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**Evaluation of the Clwyd Mental Health Community
Service: An Interim Report: Paper 3 Quality of Life**

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1990

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3.1 INTRODUCTION

This section of the report concerns the evaluation of the resettlement process on residents' quality of life. This paper considers some of the principal issues involved in quality of life evaluation research, describes the development and implementation of an interview schedule to determine psychiatric residents' self-assessment of life quality, and reports on the results of the data collected at the first stage of the baseline phase.

Quality of Life Issues in the Evaluation of Deinstitutionalisation

In the area of service evaluation, quality of life issues have attracted increasing attention over the past two decades. The changes in policy concerning the design and delivery of mental health services, have been accompanied by a growing awareness of the impact of services on the lifestyles of their users. One of the major concerns with regard to hospital care was that, through the process of institutionalisation, the services had lowered the quality of life of its residents. Concepts such as normalisation, independent living, deinstitutionalisation and least restrictive environment have had a dramatic effect in recent years upon the development of mental health services. Researchers evaluating the services and the new developments have therefore increasingly concerned themselves with the broader impact of the service on the client's life, looking beyond the narrower illness-related outcomes to quality of life issues. Baker and Intagliata (1982) refer to this phenomenon as the re-emergence of the holistic perspective with its concern for the whole life situation rather than focusing on pathology. Roger Blunden (1988) writing on quality of life and service development in the area of mental handicap states that;

'the aim for services must be to maximise their positive impact on the lifestyle of their users and to minimise the damage caused'.

This shift in emphasis is also apparent in the area of mental health services where improved quality of life has become an explicit priority of the new alternatives to hospital-based treatment. Jones (1988) points out that improved quality of life is one of the most frequently cited justifications for deinstitutionalisation. However, looking to improved quality of life as a criterion for evaluating a service, one could argue that the very generality of the concept makes it a problematic guide for effective evaluation. Issues such as what constitutes a good quality of life are far from clear. Can a single definition be broadly applied across different groups in society? As researchers we are confronted with the problem of developing quantifiable indicators of quality, i.e. adequately defining quality of life in measurable terms. The issue of how client-derived assessments of life quality can be appropriately integrated into programme change and policy development also needs to be considered.

The present study concerns itself primarily with the use of quality of life measures as one of a range of outcome criteria being used to evaluate the resettlement of a group of long-stay psychiatric patients. Looking to quality of life in this context, one needs to consider the utility of the construct as an outcome measure and examine its meaning and implementation in the evaluation and planning of services for deinstitutionalised psychiatric patients. Before proceeding further it may be useful, from the outset, to clarify two of the major concepts involved ; deinstitutionalisation and quality of life. A useful definition of deinstitutionalisation was provided by the Director of the National Institute of Mental Health, USA (1975). Deinstitutionalisation is defined as : 1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment, 2) the release to the community of all institutionalised patients who have been given adequate preparation for such a change, 3) the establishment and maintenance of community support systems for noninstitutionalised people receiving mental health services in the community. The aspect of deinstitutionalisation that has engendered the greatest controversy is the resettlement of long-stay psychiatric patients. There have been many negative accounts, both newspaper articles and TV programmes, concerning the plight of many deinstitutionalised patients. However, there have been few formal studies in this area, particularly of the variety that trace the fate of the psychiatric patient as s/he moves through the deinstitutionalisation process.

Providing a single definition of quality of life is rather difficult, but generally it refers to the sense of well-being and satisfaction experienced by people under their current life conditions. At a practical level, in the area of service evaluation, quality of life issues focus attention on how the service is influencing the lives of its clients in both positive and negative ways, what are the positive goals of the service, and what it is setting out to achieve for its clients. In practice, however, one often encounters a lack of clarity in relation to these matters. The objectives and values on which a quality service is based are not always clearly articulated. Policy statements such as the following are commonplace ;

'the major objective of the home is to provide a suitable environment and atmosphere that will enhance the quality of life of its residents, ensuring that all their needs both social, physical, intellectual and emotional are adequately catered for'.

In attempting to evaluate whether or not this objective is achieved, it is difficult to know what, precisely, one is attempting to measure and/or when desired targets are 'adequately' reached. This is an example of some of the conceptual difficulties that one encounters in trying to implement quality of life as an evaluative or outcome measure. As a first step in assessing quality of life, Jones (1988) calls for detailed descriptive research on actual patient

situations. This approach involves describing and assessing patients' patterns of existence, looking at factors in the material and social environment, together with subjective life experiences that contribute to overall quality of life.

Conceptual and Methodological Issues

Quality of life is usually evaluated with some combination of life satisfaction measures and objective indicators of external life circumstances. The methods used for assessing quality of life have taken their lead from a number of national surveys on quality of life in the USA. The approach adopted by researchers such as Andrews and Withey, 1976; Campbell, Converse, and Roger, 1976, was to consider general or global measures of well-being as well as measures of satisfaction with respect to particular life areas. Though the specific domains used to describe quality of life have varied, they tend to include life areas such as work, finance, social and family relations, leisure etc. A number of measures such as rating scales, semantic differential scales etc. have been designed for this purpose.

This approach to assessing quality of life has been adapted by researchers such as Anthony Lehman in relation to chronic psychiatric patients. Lehman (1983a) developed a general quality of life model based on the national survey data. According to this model, quality of life is ultimately, 'a subjective matter reflected in a sense of global well-being' (Lehman 1983a). Three types of variables are delineated as components ; personal characteristics such as age, sex, etc., objective quality of life in various life domains and subjective quality of life in the same life domains. From this model Lehman developed a scale for assessing the well-being of chronic psychiatric patients. The schedule, which consists of a structured interview format, collects objective and subjective data covering nine life domains in addition to measures of general well-being. The objective data is obtained by asking direct questions about patients' lives, living conditions, how often they see people, how they spend their time etc. The subjective data is obtained by respondents rating their satisfaction on a 7-point scale ranging from 'delighted' to 'terrible', concerning different areas of their life. Measures of global well-being are obtained on a similar scale in addition to a semantic differential scale.

Lehman (1982) carried out a major study of 278 chronic patients living in supervised community residences in Los Angeles. The mean age of this sample was 42 years, medium length of stay in the homes was 30 months, and the majority (60%) were diagnosed schizophrenic. In a series of publications in 1982, 1983, Lehman sought to demonstrate the feasibility of this method of assessing the quality of life of chronic psychiatric patients and to determine the potential confounding effects of psychopathology on self-assessments of life quality. From his studies Lehman reported that chronic psychiatric patients were able to provide statistically reliable responses to the quality of life interview. High internal

consistency reliabilities were reported for the satisfaction scales, and a factor analysis of the satisfaction items revealed that respondents differentiated among their feelings about the various life areas. Lehman also reported that subjective quality of life indicators in specific life domains were much better indicators of global well-being compared with objective indicators in the same life domain. Areas of particular importance were health, leisure, social relations and finances. In fact, finances were the most consistent source of dissatisfaction. With regards to the effects of psychopathology on the analysis of quality of life data, Lehman (1983b) succeeded in demonstrating the convergent and discriminant construct validities of the subjective quality of life and mental health indices. However, it was found that the global quality of life and the psychopathology indices were strongly correlated ($r = .51$) but the domain-specific subjective indicators were more distinct from the psychopathology measures. A multiple regression analysis of the quality of life data, analysed before and after the effects of psychopathology were removed, by means of a step-wise regression analysis, found that the psychiatric symptoms did not alter the bivariate and multivariate relationships among the quality of life ratings except in the health domain. Lehman reported that the correlation between health related quality of life indicators and global quality of life was significantly attenuated after removing the effects of psychopathology. So while psychopathology was not found to introduce bias into the overall structure of quality of life data, the study suggested that it is important to control for mental health effects, particularly in relation to in-patients' assessment of health and satisfaction with health care.

Lehman's scale is probably the most widely used scale in this area. Researchers, Peter Huxley and Joe Oliver, at the Mental Health Research Unit at the Department of Psychiatry, University of Manchester, have been working on an ongoing programme of research concerned with the quality of life of chronic psychiatric patients. For this purpose they have devised a simplified and adapted version of Lehman's scale which is currently being piloted on a number of different populations. However, this work is as yet unpublished. On reviewing Lehman's work, one is left with a number of questions such as; how well does the general model of quality of life translate to a psychiatric population and how suitable are the measures devised for national surveys for use with chronic psychiatric patients resident in psychiatric hospitals? Lehman's model of quality of life is founded on a conceptual base which integrates access to resources and opportunities, fulfilment of social roles in multiple life domains, and expressed satisfaction with life in various domains. The application of these concepts to a chronic psychiatric population needs to be considered. Access to resources for chronic patients is obviously constrained by virtue of being hospitalised, and the resources that are available are under the control of staff and management. The availability of various opportunities is inevitably limited in a hospital setting, yet these are taken as standard by the scale.

With regard to the fulfilment of social roles in multiple life domains, the hospitalised psychiatric patient may be seen as the occupant of an ascribed and all encompassing social role, that of psychiatric patient or being "mentally ill". The average long-stay patient rarely has an occupational or domestic role apart from this, e.g. the majority are unemployed, unmarried etc. One resident, when questioned concerning what was the most important thing to him in his life, replied ; *"I'm in hospital and that's about it"*.

In Goffman's terms, life in a total institution breaks down individual identity and reduces the person to an anonymous member of an enclosed collectivity. The usual segmentation of life into domestic, occupational and recreational sections rarely occurs, the person is placed in one continuous context, that of resident of a psychiatric hospital. In this respect, looking at the dimensions that are being used to define quality of life in Lehman's scale, one has to question if these dimensions are especially central in the assessment of quality of life of psychiatric patients. Life domains such as family, work, social, financial, recreational etc. may be relevant to the population as a whole but may be of dubious relevance to people who have lost or never had occupational status, income, good health and are virtually socially isolated. The assumption that such life areas are indeed relevant to a psychiatric population is very much open to question.

The concept of satisfaction also needs to be considered in this context. Life satisfaction may be taken as referring to a cognitive assessment of one's overall conditions of existence and progress toward desired goals (Andrews and Withey,1976). Expressed satisfaction may therefore be perceived as being particularly dependent upon social comparison. In this respect one has to query the standards of comparisons used by people who have spent 30-40 years of their life in a psychiatric institution. The richness and variety of their lives will undoubtedly have been curtailed by years of hospitalisation. Satisfaction also involves an affective component regarding the fulfilment of needs, desires, expectations and hopes of the individual. Jones (1988), commenting on work on the quality of life of psychiatric patients, refers to the 'limited horizons and low aspirations' of the patients, and how expectations have been progressively hedged back to fit the realities of the situation. Goffman (1961) uses the concept of 'mortification' to describe this process of adaptation to life in a psychiatric hospital.

