Effects of Hospital Based and Community Based Treatment on Quality of Life in Adult Mental Health Clients

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Disciplines
Mental and Social Health | Occupational Therapy

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Effects of Hospital Based and Community Based Treatment on Quality of Life in Adult Mental Health Clients

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Date: 11/26/2011
Review date: November 2013

CLINICAL SCENARIO:

Occupational therapists play a large role in the treatment and recovery process for individuals who have a mental illness in a wide variety of settings. Throughout the world there has been a push for deinstitutionalization of mental health clients. With the closing of psychiatric hospitals more clients are now living and receiving treatment in the community. As an occupational therapist it is necessary to be aware of what is best for each client and advocate that they receive treatment that matches their needs and will improve their quality of life.

FOCUSED CLINICAL QUESTION:

How is quality of life in adult mental health clients affected by living in a community setting compared to living in an institution?

SUMMARY of Search, ‘Best Evidence’ appraised, and Key Findings:

- Five articles were found that best addressed quality of life for mental health clients in community and hospital/institutional settings.
- Each of these papers addressed this question in a different way, and the papers represented a wide variety of cultures including Australian, Chinese, Irish (Northern), and Viennese (Austrian).
- The article, out of those examined, that was found to be the “best evidence” was Chan, Ungvari, Shek, and Leung (2003).
- This article researched the subjective and objective quality of life for 204 Chinese mental health clients with schizophrenia living in a psychiatric hospital, long term care facility, or halfway house. The researchers found that, contrary to many Western studies, in the Chinese collectivist culture, clients have a higher subjective quality of life when they are receiving treatment in hospital settings. The researchers also found that the primary predictors for subjective quality of life were the number of life events being rated as negative, education level, anxiety/guilt, and life satisfaction.
- Hobbs, Newton, Tennant, Rosen, and Tribe (2002) did a 6 year follow up with clients who had been moved to community treatment facilities following the closure of a psychiatric hospital in Australia to examine the long term effects that deinstitutionalization has on quality of life.
- Kerrigan, Davidson, and Shannon (2008) examined quality of life for clients who were in a psychiatric hospital and those who were in community settings in Northern Ireland.
- Trauer, Farhall, Newton, and Cheung (2001) did a follow-up study with clients who were involuntarily moved to a community treatment setting following the closure of a psychiatric hospital in Australia. Their follow-up included measures on quality of life,
symptoms experienced, socialization level, and level of independence.

- Lang et al (2002) examined the differences in quality of life measures for clients in Vienna, Austria who utilized various mental health treatment settings including only in-patient, only out-patient, and mixed in and out-patient. The researchers also identified client factors that may influence the client’s overall satisfaction with their life.

**CLINICAL BOTTOM LINE:**

Research indicates that, for many cultures, clients receiving treatment in the community typically have an increased quality of life. However, there has been a limited amount of research regarding the clinical implications of community versus hospital treatments for clients who are from other cultures. Occupational therapists can play a key role in advocating for clients of all cultures to receive treatment in a facility type that best fits the client’s individual needs.

**Limitation of this CAT:** This critically appraised topic has not been extensively peer reviewed, and the literature review completed was not exhaustive. The author of this paper is not an expert in this topic and is a MOT 2 student doing this as a class assignment.

**SEARCH STRATEGY:**

**Terms used to guide Search Strategy:**

- **Patient/Client Group:** Adult, clients with mental health concerns
- **Intervention (or Assessment):** Community treatment, deinstitutionalization
- **Comparison:** Institutionalized, hospitalized
- **Outcome(s):** Quality of life

<table>
<thead>
<tr>
<th>Databases</th>
<th>Search terms</th>
<th>Limits used</th>
<th>Articles found</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsychInfo</td>
<td>Quality of Life and Community Mental Health</td>
<td>English Language</td>
<td>15 Results: None used</td>
</tr>
<tr>
<td>September, 2011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PsychInfo</td>
<td>Quality of Life and Community Mental Health Services</td>
<td>English Language, years 2001-2011</td>
<td>50 Results: 1 used Kerrigan, K., Davidson, G., &amp; Shannon, C. (2008), Irish Journal of Psychological Medicine</td>
</tr>
<tr>
<td>Database</td>
<td>Search Term</td>
<td>English Language, years 2001-2011</td>
<td>Results:</td>
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</tbody>
</table>
INCLUSION and EXCLUSION CRITERIA

