



**QUALITY OF LIFE OF OUTPATIENTS WITH MENTAL AND BEHAVIOURAL
DISORDER DUE TO SUBSTANCE USE IN NEURO PSYCHIATRIC HOSPITAL
ARO, ABEOKUTA, OGUN STATE.**

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ABSTRACT

The quality of life of Outpatients with Mental and Behavioural Disorders due to Substance Use (OwMBDSU) at Neuro Psychiatric Hospital Aro Abeokuta Ogun state was investigated in this study. An ex-post facto survey design was used, while 365 OwMBDSU who satisfied the DSM-V criteria using Fishers exact formula were specifically chosen, Neuro Psychiatric Hospital Aro Abeokuta Ogun State which is recognised as having the biggest mental health facility and the most specialised psychiatric institution in Nigeria was specifically chosen to serve patients with this specific mental health condition. The WHOQOL-BREF (1995) scale was employed along with the following scales: social ($\alpha=0.77$), physical ($\alpha=0.89$), environmental ($\alpha=0.81$) and psychological ($\alpha=0.75$). Six in-depth interviews with OwMBDSU were conducted in addition to this. The qualitative data underwent content analysis while the quantitative data underwent descriptive statistics of frequency counts, multiple regression, Analysis of Variance and T test at the 0.05 level of significance. According to the study, the four domains of quality of life: social had a mean index of 14.88, physical (mean index of 15.19), environmental (mean index of 12.23), and psychological (mean index of 14.17) were all high. Age ($\beta = -.122, p<.05$), ethnicity ($\beta = .157, p<.05$), occupation ($\beta = -.200, p<.05$), and educational status ($\beta = -.144, p<.05$) correlated with quality of life of OwMBDSU. According to the aforementioned results, early detection and intervention can enhance treatment results and possibly reduce the detrimental effects on quality of life. Early identification of substance use disorders should be a top priority for mental health professionals to enhance patient's quality of life through timely and effective treatment. Given the influence of age, ethnicity, occupation and educational attainment intervention strategies should be adjusted to fit patient demographic profile

Key words: *Quality of Life, Outpatients, Mental Behavioural Disorder, Substance Use*

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INTRODUCTION

In clinical trials (Pasareanu, Opsal Vederhus, Kristensen & Clausen, 2015) and health service research (Gigantesco and Giuliani 2011) Quality of Life (QoL) is a critical outcome that measures the unique perspective of patients on their overall well-being. To calculate quality of life a comprehensive evaluation of the patients' living situation is necessary (Yang, Dawes, Leroi & Gannon, 2018). QoL is a metric that assesses a person's general health and capacity to manage the challenges posed by mental health conditions. This includes their ability to maintain social relationships, achieve individual goals and attend to daily necessities (Grover & Sahoo, 2022). For patients with chronic illnesses like mental or substance-use disorders (SUD) which usually necessitate treatment continuation without complete remission, it has been promoted as an outcome metric in particular (Wilburn, McKenna Twiss Kemp & Campbell, 2015).

Although the definition of Quality of Life (QoL) has evolved and when considering various populations the physical, mental, social and environmental domains such as the economy, security and housing are the essential elements of QoL (Rand, Arnevik & Walderhaug, 2020). Substance Use

Disorder (SUD) is often considered a chronic relapsing condition with physical, psychological and social comorbidities (McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati & Argeriou, 1992). Research has shown that SUD patients have a lower quality of life than other patients but their QoL is still comparable to that of patients with other psychiatric diseases (Foster, Powell, Marshall & Peters 1999; Tiffany, Friedman, Greenfield, Hasin & Jackson, 2012). According to Laudet (2011) and Kelly, Robinson, Baker, Deane, Osborne, Hudson and Hides (2018) SUD causes unstable living patterns because it impacts a person's global functioning in a wide range of life domains.

