CLOSING THE ASYLUM:

THE CHANGING FACE OF CARE IN A SERVICE FOR

PEOPLE WITH LONG-TERM MENTAL HEALTH PROBLEMS

CHRISTOPHER IAIN ALLEN

Submitted in fulfilment of the requirements for
the degree of Doctor of Philosophy.

THE UNIVERSITY OF LEICESTER
DEPARTMENT OF PSYCHOLOGY

February 1998
CLOSING THE ASYLUM: THE CHANGING FACE OF CARE IN A
SERVICE FOR PEOPLE WITH LONG-TERM MENTAL HEALTH PROBLEMS

CHRISTOPHER IAIN ALLEN

ABSTRACT

In this thesis, reviews are carried out concerning the establishment of asylums, the reasons for their closure, and the methods that have been used to evaluate care quality in services for people with long-term mental health problems. The studies carried out attempt to evaluate care quality in a service moving from asylum to community-based care.

The first cross-sectional study comparing the care provided on the asylum ward and a community hostel suggested that institutional practices could be found in both. A second longitudinal study of the original asylum wards' closure and relocation to supported homes suggested that asylum closure could produce great turmoil. Although transfer to the community appeared to lead to some improvements in care, the study also highlighted how some of the measures used to determine care quality in asylums were less appropriate in community settings. A measure of interactions proved particularly useful in evaluating care in both settings and in two additional studies this was developed by using an event recorder and adding categories.

Given the changes in population seen in the longitudinal study of ward closure, a further comparative study was carried out on the asylum population's level of functioning over a six year period. Discriminant analysis suggested that the more able had moved into community settings, while individuals with challenging behaviour such as verbal aggression, had remained in the asylum. Older residents had either died or moved to homes for the elderly.

Over the eight years leading to the closure of the asylum evaluated in this thesis, there has been an increasing emphasis upon users' views. A cross-sectional study of subjective quality of life (comparing residents of a ward and people who had recently been discharged from the same ward) suggested improvements in subjective quality of life could follow a move to the community (although these differences were confounded by differences in the two populations).

A longitudinal follow-up of the original residents once discharged to the community suggested fewer differences, but also indicated that the nearness of final closure may be affecting how individuals perceived their move to the community.

A final study, which introduced two new measures of care quality, in an evaluation of a hostel setting, indicated that symptomatology may have a strong influence upon subjective quality of life, and highlighted that qualitative methods might help to generate hypotheses for investigation in community settings.

In the final chapter, it is suggested that, post-asylum closure, a number of new directions of study may be useful in evaluating quality of care in community settings. These suggestions are related to the experience of studying an asylum closing.
INTRODUCTION AND ACKNOWLEDGEMENTS

The work undertaken in this thesis was carried out in Northampton Community Healthcare NHS Trust and Northampton Social Services between 1988 and 1995 as these services attempted to shift care from a large asylum base to community settings.

I am grateful for the advice, counsel, and support of my two thesis supervisors: Dr John Hall (honorary) and Dr Celia McCrea. I am grateful to the clients and staff involved in these studies for their participation, and staff for the data gathered by them as part of their direct clinical work. I am also indebted to a number of psychology assistants, psychology students and clinical psychology trainees who, whilst working under my supervision, have assisted in this work by their contribution of ideas, and data gathering and entering. Thank you to Alison Clarke, Jennifer Greaves, Angela Kent, Dominic Markham, Gillian Procter, and Sara Tresillian for this help. I would also like to thank two members of nursing staff, Sue Jugon and Pauline Turner, for their particular assistance; Sue Willett of Northamptonshire Social Services; Dr Fraser Shaw of the Institute of Psychiatry for help with the PSE assessments; and Dr Paul Griffiths of Oxford University Computer Centre for his advice on the statistical analyses undertaken.
A number of grants also assisted: either work directly carried out in this thesis, or work as a consequence of it, and I would like to thank:-

The Oxford Regional Quality Fund for a grant enabling the purchase of computers and staff training;

The Allan Brooking Fellowship for a travel grant to visit Holland to look at the use of clients in evaluating services and the development of advocacy in that country;

and Northampton Health Authority and Northamptonshire Joint Finance Committee for supporting the development of advocacy work as a consequence of work related to this thesis.

Some of the data reported in this thesis has already been published or presented. Chronologically listed:-

'A comparison of practices, attitudes and interactions in two established units for people with a psychiatric disability' in Psychological Medicine 1989, 19, 459-467.

'The view from the ward' in Nursing Times 1990, 87, 38-40.


'Living in the community after discharge' in Nursing Times 1994, 90, 16, 11-12.

As part of developing a framework for assessing quality within the rehabilitation and continuing care directorate, a number of reports concerning the work undertaken in this thesis were distributed. This was seen as particularly important as it gave direct feedback to staff concerning the work being undertaken, and also because this thesis is based upon work in clinical settings and was intended to bring practical benefits to the service, in addition to clarifying the issues surrounding quality of care and attempting to advance the concepts and assessments currently used. These reports are listed below:-

"Establishing a system for evaluating Quality of Care in a Mental Health Unit"
"Moving towards a better Quality of Care"
"The changing needs of clients on Connolly from 1988 to 1992"
"The effect upon Quality of Care of moving to the community"
"Clients views: I mentioned it once and they didn't do anything about it - that's wrong isn't it?"
"Clients views: We help each other out"
"Clients views: You can be yourself in a more relaxed way than at St Crispin".