- **Inclusion:**
  - Publications ranging from 2001-2011
  - Peer reviewed
  - Research Article
  - English Language
  - Clients with mental illnesses in community or hospital settings
  - Clients who were over 18

- **Exclusion:**
  - Clients with physical illnesses such as cancer, diabetes, etc.
  - Clients under 18

RESULTS OF SEARCH

Table 1: Summary of Study Designs of Articles retrieved

<table>
<thead>
<tr>
<th>Study Design/ Methodology of Articles Retrieved</th>
<th>Level</th>
<th>Number Located</th>
<th>Author (Year)</th>
</tr>
</thead>
</table>

Levels of evidence derived from Oxford Centre for Evidence Based Medicine- Levels of Evidence (2009)

BEST EVIDENCE
The following study/paper was identified as the ‘best’ evidence and selected for critical appraisal:


Reasons for selecting this study were:
- It highlights the importance of cultural competency when determining treatment methods
- It examines subjective and objective aspects of quality of life
- Large sample size compared to other similar studies
- Outcomes measures were found to be reliable and valid

**SUMMARY OF BEST EVIDENCE**

<table>
<thead>
<tr>
<th>Table 2: Description and appraisal of Hospital and community based care for patients with chronic schizophrenia in Hong Kong: quality of life and its correlates by Chan, G.W.L., Ungvari, G.S., Shek, D.T.L., &amp; Leung, J.J.P., 2003.</th>
</tr>
</thead>
</table>

**Aim/Objective of the Study:** The first objective of this study was to examine the impact on subjective and objective quality of life that various types of treatment facilities including hospitals, long term care facilities, and halfway houses have on Chinese individuals living in Hong Kong who have schizophrenia. Another objective of this study was to determine what client factors played a significant role in subjective wellbeing.

**Study Design:** This was a case-control study involving Chinese clients who had schizophrenia living in a halfway house, long term care facility, or hospital. Measurements were taken during a single interview with the client done by the key researcher. Additional demographic information was obtained through a medical chart review.

**Setting:** All of the clients were living in a hospital, long term care facility, or halfway house in Hong Kong, China.

**Participants:** There were a total of 204 participants in this study. Each of these clients met the following criteria: Chinese ethnicity, between ages 18-60, had a diagnosis of schizophrenia, had this diagnosis for 5 or more years, was fluent in Cantonese dialect, and was competent and willing to give consent. The exclusion criteria included a history of drug/substance abuse and/or an acute medical or neurological condition. Any client that met the inclusion and exclusion criteria and lived in either a psychiatric hospital, long term care facility, or a halfway house in Hong Kong was invited to participate in the study. Each client was placed in one of three groups based on their housing situation (psychiatric hospital, long term care facility, or halfway house). Furthermore, participants were matched to individuals in the other housing groups based on demographic and healthcare information to ensure that each of the groups had no significant differences in these areas. Specific demographic information including age, sex, education level,
marital status, length of illness, number of hospitalizations, length of stay in current residence, and employment status were all found to be similar between all three groups. Due to the fact that the study design required a single interview no participants dropped out, although 3 potential participants moved out of the facility prior to their set interview time.

**Intervention Investigated:** There was no formal intervention given to the participants, instead the measurements were comparing the effects that various housing situations had on quality of life for the participants. The three groups included participants living in a hospital, long term care facility, or halfway house.

**Outcome Measures:** Outcome measures for subjective quality of life, objective quality of life, and psychiatric symptoms were determined during a one time interview with the primary researcher and author, Grace Chan. The location of these interviews is not discussed within the study. Demographic information was obtained through a medical chart review done by researchers. The following is a list of outcome measures that were used:
- Satisfaction With Life Scale (Subjective Quality of Life)
- World Health Organization Quality of Life Abbreviated Version- Hong Kong (Subjective Quality of Life)
  - Broke into four domains: physical, psychological, social relationship, and environment
- Global Assessment Scale (Objective Quality of Life)
- Life Events List (Objective Quality of life, developed specifically for study)
  - 62 item list comprised of objective statements regarding, conditions of residence, daily life routines, work, finances, social contacts, safety, legal issues, recreation, illness, and accidents. Participants indicated how many of these life events occurred to them within the last 1 month, 3 months, 6 months, 1 year, 2 years, and 3 years or longer.
- Brief Psychiatric Rating Scale (Psychiatric Symptoms)

**Main Findings:** Data was analysed using a univariate F test with a Bonferroni correction. Significant differences were found between each of the groups for life satisfaction (p=.001), Global Assessment Scale (p<0.000), and reported life events (p<0.000). These significances were maintained when possible socio-demographic factors were adjusted for by ANCOVA. Specific data between community and hospital groups can be found on Table 3.
Table 2. Quality of Life Measures of Participants Living in Hospitals, Halfway Houses, and Long Term Care Facilities.

