



Social functioning and quality of life of people with schizophrenia in the northern region of Malaysia

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Abstract

This is an explorative study on the quality of life of 258 people with schizophrenia living in the northern region of Malaysia. The study samples were selected from the Outpatient Department of the Departments of Psychiatry attached to the General Hospitals located in Northern Malaysia. Details on background and illness characteristics of the respondents were collected through a questionnaire prepared by the researcher. The Disability Assessment Schedule (WHO/DAS) was used to collect information related to respondents' social functioning. The Quality of Life Interview (QOLI) was used to collect the information about quality of life (QOL). Results of the present study indicated serious deficits in the areas of social functioning and quality of home environment and these deficits were found to have a significant association with low QOL. Based on these findings, the present research argues that policy makers must focus more on creating rehabilitation resources within communities which will complement the level of success achieved in reducing psychotic symptoms. Results of the study highlight an urgent need for the creation of community-based rehabilitation facilities for the successful care of people with a mental illness in Malaysia. This is necessary for other countries in the region as well.

Keywords

schizophrenia, severe mental illness, social functioning, quality of life, positive and negative symptoms, community, rehabilitation, home environment, Asia

Introduction

There is an interesting variation in the ways in which different countries have responded to the concept of treating persons with mental illnesses in the community. Depending on the prevailing sociocultural and political climate some, mainly developed, countries have responded well to the concept of treating people with mental illnesses in the community. Conversely, there are many countries experiencing difficulties in implementing community-based treatment of

people with mental illness. However, in spite of these polarities, the World Health Organization (2001) reports that there has been a world wide paradigm shift from hospital care to community-based care of people with mental illnesses which is evident from far reaching policy changes in a number of countries.

Malaysia has been a forerunner in adopting many significant changes in its mental health care delivery systems. In 1997, Malaysia's National Mental Health Policy was enacted with

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the aim of improving the quality of community-based psychiatric services and to encourage families, communities and community-based agencies to provide all the necessary care and protection of people with mental illness (Jamaiyah, 2000). Mental health services were integrated into primary health care systems (World Health Organization, 2004). In collaboration with the WHO, mental health services have been reviewed and strengthened at the primary health care level (World Health Organization, 2001). Community health teams were formed in many mental health centres around the country. Outpatient treatment for people with mental illness has become the policy of almost all the psychiatric treatment centres. As a result of these new developments, thousands of people suffering from severe mental illnesses have been living in the community in recent years. However, to the knowledge of the researcher no systematic reviews have been conducted on the life conditions of people with mental illness living in Malaysian communities. This lack of reviews of community mental health programs is relevant not only to Malaysia but also to many other Asian countries which have implemented community-based mental health programs in recent years.

Studies evaluating the effectiveness of community-based care of people with mental illness have revealed mixed results. Earlier studies such as Shepherd, Watt, Falloon and Smeeton (1989) and Huber, Cross, Schuttler and Linz (1980) in the United Kingdom have shown a symptom remission rate of 22-26% and poor social functioning in 25-35% of the patients. A similar scenario has been reported in recent studies. Munk-Jorgensen (1999) has reported an increase in suicide and remission among community-based people with a mental illness in Europe. Webster, Douglas, Belfrage and Link (2000) have reported a significant increase in imprisonment and homelessness among people with a mental illness in the United State of America. Jablensky, McGrath, Herrman et al. (2000) have reported high rates of social isolation and poor quality of life for people with a mental illness in Australia. Based on a pilot study in a treatment centre in Malaysia, Mubarak, Baba, Low and Hoe (2003) have reported that community-based patients with

schizophrenia experience a poor quality of life. In spite of these negative findings, there are a few studies which have reported the effectiveness of community-based mental health programs. Wilkinson, Piccinelli, Falloon et al. (1995) and Mason, Harrison, Glazebrook et al. (1995) in the United Kingdom, and Thara and Eaton (1996) in India, have reported a better outcome on the life conditions of people with mental illnesses living in the community.

