Singapore Med J 1997; Vol 38(11):480-484

Quality of Life Survey Among Day Release Patients at View Road Hospital

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ABSTRACT

Objectives: The aim of this study was to identify factors that contributed to the chronic patient's quality of life from both the patients' and staff's point of view. We were also interested in any lack of congruence between staff and patient perception as these could have significant implications for planning long-term care.

Method: Fifty of the patients under the Day Release Scheme at View Road Hospital and their staff were given a modified questionnaire concerning the patients' quality of life.

Results: Generally the patients reported satisfaction with life domain items covering their living conditions. The majority felt safe in the current setting, enjoyed their work, their regular outings and parole to the nearby shopping centers. Significant differences were observed between the staff and patients' perception in life domain items relating to general well-being, knowledge and education, relationships, in-patient care, leisure and vocational rehabilitation. The staff group perceived having good food, money, good treatment and in employment as being important to their patients' well-being. Patients emphasised having money, family support or a partner, being employed, having time for recreational activities and eating good food. Having good health, medication and feeling at peace were also considered important by many of our patient.

Conclusions: The findings of the study are discussed with regard to implications in planning rehabilitation services and improving the quality of care given to patients.

Keywords: View Road Hospital, day release scheme, quality of life, rehabilitation, chronically mentally ill patients

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INTRODUCTION

View Road Hospital functions as the center for rehabilitation of stabilised psychiatric patients in Singapore. The hospital offers individualised long-term in-patient care, day services and out patient follow-up. Most of the patients are not accepted by their families but are able to function adequately in a sheltered environment. One hundred and fifteen patients are in the day release scheme whereby they are employed in the community during the day and only return to the hospital in the evenings[1]. Over the weekends, they are allowed leave to go out of the hospital or to return home. Thus, the hospital facilities with the emphasis on re-socialisation and re-settlement, is used mainly as a transition from hospital to the community. Patients who do well will eventually get discharged to residential employment, back to their families or to independent living in the community.

One of the main objectives of rehabilitation is to address patients' social disablement. Efforts are made to help them develop or use their potentials to regain self-esteem and self-confidence until they are able to achieve more independent living in the community.

Ultimately, the aim of rehabilitation is to improve the standard of care and to provide an extensive range of services. It must also be borne in mind that chronically-mentally ill patients are vulnerable to stress and their behaviour is characterised by dependency, by problems with living skills, with employment, and with their social environment[2]. Patients who return to life outside the institution frequently encounter problems of unemployment, poverty, housing, lack of meaningful activity and absence of choice[3-6].

The focus of rehabilitation at View Road Hospital is to evaluate other parameters like risk of relapse, quality of life, remedying individual sensitivity to life events and enhancing the patient's capacity to deal with life generally. By looking into the patients' quality of life, we are able, at a practical level, to measure the success of our efforts and at the same time develop programs that are sufficiently flexible enough to meet the idiosyncratic needs of the individual patient. In our psychiatric setting, the assessment of patient satisfaction with their quality of life in the hospital is an important indicator of the quality of rehabilitation outcome and as an indicator of the quality of care given[7]. Also, the milieu and therapy should ideally conform to the needs and attitudes of the patient.

The aim of this study was to identify factors that contributed to the chronic patient's quality of life from both the patient's and staff's point of view. An important part of therapeutic planning is to find out which features of quality of life is particularly important to the patient and to their nurse raters, who in real life, make judgments that can have a significant impact on them[8].