It is plausible to suspect that 30-40 years in a psychiatric hospital would lead to a change in the way reality is perceived by residents, lessening or changing the relationship between living conditions and their evaluation. However this very fact is rarely discussed in the quality of life literature. While distortions in quality of life data due to psychiatric symptoms have been addressed, distortions due to the institutional setting have been largely ignored. In relation to long-stay patients, the fact that many have spent a substantial proportion of their

adult life (in the case of one patient in this study, 61 years) in a psychiatric institution would appear to be one of the most significant influences to be considered in trying to assess the quality of their life experience. Sociological and social psychological accounts of the human dynamics of a psychiatric institution as well as the biographical accounts of psychiatric patients could prove quite useful in this respect. The influence of the institutional setting cannot be ignored in any attempt to assess the quality of life of hospitalised psychiatric patients.

Present Study

The present study is essentially concerned with monitoring and evaluating the impact of the resettlement process on the quality of life of the individual residents. Therefore the quality of life of the residents will be assessed on the hospital ward prior to discharge and follow-up assessments will be carried out following their discharge from hospital, thus allowing a comparison between the hospital and community settings.

In the literature there is a relative paucity of information comparing the quality of life of clients receiving conventional hospital care with the quality of life experienced by the same clients in alternative community settings. Current studies on quality of life of psychiatric patients tend to be of comparisons between groups in hospital, hostel wards, and group homes, e.g. a study by Simpson et al. (1989) in South Manchester. However the findings from such studies are limited due to the fact that the type of placement often reflects the severity of the psychopathology and more importantly, comparisons between groups do not allow for the influence of individual differences in perception of life quality in different settings.

The present study, employing a repeated measures longitudinal design, follows up cohorts of patients as they are discharged, permitting a more direct evaluation of quality of life under the different modes of service delivery.

3.2 METHOD

Measures

Being mindful of the conceptual and methodological issues raised earlier in this paper, in attempting to assess quality of life for the hospital sample, it was decided to adopt a multimethod approach, treating quality of life as a holistic concept that could best be

addressed by means of a triangulation of data. Information on residents' quality of life will therefore be integrated from three different sources ;

- 1) client-derived data using a quality of life schedule,
- 2) staff-derived data on operational policy and management practices,
- 3) researcher-derived data based on observation studies.

These different sources and types of information will enable the researchers to gain a deeper and wider understanding of the day-to-day existence of residents, of the 'climate' of the hospital ward or unit, and of the type of services being offered, all of which constitute important determinants of quality of life for residents in an institutional setting. This paper, however, will confine itself to information obtained from residents concerning their quality of life and will report on the development of a quality of life schedule designed for this purpose.

In designing a quality of life schedule for the present study, all of the methodological issues raised earlier were considered. As a starting point it was decided to adopt an interview format, employing the basic framework of existing schedules such as that used by Lehman. However, few assumptions were made about how readily such a schedule could be implemented with a sample of long-stay chronic patients. On initial encounters one of the major concerns was whether it was possible to secure a coherent interview. It was therefore necessary to carry out a number of pilot interviews to test out various question and response formats. In selecting questions for the interview schedule it was important that the questions should be as brief and as concise as possible in order to keep the interview burden at a tolerable level. It was also considered important that the scale could be implemented with the whole sample, including the least articulate residents. A number of questions were selected from Lehman's scale, spanning both the objective and subjective indices of life domains and global ratings. Lehman's scale in its entirety is very lengthy, containing a multiplicity of indices for each of the nine life domains. Though perhaps desirable from a statistical point of view the multiplicity of measures appeared superfluous at times. For example, in the section dealing with religion, the following four satisfaction indices are used:

How do you feel about

- the amount of religion in your life?
- your religious faith?
- the religious fulfilment in your life?
- the amount of satisfaction you get from religion?

In redesigning the schedule for the present study it was decided to retain the same basic structure as Lehman's scale i.e. subjective and objective indices for nine life areas, plus a number of general life satisfaction measures. However, it was decided to keep the number of questions down to a minimum in order to ensure ease of implementation. Pilot trials of

question and response formats were carried out with 8 of the residents. During the first stage of piloting, the interview questions were asked using an open-ended response format in order to establish if the questions could be comprehended by the residents and if a coherent response could be formulated. Residents described by staff as being most and least responsive were approached and it was found that the majority could comprehend and respond to the questions asked. It was clear, however, from the early interviews that in response to questions such as 'how do you feel about ...', respondents were not providing very clearly differentiated responses. Replies were usually of the form, 'all right' or 'it's OK'. This raised a number of doubts about the practicality of implementing a 7-point 'delighted - terrible' scale for the subjective indices. The scale was reformulated and designed as a 5-point satisfaction scale, ranging from 'very satisfied' to 'very dissatisfied' with a central point labelled 'uncertain'.

Pilot trials of use of the 5-point scale however were not totally successful. It was found that while the more responsive and alert patients could possibly use this response format, the scale was greeted by looks of consternation and confusion from some of the older residents. The semantic differential scale was received in the same manner.

It was therefore necessary, at least for this phase of the study, to collapse the 5-point scale into three response categories, satisfied, uncertain and dissatisfied. On the basis of the trial interviews some of the more obscure questions were dropped and others that appeared more relevant were included e.g. questions such as 'do you ever feel lonely here?' Following the pilot phase the wording of the items and their response formats were modified and refined to increase comprehensibility. The result is an interview schedule which takes on average 30 - 40 minutes to administer and covers objective and subjective indices of both life domains and general well-being. Also included are one or two questions concerning residents' attitudes to their discharge from hospital. In addition to the interview schedule for residents, a list of questions concerning the objective indicators of life quality for each of the residents was also completed by a member of the care staff on each ward. This information was obtained in order to confirm data derived from residents concerning finances, health, family contact etc.

Procedure

Each resident in the hospital, at the time of the study, was approached for an interview. All agreed to participate and each was informed about the nature and purpose of the research. There were no outright refusals to take part in the study though five residents were unable to provide an interview mainly due to poverty of speech. The quality of life interview was carried out by members of the research team, who conducted the interview in pairs, one acting as interviewer, the other as observer. The interviews were carried out in a quiet room in the hospital in order to ensure privacy and no interruptions. The quality of life

interview was done, in most cases, in one sitting in conjunction with the psychiatric interview. Completed interviews were obtained from 62 residents who gave generally reliable and valid responses.

Design

The design of the quality of life study is in accordance with the overall design of the evaluation project. The use of a longitudinal repeated-measures design permits the collection of data at a number of points prior to and following discharge from the hospital. At present the project is working to at least two baseline measures prior to discharge and three repeat measures post discharge, at six weeks, six months and one year. The main advantage of such a design is that it affords the opportunity of monitoring normal fluctuations in the quality of life data independent of specific external changes. In this way, the study will hopefully succeed in discriminating the more permanent changes from those that may be regarded as transitional.

3.3 RESULTS

The results section presents a detailed description of residents' responses to the quality of life interview, looking at objective and subjective indices in each of the nine life areas, global life satisfaction and attitudes to resettlement. The difference in responses between the four wards are also examined, and the nature of the interrelationships between the different quality of life indicators is also explored. As it was not possible to implement a 5-point rating scale for all the residents, a 3-point rating of satisfaction was used in this phase of the baseline. Due to this fact, plus the observed clustering of responses at the positive end of the scale, appropriate nonparametric statistics were used to analyse the data.

Life Domains

The results of the objective and subjective indicators for each of the nine life areas will now be discussed in turn. Levels of expressed satisfaction in each of the life domains are displayed in Table 1. The data are depicted graphically in Figure 1 and Figure 2 displays a breakdown of the levels of satisfaction for each of the four hospital wards. Overall, reported levels of satisfaction were quite high with greatest satisfaction being reported in relation to living situation, social relations and religion. The life areas that elicited the highest levels of dissatisfaction were finance and family relations, but even in these areas the

majority of the residents appeared to be satisfied with their current situation. The detailed findings in relation to each of the life domains will now be discussed.

Table 1**Subjective Quality of Life Indicators for Total Sample (N = 62)**

Domain	Subjective Indicator	Satisfied		Dissatisfied	
		N	%	N	%
Living Situation	Accommodation	41	66	13	21
	Food	44	71	8	13
	Bedroom	52	84	2	3
	Privacy	42	68	8	13
	Freedom	44	71	5	8
Social Relations	Other Residents	43	69	7	11
	Staff	46	74	7	11
	People in General	48	77	3	5
Leisure Activities	Use of Time	45	73	5	8
	Opportunity to Enjoy Oneself	43	69	7	11
	(a) Work within the Hospital (N = 22)				
Work	Type of work	14	64	2	9
	People work with	12	55	1	5
	Place of work	15	68	1	5
	No of Hours	16	73	-	-
	Pay	12	55	3	14
	(b) Not working (N = 40)	23	58	7	18
Finances	Amount of Spending Money	35	57	18	29
	Role of Religion in Ones life	45	73	5	8
Religion	Frequency of Contact	26	42	19	31
	Relationship with family	38	61	2	3
Family Relations	Physical Health	42	68	8	13
	Amount of time with Dr	40	65	7	11
	Medical Treatment	41	66	8	13
	Opportunity to consult staff	44	71	5	8
	Emotional well-being	48	72	5	8
Health	Hospital	44	71	8	13
	Neighbourhood	42	68	6	10
Personal Safety					

Figure 1

Levels of Satisfaction in Each of the 9 Life Areas (N = 62)

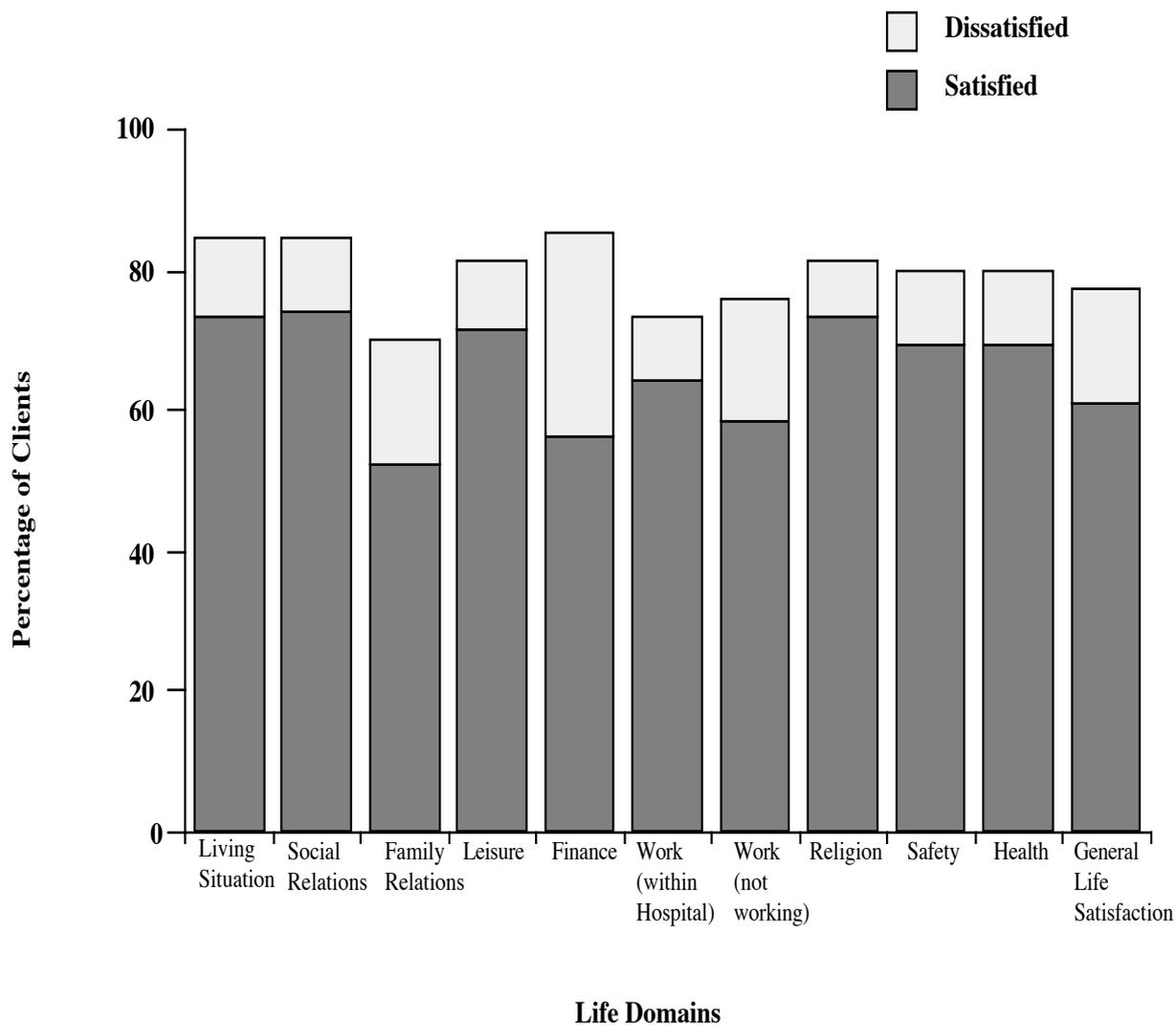
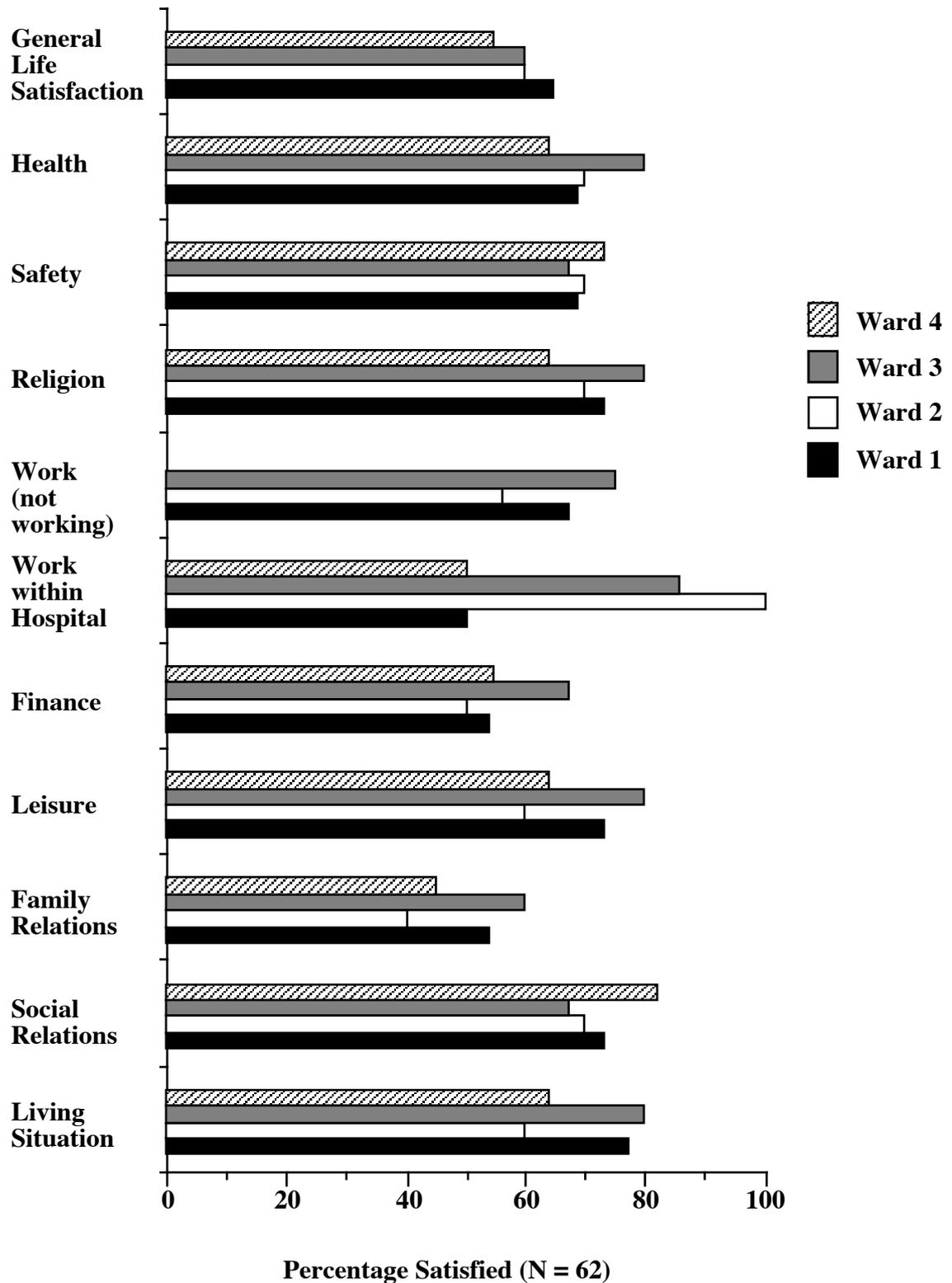


Figure 2

Life Domain Subjective Indicators for each of the 4 Wards



Living Situation

Both objective and subjective indices were used to assess living conditions and residents' perception of their living situation. Additional information on living conditions was also obtained from staff (eg HHPP) and is reported on separately in Paper 1. The objective indicators explored areas of privacy and independence and what residents liked and disliked most about their present accommodation.

The majority of residents did not have their own bedrooms, with only ward 4 providing the opportunity of a private room for all its residents. The remainder of the residents either shared a bedroom or slept in a dormitory. Apart from ward 4, residents had little in the way of a private place they could call their own. Just over half the residents (58%) reported having personal possessions such as photos, radios, cassette players etc. However, there was a significant difference between the wards in relation to this item ($\chi^2 = 22.93, p < 0.001$) with only 27% on ward 1 reporting having personal possessions, in contrast to 70-80% on wards 2, 3 and 4. Likewise in relation to caring for self and cooking their own meals. Ward 1 with its predominantly elderly group of residents stood out in contrast to the other three wards

($\chi^2 = 24.53, p < 0.0001$). Whereas 60-67% reported cooking own meals in the previous week on wards 2 and 3, dropping to 36% on ward 4, none of the residents had cooked for themselves on ward 1. It should also be noted that at the time of interviewing, residents on ward 1 were not provided with facilities apart from the main kitchen, for making snacks or teas and coffees. The residents on ward 1 presented as having little independence. This picture was confirmed by staff ratings on the Rehab scale (Hall and Baker, 1983) where residents were rated as significantly poorer at looking after their own clothes, room, etc.

($F = 3.39, p < 0.05$) and at managing their own money ($F = 3.04, p < 0.05$). (See Paper 2).

Open-ended questions were used to explore what residents liked and disliked most about living in the hospital. The responses which were coded into eight general categories including 'don't know' and 'delusional response' categories, and are presented in Table 2a.

As shown, 19% of the residents were either unable to think of anything they particularly liked about life in the hospital, eg *'I just like it'* or simply replied, *'I don't like it at all'*. Of those who did reply 47% of the responses referred to basic hospital amenities such as food, bed, receiving money for cigarettes, working in the garden etc. The broader category titled, 'general approval' included responses such as the location of the hospital in the countryside and the asylum it afforded, *'in the valley in North Wales, nobody can trouble you, out of the way'* or references to treatment, eg *'it's getting me better, nothing else'*. Few responses

referred to the company of the other residents or staff. The remaining responses were coded in the don't know category (15%) and 3% of responses were coded as delusional.

When questioned concerning what they disliked most about living in the hospital, 79% of the responses were coded as either 'don't know/no response' (24%) or 'nothing' (55%). Few of the residents were either willing or able to specify aspects of hospital life that they disliked ; *'I don't dislike anything about it'* or *'I like everything here'*. Of those who did respond, 18% of responses referred to complaints about the other residents ; *'being in the company of patients more poorly than me'*, *'there are much worse than me here, much sicker than me, it just brings me down, makes me suicidal actually, we shout at each other, I think it's because of the state of the ward and the rules that we got here'*. Potential violence was also mentioned; *'the threat that one of the other patients will hit me'*. More general complaints about patients' behaviour were also included such as 'other patients shouting' or using bad language, and stealing money and other personal items.

Table 2a

Residents' Evaluation of Present Accommodation (N = 62)

	N	%
<u>Like most about living here</u>		
General Approval	8	13
Amenities	29	47
Company of other Residents	4	6
Staff	3	5
Freedom	2	3
Nothing	12	19
Delusional Response	2	3
Don't know / No response	9	15
<u>Dislike most about living here</u>		
General Disapproval	2	3
Company of other Residents	8	13
Staff	3	5
Lack of freedom	6	10
Nothing	34	55
Delusional Response	1	2
Don't know / No response	15	24

As some residents gave more than one response to this question the overall N of responses is > 62.

Dislike of the restrictions or lack of freedom of hospital life accounted for a further 10% of responses. '*...not free like when at home, come under the rules and regulations of the place, gets you down at times*'. Some of the residents who also complained about the restrictions of being on behavioural programmes, e.g., receipt of daily money allowance was contingent on the completion of certain tasks such as washing or shaving. Only 5% of the responses referred to staff, usually commenting on the staff being 'bossy' or 'talking down' to the residents. '*...they tend to be very bossy with you, they treat you like children, they've got to be right*'. The responses coded under general disapproval (3%) were statements of overall dissatisfaction e.g. '*the food, the living conditions are poor, the medicines are poor*'.

The subjective measures included five separate indices of satisfaction with living situation (see Table 2b). Overall, residents expressed high levels of satisfaction with their present accommodation (66%), food (71%), bedroom (84%), privacy (68%) and freedom (71%). The distribution of responses for each of the four wards is displayed in Table 2b below. An analysis of the difference between wards, carried out by performing a Kruskal-Wallis test, revealed that there was a significant difference in relation to overall levels of satisfaction with living situation ($\chi^2 = 8.7, p < 0.05$). As can be seen from Table 2b the highest levels of satisfaction were expressed by residents on ward 1 with satisfaction on wards 2 and 4 tending to be lower, particularly with regard to food, privacy and freedom.

Table 2b
Living Situation: Subjective Indices of % Satisfied for each of the Four Wards

	Ward 1		Ward 2		Ward 3		Ward 4	
	N	%	N	%	N	%	N	%
Accommodation	20	77	6	60	8	53	7	64
Food	21	81	6	60	11	73	6	55
Bedroom	22	85	8	80	13	87	9	82
Privacy	18	69	4	40	13	87	7	64
Freedom	20	77	6	60	12	80	6	55

Social Relations

Residents were questioned concerning the nature and frequency of social contacts both within and outside the hospital facility. Table 3a shows the distribution of replies in response to these questions. Roughly half the residents (47%) reported having friends within the hospital, whereas only 26% reported having friends who resided outside the hospital. Regarding close friendships, 50% of the residents reported having some person that they were particularly close to. The frequency with which residents related socially, either through direct conversation or contact by phone and writing, was also ascertained. As can be seen in Table 3a the most frequent source of daily interaction was with staff, with a surprising 39% of residents reporting not interacting socially with other residents on the ward. Social interactions outside the hospital were infrequent, as was contact by phone and writing. The frequency of contact with a close or intimate friend was also rare, with 73% of residents not having experienced this type of interaction in the recent past. In relation to these figures a number of significant differences were found between the four wards. A breakdown of the figures for each of the four wards can be found in Tables 3b to 3e.

Table 3a

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Social Relations: Objective Indicators (N = 62)

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	Yes		No							
	N	%	N	%						
Presence of Friends										
Friends in Hospital	29	47	25	40						
Friends outside Hospital	16	26	37	60						
Special Friend	31	50	24	39						
Frequency of Social Contact										
	Never		Less than Monthly		Monthly		Weekly		Daily	
	N	%	N	%	N	%	N	%	N	%
Talk with Residents	24	39	3	5	-	-	8	13	20	32
Talk with Staff	9	15	2	3	2	3	13	21	27	44
Telephone Someone	40	65	3	5	4	7	4	7	4	7
Write to Someone	41	66	5	8	-	-	3	5	-	-

Visit Someone in Hospital	39	63	5	8	4	7	5	8	1	2
Spend Time with a Special Friend	45	73	2	3	-	-	3	5	2	3

A significant difference between the wards emerged in relation to the number of social contacts ($\chi^2 = 21.47$, $p < 0.0001$). Residents on wards 3 and 4 reported having more friends both within and outside the hospital, and they also reported having more close friendships.

Table 3b

Social Relations: Objective Indicators for each of the Four Wards
Presence of Friends

	N	%
<u>Friends in Hospital</u>		
Total Sample	29	47
Ward 1	4	15*
Ward 2	4	40
Ward 3	11	73
Ward 4	10	91
<u>Friends outside Hospital</u>		
Total Sample	16	26
Ward 1	3	12
Ward 2	1	10
Ward 3	5	33
Ward 4	7	64
<u>Special/Close Friend</u>		
Total Sample	31	50
Ward 1	9	35
Ward 2	3	30
Ward 3	10	67
Ward 4	9	82

* The percentage for each ward is based on the number of patients in that ward.

In relation to the difference between wards concerning frequency of social interaction within the hospital ($\chi^2 = 8.90$, $p < 0.05$), it was found that levels of interactive contact among the residents were highest on ward 4, with 64% reporting conversing with other residents on a daily basis. However a high proportion of residents on the other three wards did not interact socially with the other residents. The lowest levels of interaction were reported on ward 2 where 60% of residents did not engage others in conversation. The levels of participation in activities with other residents was also low, with 50-80% of residents on wards 1, 2, and 3, not participating. A number of residents commented on the lack of interaction on the wards;

'.....they don't mix with me and I don't mix with them',

'the people here, the attitude, they don't talk, why live here if people in general don't talk to you'

Table 3c**Frequency of Social Contact within the Hospital for each of the Four Wards**

		Activities with other Residents		Converse with Residents		Converse with Staff	
Frequency		N	%	N	%	N	%
Ward 1 (N = 26)	Daily	-	-	5	19	14	54
	Weekly	3	12	5	19	2	8
	Monthly	2	8	-	-	1	4
	Less than Monthly	2	8	2	8	1	4
	None	13	50	10	39	3	12
Ward 2 (N = 10)	Daily	-	-	3	30	4	40
	Weekly	1	10	-	-	2	20
	Monthly	2	20	-	-	-	-
	Less than Monthly	-	-	-	-	-	-
	None	5	50	6	60	3	30
Ward 3 (N = 15)	Daily	-	-	5	33	4	27
	Weekly	1	7	1	7	5	33
	Monthly	-	-	-	-	1	7
	Less than Monthly	1	7	1	7	1	7
	None	12	80	7	47	3	20
Ward 4 (N = 11)	Daily	1	9	7	64	5	46
	Weekly	3	27	2	18	4	36
	Monthly	3	27	-	-	-	-
	Less than Monthly	-	-	-	-	-	-
	None	3	27	1	9	-	-

Social contacts outside the hospital also revealed a significant difference between the wards in terms of frequency of contact, ($\chi^2 = 16.31$, $p < 0.001$). As may be seen on Table 3d social contact with persons outside the hospital were practically non-existent for residents on wards 1 and 2, as was contact by phone and writing. The picture looks somewhat better on wards 3 and 4 with more frequent visits outside the hospital and greater use of the phone to maintain contact. One possible explanation for the low levels of external social contacts on wards 1 and 2 is the longer length of stay for residents on these wards ($F = 21.39$, $p < 0.0001$). The average length of stay on wards 1 and 2 was 29 and 33 years respectively as

compared to an average length of stay of 3 years in ward 4 and 11 years on ward 3. It is likely that lengthy periods of hospitalisation result in a severing of social contacts, especially with non-family contacts. One resident, when questioned concerning contact with friends outside the hospital, put it as follows;

I thought I did (have friends) but since I've been in hospital, they haven't bothered'.

This severing of social ties is one of the obvious yet inevitable negative consequences of hospital-based care.

Table 3d
Frequency of Social Contact Outside the Hospital for each of the Four Wards

Ward	Frequency	Visit		Phone		Write	
		N	%	N	%	N	%
Ward 1	Daily	-	-	-	-	-	-
	Weekly	-	-	-	-	-	-
	Monthly	-	-	-	-	2	8
	Less than Monthly	-	-	1	4	1	4
	None	22	85	21	81	19	73
Ward 2	Daily	-	-	-	-	-	-
	Weekly	-	-	-	-	1	10
	Monthly	1	10	1	10	-	-
	Less than Monthly	1	10	-	-	1	10
	None	7	70	8	80	6	60
Ward 3	Daily	-	-	2	13	-	-
	Weekly	4	27	2	13	1	7
	Monthly	-	-	2	13	2	13
	Less than Monthly	3	20	1	7	2	13
	None	7	47	7	47	10	67
Ward 4	Daily	1	9	2	18	-	-
	Weekly	1	9	2	18	2	18
	Monthly	3	27	1	9	1	9
	Less than Monthly	1	9	1	9	1	9
	None	3	27	4	36	6	55

The frequency of contact with close friends was also significantly different between the four wards ($\chi^2 = 9.56$, $p < 0.05$). Residents on ward 3 (67%) and ward 4 (82%) were more likely to report having a special friendship than were residents on ward 1 (35%) and ward 2 (30%). Although some residents reported having close friends, further questioning

revealed that they rarely met or had contact with such friends. The frequency of reported contact was relatively low on all four wards. Although some residents reported having close friends, further questioning revealed that they rarely met or had contact with such friends.

The subjective measures looked at levels of satisfaction among the residents concerning their current social relations. As Table 1 shows, 69% expressed satisfaction with their relationship with other residents, 74% experienced satisfaction with relations with staff and 77% were satisfied with how they got on with people in general. Residents were also asked if they ever felt lonely ; 44% replied 'never', 3% 'rarely', 21% 'sometimes', 11% 'often', and 7% 'very often'.

Table 3e Frequency of Contact with Close/Special Friend

Frequency	Ward 1		Ward 2		Ward 3		Ward 4	
	N	%	N	%	N	%	N	%
Daily	-	-	-	-	-	-	2	18
Weekly	-	-	-	-	2	13	1	9
Monthly	-	-	-	-	-	-	-	-
Less than Monthly	-	-	1	10	1	7	-	-
None	20	77	8	80	11	73	6	55

From the outside, it is difficult to reconcile the subjective levels of satisfaction with the objective indicators. The latter depict the residents as a socially limited group who apart from family, have very restricted social networks outside the hospital, and in some cases experience very limited social interaction within the hospital. The high levels of expressed satisfaction in this context could be interpreted as a consequence of hospital life with restricted social contacts and the resultant lowered expectation concerning social relationships. On the other hand, the reported satisfaction with reduced levels of social activity could be perceived as resulting from lower tolerance to social interaction among psychiatric patients. As the majority of residents were diagnosed schizophrenic it may be that the influence of negative schizophrenic symptomatology, i.e. social withdrawal, lack of initiative, poverty of speech etc., may have operated to impair residents' abilities to cope with the demands of ongoing relationships. However, the psychiatric data would tend to contradict this in that levels of interaction were lowest on wards 1 and 2 yet residents on these wards did not exhibit more severe psychiatric symptomatology than residents on wards

3 and 4. In any case it would appear that social relations is an important aspect of residents' lives and has serious implications concerning how residents will adjust to and cope with life in the community. Residents' abilities to relate socially and develop friends needs to be carefully assessed during the preparation and planning of community placements.

Family Relations

The objective indicators sought to establish the existence of any living relatives and the frequency of contact. As may be seen from Table 4a the majority (74%) of the residents had living relatives and just over half (58%) of the residents had relatives living in the surrounding area. The indices concerned with frequency of contact included direct face-to-face contact (i.e. visits), contact by phone and written communication.

Table 4a

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Family Relations: Objective Indicators (N = 62)

–

	N	%
Presence of Family		
Living Relatives	46	74
Relatives living in North Wales	36	58
Frequency of Contact with Relatives		
<u>Visit with Family</u>		
Not in past year	16	26
At least once in past year	10	16
Monthly	16	26
Weekly	7	11
Daily	1	2
<u>Written Communication with Family</u>		
Not in past year	31	50
At least once in past year	13	21
Monthly	4	7
Weekly	1	2
Daily	-	-
<u>In contact with Family by Phone</u>		
Not in past year	30	48
At least once in past year	5	8
Monthly	4	7
Weekly	5	8
Daily	4	7

–

As shown in Table 4a, 39% of the sample had seen their families in the month prior to the interview, 22% had been in contact by phone and 9% had had written communication. Contact by phone and writing tended to be infrequent, once or twice a year if at all. Some 26% had not seen their families in the previous year, and 16% had received a visit at least once in the previous year. A significant difference emerged between the four wards in relation to frequency of contact ($\chi^2 = 10.72$, $p < 0.01$), with the greatest contrast emerging between ward 1 and ward 4 (see Table 4b). Family visits were more infrequent on ward 1, only 20% of the residents reported visits on a monthly basis in contrast to 73% on ward 4, and 39% on ward 1 had not been visited by family in the previous year. Similarly, contact by

phone was more infrequent on ward 1 than on the other three wards. The difference in relation to frequency of contact on ward 1 could partly be explained by the fact that residents on ward 1 were predominantly elderly (mean age of 68 years) and regular visits to the hospital by ageing relatives may have proved difficult.

Table 4b
Frequency of Contact with Family Relations Broken down by Ward

Frequency		Visit		Phone		Write	
		N	%	N	%	N	%
Ward 1	Daily	-	-	-	-	-	-
(N = 26)	Weekly	2	8	-	-	-	-
	Monthly	3	12	-	-	2	8
	Annually	4	15	2	8	2	8
	Not in Past Year	10	39	16	62	14	54
Ward 2	Daily	-	-	-	-	-	-
(N = 10)	Weekly	-	-	1	10	-	-
	Monthly	4	40	2	20	1	10
	Annually	2	20	1	10	3	30
	Not in Past Year	2	20	4	40	4	40
Ward 3	Daily	-	-	1	7	-	-
(N = 15)	Weekly	3	20	3	21	1	7
	Monthly	4	27	1	7	-	-
	Annually	3	20	1	7	6	40
	Not in Past Year	3	20	7	47	6	40
Ward 4	Daily	1	9	3	27	-	-
(N = 11)	Weekly	2	18	1	9	-	-
	Monthly	5	46	1	9	1	9
	Annually	1	9	1	9	2	18
	Not in past Year	1	9	3	27	7	64

Despite the infrequent contact many residents on ward 1 still entertained the hope of returning to live with their families with some residents in their 80's failing to acknowledge the fact that their parents had been dead for some years. None of the residents from ward 1 and ward 2 were in fact expected to return to live with family. The situation on wards 3 and 4 was somewhat different, six of the residents on ward 4, had regular weekend visits to their families and it was considered by staff that five residents on ward 4 and two residents on ward 3 could return to live with their families.

The subjective indicators looked at satisfaction with relationships with family and the frequency of contact with family. The majority of residents (61%) experienced satisfaction

with the nature of their relationships with their families, with only two persons indicating any dissatisfaction. In contrast, a sizeable 31% expressed dissatisfaction with the frequency of family contact. Levels of dissatisfaction were relatively high in relation to this aspect of residents' lives (see Figure 1). Many lamented the loss of family life and expressed a strong desire to see their families more often ;

'my family they don't seem to want to come and see me or have anything to do with me I just wish my family would come and see me'

'I've four sisters, never see them, I don't believe we're the same family'.

It was apparent from replies to this question that family relationships were very important to the residents and were mentioned most frequently in response to the question *'what is the most important thing to you in your life?'* In many cases the family was the only source of emotional support and maintaining regular family contact is obviously an area of considerable importance and relevance to residents' quality of life.

Leisure

The objective indices explored how residents had spent their time during the previous week, whether or not they had a particular hobby and what activities or events had been organised during the past year. A list of nine leisure activities were presented and residents were asked to indicate if they had participated in these activities during the previous week. As can be seen in Table 5a, the most popular activity was watching TV (88%) followed by going for a walk (65%). Residents also appeared to spend their time listening to the radio or music (45%) and reading newspapers or magazines (44%).

Table 5a

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Leisure Activities: Objective Indicators for Total Sample (N = 62)

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	N	Yes	%
Activities During Past Week			
Go for a walk	40		65
Go to cinema	2		3
Watch TV	52		84
Go shopping	29		47
Go to a cafe/Restaurant	29		47

Go to a pub	13	21
Read book / newspaper	27	44
Listen to the Radio	28	45
Go to the Library	7	11
Have an Interest/Hobby	17	27
Activities During Past Year		
Day Trip	35	57
Holiday	23	37
Party	43	69

There was a significant difference between the wards in relation to participation in the listed activities ($x^2 = 11.40$, $p < 0.01$). The frequency of participation for residents on each of the four wards is to be found in Table 5b. Just under half the residents (47%) had done some shopping outside the hospital during the week and/or had been to a cafe or restaurant in the local town, while 21% had visited a local pub. Few of the residents appear to have used the local library or cinema. The main difference appeared to be in relation to participation in activities outside the hospital. As before wards 1 and 4 showed the greatest contrast e.g. 15% from ward 1 had been shopping in the previous week, as compared to 91% on ward 4 and 60% on wards 2 and 3. The use of outside cafes and pubs was also highest on ward 4.

Regarding a hobby or special interest, only 27% of the sample responded positively to this question, with the highest response rate from residents on ward 3 (53%). The range of hobbies included, gardening, following football matches, tennis, reading, writing poems, painting, stamp collecting, etc. However, for some respondents it was clear that they reported having had hobbies in the past which they no longer engaged in. Residents on ward 3 and ward 4 attended art and creative writing workshops which are based in the hospital and were very popular. Apart from this, there was little in the way of structured leisure activities planned for residents. There was a policy on all four wards of actively encouraging residents to use the resources and facilities of the local community, such as using the laundrette, visiting cafes and pubs. It is likely however that the extent of these activities were curtailed by the limited finances available to residents. When asked about the opportunity to enjoy himself, one resident explained;

'I only get £2 a day, who gets the chance to enjoy themselves on £2 a day?'

With regard to yearly activities, 37% of the residents reported having been on holiday during the previous year, 57% had been on organised day trips and 69% had attended a party

or parties. Further information, from staff revealed that staff on wards 2, 3 and 4 had organised 15-40 day trips during the previous year, holidays had been organised for residents, a small number of whom refused to go, and residents' birthdays were celebrated with a small party on the ward. Ward 1, on the other hand, had fewer day trips, one or two in the previous year, only 23% of the residents had been on holiday and residents' birthdays were not celebrated on the ward.

Table 5b
Leisure Activities: Objective Indices for each of the Four Wards

	Ward 1		Ward 2		Ward 3		Ward 4	
	N	%	N	%	N	%	N	%
Activities During Past Week								
Go for a walk	13	50	7	70	11	73	9	82
Watch TV	21	81	8	80	13	87	10	91
Listen to Radio	5	19	7	70	8	53	8	73
Go to Cinema	1	4	-	-	-	-	1	9
Read Book/Newspaper	9	35	4	40	8	53	6	55
Go to Library	3	12	1	10	-	-	3	27
Go shopping	4	15	6	60	9	60	10	91
Go to a Cafe/Restaurant	10	39	5	50	7	47	7	64
Go to a Pub	7	27	1	10	1	7	4	36
Activities During Past Year								
Day Trip	15	58	4	40	8	53	8	73
Holiday	6	23	4	40	8	53	5	46
Party	17	65	6	60	11	73	9	82
Hobby	4	15	2	20	8	53	3	27

The subjective indicators looked at residents' satisfaction with how they spent their time and the opportunity they had to enjoy themselves. As shown in Table 1, 73% were satisfied with their use of time and 69% reported satisfaction with the opportunity for enjoyment in the hospital. Although few residents actually expressed dissatisfaction with this area of their lives, statements such as the following were common ;

'I don't do much with my time, the least you do the better'

'I've been institutionalised see, I'm not one for parties, just keep going'.

'I can't seem to make the effort, I should do'.

One suspects that the statements of satisfaction reflected to a certain extent the residents' own lack of motivation in this area. Yet, the leisure activities that were organised were obviously enjoyed by residents, as leisure accounted for 18% of the responses to the questions concerning events that residents looked forward to. Each resident was also asked if s/he ever

felt bored, to which 45% replied 'never', 5% 'rarely', 18% 'sometimes', 5% 'often', and 8% 'very often'.

Health

The objective indicators explored residents' state of physical health during the past year, knowledge concerning their psychiatric illness, the purpose and helpfulness of the medication, and the frequency of contact with mental health professionals other than care staff.

As can be seen from Table 6a below, only 10% of residents reported having been seriously ill during the previous year and 8% reported having had an operation. Information from staff tended to confirm these figures. No suicide attempts or other psychiatric emergencies were reported by staff. An analysis of the differences between the wards with regard to number of illnesses ($\chi^2 = 9.82$, $p < 0.05$) showed that the 10% who reported having been ill were all residents on ward 1. As many of these residents were in their 80's, reports of deteriorating physical health are not surprising.

Table 6a

Health: Objective Indicators (N = 62)

	N	%
Physical Illness		
Serious illness in past year	6	10
Operations in past year	5	8
Psychiatric Illness		
Know what the illness is called?	17	27
Purpose of Medication?		
Reference to illness	30	48
Uncertain	6	10
Don't know / No idea	18	29
Is the Medication Helpful?		
Unhelpful	10	16
Uncertain	4	7
Helpful	30	48
Don't know	10	16

With regard to psychiatric illness, the majority of the residents did not know what their illness was called, only 27% were able to supply a name. General terms such as

'nerves', 'mental illness', 'nervous breakdown' were common. A small number of residents supplied more specific terms such as depression, schizophrenia and epilepsy. Likewise, 39% of residents were either unsure or did not know why they were taking medication. Of the 48% who did supply an answer, many referred to physical complaints such as '*stopping ulcers*' or '*some sort of poison in the blood*'. As before only a small number of residents referred to their psychiatric problems; '*tablets for the voices, moods, nerves*' or '*lithium carbonate, it actually stops you feeling a high*'. Each resident was also questioned as to whether or not they found the medication helpful; to which 48% replied positively, 23% were unsure or didn't know, and 16% felt it was not helpful. '*I've been on it so long, I wonder if it's having a detrimental effect*'. However, as many of the residents had very little insight into the nature of their difficulties or the purpose of their medication, it is doubtful if they were, in fact, in a position to assess its effectiveness. Information was obtained from staff on wards 2, 3 and 4 concerning how many patients had had a formal review of their medication with the consultant present during the last three months. It was found that 60% of the residents on ward 2 had been reviewed, 20% on ward 3, and all the residents on ward 4.

Questions concerning use of health care services looked at the frequency of contact with a number of mental health professionals. Overall, 24% reported seeing the Dr (i.e. general medical care) at least once every two months, 14% reported seeing the psychiatrist, 7% reported seeing the psychologist, 12% reported seeing the social worker and only one person reported seeing the CPN. A relatively high proportion of residents reported not seeing the various professionals in the last year. However, the reliability of these replies is in doubt as some residents were unable to differentiate between psychiatrists, psychologists and social workers. In addition, problems of accurate recall also need to be considered. Information obtained from staff suggests that the four wards were visited routinely by the various mental health professionals, whose services were available as necessary.

The subjective indicators looked at satisfaction with physical and emotional well-being and the medical treatment received in the hospital. As can be seen in Table 1, satisfaction levels were high with 68% of residents reporting satisfaction with physical health and 72% satisfied with emotional well-being. The satisfaction with emotional well-being appears somewhat high for this group, and is probably best interpreted as a relative judgement made within the context of ongoing psychiatric difficulties. For example, accompanying statements of satisfaction were comments such as the following ;

'I feel a bit down all the time, it doesn't really matter while you keep going'

'I wish I was outside but I feel I'm making a good job of the situation'.

On the whole residents appeared satisfied with the medical treatment (66%) and with the opportunity to consult staff concerning any difficulties (71%). However statements such as *'I*

keep myself to myself ' suggest that some residents may have been reluctant to confide in staff in this way.

Table 6b

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Health: Use of Health Care Services

	N	%
<u>Frequency of Contact with Dr</u>		
Not in past year	10	16
At least once in past year	15	24
Once every two months	3	5
Once a month	10	16
Weekly	2	3
<u>Frequency of Contact with Psychiatrist</u>		
Not in past year	13	21
At least once in past year	6	10
Once every two months	3	5
Once a month	4	7
Weekly	1	2
<u>Frequency of Contact with Psychologist</u>		
Not in past year	20	32
At least once in past year	2	3
Once every two months	-	-
Once a month	-	-
Weekly	4	7
<u>Frequency of Contact with Social Worker</u>		
Not in past year	11	18
At least once in past year	6	10
Once every two months	4	7
Once a month	3	5
Weekly	-	-
<u>Frequency of Contact with CPN</u>		
Not in past year	15	24
At least once in past year	2	3
Once every two months	1	2
Once a month	-	-
Weekly	-	-

Religion

The majority of the residents were brought up as either Protestant (68%) or Catholic (16%) and only one person reported having no religious affiliations. When questioned concerning attendance at church services, 40% had not been to church in the previous year, 7% had attended at least once a year, 3% attended on a monthly basis, and 34% were weekly church goers, (see Table 7a). A significant difference between the wards was found in relation to frequency of attendance ($\chi^2 = 8.42, p < 0.05$). Residents on ward 1 were the most frequent attenders with 54% attending chapel every week, as opposed to 30% on ward 2, 13% on ward 3, and 18% on ward 4. A higher proportion of residents on wards 2, 3, and 4 (50-60%) had also not been to church in the previous year. A chapel was located on the grounds close by ward 1 and a routine of attending chapel every Wednesday morning had been established for residents on ward 1, which probably accounts for the higher attendance rates on this ward.

Despite the differences in frequency of church attendance, subjective measures of satisfaction show that 73% of the sample were satisfied with the amount of religion in their lives.

Table 7a

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Religion: Objective Indicators (N = 62)

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	N	%
Religious Denomination		
Protestant	42	68
Roman Catholic	10	16
Other	-	-
None	1	2
Attend Religious Services	21	34
Frequency of Attendance		
Not in past year	25	40
At least once in past year	4	7
Monthly	2	3
Weekly	21	34

—

Work

None of the residents was in employment, at the time of the interview. Of the residents 57% had worked in various occupations prior to being hospitalised, and 36% were involved in carrying out work within the hospital, e.g. working in the gardens, hairdressing, doing jobs on the ward and/or attending the hospital's industrial therapy unit, (see Table 8a for a breakdown by ward).

Only 29% reported being paid for work done in the hospital. Information was obtained from staff concerning rates of pay etc. Work carried out at the industrial therapy unit was paid at 50p per session ie, one morning or afternoon, while work on the rehabilitation gardens paid £1 per session with a maximum earning of £8 per week. The residents who worked on the hospital garden centre, potting plants etc, received varying amounts of pay depending on the amount of work carried out, and the female patient who worked at the hospital's hair salon received £15 per week. In all, the rates of pay or reward were quite low. Yet satisfaction with the number of hours worked (73%), the place of work (68%) and the type of work (64%) and to a lesser extent with the pay (55%) and co-workers (55%) (see Table 1) were quite high. One of the residents who worked in the hair salon expressed her satisfaction as follows; *'I enjoy it, it's the only place I can escape to feel human, the other workers they're great'*. A number of residents felt that being occupied in some way, helped to pass the time.

Looking to those who were not involved in work either inside or outside the hospital (65%), valid responses were obtained from only 33 of the residents (53%). Overall 58% expressed satisfaction with being currently unemployed, with many of the elderly residents feeling that they were *'too old for work now'*. A significant difference between the wards emerged in relation to satisfaction with the absence of employment ($\chi^2 = 8.36, p < 0.05$), with the highest levels of dissatisfaction (60%) being expressed by the younger residents on ward 4 and by those residents who had worked for lengthy periods before coming to hospital.

Table 8a

Work: Objective Indicators for Total Sample broken down by Ward (N = 62)†

<u>Work prior to Hospitalisation</u>	N	%
Total Sample	35	57
Ward 1	12	46
Ward 2	7	70
Ward 3	8	53

Ward 4	8	73
<u>* Work since being Hospitalised</u>		
Total Sample	22	36
Ward 1	8	31
Ward 2	1	10
Ward 3	7	47
Ward 4	6	55
<u>Paid for Work</u>		
Total Sample	18	29
Ward 1	4	15
Ward 2	1	10
Ward 3	7	47
Ward 4	6	55

† The percentage for each ward is based on the number of patients in that ward.

*Work refers to work within the hospital such as gardening and attendance at the hospital's industrial therapy unit.

Finances

The objective index looked at the amount of spending money available to each of the residents, the results are shown in Tables 9a and 9b below.

The majority of the residents were receiving less than £20 per week, with only 13% reporting more than this amount.

Table 9a

Finance: Amount of Spending Money Per Week (N = 62)

Amount of Money	N	%
0 - £10	24	39
£10 - £20	20	32
> £20	8	13

Information from staff suggests that each resident received £9.40 per week (DSS) plus £7.50 rehabilitation money, the receipt of which was made contingent on completion of certain tasks e.g. self-care, personal hygiene etc. In addition, residents attending the OT department or working in the rehab gardens, garden centre or farm, or in receipt of disability allowances received additional sums of money. A breakdown of the average weekly income per ward is shown in Table 9b. The maximum sum reported was £35, and a number of residents reported not receiving any money. The latter usually occurred when staff managed money for very dependent residents, purchasing necessary items, such as cigarettes, etc. on their behalf. The Kruskal-Wallis test revealed a significant difference between the wards in relation to weekly income, with the lowest level of income being reported on ward 1 where significantly more of the residents had their money managed by staff (REHAB ratings, $F = 3.04$, $p < 0.05$).

Table 9b

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Average Income (£'s) for each of the 4 Wards (N = 62)

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	Mean	Minimum	Maximum
Ward 1	6.09	0	16.20
Ward 2	13.26	5.10	28.00
Ward 3	15.88	2.50	34.70
Ward 4	14.22	0	35.00

—

Satisfaction with the amount of spending money showed a lower than usual rate of satisfaction, with 57% expressing satisfaction with the amount they received, - *'as long as I have money for fags, I don't go down to the cafe that often, once or twice a week'*.

Dissatisfaction with finances was expressed by 29% of the residents who felt that they, *'could do with more'*, and a number of residents also expressed resentment at having to complete certain tasks in order to receive their rehab money, *'you've got to clean to get your own money'*.

Personal Safety

Residents were asked whether they had been robbed or attacked in the previous year, to which 24% replied positively. However, on further questioning it emerged that while

incidents of physical violence between residents had occurred, the majority of the positive responses referred to minor thefts of money, sweets, cigarettes, etc. on the hospital ward.

Table 10a

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Personal Safety: Percentage Robbed or Attacked in Past Year

	N	%
Total Sample	24	39
Ward 1	12	46
Ward 2	5	50
Ward 3	5	33
Ward 4	2	18

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While these thefts were a constant source of irritation for the residents, very few serious incidents constituting a threat to personal safety were reported. Further information from staff revealed that only two of the residents had been involved with the police during the previous year, one for shoplifting and the other for travelling on public transport without a ticket. As shown in Table 1, satisfaction with personal safety was relatively high with 71% reporting satisfaction with feeling safe within the hospital and 68% satisfied with feeling safe on the streets/roads in the neighbourhood or local town. No significant difference between the wards was found in relation to this life area.

Global Indices of Quality of Life

In addition to the domain-specific indicators of quality of life, each resident was also questioned concerning their perception of life overall. Expressed levels of satisfaction with life in general are depicted in Table 11a. Compared to the majority of the domain-specific indicators, the satisfaction with life overall tended to be somewhat lower.

Table 11a

General Life Satisfaction (N = 62)

	Satisfied		Dissatisfied	
	N	%	N	%
Total Sample	38	61	10	16
Ward 1	17	65	1	4
Ward 2	6	60	2	20
Ward 3	9	60	4	27
Ward 4	6	55	3	27

Accompanying reports of satisfaction were comments which suggested that residents had resigned themselves to their present situation and had lowered their expectations accordingly ; *'I accept it readily as it is', 'life's nearly over, things could have been better', 'I wish I was outside but I feel I'm making a good job of the situation'*. Those residents who expressed dissatisfaction with their lives tended to do so in strong terms, e.g. *'I'm fed up generally with life, I want to die', 'just being alive, don't like it, I would like it if I had a better life, I don't seem to be getting anywhere in my life', '.....it's (life) one big mishap....'* No significant difference between the four wards emerged in relation to this measure.

A number of open-ended questions were used to explore residents' perceptions of what was important in their lives, including sources of enjoyment and unhappiness and personal aspirations and hopes. In reply to the question; *'what is the most important thing to you in your life'*, 27% of residents did not provide a response and a further 24% were either 'don't know' or 'nothing' responses. In relation to the latter 18% of the responses did not specify anything of special importance to the person, replies ranged from, *'I don't think about it', 'cannot think of anything', to 'no special things, generally I enjoy my life'*. The remaining responses referred mainly to family (10%), work (89%), leisure activities such as watching TV, and going on trips in the minibus (10%), food and drink (5%), cigarettes (6%), having a sexual relationship (5%) - 'to have girlfriends, or 'marry and settle down to have a family', happiness (3%), religion (3%) and being discharged from hospital (3%), *'I'd like to get out of here and be at home, going to work, meeting people'*. (Responses total more than 100% because of multiple responses).

The question concerning things that make you feel good, that you look forward to, also elicited a range of diverse responses. The most popular reply for this group was smoking, eating and drinking, (tea, coffee, etc.), which accounted for 21% of the responses. A further 18% of the responses referred to leisure activities such as *'going on holiday'*, *'creative writing'*, *'walking in the hills'*, *'listening to football match'* etc. Trips to town, to the cafe or to the pub for *'a couple of pints at weekends'* accounted for another 10% of the replies. Contact with family and *'going home at weekends'* constituted only 10% of the responses, and a further 8% referred to social relations such as *'enjoy seeing my friends'* or simply *'company'*.

Church services, money, having a car and moving from hospital were also mentioned and 10% stated not having anything in particular to look forward to.

A response was obtained from 65% of the residents regarding things that make them feel unhappy ; 5% of these responses were coded as delusional (e.g. reference to the crows who were perceived as messengers of the devil), and 21% of responses failed to specify anything in particular. Reference to the other residents accounted for 15% of the responses e.g. *'others fighting'*, *'when they do dirty things, playing with themselves'*, *'dirty talk about sex, offensive talk about women'*, and 5% referred to the hospital staff ; *'the attitude of the staff, they put you down all the time'*. A further 15% of responses listed other unpleasant aspects of hospital life - *'just being here, don't like it, like if I had a better life'*, *'don't get enough money to spend'*, *'injections'* . Lack of family life *'not being able to bring my own son up'* (3%) and dissatisfaction with self (2%), *'losing temper'*, were mentioned to a lesser extent with only one respondent specifically mentioning closure of the hospital.

Regarding personal aspirations, each resident was asked *'can you think of one thing you'd like to change in your life....something that would make your life better?'* Of the total sample, 26% of residents did not reply to this question, 10% gave *'don't know'* responses and a further 26% did not specify any particular changes, either stating that they were content with life as it was, *'no change, happy life'*, or that they did not contemplate making any changes, *'too late now to think that, too late and not early enough'*. Of those who did specify areas of change, 15% of the responses related to leaving hospital - *'freedom from all sections and mental hospitals, to live as I want to live'*, *'like to go home and be more sociable'*, *'to get out of this dump, its an awful place'*. Improvements in health (5%) were also mentioned - *'to be well again all the time'* - as was improved family (5%) and social relations (5%) *'seeing family more often'*, *'have a girlfriend'*, *'get married, have a new home'*. One or two residents also referred to having more money, *'having better TV programmes...more westerns'*, and having a job.

Attitude to Resettlement

In addition to the quality of life indicators two questions concerning attitudes to resettlement were included in the interview schedule. With regard to whether residents would like to go on living in present accommodation or go and live somewhere else, the majority of the residents expressed either a strong desire to leave (39%), or a qualified desire to leave (13%), usually dependent on the type of alternative accommodation available. A further 32% expressed a desire to remain in hospital. A significant difference emerged between the wards in relation to how residents responded to this question, ($\chi^2 = 9.34$, $p < 0.05$). A higher proportion of residents on wards 1 (46%) and ward 2 (40%) expressed a desire to remain in hospital, in contrast to wards 3 (7%) and 4 (27%) where a greater number of residents expressed a desire to leave.

Table 12a

Residents' Attitudes to Resettlement (N = 62)

	N	%
<u>Residential Preference</u>		
Strong desire to leave	24	39
Qualified desire to leave	8	13
Ambivalent	2	3
Desire to Remain	20	32
Don't know	1	2
<u>If Moved from Hospital</u>		
Worse Off	12	19
About the same	7	11
Better Off	21	34
Don't Know	15	24

Expectations concerning discharge were explored by asking residents whether they felt they would be better off, worse off, or just about the same if moved from their present accommodation. A large proportion of residents (24%) simply responded that they did not know if moving from hospital would result in a substantial improvement or deterioration in their lives. This response is reasonable given that few residents knew where they were likely to be moved to or when. However 34% reported that they would be better off, with the 19%

feeling that they would be worse off and 11% felt they would be about the same. As before a Kruskal-Wallis test revealed a significant difference between the wards ($\chi^2 = 10.67$, $p < 0.01$). Residents on ward 3 were much more likely to feel that they would be better off (73%), in contrast to residents on ward 2 who in turn felt that they would be worse off if moved from hospital (50%). It should be noted that four of the residents on ward 3 (27%) were under restriction orders and their responses to this question would therefore be influenced by this fact. However, the overall pattern of responses suggests that residents on ward 1 and 2, held less positive attitudes concerning resettlement than residents on wards 3 and 4. This point will be returned to later.

Correlational Analyses

Spearman rank correlations were computed to assess the relationships between the various quality of life indicators used in the study. In all, three sets of correlational analyses were carried out on the data :

- intercorrelations of objective and subjective quality of life measures within each life domain;
- correlations of demographic variables, domain-specific objective indices and domain-specific subjective indices with general life satisfaction.
- correlations of general life satisfaction with measures of psychopathology.

The intra-domain correlations between subjective and objective indicators of quality of life are displayed in Table 13a. From the total set of 16 correlations, only two emerged as significant, a positive correlation between satisfaction with social relations and frequency of contacts within the hospital ($r = 0.32$, $p < 0.01$), and a negative correlation between satisfaction with living situation and independence ($r = -0.32$, $p < 0.01$). The correlation between frequency of contact with residents in the hospital and satisfaction with social relations is not altogether surprising as so few residents had frequent social contacts outside the hospital. However the negative correlation between independence and satisfaction with living situation is more difficult to explain as it is not in the expected direction. This correlation suggests that those residents who had their own personal belongings, cared for themselves and occasionally cooked their own meals, expressed greater dissatisfaction with their living conditions than did other residents. One possible interpretation of this finding is that those residents who experienced greater levels of independence in the hospital may have had as a result higher expectations and desired even more independence, leading to a dissatisfaction with restrictions of the hospital. Whereas the more dependent, institutionalised residents are likely to have had lower expectations and be more resigned to and accepting of hospital life.

In this sense higher levels of dependency may be associated with higher levels of expressed satisfaction, therefore, statements of satisfaction in this context need to be interpreted cautiously. The lack of correlation between the majority of the subjective and objective indices in each life domain is to a certain extent expected, as it is consistent with findings from a number of other quality of life studies (Andrews & Withey, 1976; Campbell et al., 1976).

Table 13a

Correlation between Subjective and Objective Indicators of Quality of Life for Total Sample (N = 62)

Subjective Indicator	Objective Indicator	Spearman Corr Coefficient	Significance
Living Situation	Privacy	-0.03	0.41
	Independence	-0.32	0.01**
Social Relations	Total No. of Contacts	0.16	0.12
	Contacts in Hospital	0.32	0.01**
	Contacts Outside Hospital	-0.12	0.20
	Close/Intimate Contacts	0.22	0.06
Family Relations Leisure	Frequency of Contact	0.18	0.12
	Number per week	-0.03	0.40
	Yearly activities	-0.10	0.24
Finances Work	Spending money per week	-0.18	0.11
	Work since coming to Hospital	0.01	0.47
	Pay	0.30	0.11
Health	Illness in past year	-0.08	0.28
	Use of Health Care Services	-0.29	0.08
Religion Safety	Attendance at Church Services	-0.01	0.47
	Victim of Crime	0.21	0.07

** p < .01

Correlations between general life satisfaction and a number of demographic variables were also carried out. Spearman rank correlations of the relationship between age of residents, current length of hospital stay, ward setting and general life satisfaction were

carried out. The effects of sex and marital status were not explored owing to the small number of female residents (N = 8) and the fact that of the total sample only four had been married and all four were either divorced or currently undergoing divorce proceedings.

Demographic variables have not been found to correlate strongly or consistently with ratings of general life satisfaction in this area, however in the present study a significant correlation emerged between age and general life satisfaction ($r = 0.23$, $p < 0.05$). Older residents tended to report greater satisfaction with life overall. This finding has been reported in the general quality of life literature, suggesting that the elderly, more generally, are known to express greater satisfaction with life. Apart from age, no other significant correlations emerged.

Table 13b

Correlations of Objective Quality of Life Indicators with Overall Life Satisfaction for Total Sample (N = 62)

Objective Indicator	Spearman Correlation Coefficient	Significance
Living Situation		
Privacy	0.03	0.42
Independence	-0.12	0.20
Social Relations		
Total number of contacts	-0.17	0.11
Contacts in Hospital	0.06	0.32
Contacts Outside Hospital	-0.24	0.04*
Close/Intimate Contacts	-0.10	0.24
Family Relations		
Frequency of Contact	0.08	0.29
Leisure		
Number per week	0.01	0.48
Yearly activities	-0.26	0.03*
Finances		
Amount of money per week	-0.19	0.10
Work		
Work since coming to Hospital	-0.01	0.47
Pay	-0.27	0.12

Health		
Illness in past year	-0.04	0.40
Use of Health Care Services	-0.35	0.03*
Religion		
Attendance at Church Services	0.11	0.22
Safety		
Victim of Crime	0.20	0.08

* $p < 0.05$

The results of the correlations between the objective indices of quality of life and general life satisfaction are shown in Table 13b. Of the 16 variables that were correlated with general life satisfaction only three were found to be significantly related. Significant negative correlations emerged in relation to frequency of social contacts outside the hospital ($r = -0.24$, $p < 0.05$), yearly organised leisure activities ($r = -0.26$, $p < 0.05$), and frequency of use of health care services ($r = -0.35$, $p < 0.5$). The strongest correlation was in relation to lower use of health care services. This finding is to a certain extent expected in that more frequent use of health care services is likely to be associated with higher rates of illness or disturbance, which in turn one would expect to be related to lower levels of satisfaction with life overall.

The negative correlation between the objective index of social relations and general life satisfaction suggests that those respondents who had more frequent contact with friends outside the hospital were less satisfied with their life overall. One possible explanation is that residents with regular outside contact, are likely to be brought in touch with a different set of 'norms' to those operating in the hospital. Contact with people living outside the hospital setting may serve to highlight the contrast between independent and institutional life and may result in residents being more critical of their current life in hospital and expressing greater dissatisfaction with their lot. Likewise in relation to leisure activities such as day trips, holidays and parties, in that these experiences may serve to remind residents of the possibilities and opportunities afforded by life outside the hospital. In this context it is interesting to note the relationship between attitudes to resettlement and overall life satisfaction. It was found that general life satisfaction correlated positively with a desire to remain in hospital ($r = 0.38$, $p < 0.01$), and was negatively correlated with positive expectations concerning discharge from hospital ($r = -0.23$, $p < 0.05$). Those residents who were keen to be discharged and set up a new life were also those residents who were less satisfied with their current life in hospital. In this way, perhaps, one could argue that expressed dissatisfaction with life in hospital could be taken as an index of a desire for

greater independence and a higher motivation to return to a 'normal' life. This interpretation is consistent with the earlier findings concerning the negative correlation between objective indices of independence and satisfaction with living situation. Wing (1962) and in a later comparative study of three psychiatric hospitals (Wing & Brown, 1970) also found that one of the central features of institutionalisation was an unfavourable attitude to discharge.

As may be seen in Table 13c, domain-specific subjective indicators were found to be significantly related to general life satisfaction. The strongest correlations were in the areas of social relations ($r = 0.61$, $p < 0.0001$), living situation ($r = 0.57$, $p < 0.0009$), and health ($r = 0.46$, $p < 0.0001$).

Table 13c

Correlations of Subjective Quality of Life Indicators with Overall Life Satisfaction (N = 62)

Domain	Spearman Correlation Coefficient	Significance
Living Situation	0.57	0.0001
Social Relations	0.61	0.0001
Family Relations	0.28	0.03
Leisure	0.34	0.01
Finances	0.22	0.05
Work	0.33	0.01
Health	0.46	0.0001
Safety	0.43	0.001
Religion	0.30	0.01

With regard to the relation between general life satisfaction and indices of psychopathology, the results are displayed in Table 13d. The measures of psychopathology used were those rated on the Brief Psychiatric Rating Scale, details of which are reported in the section of the report dealing with psychiatric functioning. In all, seven indices of psychopathology were correlated with general life satisfaction, two of which were found to be significant ; depression ($r = -0.30$, $p < 0.05$) and thought disorder ($r = -0.52$, $p < 0.0001$). As expected, residents with higher ratings of depression and thought disorder were more likely to report lower levels of overall life satisfaction.

Table 13d

Correlation of Psychopathology Measures with Overall Life Satisfaction

(N = 62)

Psychopathology	Spearman Correlation Coefficient	Significance
Anxiety	-0.06	0.69
Depression	-0.30	0.03*
Thought Disorder	-0.52	0.001****

Hallucinations	-0.20	0.16
Conceptual Disorganisation	-0.13	0.37
Blunted Affect	0.08	0.57
Emotional Withdrawal	0.01	0.52

—
 * $p < 0.05$ **** $p < 0.0001$

Lehman (1988) commenting on earlier studies, reported that, 'depression and anxiety consistently showed significant negative correlations with general life satisfaction...' (p 56), however he did not report a significant correlation between thought disorder and general life satisfaction. In contrast, the present study did not find a significant effect in relation to anxiety but did reveal a strong correlation between thought disorder and reports of overall life satisfaction. Of importance here is the index of psychopathology being used. Lehman's studies on the influences of psychopathology on quality of life, used self report measures from subscales of the Rand Health Insurance Study Mental Health Battery, and reported that this scale had been standardised on a large national sample of the American public. However, whether or not this scale has been standardised for use with a psychiatric population is unknown to the author. Commenting on the scale, Lehman (1983b) stated; 'it is conceivable that other measures of psychopathology might bear a different relationship to quality of life measures, but this issue must await future research. This type of study needs to be replicated amongst other populations and with alternative measure of quality of life and psychopathology to determine its generalisability'. (p 149).

The present study, with its comprehensive range of psychopathology measures will permit further and more sensitive analyses of the interrelationship between indices of psychopathology and quality of life data to be performed.

3.4 DISCUSSION

The overall picture that emerges from the results is of a group of residents who rate low on quality of life as objectively measured, yet evaluate their subjective life quality in a positive manner. Many of the residents were socially isolated, with social relations restricted to one or two other persons, usually other residents. Contact with family and friends was also infrequent and appeared to be a source of dissatisfaction to many of the residents, who expressed a desire to see their families more often. Also of concern to the residents was inadequate finances, with the majority receiving less than £20 per week. The amount of spending money available to the residents may be regarded as less than adequate, especially

if residents were expected to actively participate in local community activities, i.e. visiting shops, cafes, pubs etc. The quality of life of these residents, as measured by the objective indicators, appears to be severely restricted. As a group, the residents present as unemployed, economically disadvantaged, with few leisure activities and few sources of social support outside the hospital setting. The overall impression is of a very dependent and institutionalised group, who experience many social problems in addition to the limitations associated with their psychiatric disorders.

Against this background, it is quite difficult to reconcile the high rates of satisfaction expressed by the majority of the residents in relation to their current life situation. The frequently reported lack of correlation between the objective and subjective indices of quality of life, is usually interpreted as testimony to the fact that the two sets of indices are measuring different aspects of quality of life. However, one could argue that the lack of correlation between the two sets of measures implies that, from the data, we are unable to clarify what specific characteristics of residents' lives are related to satisfaction in each life area.

The problem of positive response bias is frequently encountered in relation to satisfaction measures in this area, both in the quality of life literature and consumer satisfaction research, with levels of reported satisfaction, ranging from 60-100%. Should these high levels of expressed satisfaction be accepted at face value as an expression of satisfaction with the current quality of life? Or should they be interpreted as an indication of dependency needs, a consequence of the effects institutionalisation, changing the nature of the relationship between living conditions and their evaluation? Or do they represent residents' desire to please the interviewer? Baker and Intagliata (1982) in discussing this issue concluded that ;

'there appears to be no way to completely determine whether the high levels of positive feelings represent a sincere evaluation of aspects of the clients' lives and reflect the clients' actual perceptions of the environment or are due to grateful testimonials or other biasing factors'. Clearly the demand characteristics of the interview situation need to be considered. The influence of the interview setting is relevant in that one is tempted to question whether the social environment of the hospital is conducive to the expression of dissatisfaction and demands for change. Residents may experience a certain amount of pressure to suppress feelings of dissatisfaction, as this may be a necessary part of the process of adapting to institutional life. As a result, aspirations and expectations may be lowered. In support of this line of argument is the finding in the general quality of life literature that those living under more favourable conditions are most inclined to be open to new value standards and are more likely to express criticism and dissatisfaction. It is plausible that the opposite may also be true for those living under unfavourable conditions. This would lead to the curious

phenomenon of improved living conditions leading to more expressed dissatisfaction! An additional factor to be considered in interpreting the subjective data is the observed influence of age and psychopathology on the general life satisfaction measures. The influence of these variables needs to be considered further. It is hoped that in the second stage of the baseline, a 5-point satisfaction rating scale will be implemented, thus permitting the use of more sophisticated statistical analyses in order to control for the effects of these variables on the quality of life data.

These points have quite serious implications concerning the validity of the self-report measures and how the data should best be interpreted. However, the subjective measures did appear to be sensitive to the effects of psychopathology and to the differences in living conditions on the hospital wards (i.e. satisfaction with living situation) and despite the clustering of positive responses they do manage to highlight areas of dissatisfaction. It was also found that the information obtained from staff concerning the objective indices of residents' quality of life concurred with the information derived from residents. It would appear, however, that residents' self-assessment of quality of life does have certain limitations and this is one reason for attempting to assess quality of life from a variety of different perspectives, using different methods. The gathering of data on how residents perceive their lives is obviously a very central part of assessing quality of life. However the influence of residential setting, psychopathology, staff attitudes and operational policy etc. need to be recognised. It is therefore important that the information derived from the quality of life schedule should be related to these other variables. Such an approach permits the monitoring of the impact of changes in services, i.e. residential location, operational policy, etc. on residents' self-assessments of life quality and the impact of quality of life on other client outcomes and vice versa. In this way quality of life may be related to many of the other measures being used in this study.

It is also expected that the researchers will provide feedback to staff on residents' perceptions of their quality of life and what areas they perceive as important. This information should be of interest to service practitioners directly involved in the planning and implementation of services programmes for this group, as the quality of life data suggests several areas on which to focus intervention strategies. Information on the non-medical needs of chronic patients, e.g. social and family relations, finance, etc., should be particularly useful in this respect. With this purpose in mind, the research team is developing a Needs Assessment and Fulfilment Schedule which aims to identify areas of need in association with staff members via a needs case conference.

Quality of life is a complex and multidimensional concept, it accents a holistic approach to the client's life, embracing physical, social, cognitive and material dimensions of well-being and directs awareness to an examination of needs and standards. In this respect, as an evaluation measure, it holds much promise. However, certain definitional and methodological obstacles need to be overcome before definite conclusions can be drawn from research evaluation in this area. In developing adequate outcome measures of quality of life for evaluation purposes, attention needs to be given to issues of sensitivity to change, and the validity of the measures being used. The observed lack of correlation between the objective and subjective indicators raises the question of which set of indicators should be used for evaluation purposes and/or if both sets are used how much weight should be given to each in terms of informing policy decisions. As pointed out by George and Bearon (1980), 'if quality of life is to be an organising rubric for research, planning and practice, the distribution, predictors and correlations and implications of life quality need to be carefully delineated'.

The design and scope of the present study, with a comprehensive range of data being collected at repeated intervals before and after the move from hospital, provides a unique opportunity to carry out a detailed investigation of these issues. The relationships between and among the dimensions of life quality will be monitored over time and the extent to which life satisfaction is responsive to changes in external conditions will be explored. Likewise, the pattern of relationships between quality of life and the other outcome measures e.g. psychiatric functioning, staff practices, economic measures, will be catalogued and examined.

It is intended that further usage of the schedule in this manner will inform the conceptualisation and measurement of quality of life as well as providing useful information to service providers committed to improving the general life quality of their clients.

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