In addition to these inconclusive findings of reviews on community-based care of people with mental illness, there are a few other limitations to their methodologies. Their objectives, psychiatric treatment methods, cohorts, time and duration of study differ depending on the purposes for which they were conducted. A few of these studies were conducted to follow-up de-institutionalised people with mental illnesses and others were reviews of people who were not hospitalised for mental health problems and were receiving outpatient psychiatric treatment in the community. These subtle differences among studies have implications for the ways in which their results can be interpreted for policy making purposes. From this point of view it can be argued that very few reviews have been conducted so far with a specific objective of formulating better policies to improve the life conditions of people with severe mental illnesses.

Since the implementation of Malaysia's National Mental Health Policy in 1997 a large number of people with severe mental illnesses have been receiving psychiatric treatment in the communities. A systematic review of the quality of life (QOL) of people with severe mental illness is timely due to the sociocultural environment prevailing in Malaysia which is not conducive to people with mental illness. Malaysian society attaches strong stigma to mental health problems (Jamaiyah, 2000). It is very common to see persons with mental health problems being ridiculed (Crabtree, 1999) and employers refusing to provide employment opportunities to people with mental illnesses (Mubarak, 2003). The sociocultural belief systems for the cause of mental illness, and their implications for help seeking, are also important aspects requiring attention. Razali, Khan and Hasanah (1996) report that Malaysian

sociocultural belief systems attribute the cause of mental illnesses to supernatural agents. Witchcraft and possession of evil spirits were regarded as common causes of mental illness. These belief systems were found to be closely related to the help seeking behaviours of people with mental illnesses. Treatment defaulting rate was high among people who attributed the cause of mental illness to supernatural powers.

Due to the challenging social environment prevalent in Malaysian communities, reviews of the life conditions of people with mental illness are very timely. Such reviews will help policy makers to focus on enhancing the life quality of people living in Malaysian communities. Such reviews will also benefit neighbouring countries in South East Asia which have comparable sociocultural environments. With this in mind, the current research was conducted to explore the level of social functioning and subjective quality of life (QOL) of people with mental illness living in the northern region of Malaysia.

Method

Samples

The study samples were selected from the Outpatient Department of the Departments of Psychiatry attached to the General Hospitals located in Penang, Sungai Petani, Alor Setar, Kangar and Taiping. These are the major community-based treatment centres for people with mental illness in northern Malaysia. Purposive sampling was used to select the respondents. Case records of the patients who had registered themselves at the Outpatient Departments were scanned initially to identify those who fulfill the study criteria. First, at the time of the study the patient had to be diagnosed by the treatment centre as suffering from schizophrenia of any sub-type. All the treatment centres included in this study used the diagnostic criteria of DSM-IV (American Psychiatric Association, 1994) to make a psychiatric diagnosis. Second, the illness duration had to be at least two years. Third, respondents fulfilling these criteria had to be living in the community with a family or caregiver. The patients fulfilling all of these criteria and their primary caregivers were then explained the purpose of the research and were invited to participate in the study. Out of 299 patients invited to participate in the

research, 262 provided their consent. Four patients dropped out of the research while the study was in progress and hence the total sample was 258. Sample selection was carried out over a period of one year. However, it is possible that these samples represented people who were regular in seeking psychiatric treatment.

Materials

Details on respondents' background characteristics were collected through a questionnaire prepared by the researcher. The psychiatric symptom severity of the study samples was assessed by the treating psychiatrist using the criteria included in the *Positive and Negative Symptom Severity of Schizophrenia* (PANSS) scale (Kay, Opler & Fiszbein, 1987). PANSS uses a 7-point scale to assess the severity of positive symptoms, negative symptoms, general psychopathology and supplemental aggression risk. The 7-point scale ranges from 1 (absent) to 7 (extreme). This is a widely used scale which has been reported as having a high reliability and validity ranging from .77 to .83 (Kay, et al. 1987).