The physical and mental health, social life, professional lives and interpersonal relationships of patients with SUD are all negatively impacted (Bourion-Bédès *et al.*, 2017; Müller *et al.*, 2020). Mental and behavioural disorders are among the leading causes of disability and public health problems globally (World Health Organisation, (WHO) 2003). Social roles and interpersonal relationships are difficult for people with mental illnesses and behavioural disorders to manage which

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makes it more difficult for them to meet the expectations of the community in which they live and work (Brkić-Kovačević, Hrvić, Selimbašić & Avdibegović, 2019). How their mental illness presents itself adverse drug reactions from prescription medications and a lack of social support are some of the possible causes of this. Prior studies focused primarily on treatments that addressed risk factors, caregiver stress and stigmatisation with little attention paid to quality of life of people mental and behavioural disorders due to substance use as often struggle to control their use of substances like alcohol and legal or illicit drugs, because these disorders affect their behaviour, emotions and thought processes. These conditions can affect various facets of human functioning and require substantial assistance. Hence the study's necessity.

Objectives

The Purpose of the Study is to:

- i. assess the quality of life of outpatients with mental and behavioural disorder due to substance use.
- ii. determine the association between socio-demographic characteristics and quality of life of outpatients with mental and behavioural disorder due to substance use.

- iii. assess the differences in the quality of life of outpatients with mental and behavioural disorder due to substance use based on gender, marital status and occupation.

Research Question

In view of the forgoing therefore, the following research question guided the study:

- i. What is the quality of life of outpatients with mental and behavioural disorder due to substance use.?

Hypotheses

The following null hypotheses were tested at 0.05 level of significance.

- H₀₁: There is no significant relationship between socio-demographics characteristics and quality of life of outpatients with mental and behavioural disorder due to substance use.
- H₀₂ There is no significant difference in the quality of life of outpatients with mental and behavioural disorder due to substance use based on gender, marital status, and occupation.

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METHOD

Design

The study utilised a mixed method. The quantitative is a descriptive research design of *ex-post facto* type while the qualitative involves the In-depth interview. This design was chosen because it provides the researchers with an opportunity to gather data without manipulation of the independent variables that had already occurred.

Participants

The study's population consisted of all Federal Neuro Psychiatric Hospital Aro Abeokuta Outpatients with Mental and Behavioural Disorder due to Substance Abuse (OwMBDSU). The following are the study's inclusion criteria.

- i. OwMBDSU between 18 and 65 years old.
- ii. The capacity to sign and comprehend the informed consent form.
- iii. OwMBDSU who visit the facility for a follow-up visit one year or more after being discharged.
- iv. OMBDSU patients who reside with family caregivers and who are brought to the clinic for follow-up care by family caregivers. The study's sample size was established by applying Fishers precise formula

which calculates populations under 10000 (Jung , 2014).

Fisher's formula for sample size is:

$$n = z^2 * p(1 - p) / e^2$$

where: n = desired sample size = 384

z = Normal deviate at 95% confidence interval, z= 1.96

$$p = 0.5)$$

$$e = 0.05$$

With a 95% confidence level (z = 1.96), an estimated proportion of 0.5 (p = 0.5), and a desired margin of error of 0.05 (e = 0.05).

$$n = (1.96^2) (0.5) (1 - 0.5) / (0.05^2)$$

$$n \approx 384$$

Anticipating a non-response of 10%, this minimum sample size will be increased to 394

Instrument

Section A is dedicated to collecting demographic data including age, gender, marital status ethnicity, religion, occupation ,educational attainment, years of illness prior to recovery, time spent in the hospital ,last follow-up visit and people they have lived with during the last six months. Section B: The 26-item World

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Health Organisation (WHO)WHOQOL-BREF 1995 scale was modified to measure the following broad domains: general health and overall quality of life (2 items), environment (7 items), social relationships (3 items), psychological (6 items) and physical (7 items). Only three questions on the 26 items are negative the other 23 questions are positive. Scores range from 1 (not at all) to 5 (extreme amount) 2 (a little) 3 (a moderate amount) and 4 (very much). A scale of 0–10 (low) and 11–20 (high) was used to classify the patients quality of life. A Cronbachs alpha of 0.833 was reported by Nkporbu Ogaji and Nduka (2023) who stated that higher scores correspond to higher QoL. Six respondents were interviewed using the qualitative method of in-depth interviews for the study. The interview was conducted at Federal Neuro Psychiatric Hospital Aro Abeokuta on February 2nd and 5th ,2024 and the investigators used an interview guide with open-ended questions to facilitate in-depth discussions on the four dimensions of quality of life.