Finally, thanks to my wife Caroline and young son William for their understanding and patience.
Attempts to improve quality of care have been one of the driving forces for change in the provision of services to people with long-term mental health problems. This has been in despite of disagreement concerning the concept of the term itself and definitions remaining vague and dependent upon different theoretical models (Lavender 1985, Shepherd 1984, 1988) held in varying degrees of complexity by clinicians, clients, carers, managers, the general public and the government.

A desire to improve the quality of care led to the foundation of asylums by the Lunatics Act 1845, as a response to the lack of care offered by newly industrialised society and the inappropriate care of madhouses. Similarly these asylums are themselves in the process of being closed due to a desire to prevent institutionalisation and improve quality of care by offering services in homely integrated settings in the community (Caring for People, Department of Health 1990). This change in provision of care is itself now being questioned due the availability of community care services and a number of high profile incidents concerning individuals discharged to the community (Ritchie et al. 1994). These historical changes in service direction, their rationale, and accompanying legislation are reviewed.
Due to the lack of clarity of what good quality care actually constitutes, there is a danger of an untested assumption that change will automatically lead to improvement. This could cause the repetition of care problems in different settings; this has already been commented upon in relation to the current development of community services (Bachrach 1980).

An alternative conception of the changes in provision could be one of change for changes' sake, rather than change based on a coherent understanding of the constituents of good quality care for people with long-term mental health problems.

Attempting to identify the elements which constitute good quality would appear essential, and establishing ways of monitoring services based upon these elements. This would appear particularly important whilst services are in the process of moving from asylum to community settings to test whether the assumed benefits are actually occurring. Reviewing the literature suggested that three major approaches have been developed as a means of judging services based upon different but not mutually exclusive views of good quality care.
These are reviewed in separate chapters and are based upon the following beliefs:-

- a good quality care system maximises and maintains clients' level of functioning;

- that there are particular environmental features of a good quality care system;

- the recipients of a good care system have a role in identifying and evaluating the quality of a service.

Small scale experimental studies were carried out to ascertain the utility of these approaches for measuring and monitoring aspects of quality of care in a care system in the process of moving from a hospital to a community base. During the lifetime of this theses, the care system changed from one based on a hospital setting of 11 wards, to hospital closure and the establishment of alternative community-based facilities. Part of the methodology was further developed and suggestions made concerning a practical framework for measuring quality of care for this and other long-term disabled client groups, which was utilised in a final study of the community unit.
CONTENTS

Introduction and Acknowledgements

Chapter 1 - Historical and Legislative Overview

Chapter 2 - Models, Measures and Outcomes

Chapter 3 - Assessing Needs

Chapter 4 - Assessing Users' Views

Chapter 5 - Studies of Social Environment Care Quality

• Study 1
  A Comparison of Staff Attitudes and Practices in a Community Residential Setting and a Hospital Setting

• Study 2
  The Changing Face of Care: The Effect of Moving a Unit for People with a Psychiatric Disability from a Hospital to a Community Based Setting

• Study 3
  Interactions as a Measure of Quality of Care on a Ward for Older People

• Study 4
  Interaction Content, Quality, Duration and Response: The Use of an Event Recorder on a Unit for People with Long Term Mental Health Problems

continued over ...
• Study 5
Which Patients Leave the Asylum First? A Longitudinal
Comparison of Patient Outcome in Relation to their
Level of Functioning
Page 214

• Study 6
A Comparative Study of Quality of Life in Hospital and
Community for People with Long Term Mental Health
Problems
Page 238

• Study 7
A Longitudinal Study Comparing Users' Views of their
Quality of Life when in Hospital and when Discharged to
the Community
Page 279

• Study 8
A Study in a Community-Based Unit to Explore the
Relationship between Interaction Levels and Management
Practices in Staff and Quality of Life, Level of
Disability and Symptom Level in Clients
Page 296

Chapter 6 - Discussion and Conclusion
Page 336
LIST OF TABLES

Chapter 5:

- Table 1: Reliability Data, Comparison of Long-Stay Study and Published REHAB Figures  
  Page 115

- Table 2: Inter-Rater Reliabilities on Direct Observation Schedules  
  Page 120

Study 1:

- Table 3: Demographic Details of Residents in Hospital Ward and Hostel  
  Page 124

- Table 4: Demographic Details of Staff in Hospital Ward and Hostel  
  Page 125

Study 2:

- Table 5: Comparison of Staff and Client Variables in the Unit at Six Months Prior to Move, and 18 Months and 42 Months after the Move to the Community  
  Page 153

Study 3:

- Table 6: Comparisons of Patient Variables Pre- and Post-Intervention  
  Page 174

- Table 7: Inter-rater Reliabilities on Direct Observation Schedule  
  Page 179
Study 4:

- Table 8: Observational Category Coefficient and Concordance
  Page 196
- Table 9: Interaction Category Index of Concordance
  Page 196
- Table 10: Duration of Interaction Spearman's Coefficient
  Page 196
- Table 11: Frequencies, Durations, and Medians of Interaction Categories
  Page 199
- Table 12: Frequencies, Durations, and Medians of Content Categories
  Page 200
- Table 13: Quality of Interaction, Frequencies, Durations and Medians
  Page 202
- Table 14: Type of Response, Frequencies, Durations and Medians
  Page 203

Study 5:

- Table 15: Comparison of the Age and Length of Stay of the Two Hospital Populations Six Years' Apart
  Page 219
- Table 16: Comparison of the Two Hospital Populations' REHAB Profiles Six Years' Apart by Age
  Page 221
- Table 17: Comparison of the Two Hospital Populations' REHAB Profiles Six Years' Apart by Length of Stay
  Page 221
- Table 18: Comparison of the Outcome of the Original Hospital Group
  Page 223
- Table 19: Long-Stay Bed Requirements using DHA Attrition Rates
  Page 231
- Table 20: Long-Stay Bed Requirements using RHA Attrition Rates
  Page 231
Study 6:

- Table 21: Reasons for Non-Participation Page 240
- Table 22: Assessor and Relation to Participant Page 241
- Table 23: Community Group Demographic Details Page 244
- Table 24: Placement Type Page 245
- Table 25: Time in Setting and Admission Data Page 245
- Table 26: Age and Time Since First Episode Page 246
- Table 27: Time in Setting and Admission Data, Hospital Group Page 246
- Table 28: Demographic Details and Ward REHAB Page 250
- Table 29: Subjective Ratings of Satisfaction: Hospital vs Community Groups Page 252
- Table 30: Objective QoL - Hospital vs Community Groups Page 253
- Table 31: Items Scores on Deviant Behaviour Scale, Hospital and Community, Current and when on Ward Page 257
- Table 32: QUARTZ Measures, Hospital vs Community Groups Page 258
- Table 33: Correlations with Ratings of Satisfaction Page 259
Study 7:

- Table 34: Placement at Reassessment  
  Page 280

- Table 35: Age and Time Since First Episode  
  Page 281

- Table 36: Time on Unit Prior to Discharge  
  Page 282

- Table 37: Assessor & Relation to Participant  
  Page 283

- Table 38: Comparison of REHAB Assessments for Individuals in Hospital and Community  
  Page 283

- Table 39: Subjective Ratings of Satisfaction - Hospital vs Community after Discharge  
  Page 285

- Table 40: Objective Q of L - Hospital vs Community Experience  
  Page 288

- Table 41: QUARTZ Measure. Comparison of Ward Setting and Settings Group were Discharged to in the Community  
  Page 289

- Table 42: Correlations with Ratings of Satisfaction - Longitudinal Study  
  Page 293
Study 8:

- Table 43: Demographic Details of Staff and Residents of Unit  
  Page 298

- Table 44: Results of Staff Assessments in Community Hostel  
  Page 302

- Table 45: Results of Resident Assessments in Community Hostel Level of Functioning and Symptoms  
  Page 306

- Table 46: Results of Resident Assessments in Community Hostel Quality of Life  
  Page 308
HISTORICAL AND LEGISLATIVE OVERVIEW

Care Prior To The Establishment Of Asylums

In the last century the 'needy' tended to be seen as a large group of deprived individuals defined by lack or want of something, but without reference to the cause of their deprivation, or what they lacked except in the most general terms. Such institutions for the 'needy' were provided throughout Europe at the end of the eighteenth and beginning of nineteenth century, be they mental institutions, prisons, or workhouses, tending to cater for a wide and varied population. The Duc de Rocheforcoult-Lioncourt describes the following in relation to the Bicetre Institution in 1786 (Castel 1988):

"The Bicetre Institution shuts away poor people who are admitted free, other poor paying for their board, men and children who are epileptic, scrofula, paralysed, or insane, and men shut away by royal order, by decree of Parliament - and these also with or without board; children arrested by order of the police, or convicted for theft or an offence, children without any vice or sickness who are admitted free; finally men and women being treated for venereal disease. Thus this establishment is at one and the same time: hospice, hotel-dieu, boarding establishment, prison and penitentiary". (p.70)
Similar conditions were to be found in Britain, Bedlam (Bethlem Hospital) being infamous for its varied population, abuses, and use of physical restraints. Provision for the needy became a political issue at the forefront of debate: Charles Dickens (1853) helped widen the debate with his popular novels of that period, attacking the provision provided via workhouses in Oliver Twist, and the lack of parliamentary activity concerning the needs and the environment in which people lived, in Bleak House:—

"Much mighty speech-making there has been, both in and out of Parliament, concerning Tom, and much wrathful disputation how Tom shall be got right. Whether he shall be put into the main road by constables, or by beadles, or by bell-ringing, or by force of figures, or by correct principles of taste, or by high church, or by low church, or by no church; whether he shall be set to splitting trusses of polemical straws with the crooked knife of his mind, or whether he shall be put to stone-breaking instead. In the midst of which dust and noise there is but one thing perfectly clear, to wit, that Tom only may and can, or shall and will, be reclaimed according to somebody's theory but nobody's practice". (p.548)

Prior to the industrial revolution, the needy had been cared for by the communities in which they lived. Rural communities tolerated, but perhaps also ridiculed or
condescended to the village idiot or imbecile. Industrialisation brought urbanisation and the breakdown of support for less fortunate individuals.

The Establishment Of Asylums

The Parliamentary Select Committee on Madhouses (1815-1816) reported on the inhuman conditions in madhouses operating in a manner similar to that described by the Duc de Rochefoucalt-Lioncourt. They became dumping grounds for the unfortunate and unwanted members of society, out of the public eye. Care was custodial at best, cruel at worst. The new social conscience represented in the public domain by writers such as Dickens, and in Parliament by reformers such as Lord Ashley, produced a series of Acts of Parliament aimed at differentiating causes of need. The desire was to improve the quality of care by providing appropriate forms of provision dependent upon the cause of the need. In the field of mental health, William Tuke (1813) at the York Retreat had provided a form of 'moral' care that was shown to be beneficial for the group of needy known as lunatics or insane.

Those at the bottom of the new urban society had been differentiated as the deserving needy, who had reached that position through no fault of their own, while the undeserving needy were judged to have brought that fate upon themselves. Lunatics or the insane were seen as part of the deserving needy. Early attempts had already been made to try to establish
separate facilities for the care of such individuals. Facilities had previously existed for the mentally ill from better-off families via private institutions.