The social functioning of the study samples was assessed using the *Disability Assessment Schedule* (WHO/DAS) (World Health Organization, 1988). This instrument contains four sections which include a total of 97 items. Section 1 deals with overall behaviour (self care, level of activity and social withdrawal). Section 2 is an inventory of social roles that can be found in most cultures (e.g. participation in household activities, marriage, care of children, occupation, etc.). Section 3 is only for the respondents who were hospitalised for most of the time in the last month. Since all respondents of the present research had not been admitted to hospital in the last month, this section was not included for the present research. Section 4 (modifying factors) includes items designed to describe specific assets (e.g. above average abilities, support relationships) of the respondents, as well as salient features of his/her home environment. At the end of the schedule, a global judgement about the level of disability of the respondents is made.

Information for the DAS is collected from primary caregivers of people with mental illness. For the present research purpose, respondents

who scored 0 (no dysfunction) within the domains 'Overall behaviour' and 'Social role performance' were categorised as people with no disability (disability absent). Respondents with all the other response categories ranging from 1 (Minimum dysfunction) to 5 (maximum dysfunction) were categorised as people with disability (disability present). While collecting information related to modifying factors, the domains 'Assets' and 'Liabilities' are responded to using a 2-point scale ranging from 0 (No) to 1 (Yes). For the domain 'Home atmosphere', DAS collects information using a 3-point scale ranging from 0 to 2. For the purpose of the present research respondents with a score of 0 were categorised as living in a household with no emotional involvement, control or attitude of rejection of the primary caregiver (absent). Respondents with a score of 1 and 2 were categorised as living in a household with emotional involvement, control or attitude of rejection of primary caregiver (present) (Table 3). The DAS is known to possess a high inter-rater reliability ranging from 0.73 to 1.00 (World Health Organization, 1998).

The Quality of Life Interview (QOLI) (Lehman, 1988) was used to collect information on the respondents' quality of life. The QOLI was developed specifically for persons suffering from severe forms of mental illness and it measures quality of life in eight areas: General life satisfaction, Living situation, Daily activities, Family social relations, Work and school, Legal and safety issues, Health, and Overall rating of the quality of life. The QOLI assesses the life circumstances of persons with severe forms of mental illness in terms of what they actually do and experience (objective quality of life) and their feelings about these experiences (subjective quality of life or satisfaction). The objective indicators included in the QOLI are of two types: measures of functioning (e.g. frequency of social contacts or daily activities) and measures of access to resources and opportunities (e.g. income support or housing type). The subjective quality of life indicators include individual items on the respondent's subjective reactions towards the objective indicators. Only items related to the subjective QOL are included in the present research. These items are scored on fixed interval 7-point scales ranging from 1 (delighted) to 7 (terrible). A chart with seven different

images from feeling delighted to terrible was also used whenever the respondents had problems comprehending the response categories. For cross-tabulation purposes, responses 'terrible', 'unhappy', 'mostly dissatisfied', 'pleased' and 'delighted' were categorised as 'Satisfactory QOL' (Table 4). Both DAS and QOLI were translated into the Bahasa Malaysia language using back translation technique.

Procedure

Initial contacts with the respondents and their key caregivers were made at the Outpatient Department. The respondents who signed up to participate in the research were visited at their homes. The data was collected through face-to-face interviews. Separate interviews were conducted with the respondents and their caregivers in order to ensure confidentiality of the information provided. Three researchers (the author and two graduate students in social work) were involved in collecting data for the study. The graduate students were given extensive training in collecting data by administering the instruments selected for this study. A pilot study involving 10 male and 10 female respondents from each participating treatment centre was conducted and all the interviewers independently rated the responses of study samples. Comparison of these ratings, including the translated versions of QOLI and DAS, revealed an inter-rater reliability of 0.81 – 0.92. Similarly, the psychiatrists in each treatment centre who participated in the present research performed an independent assessment of the symptom severity of three common respondents using PANSS (Kay, et al. 1987). A comparison of these ratings revealed a satisfactory inter-rater reliability ranging from 0.81 to 0.96.