Procedure

The management of the Federal Neuro Psychiatric Hospital, Aro, Abeokuta, granted ethical approval for the study. The reference number was

NFHA/277/VCLVI/202, the assigned number was PRO07/24, and the registration number was NHRC/FNPH-HREC/29/08/2023. The ethical review concluded that the study posed minimal risk, as there was very little chance of participants suffering any harm. All participants were in recovery and voluntarily consented to participate after reading and accepting the terms outlined in the participant consent form. Researchers provided guidance and assistance in accurately completing the questionnaires to ensure proper understanding. Only fully and correctly completed questionnaire copies were considered for analysis.

Method of Data Analysis

The study adopted both quantitative and qualitative methods of data analysis in line with its mixed-method design. Quantitative data obtained from the duly completed copies of the structured questionnaire were subjected to descriptive and inferential statistical analyses. Descriptive statistics such as frequency counts and percentages were employed to present respondents' demographic information and general response patterns. Inferential statistics, including multiple regression, Analysis of Variance (ANOVA), and the t-test, were utilised to test hypotheses and determine the existence of significant relationships or

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differences among the study variables. On the other hand, qualitative data generated through semi-structured interviews were analysed using thematic analysis. The interview responses were transcribed verbatim and carefully examined to identify recurring patterns and meanings. The data were then manually coded, and emerging themes were categorised into major themes

RESULTS

The socio demographic details of outpatients with mental and behavioural disorders brought on by substance abuse were displayed in Table 1. The age distribution revealed that the majority of responders (75.1%), were between the ages of 18 and 30. The percentages of respondents in the 31–45 and 44–56 age groups were lower (22.5%) and (2.5%) respectively). In terms of gender the sample is significantly more male (87.1%) than female (12.9%). With regard to marital status the vast majority are unmarried (82.2%), married (11.0 %) and divorced (6.8 %). The majority of respondents according to ethnicity are Yoruba (73.4%), followed by Igbo (18.6%), Hausa (4.7%) and others (3.3%). Regarding religion the majority identify as Christian (71.2%), followed by Islam (27.4%), and a small minority as belonging to other religions

and sub-themes. The researchers ensured that the interpretation of the themes was supported with illustrative quotes from participants to give voice to their experiences and perspectives. This combination of statistical and thematic techniques provided a robust and comprehensive understanding of the research problem

(1.4%). The majority of respondents (46.0%), are traders followed by artisans 16.2%), civil servants (15.9%), and farmers (4.9%). The remaining respondents were 17.0%. The distribution of respondents educational status revealed a nearly equal distribution between those with tertiary 46.0%) and secondary (42.7%), education with fewer having primary (7.7%) or no formal education (3.6%). When asked how long they had been ill before getting better the majority of respondents said they had been ill for six months (48.8%), followed by four months 29.6%), two months 15.9%), and more than six months (5.8%). Time since hospital discharge varies the majority were released one year ago (85.2%), two years ago (2.2%), three years (3.0%) , more than 3 years (0.5%) while a smaller percentage were released less than a year(9.0%) .The percentage of follow-up

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visits within the last month is high (85.8%) ,2 months (1.6%), while the percentages for visits within three months (10.1%) and beyond three months (2.5%) are lower. In the previous six months respondents reported a variety of living arrangements including living alone (35.6%) with

children (7.9%), parents (38.4%), partners (6.6%), friends/roommates (9.0%), and others (2.5%).