What is clear from previous attempts to measure

Table I - Demographic profile of respondents in survey

Race	**Male**	**Female**
Chinese	32 (64%)	10 (20%)
Malay	2 (4%)	-
Indian	2 (4%)	2 (4%)
Others	1 (2%)	1 (2%)
Total	37 (74%)	13 (26%)
Educational level	**Count**	**%**
No education	2	4
Primary	25	50
Secondary - 'O'levels	17	34
'A'Levels/Vocational	4	8
Tertiary/Polytechnic	2	4
Religion	**Count**	**%**
Christianity	16	32
Islam	4	8
Hinduism	2	4
Buddhism	19	38
Free thinker	3	6
Others	3	6
Not known	3	6
Income level	**Count**	**%**
≤ $12	13	26
≤ $300 - $400	34	68
≤ $400 - $500	1	2
≥ $500	2	4
Total	50	100
Mean (SD)	**Range**	
Duration at VRH (mths)	39.36 (31.17)	2-96
Age	51.88 (7.47)	37-67

or define quality of life is that no simple, uni-dimensional approach is sufficient. Quality of life must be judged on a series of different dimensions[6,7, 9-11].

We used Maslow's[12] hierarchy of human needs when we looked for an appropriate quality of life check-list. Although there are 5 basic types of human needs, each level of need has to be satisfied before the individual can fully experience the next. The hierarchy of needs for our long-stay patients, is as follows :

1. Physical and psychological needs which include high quality medical and psychiatric treatment, suitable accommodation and adequate food.
2. Stability and security which means there must be adequate personal safety and protection, adequate hygiene and clothing, etc., personal privacy, access to counselling and psychotherapy, a therapeutic milieu and visits from friends and relatives.
3. Purpose in life. This includes engagement in an occupation, work activity or education, physical exercise, leisure activity, companionship and belonging, religious freedom and freedom of sexual expression.
4. Autonomy which comprise of material comfort, personal possessions, personal space, quiet space and patient's advocacy and sense of control over life.
5. Aesthetic and intellectual satisfaction in areas of art and music and the pursuit of personal success and achievement.

In this study, we surveyed 50 schizophrenic in-patients residing in the hospital but who were working in the community under the day release scheme. Staff members were actively engaged in providing a comprehensive but predominantly vocational-based rehabilitation service. They included psychiatrists, psychologists, social workers, occupational therapists and nurses. Most of these patients had participated in rehabilitation programs in the hospital before being assessed by the rehabilitation team, to be certified ready for outside employment. We hope that the findings of this survey will help to improve the standard of care in patients' rehabilitation, since patient satisfaction is generally regarded as a precondition for high quality treatment.

PATIENTS AND METHOD

The sampling frame consisted of 236 psychiatric in-patients staying in Woodbridge Hospital. We decided to focus only on the 115 patients who were working under the day release scheme. Respondents were selected from a range of cultural, gender and educational background. Their overall satisfaction with life was a good indicator of the quality of service provided.

Ad hoc estimate for this research indicated 70 patients to be sampled. This represented approximately 1:4 of the psychiatric patient population in View Road Hospital. However, we used random number tables to select 50 patients for the study. The criteria for selection included a diagnosis of Schizophrenia as defined under the DSM III axis 1, so as to ensure a standardised and accepted definition of schizophrenia. Patients with epilepsy, past history of alcohol and drug abuse, organic brain damage and IQ less than 70, were excluded from the study. Only schizophrenic patients were selected for the study as the majority of the patients in the hospital belonged to this diagnostic category. Also, all the selected patients had to be in the hospital for at least 3 months, to ensure that they had fully adjusted to the new hospital environment. In addition, the patients should not be actively suicidal or psychotic at the time of the survey.

Content validity

Content validity of the quality of life questionnaire was evaluated by a psychiatrist and 3 nursing staff. For our study purposes, we adopted the quality of life checklist as proposed by Malm et al 1981[9], for a quick, simple recording of assessments of the various aspects of quality of life. However, we modified the original questionnaire meant for use in an out-patient setting for use with our patients.