The County Asylums Act of 1808 had made possible the setting up of institutions for 'criminal and pauper lunatics'. By the 1840s there were 16 county asylums, and while they offered more humane interventions specifically for people with a mental illness, the majority of such individuals remained in workhouses, prisons or on the streets. In 1842 the Metropolitan Commissioners in Lunacy were given the power to inspect all facilities caring for people with a mental illness, and their report led to the Lunatics Act of 1845. This Act represented the first legislation that shifted policies away from seeing the mentally ill as a problem group for society, and the purpose of care being to protect the productive members of society from their disruptive influence. Attempts were made within the Act to recognise the 'needs' of people with mental health problems and to protect their rights. Non-medical lay people such as a Justice of the Peace or relieving officer of the parish became involved in the certifying of mentally ill people to prevent collusion by doctors and families.

The Lunatics Commission became a permanent body to set minimum standards and ensure they were met, and to encourage good practice and high quality care. Physical methods of restraint were replaced by social forms of care. For example
Dr John Connolly, the administrator of Hanwell, the largest asylum in Britain, removed all forms of physical restraint in seven weeks, replacing them with increased activity as the predominant form of care.

Connolly (1847) also went on to describe the staff attitudes, practices and training that he felt were necessary in the provision of good quality care that met the needs of people with enduring mental health problems:

"In asylums in which bodily restraints are never resorted to, the great substitutes are continual superintendence and care". (p.110)

He felt that this would be best achieved if the object of the asylum was to:

"bring to bear on all the patients such an amount of intelligence and benevolence as may soothe many and direct all, and raise each to the point of cure attainable in each particular case. All the details should be part of a harmonious whole. The patients should be accustomed to look on the attendants as their constant friends and guardians." (p.131)
Connolly also comments on the type of environment that he felt would be most beneficial, seeing the asylum as:-

"A place of refuge and of recovery from all the mental distractions incidental to mankind." (p.131)

Thus, in Britain, the explicit motives for creating asylums were not to segregate the mentally ill from the rest of society and to protect the workforce, but a desire to provide good quality care and meet what was perceived as the needs of this client group. Foucault proposes that this separation ethic was the purpose in France and no doubt would argue that similar forces were also at work in Britain.

Connolly felt a pleasant natural environment was of assistance and emphasised activities carried out in the open air:-

"Farm and garden work is not only more active, but more various, and therefore more remedial. This advantage and that of it being carried out in the open air, and exciting no violent emotions, are justly enumerated amongst its recommendations." (p.79)

The Victorians sought to build their asylums in pleasant countryside as a consequence of their perception of need. For example when establishing the county asylum of Northamptonshire in 1871 (the hospital closed during these studies) they
purchased "180 acres of rich land, finely timbered with oaks of good growth and ornamental appearance." This prime hunting land was particularly sought because its location offered "charming views of the surrounding country" and good air which were assumed to be beneficial.

Connolly also argued for the creation of establishments:-
"Intermediate between asylums and ordinary life, in which profitable labour could be supplied to some for a short time, and to others for a longer period". (p.82)

He saw this as a means of helping individuals back into society, and to prevent asylums growing interminably in size. County asylums had not been set up in the numbers expected, and therefore the Lunacy Commission expanded the use of the Consolidated Fund, a device introduced by Peel in 1846 to ensure the provision of parish medical officers and workhouse teachers, to now provide a sum of four shillings per head for each pauper lunatic placed into an asylum. They reported in 1875 that this:-

"might be beneficial in promoting the removal to asylums of patients requiring such treatment ... "

but were also concerned that it might:-
"have the effect of causing unnecessarily the transfer to asylums of chronic cases ... thus rendering necessary ... a still larger outlay than heretofore in providing additional asylum accommodation".
Popular novelists of the period continued to be concerned both with the topic of 'madness' and the way the 'mad' were treated by society. These ranged from unsympathetic portrayals such as Mrs Rochester in Jane Eyre, to more sympathetic portrayals such as that by Charles Reade in Hard Cash, and Wilkie Collins in The Woman in White. Reade and Collins took the themes of maltreatment in mental institutions and the dangers of illegal detention. In the latter story Lady Laura Glyde is mistakenly locked in an asylum, Collins (1860) commenting:

"Any attempt ... to rescue her by legal means would, even if successful, involve a delay which might be fatal to her ... intellects, which were shaken already by the horror of the situation to which she had been consigned"

(p.387).

Popular literature both reflected and helped to magnify concerns about the state of the mental health system. There was a general concern that the system had failed to meet its aims. The Select Committee of 1877 was set up to inquire specifically, "Into the operations of the lunacy law so far as regards security afforded for it against violations of personal liberty". This concern culminated in a new Act: The Lunacy Act of 1890, which contained safeguards to prevent the sane from being admitted to asylums, and had less emphasis on the provision of good quality care or the needs of the 'lunatics' themselves.
'Lunatics' in the Act were defined as, "An idiot or person of unsound mind", and there was no attempt to discriminate between these two different groups and their respective needs. Jones (1960) argued that this Act alone had the effect:-

"To hamper the progress of the mental health movement for nearly 70 years".

The Act also required all local authorities to build asylums, but the emphasis was on the actual building of them rather than the care provided within. The result was the building of large new asylums and the extension of older asylums in an attempt to lower overall costs. There was a huge increase in the number of people cared for in asylums and the size of the asylums themselves. The 24 asylums existing in 1850 held on average 297 people, the 77 asylums opened by 1900 held on average 961 people. Similarly, the total inpatient population rose from 31,400 in 1859 (1.6 per thousand of the population) to a peak of 151,400 in 1954 (3.4 per thousand of the population). Most of the present psychiatric hospitals were built in this period of rapid expansion prior to the First World War. No attempt was made to provide the establishments Connolly had argued for to bridge the gap between asylums and society, and as he feared, asylums grew interminably, and individuals remained within them for long periods of time.
Problems With Asylums

Wing and Brown (1970) reported that over 60% of those diagnosed as suffering from schizophrenia remained in hospital for over two years, and that after two years the chance of any discharge became low. The increase in numbers of people in the asylum, and the increase in the size of the asylums themselves, led to individual needs not being addressed and people being treated en masse. Buildings were built with large numbers and surveillance as the guiding principles. The outdoor activities previously seen as beneficial to some individuals were organised increasingly to maintain the institution. A later administrator of Hanwell noted the effect of the increase in size of the institution:-

"The treatment is humane, but it necessarily lacks individuality, and that special character which arises from dealing with a limited number of cases directly".

The whole nature of the asylum could be argued to have changed from one of meeting individual need and providing asylum from the pressures of society, to segregating individuals from society and running cost effective, efficient institutions for keeping them permanently removed.

Legislation, the provision of better quality care, and the definition of need continued to be interlinked, the emphasis on
protection of sane individuals against wrongful detainment being replaced in the 1930 Mental Treatment Act with a shift to a medical conception of mental illness. This Act made voluntary treatment possible and placed an emphasis on early identification and intervention preferably in out-patient settings. The creation of the National Health Service following the Second World War and its doctrine of:

"Full preventative and curative treatment of every kind to every citizen without exceptions, without remuneration limit, and without an economic barrier at any point to delay recourse to it"

led to further reforms of both legislation and provision for people with mental health problems. The National Health Service led to a more integrated service and eventually to the 1959 Mental Health Act. The intervening years before the 1959 Mental Health Act saw an emphasis on the social determinants and treatment of mental illness, the introduction of psychotropic drugs for the management of symptoms associated with such illnesses, and an emphasis on both rehabilitation and resettlement through, for example, therapeutic communities of the type pioneered by Maxwell Jones (1952). The 1983 Mental Health Act reinforced the provisions of the 1959 Act, but gave more safeguards to patients, and gave the Mental Health Act Commissioners a monitoring role in relation to standards of care.
The Royal Commission on Mental Illness (1957) signalled a move in legislation, with asylums no longer being seen as the best setting for meeting the needs of people with mental health problems and being replaced by the concept of 'care in the community' as represented by:-

"Forms of training and Social Services which can be given without bringing patients into hospitals as in-patients, or which make it possible to discharge from hospital sooner".

Hospitals 'exercising a solely custodial role' (Lader 1980) were thus not seen as the best settings for the provision of good quality care. A number of studies demonstrated that people could be returned to the community even after years in hospital following therapeutic/rehabilitative interventions (Bennett and Robertson 1955, Macmillan 1956, Tibbits and Harbert 1960, Cooper and Early 1961, Norton 1961). Studies also suggested that better quality care could be provided in other forms of residential care and that interventions could be applied in the community (Cross, Harrington and Mayer-Gross 1957, Garratt, Lowe and McKeown 1958, Cooper and Early 1961, Tooth and Brooke 1961). This optimism was reflected in the speech of the then Health Minister, Enoch Powell, to the MIND Annual Conference of 1961, when he predicted that in fifteen years the population in
asylums would be halved and their external symbols - the water tower - would be removed from the landscape.

Objectives of community care were outlined in 'Better Services for the Mentally Ill' (1975) as:-

1. The expansion of local authority personal social services to provide residential, domiciliary, day care and social work support;

2. The relocation of specialist services in local settings;

3. The establishment of the right organisational links;

4. A significant improvement in staffing.

These were reinforced in 1985 by the House of Commons Social Services Committee (DHSS, 1985). The Government confirmed:

"its commitment to the development of the integrated network of central policies and local services necessary for community care, and its priority for mentally ill and mentally handicapped people."

The figures suggest that while numbers of in-patients have fallen from their peak in the 1950's to 100,000 in 1972, and 69,000 in 1985, in the 15 years to 1993, the number of occupied
beds per 100,000 halved from 176 in 1977 to 82 in 1993. This decline has been disproportionately larger for the old long-stay population (over 5-years' admission) when compared with the new long-stay (1-5 years' admission). Nevertheless 80 per cent of all UK mental health and social care spending is still taken up by NHS mental hospital and unit costs (Taylor & Taylor, 1990). Closure of hospital based provision has not resulted in the provision of community based services dependent on need. Need has either not been assessed, inadequately assessed, or assessed and not acted upon. Both residential and day care provision have not been adequate. The increase in day centre places for people with a mental illness has been much slower than the run down in hospital provision. There was a 50% increase in day centre places between 1977 and 1982 - from 3.9 to 5.9 thousand. Over the same period there was a decrease of 24,000 mental illness patients from NHS hospitals. Some of those discharged will have gone back to their families, some will have gone into sheltered housing, and local authorities will have given others preferential lettings of their ordinary housing stock. Over the same period, ie between 1977 and 1982, the number of places in residential homes for mentally ill people increased by an average of 400 a year, which suggests either that only a small proportion of in-patients was discharged to this kind of community provision, or that there is a fast turnover of residents in the community. Community Psychiatric Nurse (CPN) numbers have risen from 1,080 in 1981 to 2,310 in 1985 compared with 80,000 nurses still working in mental hospital settings (Hunter 1992).
These difficulties have not gone unnoticed and have attracted negative press attention and adverse comment from pressure groups such as the National Schizophrenia Fellowship, MIND, and SANE. The House of Commons Social Services Committee (1985) commented on the:—

"Almost obsessive concentration on the mechanisms for getting people out of hospital".

The committee felt that this had not made clear the fact that most people with a mental illness already lived in the community, while most care was still provided in hospital settings. This was felt to be due to the fact that the services were overly health profession led and that users views had little impact. The National Audit Offices (1987) investigation of community care suggested that:—

"a lack of information on local authority plans placed in doubt the DHSS's ability effectively to oversee and guide the overall development of community care policies and may result in an undue concentration on the run down of NHS hospitals rather than the build up of community services".

and that

"a considerable proportion of NHS hospital care is still provided in old remote long stay hospitals".
Hunter (1992) suggests that community care has failed to meet its objectives, and identifies lack of clarity concerning central governmental policy, an absence of effective monitoring of the implementation of policy, and a lack of collaboration between agencies, services and professionals, as the key obstacles to implementing the community care philosophy.

Bachrach (1980) asserted that the philosophy underlying the community care movement was the product of an unholy alliance between the values of fiscal conservatives and radical therapists and that the term "community" has been indiscriminately applied to any place that is not a hospital, and that simply placing a service in the community does not automatically invest it with all the positive attributes associated with that term. Service providers recognised that it was unrealistic to let individuals out of hospitals and expect them to survive unaided in the community. Accompanying the closure of hospitals has been a growth in the "community care" movement, which has aimed to relocate services in the community. This has emphasised the importance of training in preparing and maintaining ex-hospital residents in the community. The community mental health ideology has added to contemporary rehabilitation philosophy with the inclusion of accessibility to and comprehensiveness of services, and continuity of care.

16
The government had addressed the concerns articulated by Bachrach, stating: "The closure of (mental illness) hospitals is not a primary aim" (DHSS, 1988).

Bennett (1983) has cited the difficulties that individuals with mental illness have in the community when attempting to establish and maintain relationships with others, and the importance of non-handicapped members of the social system (eg. care staff) in making adjustments to further enable rehabilitation.

Since the mid-1980's, there have also been a number of high profile incidents involving people discharged to the community. Shepherd (1995) summarised 17 such reports/inquiries between 1985 and 1994 (including Clunis 1994) for the Zito Trust; since then there have been two further inquiries (Gray 1995 and Newby 1995). In total these reports have led to 300-400 recommendations concerning community care.

Prior to these concerns, Griffiths (1988) reviewed community care, and the Caring for People (1989) white paper implemented some of his suggestions, including the requirement that from April 1991 all Health Authorities in conjunction with Social Service Authorities should adopt a care programme approach for people residing in the community who required continuing care.
Guidance concerning arrangements for inter-agency working for the care and protection of severe mentally ill people have been outlined in Building Bridges (1995). The key elements identified in this document have been to reinforce the care programme approach, and tie this to guidance on the discharge of mentally disordered people and their continuing care in the community; the establishment of supervision registers; and the introduction of supervised discharge. The following principles of inter-agency working were outlined:

- a commitment to joint working at all levels of the agencies involved, including senior management;
- a focus on service-users, including sensitivity to the particular needs of individual (specifically including people from ethnic minorities) and a commitment to user and carer involvement in the planning and delivery of care;
- an agreed and jointly 'owned' strategy for the care of severely mentally ill people;
- agreed and well-understood procedures for accessing services;
- appropriate and effective arrangements for inter-agency information exchange;
- joint commissioning wherever possible to maximise the use of available resources;
- a commitment to training, on a single and multi-agency basis, which underpins effective joint working and encourages a better understanding of other agencies' roles and structures;
• regular review and evaluation of arrangements for inter-agency working.

These principles assume a level of knowledge concerning services in the community which is currently not available. Shepherd et al. (1995) suggests that, with the shift to community care, it may be that previous forms of service evaluation are no longer applicable, and that services are now attempting to re-provide for the patients with the most severe difficulties who may be difficult to adequately support in the community. Specialist staff, such as Community Psychiatric Nurses (CPNs) have also moved into the community, but in primary care settings the focus of their work has often shifted from work with seriously ill clients to the less severe end of the spectrum (Conway, Melzer et al, 1994). When exploring individual components of community care, Conway, Melzer et al, 1994, suggest that studies have been able to identify beneficial aspects of community care, but it is difficult to put these into everyday practice because of the reliance of other aspects of care. Similarly, when reviewing case management, Holloway et al. 1995, found that the wide and varying range of descriptions and definitions made comparisons difficult, and a study of Social Services case management of people with long-term mental disorders found no differences on a number of measures when compared with controls at 14 months (Marshall, Lockwood et al, 1995). Variation was also seen in the content and format of plans when 25 community care plans produced by local authorities
were examined (Wistow et al, 1993). Some of the factors associated with unsuccessful care in the community (Conway, Melzer et al, 1994), are:

- lack of clear goals;
- failure to change models of working;
- high staff turnover and burn-out.

The Sainsbury Centre is conducting an inquiry into the training of staff to work in community settings, arguing that the new settings of care has placed demands on a staff group that has been largely trained in hospital settings. The centre has convened a working party to examine the following issues (Allen, 1995):

- to identify the type of care required by people with severe and enduring mental health problems;
- to ascertain the range of skills required by mental health services to deliver this care;
- to identify which professions are most appropriate to deliver this care and how the different professions can best complement each other;
- to establish what sort of training is required to achieve this.

To provide new community-based services may require both new training programmes and re-training of existing staff.
Both health and social care needs should be identified and provided for each patient. This gives a key role to the assessment of need for both community and hospital residents requiring long term input:

"Community care means providing the services and support which people who are affected by problems of ageing, mental illness, mental handicap, or physical or sensory disability need to be able to live as independently as possible in their own homes, or in 'homely' settings in the community. The Government is firmly committed to a policy of community care which enables people to achieve their full potential." (Caring for People White Paper 1989)

This is reinforced in the accompanying White Paper "Working for Patients" in the foreword of which Margaret Thatcher, the then Prime Minister, states that for all patients receiving National Health Service care:

"All the proposals in this White Paper put the needs of the patients first"

and concludes with:

"The patient's needs will always be paramount".
Within the proposals outlined in the accompanying white paper "Working for Patients" (1989) and its creation of an internal market, there is a requirement upon district health authorities, as purchasers of services, to assess the health needs of the population they serve, and purchase from providers appropriate services to meet those needs. District health authorities attempt to detect areas of greater health need to improve access to services for people in those targeted groups. At a health district population level, indicators of deprivation such as the "Jarman index" which reflect the number of unemployed, single parent families etc, are being used as means of identifying greater health need. This requirement to identify needs has led to attempts to clarify the concept of need itself by public health departments and others being given the task of assessing their local health population needs. An example of this type of exercise is outlined in "Defining and Quantifying Health Needs" (1991) undertaken by the Oxford Health Region.

Further differentiation based upon other client characteristics has also been proposed. Mann and Cree (1976) described a number of new individuals continuing to be identified by the service as requiring continuing input and having a number of needs. This group was termed the 'new long stay', and were defined as being aged between 18 and 65, resident in supported settings (commonly hospitals for 1-5 years), and difficult to place outside such settings.
They were thus discriminated from the old long stay group by their relatively short period of hospitalisation, and by the difficulty in moving them onto to less supported settings. Mann and Cree describe this group as typically having a high level of dependency, noticeable social problems, poorly controlled symptoms and a tendency to be disruptive.

Davis (1991) and Hall (1992) also describe a sub-set of individuals within those with chronic continuing mental health problems who present with "challenging" behaviour. A study by Barber et al. (1988) found that 3.3 of the population of a psychiatric hospital accounted for 48.6 of assaults. Davis argues that this group is identified by a combination of individual, situation and structural factors. Individual factors can include the presence of acute illness, psychosis, drug abuse, young adulthood, and a history of violence, while situation factors encompass overcrowding, provocation, staff inexperience and a culture tolerant of violence. Structural factors included changes to mental health policy such as making 'dangerousness' a criteria for sectioning and shortage of therapeutic intervention resources.

Davis felt that the rates of violence were increasing with time and Hall stated that such problems presented a major management issue. It is unclear whether the number of individuals with challenging behaviour is increasing, or if, as needs assessments develop, that the needs of such individuals are being more accurately delineated, thus allowing their
identification as a group. It is possible that both factors are important.

Identifying and meeting needs have thus been seen as the linchpin in providing a good quality service. It is an appropriate point to consider a closer analysis of the make up of the population with chronic mental health problems and the development of needs assessments, measures of the social environment, and the increasing importance of users' views.
CHAPTER 2

MODELS, MEASURES AND OUTCOMES

Introduction

This chapter reviews the use of social environmental measures as a means of evaluating quality of care. The review begins with a brief account of the work of Goffman (1960) and Barton (1959) on institutionalisation which led to an interest in the effect of the care environment upon people with long term mental health problems, and the development of a range of measures to assess environmental care quality. It is suggested that these concerns are as relevant today in the new community settings as they were previously in the large old asylums. There follows a review of measures concerning management practices, staff attitudes and interactions which have been used with this population. A review of studies of hospital/hostels follows as this is the type of new community residence which has served as a model of care for people with long term mental health problems and has been evaluated by a number of researchers. Finally some consideration is given to the quality evaluation process as a framework for looking at care.

These measures and issues are returned to later in the thesis, once studies utilising them have given some insight into their application in a system in transition.
Institutionalisation

Goffman (1961) in the United States of America and Barton (1959) in Britain, suggested that some care environments had deleterious effects upon those who received care within them. The process they described was termed "institutionalisation" or "institutional neurosis" and has served as a basis for the analysis of institutional practices. Goffman described such practices as including, all aspects of life being conducted in the same place and under the same authority; activities being carried out by large numbers of people doing the same thing and being treated alike, the day's activities being tightly scheduled and imposed from above, and all activities being part of a single plan designed to fulfil the official aims of the institution.

Studies based on this analysis have suggested that some of the institutionalised practices evident in hospitals have also been transferred to the community. A survey of day care settings carried out by Carter and Edwards (1975) found that many still contained features of traditional hospital institutions. Similarly in a study of four community day care centres Shepherd and Richardson (1979) also found evidence of institutional practices, and these investigators felt that this finding could equally apply to environments other than hospitals, such as hostels, workshops, day centres and families.
They concluded that:-

"The effectiveness of long-term care is therefore ultimately dependent on the exact nature of the service and not on its location, and discharge from hospital is no guarantee that deterioration will not taken place".

Bachrach (1980) has also raised concerns about the possible cosmetic moves to community settings of services, and the assumption that any place that is not hospital is better. Lamb (1979) suggested that care varied widely from unit to unit, and Wing and Creer (1980) went so far as to suggest that institutional practices could be found within the family, in that families demonstrated patterns of restrictive behaviour similar to those found in hospitals. Shepherd (1991) has suggested that it will be important to monitor the relocation of units from hospital to community settings over a period of time to ensure that small institutions or ghettos had not been created.