Research Question: What is the quality of life of outpatients with mental and behavioural disorder due to substance use?

Table 1: Test of norm showing the level of Quality of Life of Outpatients with Mental and Behavioural Disorder due to Substance Abuse

Domain	Interval	Mean index	Level of quality of life	Frequency	Percentage
Social	0-10		Low	-	-
	11-20	14.88	High	365	100.0
Physical	0-10		Low	-	-
	11-20	15.19	High	365	100.0
Environmental	0-10		Low	32	8.8
	11-20	12.23	High	333	91.2
Psychological	0-10		Low	6	1.6
	11-20	14.17	High	359	98.4

According to Table 2 outpatients with mental and behavioural disorders brought on by substance abuse have generally high quality of life across all domains evaluated. All 365 respondents (100 percent) reported having a high quality of life and the social domain showed a mean index of 14. 88. A high quality of life was also reported by all participants in the Physical domain which had a mean index of 15. 19. These findings showed that the participants had strong social ties and were in good physical health which may have been caused by personal coping strategies, successful support networks or rehabilitation initiatives. On

the other hand minor differences are noted in the fields of psychology and the environment. With a mean index of 12. 23 the environmental domain revealed that 8. 8 percent (32 respondents) had a low quality of life while 91.2 percent had a high level of environmental domain. Comparably the psychological domain reported a lower percentage of 6 respondents (1 .6%) with low quality of life whereas the majority (98 .4%) with a mean index of 14 .17 maintain a high level. According to these results although overall quality of life is high. In line with the

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above, one of the respondents in IDI expressed that:

I have a good relationship with people around me. I have been a friendly person all my life and people tend to like me too because of my friendly nature. I have no dull moment (IDI/ 02/02/2024)

Another said:

I socialise with friends, and neighbours. I have a lovely family. Having a good relationship with people is very important. If there is no one to call as a friend, then that person's life is meaningless (IDI/ 05/02/2024)

Daily physical exercise represents a beneficial and low-cost strategy, easily accessible to the general population and potentially customizable to specific needs through brief training programmes. One of the respondents in IDI responded that:

I do not wait for anyone to do so many things for me. On a daily basis, I perform different tasks at home like cooking my meals, going to the market to get my stuffs, going around to visit friends, attending social functions and so on. All these keep me going (IDI, 2/02/2024)

A respondent also said:

I engage in physical activities like gardening around my house everyday but I do rest very too (IDI, 5/02/2024)

Another outpatient responded that:

I still exhibit the same energy that I had always to things I do initially and now. I still wake up before 5 a.m (as if I'm going to the office). I do my normal morning devotion and routines (IDI, 2/02/2024).

This implies that the quality of life of Outpatients living with Mental and Behavioural Disorders due to Substance Abuse in environmental domain was high

To corroborate this, one of the respondents said:

I have access to good health care. My wife is a nurse and she assists me in getting the right health care that I needed at home. (IDI, 02/02/2024)

One other respondent said:

I live in a very good environment by my standard and my family also assist me in getting the best in life. I'm happy and contented with my physical environment. ((IDI, 02/02/2024)

Most of the respondents in (IDI) were of the opinion that environment has a role to play in their wellbeing. The most important aspect of living a life full of quality is when an individual is receiving adequate care and support from people around, most especially the family. They also emphasized on the fact that home environment and financial resources help in attaining quality of life.

One respondent noted:

Having the basic needs in life like money, good home basic amenities and good health portrays living a life full of quality. When you have money and there is no one to adequately relate with in your environment, you will be unhappy and being unhappiness does not bring about good life. (IDI, 02/02/2024)

This implies that the quality of life of Outpatients living with Mental and Behavioural Disorders due to Substance Abuse in psychological domain was high. Hence, one of the respondents in IDI on level of psychological quality of life of outpatient said:

I challenge myself to take a risk each day, talking to people more, setting a tough workout goals or anything that pushes me out of my comfort zone. All

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these get me going psychologically (IDI,
5/02/2024)

One respondent noted that:

*I live my life as if tomorrow will not come,
I free my mind from negative thoughts or
feelings that will have negative impact on
my health and I'm very optimistic about
life.* (IDI, 2/02/2024)

Hypotheses Testing

H₀₁: There is no significant relationship between socio-demographic characteristics and quality of life of outpatients with

mental and behavioural disorder due to substance use.