<table>
<thead>
<tr>
<th>Treatment Setting</th>
<th>Hospital</th>
<th>Long Term Care Facility</th>
<th>Halfway House</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Satisfaction</td>
<td>4.56 ± 1.46</td>
<td>5.28 ± 1.10</td>
<td>4.48 ± 1.33</td>
<td>p=0.001*</td>
</tr>
<tr>
<td>Physical Domain</td>
<td>14.11± 2.66</td>
<td>14.49 ± 2.74</td>
<td>14.10 ± 2.76</td>
<td>p=0.64</td>
</tr>
<tr>
<td>Psychological Domain</td>
<td>13.23 ± 3.66</td>
<td>14.09 ± 3.51</td>
<td>13.34 ± 2.89</td>
<td>p= 0.27</td>
</tr>
<tr>
<td>Social Relationship Domain</td>
<td>12.99 ± 3.85</td>
<td>14.00 ± 3.46</td>
<td>12.76 ± 2.43</td>
<td>p=0.19</td>
</tr>
<tr>
<td>Environment Domain</td>
<td>13.69 ± 3.31</td>
<td>15.00 ± 3.16</td>
<td>13.96 ± 2.51</td>
<td>p=0.03</td>
</tr>
<tr>
<td>Global Assessment Score</td>
<td>48.81 ± 7.79</td>
<td>54.86 ± 6.64</td>
<td>60.88 ± 7.87</td>
<td>p&lt;0.000*</td>
</tr>
<tr>
<td>Total Life Events</td>
<td>17.78 ± 5.43</td>
<td>18.88 ± 5.42</td>
<td>23.71 ± 5.41</td>
<td>p&lt;0.000*</td>
</tr>
<tr>
<td>Brief Psychiatric Rating Scale</td>
<td>15.6 ± 7.68</td>
<td>14.41 ± 7.33</td>
<td>12.85 ± 6.63</td>
<td>p=.089</td>
</tr>
</tbody>
</table>

* Indicates statistical significance


**Original Authors’ Conclusions:** The objective quality of life was found to be significantly better in the community settings (long term care facility and halfway house) when compared to the hospital setting. The results for subjective quality of life varied from what has been found by research done in Western cultures. In this study it was found that participants living in the least restrictive treatment environment, the halfway house, had a lower subjective quality of life with relation to life satisfaction compared to those living in the more restrictive long term care facility. This stresses the importance of cultural awareness when determining treatment locations for individuals.

**Critical Appraisal:** The primary limitation of this study was that the inclusion criteria were extremely specific which makes it hard to generalize the results to other potential clients.

**Validity:** The outcome measures used were reported to be valid and reliable. The only outcome measure that was not addressed was the Life Events List that was developed specifically for this study. No additional information regarding the validity of the study was addressed by the authors. By using the Bonferroni correction the authors decreased their likelihood of having a
false positive, however, they also increased their chances of having a false negative. This could affect the validity of the results found.

**Interpretation of Results:** The results pertaining to subjective quality of life are of particular interest because they contradict what has previously been found by other researchers. These results are hard to interpret because not all aspects of subjective quality of life showed this trend. Statistically there was significance for subjective quality of life with regards to the participant’s life satisfaction. This could also be considered clinically significant when considering placement for clients with mental health concerns, however, a clinician would want to use their own clinical judgement when considering individual clients because this study was conducted on a specific group of mental health treatment consumers.

**Summary/Conclusion:** This article can be interpreted to suggest that subjective quality of life may be higher for clients who live in facilities that are more restrictive when the client comes from a collectivist culture. It also suggested that objective quality of life is higher in settings that are less restrictive. The other four studies that were reviewed concur with the results about objective quality of life, however, the other studies do not support the results about subjective quality of life. This disagreement supports the idea of there being a cultural component to the effects that treatment setting have on quality of life in adult mental health clients.