Three ward nurses were trained in the administration of a modified version of the quality of life checklist developed by Malm et al[9]. They were given the questionnaire prior to the group discussion. A 5-point rating scale was used for patients to assess their degree of satisfaction with life at the hospital. This included ratings for very satisfied, satisfied, unsure, unsatisfied, very unsatisfied and not relevant. The 3 nurse raters also

Table II - Comparison of mean satisfaction life ratings of patients at View Road Hospital

Life Domains		mean[1]	factor analysis (coef. α)
I	Material well-being (29 items)	2.19	0.77
II	Knowledge & education (7 items)	2.25	0.76
III	Relationships (4 items)	3.59	0.48
IV	Dependency (2 items)	2.14	0.29
V	Inner experience (6 items)	2.21	0.82
VI	In-patient care (7 items)	2.18	0.72
VII	Leisure (4 items)	3.10	0.47
VIII	Work/vocational rehabilitation (2 items)	2.86	0.53
IX	Religion (2 items)	3.08	0.042

[1] Mean life domain ratings for View Road Hospital ranged from 1, very satisfied to 5, very dissatisfied. Patients were asked to give a 0 rating for items not considered relevant to them.

gave their perception of the patients' quality of life. They knew the patients' clinical and social functioning over the past one year. The period to be evaluated was the preceding one month.

On completion of the questionnaire, both the patients and the 3 nurse raters were asked to indicate the 3 most important and the 3 least important contributors to patients' satisfaction with their quality of life. They were also asked for recommendations and feedback in relation to accuracy, appropriateness, grammar, appearance of bias and level of reliability. Standardised operational definitions were worked out to ensure a high scale reliability. The main life domains and items studied included: (1) Material quality of life (A) living conditions including ward facilities, clothing, nutrition and food, privacy, etc. (15 items); (B) environment (6 items); (C) safety services (3 items); (D) travel/communications (5 items).

Although the hospital functioned as a hostel for the day release patients, nevertheless, it was important to assess whether the milieu conformed to the needs and attitudes of the patients[9,13]. For many of our patients, the hospital will remain their home for some time. Equally important was to see if our patients were confident and knew what to do in case of a fire within the hospital grounds. Competent use of transport and communication facilities are also a basic requirement, if these patients are to return to the community upon their discharge from the hospital.

(II) Knowledge and education: including availability of newspapers, magazines, books, radio, television sets, educational talks, health posters 7 items) etc.

The objective here was to ensure that our patients were exposed sufficiently to what was happening in the outside world with the opportunity to widen their horizons and improve on their awareness and capabilities[9]. Educational talks and posters also had to be translated into the other main languages (ie Mandarin, Malay and Tamil) to benefit the non-English speaking patients.

(III) Human relationships: family; friendship and human contact; discrimination etc.

Here, we were concerned with the interpersonal qualities of life especially with the patients' perceived support from their families and friends. We felt that most of our recovering schizophrenic patients could reduce some of their problems in daily living if they could develop satisfying relationships with others around them. They could also remedy their sense of alienation with the outside world if they could find satisfaction in their interaction with ordinary people apart from professional staff, for example, with family, friends, volunteers and employers[9].

Given the conservative mind-set of our patients and staff, the section on patients' satisfaction with sexual relationships was left out. As most Asian cultures still discourage free mingling of the two sexes, the hospital had segregated the opposite sexes to separate dormitories. Patients were however, allowed to speak freely to each other and encouraged to participate in mixed group recreational activities.

(IV) Dependency issues
This covered patients' concept of their financial and psychological dependency and how much they felt that this posed a problem to them. Bearing in mind that although patients doing the survey were working outside in the community, they were definitely paid lower rates as compared to their normal colleagues. Moreover, living in an institutional setting meant that most patients experienced some degree of loss of personal friends, possessions and other contacts with the outside world. Also, the fixed routine of life at the hospital meant that the patients were generally dependent on the hospital staff for help and guidance in times of crises.

(V) Inner experience
This included the patients' sense of inner peace, pleasure from life, sense of purpose and sense of identity (6 items).

(VI) Medical care
This section examined the treatment given for relieving psychiatric signs and symptoms; preventing relapse; relieving and preventing physical disease (7 items).

(VII) Recreational activities
This included participation in art and craft sessions, hobbies, music/karaoke sessions etc (4 items).