Table 3: Multiple Regression Analysis Showing the Independent and Joint Prediction of Socio-demographics Characteristics and Quality of life among Outpatients with Mental Disorder due to Substance Use

A N O V A						
Model	Sum of Squares	DF	Mean Square	F	Sig.	Remark
Regression	227.212	7	32.459	4.538	.001	Sig.
Residual	2553.292	358	7.152			
Total	2780.504	365				
Model	Unstandardized Coefficient		Standardized Coefficient	t	Sig.	
	B	Std. Error	Beta			
(Constant)	46.006	.983		46.822	.001	
Age	-.678	.340	-.122	-1.992	.047	
Sex	-.324	.434	-.039	-.747	.456	
Marital status	-.369	.304	-.076	-1.211	.227	
Ethnicity	.599	.198	.157	3.028	.003	
Religion	-.475	.294	-.084	-1.615	.107	
Occupation	-.405	.111	-.200	-3.634	.001	
Educational status	-.520	.191	-.144	-2.717	.007	

Table 3 demonstrates the significant combined impact of socio-demographic factors on the quality of life for outpatients with mental and behavioural disorders due to substance abuse. A multiple R = .286 and a multiple R² of .082 are also displayed in the table. This indicates that when seven predictor variables were combined, they explained 8.2% of the variance. The

composite contributions' significance was examined at $\alpha = 0.05$. Additionally, the table demonstrates that the regression analysis of variance produced an F-ratio of 4.538 with a significance level of 0.05. This suggests that the independent variables' combined contribution to the dependent variable was significant. It also showed the relative contributions of the

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seven independent variables to the dependent variable in the form of beta weights such Age ($\beta = -.122, p < .05$), Sex ($\beta = -.039, p > .05$), Marital status ($\beta = -.076, p > .05$), Ethnicity ($\beta = .157, p < .05$), Religion ($\beta = -.084, p > .05$), Occupation ($\beta = -.200, p < .05$), and educational status ($\beta = -.144, p < .05$) respectively. Therefore age, ethnicity, occupation and educational

attainment were important because they could predict the quality of life of study participants who were outpatients with mental disorders in an independent and significant way.

H₀₂ There is no significant difference in the quality of life of outpatients with mental and behavioural disorder due to substance use based on gender, marital status, and occupation

Table 4 (a) Independent T-Test Showing the Difference between the Quality of Life of Male and Female Outpatients with Mental and Behavioural Disorder Due To Substance Abuse

Dv	Gender	N	Mean	SD	t-value	df	p value
Quality of life	Male	318	42.58	2.92	0.657	363	.512
	Female	47	42.30	1.28			

The quality of life of outpatients with mental and behavioural disorders resulting from substance use does not differ statistically significantly based on gender according to Table 4(a) Crit-t = 1.96, Cal.t

= 0.657, df = 363, p(0.512) > .05 level of significance). Male and female outpatients with mental and behavioural disorders in the study therefore have the same quality of life.

Table 4(b) Analysis of Variance (ANOVA) Showing the Differences in the Quality of Life of Outpatients with Mental and Behavioural Disorder Due to Substance Abuse Based on Marital Status

Source of variation	Sum of square	DF	Mean square	F	P-value
Marital status	10.464	2	5.232	0.684	0.505
Error	2770.040	363	7.652		
Total	2780.504	365			

According to Table 4(b) the quality of life of outpatients with mental and behavioural disorders brought on by substance use is unaffected by marital status F= 0.684, p (0.505) < .05). Consequently the study

discovered that marital status does not improve quality of life among outpatients with mental and behavioural disorders due to substance use. One-way analysis of variance was used to analyze the data.

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Table 4 (c) Analysis of Variance (ANOVA) Showing the Differences in the Quality of Life of Outpatients with Mental and Behavioural Disorder due to Substance Abuse Based on Occupation

Source of variation	Sum of square	DF	Mean square	F	P-value
Occupation	91.943	4	22.986	3.08	0.016
Error	2688.562	361	7.468		
Total	2780.504	365			

Table 4 (c) showed that occupation significantly affected the quality of life for outpatients with substance-use-related mental and behavioural disorders ($F=3.078, p(0.016) < .05$). One-way analysis of

variance was used to analyse the data and the study concluded that occupational status improved quality of life among outpatients with mental and behavioural disorders brought on by substance use.

Table 4 (c) i Descriptive statistics showing the mean and standard deviation of Quality of Life of Outpatients with Mental and Behavioural Disorder due to Substance Abuse based on occupation

Occupation	N	Mean	SD	SE
Civil servant	58	43.03	2.27	0.30
Trader	168	42.60	2.846	0.22
Farmer	18	43.22	2.76	0.65
Artisans	59	42.80	2.30	0.30
Others	62	41.52	3.15	0.40
Total	365	42.55	2.76	0.14

Table 4 (c) ii Multiple Comparisons Quality of Life of Outpatients with Mental and Behavioural Disorder due to Substance Abuse based on occupation

Compared Groups	Mean Difference (I-J)	Sig. (p-value)	Remark
Civil Servant vs Trader	0.44	0.29	No
Civil Servant vs Farmer	-0.19	0.80	No
Civil Servant vs Artisan	0.24	0.64	No
Civil Servant vs Others	1.52	0.003	Yes
Trader vs Farmer	-0.63	0.34	No
Trader vs Artisan	-0.20	0.63	No
Trader vs Others	1.08	0.008	Yes
Farmer vs Artisan	0.43	0.56	No
Farmer vs Others	1.71	0.02	Yes
Artisan vs Others	1.28	0.01	Yes

Table 4 (c) ii reveals the significant variations in the quality of life among

occupational groups found by the post hoc analysis employing LSD (Least Significant

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Difference). More specifically compared to civil servants, traders, farmers and artisans people in the other occupational status category continuously demonstrated a noticeably higher quality of life. Between 1.07911 and 1.70609 the mean differences between these groups and other occupational status categories are statistically significant at the 0.05 level. As compared to other occupational groups this suggested that people in the other category who might represent non-traditional or ambiguous occupational roles have a higher perceived quality of life. However since the p-values are always greater than 0.05 comparisons between civil servants, traders, farmers and artisans do not produce statistically significant differences. This suggested that these groups' perceptions of quality of life were comparatively uniform. These results demonstrated occupational differences in quality of life suggesting that interventions aimed at enhancing well-being should pay special attention to traditionally defined occupational groups while also investigating the factors that contribute to increased quality of life in the other occupational status categories. According to the findings the majority of respondents were traders, followed by artisans, civil servants, farmers and others. Any occupational activity could have an

impact on the quality of life (QoL) of outpatients with mental and behavioural disorders brought on by substance abuse. Farmers had the highest QoL followed by civil servants, artisans, traders and finally those with other occupational statuses aside from those mentioned above.

DISCUSSION

The research found that outpatients with mental and behavioural disorders due to substance use in a neuropsychiatric hospital had high quality of life in the four main domains of social, physical, environmental and psychological. The study also found that outpatients had high social health which suggests that more social support led to better QoL, because people who have more social support are less likely to feel abandoned, as outpatients still have people they can trust. These findings are consistent with previous studies by Wang, Mann, Lloyd-Evans, Ma and Johnson (2018), United Nations (UN) (2020) and Omokhabi (2021) which discovered that social support is essential for preventing and treating mental illness as well as assisting individuals in achieving and preserving mental health. Because it makes them feel loved and less alone it also demonstrates how important social support is for people getting better from any illness. This study supports the findings of Hanson (2006) and

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Baumeister (2016) who confirmed in their research that people who feel supported and have a sense of belonging have better quality of life. The findings of this study provide insight into the quality of life that outpatients with substance-related mental and behavioural disorders experience of social support from friends and family. Oluwagbemiga (2016) found that family provides both tangible and intangible support including food, clothing and financial assistance while Olanrewaju Omotoso and Alabi (2018) suggested that companionship advice and care during illness, home repairs, listening ears and assistance with everyday tasks contribute to the patient's health. For outpatients with mental and behavioural disorders caused by substance abuse a lack of social support can have major repercussions.

Outpatients who suffered from mental and behavioural disorders as a result of substance abuse had a high physical quality of life. This is in line with previous research by Wang, Wang, Wang Li and Zhou (2014), that Physical activity (PA) has been shown to improve abstinence rates, reduce anxiety and depression symptoms improve mood and improve quality of life ((Dowla, Sinmaz, Mavros. Murnion, Cayanan, & Rooney, 2022), lowers self-reported

withdrawal (Horrell, Thompson, Taylor Neale Husk, Wanner. Creanor, Wei, Kandiyali., Sinclair, Nasser, & Wallace, 2020). Additionally PA has been demonstrated to decrease cravings while undergoing treatment (Piché, Daneau, Plourde, Girard., & Romain 2023). In particular the World Health Organisation (2024) suggests doing moderately intense exercise regularly to enhance physical well-being build muscle, lower the risk of falling and improve balance. Frequent exercise is a beneficial and affordable approach that the general public including OwMBDSU can readily adopt.

Regarding the environmental domain it suggests that outpatients with behavioural and mental disorders brought on by substance abuse had a high quality of life. Environmental factors can have a big impact on finishing treatment for substance use disorders and staying drug-free. This is consistent with Stahler, Mennis and DuCette, (2016) study. Prior research has also shown that public transportation from home and the outpatient treatment programme may play a significant role in enabling the impoverished who are less likely to own cars to attend treatments. As a result the majority of programmes for treating substance use disorders are

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outpatient rather than residential, requiring clients to travel from their homes to the treatment location. One of the most significant environmental influences on treatment is travel to treatment. Treatment attendance and completion are impacted by the time and distance traveled from home to the treatment programme (Mennis Stahler & Baron 2012; Guerrero, Kao, & Perron 2013). According to a study by Brorson, Arnevik, Rand-Hendriksen and Duckert (2013) completing treatment is a critical indicator of success following treatment in terms of future drug abstinence, employment decreased involvement with the criminal justice system and other positive outcomes. Good psychological health was reported by outpatients with mental and behavioural disorders due to substance abuse which supports the findings of Steptoe, Deaton and Stone (2015) that psychological quality of life and health are closely related. This relationship may become even more significant if only the prevalence of chronic illness rises with age. Maintaining a high standard of living is becoming more and more important as life expectancy rises and therapies for serious illnesses improve.

The findings showed how demographic factors significantly affect the quality of life

for outpatients with mental and behavioural disorders brought on by substance abuse. The study found that the quality of life (QoL) of outpatients with mental and behavioural disorders brought on by substance abuse was correlated with age, ethnicity, occupation and educational attainment. Research has shown for example that patients with mental illness have a lower quality of life (QoL) when they are older (Dong, Lu, Zhang, Zhang & Ng 2019; Cho, Lee, Kim, Park & Choi 2019) have less education (Hasan & Tumah 2019; Desalegn Girma & Abdeta, 2020) and are unemployed (Wilmer Anderson & Reynolds, 2021). This aligns with a study by Shumye, Amare, Derajew, Endris, Molla and Mengistu (2021) that established a significant relationship between patient age and all QOL domains. For those with mental illness ethnicity can have a substantial impact on their quality of life in many ways. Cultural beliefs social norms systemic factors and the accessibility of mental health care all have an impact on these effects which can affect how individuals with mental illness perceive their illness, seek treatment and go about their daily lives. The results of this study are also consistent with a study by the World Health Organisation (WHO) (2016) which emphasized that education for people with

