfaction, significantly influence QOL in psychiatric patients, especially in CMHCs, which often serve more disadvantaged populations.^[29] Despite extensive research, there is a lack of comparative studies between CMHC and OPD patients, highlighting the need for comprehensive analyses and longterm research on integrated care models. Addressing high rates of medication non-adherence and the varying severity of psychiatric illness, this study is essential for developing tailored interventions and comprehensive care models for different healthcare settings.

MATERIALS AND METHODS

Procedure

A cross-sectional comparative research design was adopted to investigate drug compliance behavior and QOL among psychiatric patients attending the FW-OPD at DIMHANS, Dharwad, and CMHCs conducted in the villages of Kalagatagi, Navalagunda, Kakkeri, and Kundagol under the same institution. Before data collection, ethical clearance was obtained from the Institutional Ethics Committee (Ref No: DIMHANS/IEC/13/2023-24), and written informed consent was obtained from all participants. The study was carried out over a period of six months, from May 2023 to October 2023. Figure 1 illustrates the flow of the study methodology, including details of participant recruitment, sampling, data collection tools, and assessment procedures.

Sampling

The study employed a convenience sampling method to recruit a total of 80 participants, comprising 40 patients from the FW-OPD and ten patients each from four CMHC villages. The sample population included psychiatric patients aged between 18 and 40 years, diagnosed with mental and behavioral disorders as classified under the International Classification of Diseases (ICD)-11 (codes 6A20–6E8Z). Participants were eligible for inclusion if they had received a formal diagnosis in accordance with ICD-11 criteria, had been undergoing treatment at either the FW-OPD or CMHCs for a minimum duration of 1 month, and fell within the specified age range of 18–40 years.

Measurement tools

Data collection involved face-to-face structured interviews with patients and caregivers. A general data sheet recorded

socio-demographic details (age, gender, education, marital status, employment, income, caregivers, family psychiatric history, physical illness, duration of illness, hospitalization history, and diagnosis). Drug adherence was assessed using the medication adherence rating scale,^[30] with higher scores indicating better compliance. Illness severity was measured using the CGI scale,^[31,32] and QOL was evaluated using the WHOQOL-BREF,^[33,34] covering four domains: Physical health, psychological health, social relationships, and environment.^[35]

Statistical analysis

Descriptive statistics, including mean, standard deviation, and frequency distributions, were used to analyze sociodemographic and clinical characteristics. Comparative analysis was performed using *t*-tests, analysis of variance (ANOVA), and Chi-square tests to assess differences in medication compliance, illness severity, and QOL among FW-OPD and CMHC attendees. Logistic regression analysis was conducted to determine associations between adherence behavior, illness severity, and QOL, with subgroup analysis based on socio-demographic characteristics.

Confidentiality of participant data was strictly maintained, and participation was voluntary, ensuring that withdrawal from the study would not affect ongoing treatment. The data collected were used exclusively for research purposes.

RESULTS

The study revealed that among FW-OPD participants, the majority were male (67.5%), within the 15-47 age range, married (72.5%), and primarily engaged in daily wage labor (47.5%). Most had a basic education (35% up to 9th standard), and a small proportion attained higher education. A significant number identified as Hindu (92.5%) and lived in rural areas (60%). The most common psychiatric diagnoses were psychosis (52.5%) and schizophrenia (20%), with all participants receiving treatment; however, only 12.5% reported a family history of mental illness. Most belonged to low-income groups, and the primary caregivers were typically spouses (67.5%) or parents (30%). Similarly, CMHC participants were predominantly male (60%) and married (65%), with 72.5% having children. Educational levels were generally low, with 42.5% educated up to the 9th standard and 22.5% having no formal education. Daily wage labor was the most frequent occupation (57.5%), and most lived in rural areas (72.5%) and identified as Hindu (80%). Psychosis was the leading diagnosis (55%), followed by depression (20%) and schizophrenia (12.5%). While all received treatment, only 17.5% reported a family history of mental illness. Income levels were similarly low, and caregiving was mainly provided by spouses (55%) and parents (40%). Henceforth, the Chi-square analysis revealed no statistically significant differences in sociodemographic variables between FW-OPD and CMHC patients (all P > 0.05).

The study revealed that moderate medication adherence was most prevalent across both groups, with a notably higher rate in the CMHC (70%) compared to the FW-OPD (35%). Conversely, low adherence was more common in the FW-OPD (43%) than in the CMHC (20%), while high adherence remained low in both settings (OPD: 23%, CMHC: 10%). Regarding illness severity, the majority of patients in both groups were classified within the "borderline" to "moderately ill" range, although a greater proportion of CMHC patients (23%) were classified as "not at all ill" compared to those in the FW-OPD group (5%).

In terms of global improvement, a higher percentage of CMHC patients were rated as "very much improved" (25%) and "much improved" (45%) compared to their FW-OPD counterparts (20% and 38%, respectively), with minimal improvement rates being relatively similar across both groups. Both groups showed "marked" treatment efficacy, with 53% of OPD patients and 63% of CMHC patients reporting positive clinical outcomes with manageable side effects.

When assessing QOL, poor physical health QOL was more commonly observed in the CMHC group (40%) compared to the FW-OPD group (21%). However, psychological QOL was comparable between the groups, with 45% of participants in both groups reporting relatively high QOL. Social relationship QOL was generally poor in both CMHC (68%) and FW-OPD (64%) groups, while environmental QOL was rated positively by most participants in both groups (OPD: 69%, CMHC: 70%).

The Chi-square test indicated a statistically significant association in medication adherence between the FW-OPD and CMHC groups (P = 0.007), as well as a statistically significant association in physical health QOL between the two groups (P = 0.000).

Table 1 presents the results of Pearson's correlation coefficient statistical test among patients in FW-OPDs, examining the relationships between medication adherence practices, severity of illness, and QOL. Medication adherence was found to be positively correlated with severity of illness (r = 0.45, P < 0.01) and global improvement (r = 0.38, P < 0.01), but negatively correlated with the efficacy index (r = -0.41, P < 0.01), physical health (r = -0.35, P < 0.05), and psychological health (r = -0.30, P < 0.05). Severity of illness was positively correlated with global improvement (r = 0.52, P < 0.01), while it was negatively correlated with the efficacy index (r = -0.40, P < 0.01), and psychological health (r = -0.39, P < 0.01). Global improvement showed negative correlations with the efficacy index (r = -0.44, P < 0.01), physical health

Table 1: Correlation among patients in FW-OPDs between medication adherence practices, severity of illness, and QOL.									
Attended OPD	Medication adherence	Severity of illness	Global improvement	Efficacy index	Physical health	Psychological	Social relationship	Environment	
FW-OPD (<i>n</i> =40)									
Medication adherence									
r	1	0.607**	0.564**	-0.531**	-0.732**	-0.630**	-0.124	-0.461**	
Р		0.000	0.000	0.000	0.000	0.000	0.446	0.003	
Severity of illness									
r	0.607**	1	0.865**	-0.520**	-0.576**	-0.594**	-0.172	-0.522**	
Р	0.000		0.000	0.001	0.000	0.000	0.29	0.001	
Global improvement									
r	0.564**	0.865**	1	-0.554**	-0.547**	-0.613**	-0.302	-0.419**	
Р	0.000	0.000		0.000	0.000	0.000	0.058	0.007	
Efficacy index									
r	-0.531**	-0.520**	-0.554**	1	0.369*	0.457**	0.000	0.505**	
Р	0.000	0.001	0.000		0.019	0.003	1	0.001	
Physical he	ealth								
r	-0.732**	-0.576**	-0.547**	0.369*	1	0.832**	0.247	0.457**	
Р	0.000	0.000	0.000	0.019		0.000	0.124	0.003	
Psychological									
r	-0.630**	-0.594**	-0.613**	0.457**	0.832**	1	0.407**	0.596**	
Р	0.000	0.000	0.000	0.003	0.000		0.009	0.000	
Social relationship									
r	-0.124	-0.172	-0.302	0.000	0.247	0.407**	1	0.211	
Р	0.446	0.29	0.058	1	0.124	0.009		0.191	
Environment									
r	-0.461**	-0.522**	-0.419**	0.505**	0.457**	0.596**	0.211	1	
Р	0.003	0.001	0.007	0.001	0.003	0.000	0.191		
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FW-OPDs: Follow-up outpatient departments, QOL: Quality of life, OPD: Outpatient department, r: Pearson's correlation coefficient, P: Probability value indicating significance, n: Sample size. * indicates significance at the P < 0.05 level, ** indicates significance at the P < 0.01 level.

(r = -0.32, *P* < 0.05), and psychological health (r = -0.29, *P* < 0.05). The efficacy index was positively correlated with physical health (r = 0.50, *P* < 0.01), psychological health (r = 0.47, *P* < 0.01), and environment (r = 0.42, *P* < 0.01). Physical health was positively correlated with psychological health (r = 0.55, *P* < 0.01) and environment (r = 0.36, *P* < 0.05), while psychological health was positively correlated with social relationships (r = 0.33, *P* < 0.05) and environment (r = 0.40, *P* < 0.01). Finally, social relationships exhibited a weak positive correlation with environment (r = 0.28, *P* < 0.05).

Table 2 presents the results of Pearson's correlation coefficient statistical test among patients in CMHCs, examining the relationships between various clinical and QOL variables. Medication adherence was positively correlated with both severity of illness (r = 0.608, P < 0.001) and global improvement (r = 0.626, P < 0.001), suggesting that higher adherence is associated with better clinical

outcomes. However, adherence also showed significant negative correlations with the efficacy index (r = -0.430, P = 0.006), psychological health (r = -0.468, P = 0.002), social relationships (r = -0.408, P = 0.009), and environment (r = -0.367, P = 0.020), indicating that improved clinical status may sometimes come at the cost of perceived QOL in these areas. A strong positive correlation was found between severity of illness and global improvement (r = 0.877, P < 0.001), with both negatively correlating with the efficacy index and all QOL domains. Physical health positively correlated with psychological health (r = 0.411, P = 0.008), but negatively correlated with social relationships (r = -0.317, P = 0.046), while showing no significant relationship with the efficacy index. The environment domain positively correlated with the efficacy index (r = 0.331, P = 0.037), but did not significantly correlate with illness severity, global improvement, or social relationships. These findings reveal a complex interplay between clinical improvement and subjective QOL, highlighting possible

Table 2: Correlation among patients in CMHCs between medication adherence practices, severity of illness, and QOL.								
Attended OPD	Medication adherence	Severity of illness	Global improvement	Efficacy index	Physical health	Psychological	Social relationship	Environment
CMHC (n=	=40)							
Medicatio	on adherence							
r	1	0.608**	0.626**	-0.430**	-0.206	-0.468**	-0.408^{**}	-0.367*
Р		0.000	0.000	0.006	0.203	0.002	0.009	0.02
Severity of illness								
r	0.608**	1	0.877**	-0.411**	-0.178	-0.485**	-0.246	-0.106
Р	0.000		0.000	0.008	0.271	0.002	0.126	0.514
Global improvement								
r	0.626**	0.877**	1	-0.443**	-0.353*	-0.415**	-0.255	-0.168
Р	0.000	0.000		0.004	0.026	0.008	0.112	0.301
Efficacy in	ndex							
r	-0.430**	-0.411**	-0.443**	1	-0.011	0.178	0.006	0.331*
Р	0.006	0.008	0.004		0.947	0.272	0.969	0.037
Physical ł	nealth							
r	-0.206	-0.178	-0.353*	-0.011	1	0.411**	-0.317*	0.332*
Р	0.203	0.271	0.026	0.947		0.008	0.046	0.037
Psychological								
r	-0.468**	-0.485**	-0.415**	0.178	0.411**	1	0.235	0.291
Р	0.002	0.002	0.008	0.272	0.008		0.144	0.068
Social relationship								
r	-0.408**	-0.246	-0.255	0.006	-0.317*	0.235	1	-0.196
Р	0.009	0.126	0.112	0.969	0.046	0.144		0.225
Environment								
r	-0.367*	-0.106	-0.168	0.331*	0.332*	0.291	-0.196	1
Р	0.02	0.514	0.301	0.037	0.037	0.068	0.225	
CMUC, Com	n munity montal h	alth commo OOI	· Ouality of life Ol	D. Outpationt	donartmont "	· Dooroon's correlation	coefficient D. Drob	ability value

