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Functional remission and employment among patients with schizophrenia in Malaysia

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Abstract

Objective: The study aimed to determine the rates of functional remission and employment as well as the factors associated with functional remission among patients with Schizophrenia, receiving community psychiatric service in an urban setting in Malaysia.
Methods: From a total of 250 patients randomly selected, 155 fulfilled the study requirement and were assessed on their functional remission status using the Personal and Social Performance Scale. The relationships between functional remission and socio-demographic factors, clinical factors, social support, symptom remission and rates of hospitalization were examined.
Results: The results revealed that 74% (n = 115) of the respondents had functional remission with only 20% (n = 31) currently employed. Functional remission was found to be significantly associated with good social support (84.4% versus 36.4% $p < 0.001$, OR = 9.487 [95% CI = 4.008–22.457]); shorter illness duration of less than 10 years (81.2% versus 66.7% $p = 0.038$, OR = 2.167 [95% CI = 1.035–4.535]); good medication compliance (79.1% versus 50.0% $p = 0.002$, OR = 3.778 [95% CI = 1.570–9.090]); hospital admissions of lower than 3 per year (80.5% versus 44.4% $p < 0.001$ OR = 5.150 [95% CI = 2.145–12.365]) and; symptomatic remission (87.3% versus 37.4% $p < 0.001$ [95% CI = 0.070 (0.029–0.168]). A multiple regression analysis revealed only social support, lower hospitalization rate and symptom remission, as significant predictors of functional remission.
Conclusion: A majority of patients with Schizophrenia in this study achieved functional remission, however, only a small percentage of them were employed. Functional remission was influenced by severity of illness and levels of social support in these patients.

1. Introduction

The concept of recovery in schizophrenia has been extended beyond symptom remission to recovery of functioning. Employment as one of the major areas of functioning has been taken as one of the goals in the management of schizophrenia. This emphasis grew out of the high unemployment rates among this group of people causing a high burden to the patients, families and countries. The rates of unemployment were reported to be as high as 80%–90% in Europe [1], and 75%–85% in the United States [2,3] even in the context that most people with SMIs consistently expressed their keenness to work [2,4].

In Malaysia, according to the National Schizophrenia Registry for 2003 and 2004, 50% of patients with Schizophrenia were unemployed during their first contact with Psychiatric services [5]. This finding was replicated in another study among people with schizophrenia attending an outpatient clinic setting [6]. This lower rate compared to those of the Western countries may be partly due to the studies employing a looser term of employment. In the first study, only 17% of were in full-time employment, while the

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rest were in some forms of employment [5]. These two studies also presumably focussed on the less disabled group of patients based on their study setting.

Patients who are referred to the community psychiatric services are typically more disabled with more complex illness and psychosocial needs. In Malaysia, community psychiatric service (CPS) has slowly developed since 1990s [7] with the main purpose of reducing hospital admission as a result of inadequate bed numbers. It caters to patients with multiple readmissions due to many reasons such as having poor insight towards illness leading to poor compliance towards medication, having poor support from the caregivers or having many unmet needs. It is now a part of the national service development strategies [8]. In the Malaysian model, community psychiatric team members are based in the hospitals where psychiatric resources are located unlike in the western models where services are based at community mental health centers, equipped with better levels of resources and provide more comprehensive services [9,10]. The hospital-based community psychiatric service (HCPS) in Malaysia, generally has larger patients load and does not operate after office hours [11] because of limitations in resources.

To date, no study has ever looked into the functional remission or employment among patients receiving this relatively new service in Malaysia. Thus, the main aim of the present study was to determine the rates of functional remission and employment as well as the factors associated with functional remission among patients with Schizophrenia receiving HCPS in an urban setting of Kuala Lumpur. The results from this study may be useful in informing further service development.

2. Materials and methods

2.1. Study design, setting and subjects

This cross sectional study was conducted among patients with Schizophrenia, who had received HCPS for at least one year in the largest general hospital in Malaysia i.e. Hospital Kuala Lumpur (HKL), located at the centre of metropolitan city of Kuala Lumpur. Its community psychiatry service caters to patients with severe mental illnesses within a catchment area of 30 km radius from the hospital. Simple random sampling was employed, and data collection was done within a 3-month period from February to May 2010.

The service team was multidisciplinary in nature, offering community service from 8 am to 5 pm. They typically started work on any day with a team meeting to discuss the management and progress of the patients receiving active interventions in the community. The team had 11 case managers who were trained psychiatric nurses and medical assistants. Each case case-manager managed approximately 40 patients [12].

Generally, those with frequent admissions of 3 or more per year were managed by this team. The team treated an average of 500 patients per month. The services were individualized and the intensity depended on the needs of each patient based on the severity of the psychiatric symptoms and functional capacity especially of self-care and social support [12].

All patients who met the study requirement based on the inclusion and exclusion criteria were recruited into the study. The inclusion criteria were: (i) Having diagnosis of schizophrenia based on DSM-IV(TR) by consultant psychiatrists, (ii) Having received home care for at least one year, (iii) Age between 18 and 60 years; (iv) Consenting to participate. Exclusion criterion was: (i) those who refused to give consent. Information was gathered through interviews during the home visits and from the medical records. Approval from the ethics committee was obtained prior to conducting the study.

The case notes of 553 patients receiving the community service at the time of the study were screened for suitability to participate in the study. Out of this, 303 fulfilled the exclusion criteria where 243 had received the service for less than one year and 60 had other diagnosis than schizophrenia. A simple random sampling was done on the remaining 250 eligible patients, however, 8 refused consent and 15 were admitted in a mental hospital and 2 did not complete the questionnaire, leaving the final sample of 155.

2.2. Study instruments and procedures

2.2.1. Socio-demographic questionnaires

The socio-demographic questionnaire was devised to obtain information from patients regarding their socio-demographic variables such as age, gender, ethnicity, marital status, education, employment and total income. Other relevant social variables that were included in the questionnaire were: family and social support.

Family support was assessed with two main questions on: (i) Monitoring treatment — with the response options of *yes*, *not bothered*, and *seldom*; and (i) Support for rehabilitation — with the response options of *giving support* and *not bothered*. Family support was rated as good if the responses were *yes* and *giving support* for item 1 and 2 respectively. Social support was measured based on 3 items with response options as the following: (i) Relationship with neighbor — *good* and *poor*; (ii) Neighbour/community support — *accepting and helping patient*, *accepting their presence in the community* or *not accepting patient in the community*; (iii) Patient's involvement in the social activities — *involved in activity/activities*, *isolate him/herself* or *involvement in activity/ies not allowed*. Social support was considered good when it was rated as *good* for item 1 and either *accepting and helping patient* or *accepting their presence in the community* for item 2 and *involved in the activity/ies* for item 3. Information on family and social support was obtained from a key family member, taking into account, judgment from case managers.

2.3. Personal and Social Performance (PSP)

The PSP [13] measured routine social functioning. It contained four main areas namely socially useful