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mental illness (PWMI) will improve social and cognitive abilities boost self-esteem and widened social networks and intern all of these support people's ability to live independently and to have a decent income. Priebe *et al.* (2010) found that people with severe mental illness have a better quality of life as they get older. Perhaps this is because people tend to accept themselves and their lives as they age. This could be because mentally ill people who have received education develop new skills and abilities that can help them feel better mentally and alleviate their symptoms which can lead to a lack of education and employment. But research has also shown that education has a high predictive value for improved health and well-being since it predicts employment wealth and social standing all of which have been linked to quality of life (QoL) (Avendano, de Coulon , Nafilyan , de Coulon & Nafilyan 2017; Belo *et al*, 2020)

The study found no difference in the quality of life (QoL) of male and female outpatients with mental and behavioural disorders brought on by substance abuse. This suggests that the quality of life (social, physical environmental and psychological) of male and female outpatients is nearly equal. A study conducted at the WHO

conference in 2016 found that men have a higher quality of life in terms of their physical social and mental aspects when compared to women. This finding contradicts the findings of this study. This study contradicts that conducted by Mishra *et al.* (2009) in India, it demonstrated that men's quality of life was superior to women's.

The findings demonstrated that the quality of life (QoL) of outpatients with mental and behavioural disorders due to substance abuse was unrelated to their marital status. Conversely a study carried out in southern Ethiopia revealed that individuals with mental illness who were single had a higher quality of life (QoL) than those who were married (Shor , Roelfs , Bugyi & Schwartz ,2012). Given that numerous studies have found that married people have better health outcomes than single people this could be because marital status is a crucial socioeconomic factor associated with longevity and good health (Chiang ,Chang , Liu &, Tzeng ,2021). An earlier study found that participants aged 30 to 39 who were single and women had higher HRQoL (Han, Park, Kim, Kim & Park, 2014) Married people might therefore view their HRQoL negatively feeling like a burden to their families neglecting to take care of

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children or other family members and not appropriately handling their responsibilities. Additionally marital issues are associated with the spouse including redefining shared life goals rearranging family and partnership duties and questioning intimacy and commonality within the marriage (Jungbauer & Angermeyer, 2002). Nonetheless other studies also showed that higher HRQoL is predicted by marriage (Gutiérrez-Vega, Esparza-Del Villar, Carrillo-Saucedo & Montañez-Alvarado, 2018). In other words people who are in a relationship are more likely to communicate their feelings thoughts and everyday experiences. They are also more likely to receive adequate social support which leads to being optimistic about life.

Occupation indicated the QoL of outpatients living with mental and behavioural disorder due to substance abuse in the study. Similarly, other studies have found that employed patients have higher HRQoL scores than those who are unemployed (Haro, Novick , Perrin , Bertsch , & Knapp , 2014; Arraras, Ibañez, Basterra, Pereda, Martin & Iribarren

(2018). This could be explained by higher self-esteem among patients with employment, which has been described as a moderating factor between employment and HRQoL, as well as having a larger social network as a result of employment (Tan *et al.*, 2019). Moreover, the relationship between employment status and HRQoL in our study may be due to differences in income because employed patients had a higher source of income, while students and unemployed patients may not have had enough income to cover their basic needs.

Recommendations

To improve patient's quality of life through prompt and efficient treatment mental health practitioners should place a high priority on the early detection of substance use disorders. Intervention techniques should be modified to match patient demographic profiles taking into account the impact of age ethnicity occupation and educational attainment. In order to facilitate reintegration and lower relapse rates among outpatient's policies should encourage the growth of robust social and community networks.

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