Here, we were concerned with providing an optimum level of stimulation through suitable leisure activities tailored to the individual patient's needs and to lessen the effects of boredom and inactivity commonly seen in institutions.

(VIII) Work and vocational rehabilitation
This covered open employment, sheltered

Table III - Items on which significant differences were obtained between staff and patient groups using the Wilcoxon Matched-Pairs Signed-Ranks Test (The lower the mean score the better the satisfaction in that particular item)

		Groups				
		Staff		Patient		
Life Domain Item	Section	Mean	SD	Mean	SD	p value
General appearance	IA	1.98	0.14	1.76	0.56	0.016
Crime	IC	2.02	0.14	3.12	1.08	0.000
Outings	ID	2.3	0.84	2.0	0.64	0.027
Leave	ID	3.14	1.28	2.62	1.35	0.021
Visits	ID	3.72	0.78	3.16	1.32	0.005
Books	II	2.82	0.98	2.34	0.82	0.013
Friends (same sex)	III	3.1	1.04	2.66	1.15	0.053
Friends (opp. sex)	III	4.04	1.28	4.88	1.62	0.024
Individual therapy	VI	2.04	0.28	2.4	0.9	0.005
Compliance	VI	1.98	0.14	2.18	0.72	0.042
Hobbies	VII	2.26	0.69	2.7	1.21	0.021
Smoking	VII	3.9	1.73	3.12	1.87	0.0023
Movies	VII	2.9	1.06	2.02	0.71	0.0002
Occupational therapy	VIII	2.3	0.95	3.06	1.68	0.005

employment in occupational therapy and at Woodbridge Hospital, and helping with general housekeeping chores (4 items). The patients' overall satisfaction with his work situation becomes the outcome criteria.

(IX) Religious and spiritual experience
Patients' freedom in religious expression is explored in this section (2 items). Given the patients' different religions and cultural beliefs, tolerance of one another's religious faiths is important for a harmonious co-existence.

The data was computed and the results were analysed using the statistical package for social sciences (SPSS)[17].

RESULTS

All the 50 patients answered the questions put to them. However, we only considered the answers from patients who thought that the question was relevant to them.

There were 251 patients at View Road Hospital. All of them except for one, were diagnosed to have chronic schizophrenia. The remaining patient was noted to have a diagnosis of personality disorder.

The demographic profile for the 50 patients in the study is shown in Table I. There were 37 males and 13 females in the study sample, a ratio of 1:2.85. Their racial composition comprised 84% Chinese, 8% Indians, 4% Malays and another 4% made up of mainly Eurasians. The mean age was 51.88 years ranging from 37- 67 years (SD 7.47). Their mean stay at View Road Hospital was 39.36 months (SD 31.17). With regards to their educational background, 50% have had Primary education, and 34% have gone through at least Secondary or up to the 'O' levels. Two patients had received tertiary education. We also noted that 38% of our respondents were Buddhists and 32% were Christians. For the majority (68%), their income per month was in the $300-$400 range. Two patients earned more than $500 a month.

The mean ratings given by patients for the 9 life domains are presented in Table II. The ratings given are mean values for the respective sections of life domains in the checklist. Patients rated 1 for very satisfactory down to 5 for very unsatisfactory. A lower mean score indicated better satisfaction in that particular item. Lower scores were noted in life domains that represented items in relationships, leisure activities and religion.

Mean differences between staff and patients ratings on individual items were also computed. Significant differences were observed in items relating to general well-being, knowledge and education, relationships, in-patient care, leisure and vocational rehabilitation. These items are presented in Table III.

A frequency count of the three most important and three least important items identified by the 2 groups of respondents was compiled and percentages were computed. The items extended over several life areas. The 2 groups agreed that having luxury items like beautiful clothes, shoes etc. were not important. The staff group perceived good food, money, good treatment and being employed as important to their patients' well-being. Some of them also mentioned feeling accepted and understood by family and society as important predictors of patients' quality of life. The staff perceived marriage and sex as not priority factors for the patients' well-being.