Results

Table 1 presents the background characteristics of the study sample. The mean age of the respondents was 41 years. Most of them were educated up to secondary school and above. Occupational background indicated that the majority of the study respondents were unemployed and their mean monthly income was 303 Malaysian Ringit (US \$80). A majority of them were Malays followed by Chinese and Indians - roughly representing Malaysia's overall

national distribution of population. The marital status indicated that 64% of the samples were single and the remaining 36% were married. The number of respondents who came from rural and urban area was almost equal. Mean duration of illness of the study sample was 15 years. Symptom severity indicated a mean PANSS score of 1.55 (out of 7.00) indicating that a vast majority of respondents were suffering from a mild level of schizophrenia symptoms.

Table 1. Background and psychiatric symptom characteristics

Characteristic	N	%	Mean	SD
Age (years)			41.40	11.88
Gender				
Male	158	61.2	-	-
Female	100	38.8	-	-
Education				
Illiterate	21	8.2	-	-
Primary school	68	26.4	-	-
Secondary & above	168	65.1	-	-
Occupation				
Unemployed	176	68.2	-	-
Unskilled	52	20.2	-	-
Skilled & Others	29	11.4	-	-
Ethnic background				
Malay	159	61.6	-	-
Chinese	69	26.7	-	-
Indian	27	10.5	-	-
Other	3	1.2	-	-
Marital status				
Single	165	64.0	-	-
Married	93	36.0	-	-
Domicile				
Rural	124	48.1	-	-
Urban	134	51.9	-	-
Mean monthly income (RM)			303.25	437.77
Duration of illness (yrs)			15.51	9.82
Mean PANSS score (Out of a total score of 7)			1.55	0.58
Mean Positive symptoms			1.41	0.63
Mean Negative symptoms			2.03	0.93
Mean General symptoms			1.41	0.50
Mean Supplemental symptoms			1.34	0.70

Table 2. Psychiatric disability (assessed by Disability Assessment Schedule, WHO, 1988)

Psychiatric functioning	Disability	N	%
Overall behaviour			
Self-care	Present	135	52.73
Underactivity	Present	173	67.58
Slowness	Present	144	56.25
Social withdrawal	Present	169	66.02
Social role performance			
Participation in household activities	Present	160	62.50
Affective relationship with spouse	Present	35	41.66
Sexual relationship with spouse	Present	34	50.75
Parental role	Present	39	38.24
Social contacts	Present	85	33.33
Work performance	Present	32	34.78
Interest in getting job/work/study	Present	116	87.88
Interest and information	Present	173	68.11
Behaviour in emergencies	Present	112	44.09
Specific assets			
Activity to increase knowledge/skills	No	223	86.40
Developing special interest/social activity	No	190	73.60
Having above average ability	No	211	81.80
Favourable environment for functioning	No	133	51.60
Presence of stable confiding relationship	No	154	59.70
Liabilities			
Disadvantages in the environment	Yes	101	39.10
Having physical/neurological deficits	Yes	45	17.40
Other factors unfavourably affecting	Yes	53	20.50
Home environment			
Level of emotional involvement of carer	V. strong	30	11.60
Exercising control by the carer	V. strong	96	37.30
Attitude of rejection by the carer	Present	141	54.70
Global social adjustment			
	Excellent/Good	81	31.40
	Fair/poor	177	68.60

Table 2 is based on social functioning of the study samples using the DAS. Information for this scale was collected from primary caregivers. This table indicates that more than half of the respondents had social dysfunction in the domain 'Overall behaviour'. In the domain 'Social role performance', more than one third of the respondents had social dysfunction in spite of

a majority of them showing adequate interest in obtaining employment (68%) and getting to know their social environment (88%). In the area of 'Specific assets', the table indicates that a majority of the respondents lived in social environments which had limited assets. However, the results based on 'Liabilities' indicated that only 39% of the respondents had liabilities in their social environment. The 'Home environment' of the study respondents was assessed based on the level of emotional involvement, exercising control and attitude of rejection as expressed by the primary caregiver. The results indicated that at least one third of the respondents lived with key caregivers who exercised control of the respondents and more than half of the caregivers expressed an attitude of rejection towards the respondents. A global assessment of social functioning based on all the areas covered by the DAS revealed that a majority of the respondents (69%) were not having a satisfactory level of social functioning in the community.

Table 3 is based on subjective quality of life and indicates that approximately one quarter of the respondents had perceived low QOL in the areas of living situation, family relations and social relations. Approximately one third of the respondents had expressed low QOL in the areas of daily activities and work. The quality of life in the areas of finance and health revealed that approximately half were not satisfied. The 'Overall QOL' score revealed that almost half of the respondents were subjectively not satisfied with their life quality.

Since the 'Overall QOL' score was derived by calculating the average for all 8 areas of QOL covered in the QOLI (Lehman, 1988), this score provides the overall QOL of the study respondents. Hence, only this score was included in the cross-tabulation between social functioning and QOL (Table 4). Table 4 presents the means and standard deviations of the social dysfunction and PANSS scores broken down by Low and Satisfactory 'Overall QOL'. In all the areas of psychiatric disability the respondents with high social dysfunction had expressed low QOL. A similar trend was also observed in relation to the PANSS scores, except in the case of Supplemental symptoms. The differences between mean values of social functioning were

subjected to Student's t-tests and this revealed a statistically significant difference between the groups in all the areas of social functioning. The t-tests for PANSS scores revealed a statistically significant difference only for Negative symptoms.

Table 3. Quality of Life

Area of quality of life (QOL)	Perceived QOL	N	%
<i>Living situation</i>	Low	68	26.40
	Satisfactory	186	72.10
<i>Daily activities</i>	Low	81	31.40
	Satisfactory	175	68.40
<i>Family relations</i>	Low	61	23.60
	Satisfactory	192	74.40
<i>Social relations</i>	Low	74	28.70
	Satisfactory	164	65.10
<i>Finance</i>	Low	125	48.40
	Satisfactory	120	46.50
<i>Work</i>	Low	32	34.78
	Satisfactory	60	65.22
<i>Legal and safety</i>	Low	43	16.70
	Satisfactory	211	83.10
<i>Health</i>	Low	143	55.40
	Satisfactory	113	43.80
Overall QOL	Low	120	46.50
	Satisfactory	137	53.10

Discussion

The present research on social functioning and quality of life of people with severe mental illnesses living in the community has highlighted interesting strengths and weaknesses within Malaysia's mental health policies. The background characteristics of the present study samples indicated a fairly good representation from all of Malaysia's major ethnic groups. Table 1 indicates that in spite of a long duration of mental illness (15 years), a majority of the study samples reported mild psychotic symptoms at the time of the study. This implies the efficiency of psychiatric treatment delivered at community level. In collaboration with the WHO, Malaysia has been working on decentralising its mental health services since 1997 (World Health Organization, 2001). As part of this policy initiative, community health teams were formed in many mental health

centres around the country. Outpatient treatment of people with mental illness has become the policy of almost all psychiatric treatment centres in Malaysia. The results of the present study clearly indicate that Malaysia has managed to achieve a satisfactory level of progress in reducing the severity of psychotic symptoms of people with severe forms of mental illnesses in the community.

The findings of the present research regarding social functioning of people with mental illnesses indicated an interesting trend. In spite of reporting mild levels of psychotic symptoms, a majority of the study samples did not have a satisfactory level of social functioning. The results based on social functioning of more than half of the respondents in all 'Overall behaviour' areas and more than one third of the respondents in most of the areas under 'Social role performance' indicate that they were not experiencing adequate social functioning. Table 2 also indicates that in spite of having only a few liabilities present in their immediate social

environment, the study samples' social functioning did not improve.

The results also indicated that people with schizophrenia faced some major challenges in their family environment. At least one third of the primary caregivers indicated the possibility of exercising undue control of, and holding an attitude of rejection towards, the person with a mental illness under their care. These findings indicate that mere reduction in symptom severity is not adequate to improve the social functioning of people with severe mental illnesses. The importance of enhancing the social environment prevailing within the community and family is crucial to enhancing social functioning. Social functioning is an outcome of the extent to which the social environment is stimulating and provides opportunities to maximise one's own potential. Particularly, the social forces such as families and communities have major influences on people living in pluralistic societies such as Malaysia.

Table 4. Psychiatric disability vs. Quality of life (QOL)

Area of psychiatric disability	Level of QOL	N	Mean	SD	t	sig
<i>Disability Assessment Schedule e</i>						
Overall behaviour	Low	120	1.24	0.89	4.31	0.00
	Satisfactory	137	0.81	0.71		
Social role performance	Low	120	1.24	0.86	5.20	0.00
	Satisfactory	137	0.75	0.64		
Specific assets	Low	120	1.10	1.06	-4.31	0.00
	Satisfactory	137	1.74	1.28		
Specific liabilities	Low	120	0.92	0.89	2.50	0.01
	Satisfactory	137	0.65	0.82		
Home environment	Low	120	2.38	2.02	4.29	0.00
	Satisfactory	137	1.37	1.75		
<i>Global social adjustment</i>	Low	120	2.18	0.85	5.51	0.00
	Satisfactory	137	1.61	0.81		
PANSS						
Positive symptoms	Low	120	1.44	0.62	0.71	n.s.
	Satisfactory	137	1.39	0.65		
Negative symptoms	Low	120	2.14	0.98	1.91	0.05
	Satisfactory	137	1.92	0.87		
General symptoms	Low	120	1.46	0.52	1.40	n.s.
	Satisfactory	137	1.37	0.47		
Supplemental	Low	120	1.31	0.61	-0.82	n.s.
	Satisfactory	137	1.38	0.76		
<i>PANSS – Overall</i>	Low	120	1.59	0.58	1.01	n.s.
	Satisfactory	137	1.51	0.58		

The findings of the present study are clear reminders of the important fact that sociocultural context is one of the major deciding factors determining the level of overall treatment outcome for people with mental illness. Arguably, these observations demand the attention of policy makers, who need to ensure that patients' level of social functioning improves so that they can enjoy the benefits of mild levels of psychotic symptoms as reported by the present study samples.

The results based on subjective Quality of Life of the respondents were consistent with the results based on social functioning. Quality of Life in the areas of daily activities, finance, employment and health were major concerns to the study respondents. The Overall QOL indicated that QOL was an area of concern for nearly half of the study subjects. The association between levels of social functioning and Overall subjective QOL (Table 4) revealed that respondents' poor social functioning had significantly affected their subjective QOL. Based on these findings, the present research argues that the mild level of psychotic symptoms observed among the respondents did not adequately enhance the perceived subjective QOL of persons with schizophrenia living in the community. Creating opportunities to improve their level of social functioning is as important as symptom reduction. The results based on PANSS (Tables 1 and 4) also indicate a similar trend. Positive symptoms such as delusions, hallucinations, hostility, aggressiveness, agitation, anxiety, restlessness and cognitive disorganisation respond very well to neuroleptic medication (Mueser & McGurk, 2004). Furthermore, negative symptoms such as flattening of affect, social withdrawal, apathy, anhedonia, depressed mood, poverty of speech, poor grooming, poor self care and psychomotor activity also respond very well to rehabilitation opportunities provided to patients (Bellack, Schooler, Marder et al., 2004).

The results of the present study have clearly indicated that a successful medical treatment delivered at the community level could only help patients with severe mental illnesses to recover from their positive symptoms. Without the challenges posed by positive symptoms, it could be assumed that patients' QOL would have

improved, but this was not the case in this study. Hence, it is evident that in addition to reducing positive symptoms, negative symptoms must also be reduced by creating rehabilitation facilities which will improve social functioning. Results based on PANSS presented in Table 4 also indicate that creating opportunities to improve the level of social functioning might well lead to improving the subjective QOL of the patients.

The results based on 'Home environment' indicated that there is an urgent need for professional assistance to key caregivers. Professional guidance in the ways in which they could express their emotions would have benefited both the carers and patients. It is important to highlight that since people with severe mental illnesses do not receive any form of financial assistance from the government or other sources, families are the primary source of care for people with mental illnesses in Malaysia (Mubarak, 2003; Mubarak, Ismail, Low & Hoe, 2000). Thus, strengthening this key resource by providing necessary professional help is crucial for the success of Malaysia's community mental health program.

It is vital that community-based rehabilitation teams are created, with professionals such as social workers and psychologists working closely with the key caregivers. In all the four treatment centres included in the present study there were only one or two social workers and/or psychologists, all with heavy caseloads. Obviously, they were unable to work closely enough with the carers. Jamaayah (2000) reviewed the mental health services in Malaysia and concluded that there is a severe shortage of social workers and other mental health professionals. However, the National Mental Health Policy of Malaysia does not stress the importance of recruiting professionals to strengthen the community mental health teams. The current community mental health teams predominantly adopt medical models and consist of medical and nursing professionals. Based on his nine years' work experience as an academic in social work in Malaysia, the author is also aware of the fact that currently people who are not trained as social workers have been employed as social welfare workers in Malaysia. The right professionals must be recruited to

work closely with the primary caregivers of people with schizophrenia.

The respondents' occupational background also indicated an interesting policy-related trend. In spite of a majority of the study subjects suffering from mild psychotic symptoms and having an educational background of secondary level and higher, 68% of them remained unemployed. Obviously, this had an impact on their monthly income, which was an average RM 303. The Eighth Malaysia Plan indicates that only 5% of Malaysia's population is currently earning less than RM 500 per month (Government of Malaysia, 2000). The results based on QOL also support the concerns of more than a third of the respondents who were not satisfied with their life quality in the areas of work and finance. Providing a conducive occupational environment to people with severe mental illnesses can be a challenging task (Krupa, 2004) and this task can be even more complicated given the severe stigma attached to mental illness in Malaysia (Mubarak, 2003). However, the National Mental Health Policy recognises the challenges involved and states that this problem will be tackled through other means such as providing incentives to employers hiring people with mental disorders (Ministry of Health Malaysia, 1997). Results of the present study clearly indicate that this policy, however, has not achieved positive outcome so far. The researcher is unaware of any reviews measuring the success of Malaysia's National Mental Health Policy's incentives to employers of persons with severe mental illnesses. It is also crucial that more facilities are created to prepare people with schizophrenia to take up employment training. These will prepare them to take up occupational roles even if employers are not prepared to make any concessions to persons with mental health problems.

Conclusion

The present research on social functioning and QOL of community-based people with schizophrenia in the northern region of Malaysia suggests that psychiatric treatment provided at the community level could effectively reduce the severity of symptoms. However, this was not sufficient in itself for the patients to measure their QOL as good. An exploration on the association between social functioning and QOL

indicated that social functioning and quality of home environment are significantly associated with low QOL. Based on these findings, the present research argues that policy makers must focus more on creating a conducive social environment within communities, which will complement the level of success achieved in reducing psychotic symptoms. Creation of rehabilitation facilities and increasing the participation of families and communities in the treatment for people with mental illness will significantly improve the quality of life of people with mental illness.

It is important to note that the present research has some limitations. This is a cross-sectional study and its samples were selected using a purposive sampling method. Hence findings of the present research need to be generalised carefully. The study may also not represent the views of people with mental illness who are not regular in following up their treatment. Further, family members assessed the social functioning of the study samples. There are possibilities for these assessments to be influenced by personal biases towards the persons with schizophrenia, emotional expressiveness (Mubarak et al., 2003), or other factors related to overall family environment. Results of the present research clearly highlight an urgent need for the creation of more psychosocial and occupational rehabilitation facilities within communities in order to achieve successful community-based care for people with a mental illness in this region. Findings of the present research also remind us of the need to evaluate the progress made by other countries in the region.

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