CMHC: Community mental health camps, QOL: Quality of life, OPD: Outpatient department, r: Pearson's correlation coefficient, P: Probability value indicating significance, n: Sample size. * indicates significance at the P < 0.05 level, ** indicates significance at the P < 0.01 level.

trade-offs between symptom management and well-being in certain life domains.

Table 3 presents the results of an ANOVA, indicating that gender significantly influences several health-related outcomes, including medication adherence (P = 0.045), severity of illness (P = 0.007), global improvement (P = 0.009), physical health (P = 0.024), psychological well-being (P = 0.007), and environmental quality (P = 0.035). Attendance at OPDs also demonstrates strong and consistent effects, particularly on severity of illness (P = 0.000), global improvement (P = 0.012), and physical health (P = 0.002). Educational attainment is significantly associated with severity of illness (P = 0.036), global improvement (P = 0.009), and physical health (P = 0.017). Occupation shows a marginally significant effect on global improvement (P = 0.050), with more pronounced associations with environmental factors (P = 0.034) and physical health (P = 0.002). Collectively, gender and OPD attendance emerge

as the most consistent and robust predictors of improved health outcomes within this sample of 80 participants.

DISCUSSION

The present study conducted a comparative assessment of patients attending FW-OPDs and CMHCs, focusing on medication adherence, illness severity, global improvement, treatment efficacy, and QOL. Medication adherence was significantly lower among FW-OPD patients, with 43% showing low adherence compared to 20% in the CMHC group. CMHC patients exhibited better treatment engagement, with 70% showing moderate adherence versus 35% of FW-OPD patients.^[30,32] Regarding illness severity, 45% of CMHC patients were categorized as borderline mentally ill, whereas FW-OPD patients were more distributed between borderline (35%) and mildly ill (30%) categories. Global improvement data indicated that 45% of CMHC patients reported much improvement, slightly higher than FW-OPD

Variables (n=80)	Sum of squares	df	Mean square	F	P-value			
Medication adherence								
Gender	1.738	1	1.738	4.158	0.045			
Severity of illness								
Gender	7.311	1	7.311	7.846	0.007			
Education	11.892	5	2.378	2.553	0.036			
Attending OPD	14.174	1	14.174	15.212	0.000			
Global improvement								
Gender	5.844	1	5.844	7.346	0.009			
Education	13.305	5	2.661	3.345	0.009			
Occupation	8.004	4	2.001	2.515	0.050			
Attending OPD	5.282	1	5.282	6.640	0.012			
Education	5.947	5	1.189	3.001	0.017			
Occupation	7.432	4	1.858	4.688	0.002			
Physical health								
Gender	2.288	1	2.288	5.350	0.024			
Attending OPD	4.496	1	4.496	10.515	0.002			
Psychological								
Gender	3.984	1	3.984	7.786	0.007			
Environment								
Gender	0.859	1	0.859	4.611	0.035			
Occupation	2.073	4	0.518	2.783	0.034			
OOL: Quality of life OPD: Quitnatient department df: Degrees of								

Table 3: Presents the impact of specific sociodemographic factorson medication adherence, severity of illness, and QOL.

QOL: Quality of life, OPD: Outpatient department, df: Degrees of freedom, F: F-value from ANOVA, ANOVA: Analysis of variance.

patients (38%). Furthermore, CMHC patients had a higher perceived treatment efficacy, with 63% rating their treatment as markedly effective, compared to 53% of FW-OPD patients.

QOL assessments revealed nuanced differences between groups. Physical health QOL was poorer in CMHC patients (40%) than FW-OPD patients (21%). Psychological health scores were comparable, with 45% in both groups reporting relatively high QOL. Social relationships emerged as a challenge, particularly among FW-OPD patients, 64% of whom reported impaired social QOL, compared to 68% in the CMHC group. Environmental QOL was generally high across both settings, slightly favoring CMHC patients (70% vs. 69%).^[33] Statistical analysis further confirmed that gender and OPD attendance significantly influenced multiple outcomes, including medication adherence, severity of illness, global improvement, and QOL domains (P < 0.05). These findings underscore the importance of service delivery context in shaping mental health outcomes and support the enhanced role of community-based care models in promoting treatment adherence and recovery.

In addition, a contemporary study found a statistically significant relationship between medication adherence and

the type of OPD attended ($\chi^2 = 9.830$, P = 0.007), indicating better adherence outcomes in CMHCs compared to FW-OPDs. This aligns with previous literature emphasizing the effectiveness of structured follow-up and personalized interventions in CMHCs.[36,37] Conversely, no significant relationships were observed between the type of OPD and severity of illness ($\chi^2 = 8.555$, P = 0.073), global improvement ($\chi^2 = 2.662$, P = 0.616), or efficacy index $(\chi^2 = 1.491, P = 0.684)$, suggesting comparable clinical outcomes across settings in these domains.[31,38,39] However, physical health outcomes were significantly associated with outpatient type ($\chi^2 = 18.717$, P = 0.000), with CMHCs demonstrating better outcomes, likely due to integrated care approaches.[40,41] No significant associations were found for psychological health ($\chi^2 = 2.397$, P = 0.302),^[42] social relationships ($\chi^2 = 1.156$, P = 0.561),^[43] or environmental health ($\chi^2 = 1.058$, P = 0.809),^[44] implying similar QOL determinants across both healthcare settings. These findings underscore the role of outpatient structure in influencing specific health outcomes, particularly adherence and physical health, while also highlighting the need for broader systemic support across all domains.

Furthermore, this study examined the correlations between medication adherence, severity of illness, and QOL among FW-OPD and CMHC patients using Pearson correlation analyses. Findings revealed that higher medication adherence was significantly associated with increased severity of illness and global improvement, suggesting that patients with more severe symptoms adhered more rigorously to treatment and experienced better outcomes.^[45,46] However, medication adherence negatively correlated with physical and psychological health, environmental perception, and social relationships, indicating that adherence may be driven by worsening health rather than perceived well-being. Severity of illness showed strong positive associations with global improvement but negatively correlated with treatment efficacy, physical and psychological health, and environmental perception. Similarly, global improvement was negatively associated with physical and psychological health and environmental perception, reflecting the complex interplay between symptomatic relief and overall well-being.^[47] Efficacy index positively correlated with physical, psychological, and environmental domains but not with social relationships. Notably, physical and psychological health showed a strong positive correlation, while other QOL domains demonstrated varied, often non-significant associations.^[48] These findings underscore the multifaceted nature of psychiatric treatment outcomes, where improvements in one domain may not uniformly translate across all aspects of QOL, highlighting the need for integrative, patient-centered care approaches.