Among the important contributors to quality of life, patients emphasised having money, family support or a partner, being employed, having time for recreational activities and eating good food. Having good health, medication and feeling at peace were also considered important by many of our patients.

DISCUSSION

As we saw it, the challenge was to describe the patients' patterns of existence. A wide range of factors in the material and social environment together with subjective experience, contributed to their overall perception of quality of life[11,14-16]. Lehman[11], using a quality of life interview reported evidence attesting to the reliability of responses given by chronic mental patients, and found that subjective quality of life indicators were better predictors of well-being rather than supposedly objective indices.

In general, patients expressed satisfaction with their living conditions. The majority felt safe in the current setting, enjoyed their work, their regular outings and parole to the nearby shopping centres. They also expressed satisfaction with the ready availability of television sets and radios during their leisure hours. Many of the patients said that they were satisfied with their relationship with staff and their respective employers, but not in their relationship with members of the opposite sex. A

lack of self-esteem, deficient social skills and painful memories and fears of rejection made it difficult for some patients to enjoy interaction with members of the opposite sex. Free mixing of the sexes and any development of sexual relationships among patients is also actively discouraged by hospital staff and management.

When we looked at the individual item scores, a number of patients expressed their unhappiness with their home leave and visits by their relatives and friends. As Sunday was their only off day, many relatives had difficulty accommodating patients for overnight stay in an already cramped public housing apartment. Fear of neighbours finding out about their mentally ill relative, the prevailing stigma of mental illness in the community and past experiences with patients' poor compliance with medication and subsequent relapses had also contributed to the family's hesitation in bringing their mentally ill relative home. Also, since the hospital is situated some distance from popular bus routes, it made it even more difficult for relatives and friends to visit patients regularly in the hospital. Patients also commented that they were not satisfied with some of their leisure pursuits. One reason could be the lack of funds as most of them were not receiving a high salary. Moreover, they were strongly encouraged to keep their earnings in the savings bank and their savings book was given to them only at certain times, with a limit on the amount withdrawn. There was a lack of interest in activities like dancing, hobbies, games etc. However, patients expressed satisfaction in participating in the karaoke and music sessions held in the hospital, and in going to the movies.

There were significant differences as well as some similarities in staff and patient perspectives on quality of life and well-being. Generally, patients' ratings exceeded those given by staff across most of life domains. Patients were noted to be less satisfied than staff in items including level of crime, relationship with members of the opposite sex, individual therapy sessions, compliance with medication, hobbies and occupational therapy. Most of the patients were single and many had lost contact with members of their immediate families. Generally, nurses lacked information on their patients' private/social lives. However, both groups agreed that patients were happy in their interaction with fellow patients and staff in the hospital.

The 2 groups were not found to agree, however, on factors which were important in contributing to quality of life. While the staff group stressed good living conditions, being employed and accepted by others as important variables, patients emphasised the importance of having money, a job, relationships, time for recreational activities as well as good health and experiential factors. Religion was not regarded as important by most respondents.

The findings in this study suggest patients often have views regarding their life situation that vary from those held by their caregivers. Mental health workers providing care and support for individuals with chronic mental illness are often reminded to provide individualised and comprehensive services. But as the present data show, doing this without consulting the patient runs the risk of providing services that fail to address the issues that patients perceive as being important. As a result, patient engagement and compliance with treatment goals can be seriously compromised.

This paper has attempted to identify problems in ensuring quality, care for recovering schizophrenic patients at View Road Hospital. The patients' quality of life issues presented here are important, both in the evaluation and in the implementation of appropriate psychiatric treatment for patients who are being prepared for life in the community.

ACKNOWLEDGMENTS

The authors would like to thank Prof Teo Seng Hock, Medical Director of Woodbridge Hospital and Dr O K Leong, Medical Director View Road Hospital for their kind permission in printing this article.

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