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**Table 3: Characteristics of Included Studies**

<table>
<thead>
<tr>
<th>Study 1 (Hobbs, C., Newton, L., Tennant, C., Rosen, A., &amp; Tribe, K., 2002)</th>
<th>Intervention investigated</th>
<th>Comparison intervention</th>
<th>Outcomes used</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effects of long term community housing on quality of life in clients following the closure of a psychiatric hospital in Australia.</td>
<td>The same clients were assessed prior to discharge, the 6 year follow up results were compared to these baseline values.</td>
<td>Interview, Brief Psychiatric Rating Scale, Social Behavior Scale, Montgomery Asberg Depression Scale, Quality of Life Index, Medical Chart Reviews, and Life Skills Profile</td>
<td>Clients had an increased quality of life when living in the community despite the fact that they do not have improvements in their clinical state or appropriate social behaviors. In order for the increase in quality of life to occur clients must have adequate supports within the community.</td>
<td></td>
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</tbody>
</table>

| Study 2 (Kerrigan, K., Davidson, G., & Shannon, C.,) | Effects of community housing on quality of life in clients in Northern Ireland following the closure of a psychiatric hospital | Some clients were transferred to other psychiatric hospitals | Community Placement Questionnaire, Carers and Users Expectations of Services, and | Community treatment is better for improving quality of life, satisfaction with services, and |
In 2008, psychiatric hospitals were closed, and clients who were at these hospitals were compared to those who moved into the community. Empowerment levels in clients with schizophrenia were compared to hospitalization. Low readmission rates also supported the idea that community dwellers do not put undue burden on the hospitals once discharged.

**Study 3**  
(Lang, A., Steiner, E., Berghofner, G., Henkel, H., Schmitz, M., Schmidi, F., & Rudas, S., 2002)  
**Effects of the type of treatment Viennese clients receive on their quality of life.** Treatment types included in-patient only, out-patient only, and both in and out-patient services. See Intervention Investigated column for list of three treatment types being investigated. Global Assessment Scale, Clinical Global Impression Scale, Social Function Questionnaire, quality of Life Satisfaction and Enjoyment Scale, and client/physician mental health status ratings. At discharge the clients who received both in and out-patient services had an increase in most domains of quality of life that were measured. Additionally, the clients who received only out-patient services had a higher quality of life compared to those who only received in-patient services, but a lower quality of life compared to those who used both in and out-patient services. This suggests that the highest quality of life can be obtained when clients have a balance of in and out-patient services.

**Study 4**  
(Trauer, T., Farhall, J., Newton, R., & Cheung, P., 2001)  
**Effects of deinstitutionalization on clients who were placed into the community involuntarily.** The same clients were evaluated 1 month prior to move, 1 month after Positive and Negative Syndrome Scale, Life Skills Profile, Family Questionnaire, Many clients benefit from community living, but there are some that do not thrive and need to remain in hospital.
following the closure of a psychiatric hospital in Australia the move, and 1 year after the move. The results from these various times were compared. Lancashire Quality of Life Profile, Staff Observation Aggression Scale, Patient Attitude Questionnaire, and Social Network Assessment settings. The change in living situation, overall, had a positive effect on quality of life, but did not decrease symptom levels. Additionally, in order for this increase in quality of life to occur clients need to have appropriate supports set up in the community prior to discharge.

IMPLICATIONS FOR PRACTICE, EDUCATION and FUTURE RESEARCH

- In general research indicates that in cultures influenced by Western values and beliefs, living in the community can increase the quality of life for adults with mental illnesses, and supports deinstitutionalization.
- For individuals from collectivist cultures this answer is not clear because research suggests that clients from these cultures may have a better quality of life when living in a more controlled setting such as a hospital.
- Due to the fact that America is comprised of a wide variety of cultures, it is necessary for OTs and other mental health professionals to be aware of these differences and shape treatment to match the client’s needs.
- Since OTs take a holistic approach when looking at clients, they could play a major role in advocating for appropriate placement for clients.
- Education about cultural differences should continue to be emphasized throughout OT programs’ curricula and continuing education sessions for practicing OTs. Further education could also be addressed in others who are impacted by this such as other professionals working in mental health and third party payers.
- Research could be done to further examine the cultural differences in how treatment settings affect quality of life, particularly in other collectivist cultures outside of China.
- Research could also be done to examine other populations that may respond differently to treatment setting type, such as older adults with dementia or individuals from cultures that do not formally recognize mental illnesses.
REFERENCES:


