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Disability status among outpatients with mental disorders at Hanoi Mental Hospital

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ABSTRACT

Objective: *To describe disability status among outpatients with mental disorders at Hanoi Mental Hospital and to identify some related factors.* ***Subjects and methods:*** *A cross-sectional descriptive study was conducted among 367 outpatients with mental disorders aged 18–65 years at Hanoi Mental Hospital from December 2025 to March 2026. Disability status was assessed using the WHODAS 2.0 scale. Multiple linear regression analysis was used to identify related factors ($p < 0.05$).* ***Results:*** *Regarding disability status, anxiety and stress-related disorders accounted for the highest proportion (40.9%), followed by schizophrenia and psychotic disorders (34.3%). Disability scores differed significantly among diagnostic groups ($p < 0.01$), with the schizophrenia and psychotic disorders group having the highest mean disability score (9.16 ± 12.45). Across WHODAS 2.0 domains, the highest disability score was observed in social participation, followed by life activities, while self-care and mobility had the lowest scores. Regarding related factors, multiple linear regression analysis showed that marital status, religious belief, occupation, and perceived social support were significantly associated with disability scores.* ***Conclusion:*** *Outpatients with mental disorders experienced disability across several functional domains, particularly social participation and life activities. Disability assessment using WHODAS 2.0 should be strengthened in outpatient management, with attention to social, occupational, and social support factors when developing care, treatment, and rehabilitation plans.*

Keywords: *Mental disorders; Disability; WHODAS 2.0.*

INTRODUCTION

Mental disorders (MDs) are characterized by clinically significant disturbances in an individual's cognition, emotional regulation, or behavior [1]. According to the World Health Organization (WHO), 1 in 7 people – approximately 1.1 billion people worldwide – are living with a mental disorder, with anxiety and depression being the most common [2]. Mental disorders tend to have an early onset and typically follow a chronic, relapsing course [3]. In Vietnam, according to statistics from the National Psychiatric Hospital No. 1, the prevalence of the ten most common mental disorders in the community is estimated at approximately 14.2% of the population [4]. Mental disorders are among the leading causes of disability and account for a substantial share of the global burden of disease.

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Disability is not merely a pathological or social attribute, but rather the result of the interaction between a person's health condition and environmental and personal factors, manifesting at three levels: impairment of body function or structure; activity limitation, such as difficulty moving; and participation restriction, such as dropping out of school or being unable to work [5]. An estimated 16% of the global population (1.3 billion people) currently experiences significant disability. This figure is rising, partly owing to population aging and the increasing prevalence of noncommunicable diseases.

A study in South Korea comparing disability levels using the WHO Disability Assessment Schedule (WHODAS 2.0) between patients with schizophrenia (SCZ) and those with bipolar affective disorder (BPAD) found that the disability level in the schizophrenia group was higher than in the bipolar disorder group (19.94 ± 9.55 versus 11.03 ± 7.01). Moreover, the study also found that patients with schizophrenia and bipolar disorder had disability levels 25-fold and 14-fold higher, respectively, than healthy individuals [6]. A study conducted in Curaçao, the Netherlands, found that the mean disability score among outpatients was lower than among inpatients (WHODAS 2.0 scores of 38.3 ± 19.6 and 29.6 ± 15.5, respectively), with only the decline in the social participation domain reaching statistical significance [7]. In Canada, a study found high WHODAS 2.0 disability scores among patients with depression, 20.4 (19.6–21.1); anxiety disorders, 22.4 (21.2–23.6); bipolar disorder, 22.0 (20.0–24.0); and schizophrenia, 23.1 (19.5–26.7) [8]. In Vietnam, a study by Huy et al. at Bach Mai Hospital describing disability characteristics among patients with schizophrenia found that disability was a fairly common problem in this group. Patients aged 40 years and older had higher disability scores in the domains of cognition and communication (6.88 ± 6.13 versus 3.22 ± 4.50) and getting along with others (6.63 ± 4.84 versus 3.68 ± 3.89), as well as higher total disability scores, compared with those under 40 years of age. The study also found a statistically significant difference in disability scores between patients with and without a history of psychiatric medication use, with higher disability scores among those with a history of medication use (34.51 ± 25.42 versus 15.33 ± 14.59) [9]. In addition to age and medication adherence, sex, employment status, long illness duration, and lack of social support were also factors associated with disability among patients with mental disorders [10].