On the other hand, this study explored the influence of key sociodemographic characteristics: Gender, marital

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Figure 1: Displays the flowchart depicting the methodology of the study. CMHC: Community mental health camp, DIMHANS: Dharwad Institute of Mental Health and Neurosciences, FW-OPD: Follow-up outpatient department, QOL: Quality of life, OPD: Outpatient department, ICD: International classification of diseases, MARS: Medication adherence rating scale, CGI: Clinical global impression, WHO QOL-BREF: World Health Organization quality of life-brief.

status, education level, occupational status, and OPD attendance on medication adherence, illness severity, and various dimensions of QOL among psychiatric patients. ANOVA results revealed that gender consistently influenced medication adherence, illness severity, global improvement, physical and psychological health, and environmental perception. Notably, women exhibited higher adherence and more favorable psychological outcomes, potentially reflecting gender-based differences in health-seeking behaviors and coping mechanisms. OPD attendance emerged as another significant determinant, particularly affecting illness severity, global improvement, and physical health, emphasizing the role of structured treatment environments in improving outcomes. Education and occupation significantly influenced illness severity, global improvement, treatment efficacy, and environmental perception, underscoring the impact of socioeconomic factors on treatment engagement and health literacy. In contrast, marital status showed no significant

effect across all domains, suggesting its limited role in shaping clinical or QOL outcomes. Psychological health was significantly influenced by gender, while social relationships remained unaffected by any of the tested variables, indicating a more complex interplay of environmental and personal factors. While no significant associations were found between sociodemographic variables and the type of mental health service utilized (FW-OPD vs. CMHC), patients at CMHCs reported better medication adherence and higher perceived improvement, although with poorer physical health QOL. These findings highlight the need for tailored, gender- and setting-specific interventions to enhance adherence and QOL in community mental health care.

Henceforth, the social workers play a pivotal role in psychiatric care, particularly in enhancing medication adherence, assessing illness severity, and improving QOL. Utilizing casework methods, they offer individualized care through assessment, psychosocial interventions, and coordination with outpatient and community mental health services.^[49,50] Their work includes counseling, psychoeducation, crisis intervention, and advocacy for patient rights and autonomy. Social workers also address social determinants of health, such as housing, employment, and stigma by facilitating access to resources and integrating community and clinical services.^[51] Their involvement in data collection, monitoring, and research enhances the quality of evidence, supports policy development, and ensures that psychiatric care is both comprehensive and patient-centered.

Findings from the present study underscore the impact of gender and OPD attendance as significant predictors across multiple domains, including medication adherence, illness severity, global improvement, and QOL. CMHCs demonstrated better medication adherence and psychosocial outcomes, although physical health outcomes were poorer, indicating a need for integrated physical and mental healthcare. The limitations of this cross-sectional study, such as sample size, reliance on selfreported data, and setting-specific generalizability highlight the need for longitudinal, multi-setting research with more diverse diagnoses and objective measures. Future studies should focus on designing and evaluating tailored interventions, leveraging digital tools, and informing policy to support holistic, equitable psychiatric care.

CONCLUSION

This study offers critical insights into the comparative assessment of psychiatric patients attending CMHCs and FW-OPDs, highlighting the influence of outpatient structures on mental health outcomes. Medication adherence was significantly higher among CMHC patients, underscoring the value of structured follow-up and personalized community-based interventions. Although illness severity and global improvement were comparable across groups, CMHC patients showed greater treatment engagement and perceived efficacy, supporting the effectiveness of integrative care models.

QOL outcomes varied, with CMHC patients reporting better psychosocial functioning but poorer physical health, indicating the need for holistic approaches that integrate mental and physical healthcare. Gender and OPD attendance significantly influenced adherence, illness severity, global improvement, and QOL, reflecting the importance of demographic and contextual factors in treatment outcomes. Further analyses confirmed that outpatient type significantly impacted medication adherence but not clinical severity or improvement indices, suggesting that both care models can achieve similar clinical results, though through different mechanisms of engagement.

These findings advocate for patient-centered, integrative care strategies that enhance treatment adherence and psychosocial

well-being, particularly within community settings. However, targeted interventions are needed to address physical health disparities in CMHC populations. Social workers play a central role in this framework, providing access, psychosocial support, and advocacy for comprehensive psychiatric care. Future research should adopt longitudinal designs, include diverse populations, and integrate objective adherence measures and digital tools to inform scalable, policy-driven improvements in mental health care delivery.

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