Mental disorders tend to follow a prolonged, relapsing course and directly affect patients' capacity for self-care, communication, work, and social participation [3, 5]. Among outpatients, even when acute symptoms have stabilized, functional difficulties in daily activities, social relationships, and work capacity may persist, substantially affecting the recovery process [7,11]. Assessing disability status among patients with mental disorders therefore provides evidence for nurses and physicians to develop appropriate rehabilitation plans and to inform social welfare and protection policies for this population. Based on this rationale, our research team conducted the study 'Disability Status Among Outpatients with Mental Disorders at Hanoi Mental Hospital' with two objectives: (1) To describe disability status among outpatients with mental disorders at Hanoi Mental Hospital using the WHODAS 2.0 scale; and (2) To identify some factors associated with disability status in this population.

SUBJECTS AND METHODS

Study subjects

Inclusion criteria: Patients with a confirmed diagnosis of a mental disorder according to ICD-10 criteria, established at least 6 months earlier, aged 18–65 years, and receiving outpatient treatment for at least 2 months after hospital discharge.

Exclusion criteria: Patients in an acute, severe phase (agitation, dangerous behavior, loss of behavioral control, or being dominated by delusions or hallucinations) who were unable to participate in an interview; patients with cognitive impairment or moderate-to-severe dementia limiting their ability to understand and answer questions; and patients with severe medical or neurological conditions that could affect their ability to participate in the interview or bias the assessment results.

Study time and setting: The study was conducted from November 2025 to September 2026, with data collection from December 15, 2025 to March 15, 2026, at Hanoi Mental Hospital.

Study design: A cross-sectional descriptive study.

Sample size and sampling method: The sample size was estimated using G*Power 3.1 software for multiple linear regression analysis [11]. Using an F test for linear multiple regression (fixed model, R^2 deviation from zero) with an a priori analysis, a significance level of $\alpha = 0.05$, statistical power of 80%, a medium effect size of $f^2 = 0.15$, and 14 independent variables anticipated in the model, the minimum required sample size was 135 patients. In practice, the research team recruited 392 outpatients with mental disorders at Hanoi Mental Hospital. After data checking and cleaning, 25 cases were excluded owing to incomplete questionnaires or ineligibility for analysis, leaving 367 eligible patients for analysis. This sample size exceeded the estimated minimum, ensuring adequacy for descriptive analysis and multiple linear regression.

A convenience sampling method was used.

Research instruments

General information: Included age, sex, education level, marital status, religious belief, occupation, living arrangement, ability to afford hospital costs, and illness duration.

Medication adherence scale (The Morisky Medication Adherence Scale – MMAS-8): This scale was developed by Morisky et al. (2008) and comprises 8 items assessing medication-adherence behaviors. Items 1 through 7 are answered as No (0 points) or Yes (1 point), with item 5 reverse-scored; item 8 is rated on a 5-point Likert scale from 0 (never/rarely) to 1 (daily). Total scores are classified into three levels: high adherence (8 points), medium adherence (6–7 points), and low adherence (0–5 points) [12]. The MMAS-8 is a recognized, highly reliable tool for assessing medication adherence. Cronbach's alpha in this study was 0.74.

Perceived social support scale (The Multidimensional Scale of Perceived Social Support – MSPSS): This scale was developed by Zimet et al. (1988) to assess an individual's subjective perception of social support [13]. The MSPSS comprises 12 items divided into three support sources – family, friends, and significant others – with 4 items per subscale. Items are scored from 1 (strongly disagree) to 7 (strongly agree). The mean score for each subscale is calculated as the sum of its 4 items divided

by 4; the overall score is the sum of all 12 items divided by 12. Scores range from 1 to 7, with higher scores indicating greater perceived social support. Total scores are classified into three levels: high social support (5.1–7.0), medium social support (3.0–5.0), and low social support (1.0–2.9) [14]. The MSPSS has been standardized and widely used across many countries; Cronbach's alpha in this study was 0.72.

Disability assessment scale (WHO Disability Assessment Schedule 2.0 – WHODAS 2.0): Developed by WHO based on the International Classification of Functioning, Disability and Health, this scale was used to assess disability level among patients with mental disorders [15]. The WHODAS 2.0 comprises 6 domains assessing the difficulties patients experienced in the preceding 30 days: cognition – understanding and communication (6 items); mobility – moving and getting around (5 items); self-care – hygiene, dressing, eating, and staying alone (4 items); getting along – interacting with other people (5 items); life activities – household responsibilities, leisure, work, and school (8 items); and participation in community activities (8 items). WHODAS 2.0 items are scored from 1 (no difficulty) to 5 (extreme difficulty or unable to do). Scoring involves three steps: (1) each item response is recoded from 0 to 4 and weighted according to WHO guidance; (2) domain scores are summed; and (3) the overall score is calculated by summing all 6 domain scores, with higher total scores indicating more severe disability. The WHODAS 2.0 is an internationally standardized disability assessment tool, widely used across many patient populations and translated into more than 30 languages, including Vietnamese. The instrument has high reliability (Cronbach's α 0.86–0.98) and good test–retest reliability (> 0.80), and is recommended by WHO for comprehensive disability assessment, including in mental disorders. Cronbach's alpha in this study was 0.93.

Data collection procedure: Data were collected following a standardized procedure comprising the following steps: (1) the principal investigator trained two research assistants on the instrument content, data collection procedure, and interview skills; (2) research assistants identified eligible participants and explained the study objectives; (3) eligible patients were invited to participate and signed an informed consent form; (4) direct interviews were conducted with each patient for 20–30 minutes in a private setting; and (5) questionnaires were reviewed for completeness and validity.

Data analysis: Data were processed using IBM SPSS version 27. Descriptive variables of the general characteristics were presented as medians and interquartile ranges (Median, IQR) when not normally distributed. Categorical variables were described using frequencies and percentages (%). The WHODAS 2.0 score, used as the dependent variable in the linear regression model, was presented as mean ± standard deviation to reflect central tendency and dispersion, and to facilitate comparison with previous studies. Differences in WHODAS 2.0 disability scores among diagnostic groups were assessed using the Kruskal–Wallis test. Associations between factors and WHODAS 2.0 scores were examined using multiple linear regression. Regression model assumptions, including linearity, normality of residuals, homoscedasticity, and multicollinearity, were checked prior to analysis. Results are presented as unstandardized regression coefficients

(B), standardized coefficients (β), 95% confidence intervals (95% CI), and p-values. Given the sufficiently large sample size, the linear regression model was applied in accordance with the central limit theorem. Statistical significance was set at $p < 0.05$.

Ethical considerations: The study protocol was approved by the Institutional Review Board of Thang Long University (approval No. 22/2025/HDDD). The study was also approved for implementation by the Board of Directors of Hanoi Mental Hospital. Patients were invited to participate and signed an informed consent form. For patients with limited decision-making capacity, the research team additionally consulted with family members or legal guardians before data collection. All patients' personal information was coded, kept confidential, and used solely for research purposes.

RESULTS

Table 1. Demographic and clinical characteristics of study participants (N = 367)

Characteristic	n / Median (IQR) [Min–Max]	%
Age (years)	48.00 (9.00) [18–65]	
Sex		
Male	119	32.4
Female	248	67.6
Education level		
Lower secondary or below	149	40.6
Upper secondary	134	36.5
College/University/Postgraduate	84	22.9
Marital status		
Single	77	21.0
Separated/Divorced/Widowed	36	9.8
Married/Cohabiting	254	69.2
Religious belief		
No	240	65.4
Yes	127	34.6
Occupation		
Unemployed/Not working	63	17.2
Full-time work (Worker/Civil servant/Student)	57	15.5
Part-time work (Farmer/Freelancer/Homemaker)	247	67.3

Characteristic	n / Median (IQR) [Min–Max]	%
Living arrangement		
Living alone	16	4.4
Living with others	351	95.6
Ability to afford hospital costs		
Insufficient/Sometimes insufficient	62	16.90
Sufficient (with/without health insurance)	305	83.10
Illness duration (years)	7.00 (17.00) [1–52]	
Medication adherence (MMAS-8)	7.50 (1.00) [3.25–8.00]	
Social support (MSPSS)	6.00 (0.50) [3.08–7.00]	

Table 1 presents the demographic and clinical characteristics of the 367 participating patients. The median age was 48 years (IQR: 9), ranging from 18 to 65 years. Most participants were female (67.6%, n = 248) and 32.4% (n = 119) were male. Most patients had an upper-secondary education or below, at 36.5% and 40.6%, respectively. The majority of patients were married or cohabiting with a partner (69.2%), followed by single (21.0%) and separated/divorced/widowed (9.8%). Most patients reported no religious affiliation (65.4%). Regarding occupation, the majority held part-time work (67.3%), while 17.2% were unemployed, and patients with full-time work accounted for the smallest proportion (15.5%). Most participants lived with others (95.6%). Regarding the ability to afford hospital costs, most reported sufficient coverage through health insurance (83.1%), while 16.9% reported insufficient or occasionally insufficient coverage. The median illness duration was 7 years (IQR: 17), ranging from 1 to 52 years. The median medication adherence score (MMAS-8) was 7.5 (IQR: 1.0), ranging from 3.25 to 8.0. The median social support score (MSPSS) was 6.0 (IQR: 0.5), ranging from 3.08 to 7.00.

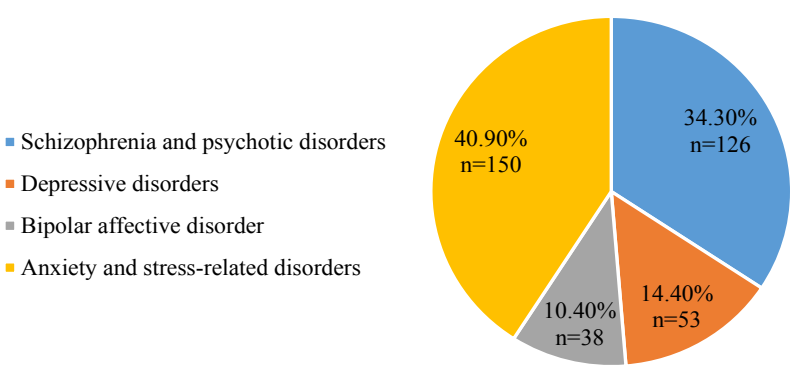


Figure 1. Distribution of mental disorder diagnostic groups among study participants (N = 367)

Figure 1 shows the distribution of diagnostic groups among the participating patients. Anxiety and stress-related disorders accounted for the highest proportion, at 40.90%, followed by schizophrenia and psychotic disorders at 34.30%. Depressive disorders and bipolar affective disorder accounted for lower proportions, at 14.40% and 10.40%, respectively.

Table 2. Mean WHODAS 2.0 disability scores by mental disorder diagnostic group (N = 367)

Diagnostic group	Mean ± SD	Min–Max	H (p-value)
Schizophrenia and psychotic disorders	9.16 ± 12.45	0–54.72	19.25 (<0.01)
Depressive disorders	4.19 ± 7.34	0–41.51	
Bipolar affective disorder	3.50 ± 9.83	0–32.61	
Anxiety and stress-related disorders	5.99 ± 9.51	0–54.72	

Disability scores measured by the WHODAS 2.0 differed significantly among diagnostic groups ($H = 19.25$; $p < 0.01$). The schizophrenia and psychotic disorders group had the highest mean disability score (9.16 ± 12.45) among the four diagnostic groups studied, followed by the anxiety and stress-related disorders group (5.99 ± 9.51), the depressive disorders group (4.19 ± 7.34), and the bipolar affective disorder group, which had the lowest score (3.50 ± 9.83).

Table 3. Mean WHODAS 2.0 domain scores among study participants (N = 367)

Functional domain	Mean ± SD	Min–Max
Cognition	6.85 ± 11.66	0.00–70.00
Mobility	2.01 ± 6.98	0.00–50.00
Self-care	0.93 ± 4.98	0.00–70.00
Getting along	6.77 ± 16.25	0.00–83.33
Life activities: Household	8.09 ± 19.58	0.00–100.00
Life activities: Work/School	4.60 ± 13.54	0.00–85.71
Participation	9.78 ± 13.22	0.00–66.67
Total WHODAS 2.0 score	**6.00 ± 9.51**	**0.00–54.72**

Table 3 shows that the overall mean WHODAS 2.0 disability score among patients was 6.00 ± 9.51, ranging from 0.00 to 54.72. Among the functional domains, participation had the highest mean score (9.78 ± 13.22), followed by life activities: household (8.09 ± 19.58), cognition (6.85 ± 11.66), getting along with others (6.77 ± 16.25), and life activities: work/school (4.60 ± 13.54). The two domains with the lowest disability scores were mobility (2.01 ± 6.98) and self-care (0.93 ± 4.98). Scores across domains showed considerable dispersion, reflecting substantial variation in the degree of functional impairment among patients.

Table 4. Multiple linear regression model of factors associated with disability status among study participants

Variable	B	β	95% CI	p-value
Age	0.035	0.042	-0.070 – 0.140	0.516
Sex	-1.446	-0.071	-3.373 – 0.481	0.141
Upper secondary education	-0.972	-0.049	-3.071 – 1.127	0.363
College/University/Postgraduate education	0.595	0.026	-1.962 – 3.151	0.648
Divorced/Widowed	-4.110	-0.129	-7.917 – -0.304	**0.034**
Married	-3.659	-0.178	-6.422 – -0.895	**0.010**
Religious belief	1.989	0.100	0.107 – 3.871	**0.038**
Part-time work (Farmer/Freelancer/Homemaker)	-3.117	-0.154	-5.570 – -0.665	**0.013**
Full-time work (Worker/Civil servant/Student)	-4.129	-0.158	-7.486 – -0.772	**0.016**
Living arrangement	-2.031	-0.044	-6.507 – 2.446	0.373
Ability to afford hospital costs	-2.366	-0.093	-4.752 – 0.020	0.052
Illness duration	0.062	0.055	-0.048 – 0.172	0.267
Medication adherence (MMAS-8)	0.132	0.013	-0.795 – 1.059	0.779
Social support (MSPSS)	-4.613	-0.318	-6.039 – -3.187	**<0.001**

$R = 0.484$; $R^2 = 0.234$; $F = 7.701$

Note: The dependent variable was the total WHODAS 2.0 score. Reference categories were: lower secondary education or below; single marital status; no religious belief; unemployed/not working; living alone; and insufficient/sometimes insufficient ability to afford hospital costs. CI: confidence interval; MMAS-8: Morisky Medication Adherence Scale; MSPSS: Multidimensional Scale of Perceived Social Support.

Multiple linear regression analysis in Table 4 showed that marital status, religious belief, occupation, and social support were significantly associated with patients' disability scores ($p < 0.05$). Specifically, widowed/divorced patients had a mean disability score 4.110 points lower than single patients (B = -4.110; 95% CI: -7.917 to -0.304; p = 0.034). Similarly, married patients had a mean disability score 3.659 points lower than single patients (B = -3.659; 95% CI: -6.422 to -0.895; p = 0.010). Patients with religious belief had a mean disability score 1.989 points higher than those without religious belief (B = 1.989; 95% CI: 0.107–3.871; p = 0.038). Regarding occupation, patients with part-time work had a mean disability score 3.117 points lower than unemployed patients (B = -3.117; 95% CI: -5.570 to -0.665; p = 0.013), while patients with full-time work had a mean disability score 4.129 points lower than unemployed patients (B = -4.129; 95% CI: -7.486 to -0.772; p = 0.016). In addition, for each 1-point increase in social support (MSPSS) score, the mean disability score decreased by 4.613 points (B = -4.613; 95% CI: -6.039 to -3.187; $p < 0.001$). The multiple linear regression model had $R = 0.484$, $R^2 = 0.234$, and $F = 7.701$, indicating that the model was statistically significant and explained approximately 23.4% of the variance in total WHODAS 2.0 scores among outpatients with mental disorders.

DISCUSSION

Our study found that participants were predominantly middle-aged (median 48 years), ranging from 18 to 65 years, with a relatively long illness duration of 7 years (IQR: 17), ranging from 1 to 52 years, reflecting the tendency of mental disorders to follow a chronic, prolonged, and relapsing course [3]. The proportion of female patients in this study was higher than that of male patients, similar to the trend observed in some epidemiological studies of common mental disorders reported by WHO [2]. Most patients had an upper-secondary education or below and lived with their families, reflecting the role of the family in caring for patients with mental disorders in Vietnam. This finding is consistent with studies from other Asian countries, where family-based care models remain predominant, in contrast to Western countries, which show a higher tendency toward living alone [16]. Regarding occupational characteristics, most patients held part-time employment (67.3%); however, a notable proportion remained unemployed (17.2%). This is consistent with the study by Worku et al., which found that unemployment is one of the factors associated with cognitive and social functional disability among patients [17]. Most patients reported being able to afford care through health insurance (80.9%), although 16.9% still experienced financial difficulty. A systematic review of the costs of treating mental disorders found that the long-term cost of treatment is a substantial burden for patients and families, and may affect access to healthcare services and treatment continuity [18].

Medication adherence was fairly good but still varied among patients with mental disorders. This finding is consistent with a study at National Psychiatric Hospital No. 2, which reported low medication adherence among patients with schizophrenia [19]. This suggests that pharmacological symptom control is necessary but may not be sufficient to comprehensively improve patients' functioning. Meanwhile, the median social support (MSPSS) score was 6.0 (range: 3.08–7.00), reflecting a high level of perceived social support, and was inversely associated with disability level ($B = -4.613$; $p < 0.001$). This is consistent with a study in Canada, which also found that patients with better social support had markedly lower disability levels [8]. The distribution of diagnostic groups in our study was uneven: anxiety and stress-related disorders accounted for the highest proportion (40.9%), followed by schizophrenia and psychotic disorders (34.3%). This reflects the fact that the composition of patients presenting at a specialized psychiatric hospital does not fully mirror the prevalence of these disorders in the community. Although anxiety and depressive disorders are the most common mental disorders in the community, psychotic disorders are usually more severe and more often require treatment at specialized facilities[1]. Disability levels differed significantly among diagnostic groups, with the schizophrenia and psychotic disorders group having the highest WHODAS 2.0 score (9.16 ± 12.45), indicating the most severe disability among all groups. This is consistent with a study in South Korea, which found that disability levels in the schizophrenia group were significantly higher than in the bipolar disorder group [6]. In contrast, the depressive disorders group had a lower disability level (4.19 ± 7.34), and the bipolar affective disorder group had the lowest (3.50 ± 9.83). This finding differs from the study by Sjonnesen et al., which found a disability score of 22.0 (20.0–24.0) in the bipolar disorder group and the lowest score, 20.4 (19.6–21.1), in the depression group [8]. Although these mental disorder groups generally have a better prognosis than schizophrenia and psychotic disorders, without timely rehabilitation support they may still cause substantial functional decline. Notably, our results showed that the anxiety and stress-related disorders

group had a higher disability level than the depression and bipolar disorder groups, consistent with the study by Sjonnesen et al. in Canada [8], which found that common mental disorders such as anxiety and stress cause clear functional decline that is often underestimated in both clinical and community settings.

Analysis by WHODAS 2.0 domain showed that participation had the highest disability score, followed by life activities: household, while mobility and self-care had the lowest scores. This finding is consistent with the study by Koopmans et al., which found that outpatients with mental disorders experienced greater difficulty with social participation than inpatients [7]. In addition, our disability findings are consistent with the study by Nguyen Thi Phuong Huy et al. at the National Institute of Mental Health – Bach Mai Hospital among patients with schizophrenia, which also found that disability was a fairly common issue in this group, particularly in the domains of cognition and communication, getting along with others, and the total disability score [9]. This suggests that among patients with mental disorders, functional decline is evident not only in basic personal activities but is also prominent in domains requiring communication skills, maintaining social relationships, fulfilling family roles, and community integration.

Multiple linear regression analysis showed that marital status, religious belief, occupation, and social support were significantly associated with patients' disability level. Marital status was associated with disability level, with patients in a more favorable marital situation having lower disability scores. This finding is consistent with the review by Lyngdoh et al., which found that marriage among patients with severe mental disorders may help provide social support, reduce isolation, and maintain daily functioning [20]. Religious belief was associated with higher disability levels; this may reflect a tendency for patients with more severe functional decline to seek additional spiritual support from religion while living with their illness[1]. Conversely, employed patients had lower disability levels than unemployed patients, consistent with the study by Anbasse et al., which found that patients with significant work impairment and unemployment had higher disability scores than their counterparts [10]. Social support was inversely associated with disability level, suggesting that patients receiving better support from family, friends, and others around them may maintain and improve their ability to participate in daily activities. Our findings are consistent with a review showing that social support plays an important role in reducing disability levels among patients[21]. Specifically, studies have shown that higher social support is associated with lower functional difficulty and improved social participation among people with mental disorders. In addition, social support is considered a protective factor that helps mitigate the negative impact of illness and improves patients' quality of life and functioning. In the regression model, medication adherence showed no statistically significant association with disability score. This finding suggests that pharmacological symptom control, while necessary, may not be sufficient to comprehensively improve patients' functioning. Therefore, alongside continued pharmacological treatment, psychological interventions, psychosocial rehabilitation, and community reintegration support should be combined to reduce disability and improve functioning among patients.

LIMITATIONS

This study was designed as a cross-sectional descriptive study, which can only establish associations between factors and disability level rather than causal relationships. A convenience sampling method was used at a specialized psychiatric hospital, which limits the generalizability of the findings to the broader population of patients with mental disorders. Some

information was collected through direct interviews and may therefore have been subject to recall bias and influenced by patients' cognitive capacity.

RECOMMENDATIONS

Based on these findings, nurses should pay closer attention to patients at higher risk of disability, including those with low social support, financial difficulty, unemployment, or impaired social participation. In addition to pharmacological treatment, psychosocial rehabilitation interventions, treatment-adherence counseling, family support, and vocational rehabilitation should be integrated to improve patients' self-care, work capacity, and community integration. At the same time, community-based support policies for patients with mental disorders should be strengthened, including post-discharge monitoring and follow-up; linkage with primary healthcare networks, families, and social organizations; and support for access to health insurance, social assistance, suitable employment, and community-based rehabilitation activities.

CONCLUSION

This study found that outpatients with mental disorders experienced disability across multiple functional domains as measured by the WHODAS 2.0, including cognition, mobility, self-care, getting along with others, life activities, and social participation, with participation and life activities showing the highest disability scores. The schizophrenia and psychotic disorders group had the highest disability score. Factors significantly associated with total WHODAS 2.0 score included marital status, religious belief, occupation, and social support. These findings suggest the need to strengthen disability assessment across functional domains and to combine medical treatment with psychosocial rehabilitation for these patients.

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