Assessment of The Social Environment

The literature derived from the work concerning institutionalisation emphasised the importance of the social environment, and particularly the way that this was structured. Two of the major methods for assessing the social environment have been management practice scales and staff-client
interactions. The application of these methods in the area of psychiatric illness is reviewed next.

Management Practices Scales

One of the major ways of assessing institutional practices has been the development of scales to assess management practices. The most influential scale has been that developed by King et al. (1968, 1971) with dimensions based on the work of Goffman. This scale was originally developed to assess residential units for children, suggesting that practices formed a continuum from institutionally orientated practices to individually orientated practices. The scale was revised by Raynes, Pratt and Roses (1979) for use with units for adults with a mental handicap, and by Shepherd and Richardson (1979) for use with day units for adults with a mental illness. Garety and Morris (1984) used a combination of Raynes et al. (1979) scale and Shepherd and Richardson's (1979) scale to produce a management practices' scale for use in a hostel ward for adults with long-term mental illness. Both Shephard and Richardson (1979) and Garety and Morris (1984) assessed both practices and staff attitudes to practices, unlike the original scale which had concentrated on practices.

Segal and Moyles (1979) used a different basis for their assessment of management practices. Their concept of a continuum was founded on client responsibility, with at the one end a client having responsibility for their own actions, and on
the opposite end of the continuum the unit having responsibility for the residents' actions.

Conning (1986) argues that this is a naive interpretation of Goffman as it assumes that clients are fully aware of all the options available to them, and that if taken to its logical conclusion then professionals advice, in terms of their knowledge and its application for a client's possible advantage, would be considered as detrimental. Conning (1986) has also questioned the bipolar assumption lying behind all present assessments of management practices. Conning's study suggested that there was no evidence for such an assumed continuum, and that management orientation and client orientation were more likely to be separate concepts. Conning demonstrates that the two are not mutually exclusive, and that it is possible to conceive an appropriate provision of care that takes an individualised approach to deciding what happens to a person (client-orientation), but on a unit which runs efficiently (management-orientation).

A number of other measures have sought to evaluate different aspects of management practices, and include work concerning the social atmosphere (Moos and Houts 1968, Moos 1989), treatment practices (Lavender 1987) and community contact (Lavender 1987, Ager 1990).
The assessment of management practices has become one of the chief research tools applied in the assessment of institutional practices. Its use has progressed from hospital settings to applications in a variety of community units and with an increasing range of clients.

Staff-Client Interactions

A second major area in the assessment of institutionalisation has been the nature of the relationship between staff and clients. The daily interactions between disabled clients and direct care staff have been seen as an important indicator of the type of practices operating in a unit. Such studies have been carried out in settings with both psychiatrically disabled and mentally handicapped individuals. As this study is concerned with the long-term mentally ill, only these studies will be reviewed.

The studies of staff-client interactions have been guided by four theoretical orientations, which have affected both how such interactions have been studied and the sort of conclusions that have been drawn. These orientations can be grouped as psychodynamic, socio-psychological, ethnological, and behavioural.
Psychodynamic Studies of Staff-Client Interactions

Most of the earlier studies of interactions between staff and clients have adopted a psychodynamic framework. Such a framework has tended to emphasise the nature of the emotional relationship between staff and clients. Menzies (1959) argued that management practices could be seen as defensive strategies in response to the involvement of staff and clients. The method used in this study and many of the other psychodynamic based ones, was observations made in interviews with members of staff.

Stanton and Schwartz (1954) also observed clients on the ward and classified them as either active, intermediate or withdrawn and explored clients effect upon staff behaviour. They concluded that staff differentially interacted with these three client sub-groups and that the most difficult group (intermediate) had the highest level of staff contact. They particularly focused upon staff-role confusion and argued that this also produced corresponding confusion amongst clients. Underlying this role confusion were, they argued, faulty communications which resulted in staff and clients developing their own separate social structure and communication networks, and also faulty decision making.
Fairweather (1964) assigned clients to one of two wards, one offering traditional approaches and the other one operating on a small-group model. Fairweather argues that the therapeutic community principles adopted in the small group model led to significant changes in staff and client roles and their subsequent behaviour. Interaction levels were higher in the small group ward, particularly for more complex behaviours.

These studies emphasised the importance of staff-client relationships, but they tended to make assumptions about this relationship based upon theory and then tended to use unsystematic, unreliable methods of gathering data to support these assumptions.

Social-Psychological Studies of Staff-Client Interactions

Altschul's (1972) study, is a good example of staff-client interaction within a socio-psychological framework. This explored the relationship between the frequency and duration of interactions between nurses and ward residents, and the formation of a relationship. The method involved focusing on interactions lasting longer than five minutes between nurses and clients. Following the observation, a description of the event was written, and nurses involved were asked for information concerning the interaction. At the end of each observation period the nurses were interviewed and asked who they felt they
had formed a 'relationship' with, and the client was asked if they were aware of any such 'relationship'.

This produced a number of interesting findings, namely that the younger clients (under 25) were involved in significantly more interactions; that clients with longer lengths of stay were involved in significantly less interactions; that nurses interacted significantly more with clients of their own sex; and that student nurses had the highest levels of contact compared with other grades.

Overall, Altschul found that nurses who experienced special relationships had higher interaction times and rates, and clients who had such relationships had higher interaction rates than their respective groups.

Lavender (1984) has criticised this study on methodological grounds as no attempts were made to assess the validity and reliability of the measures used, and interactions lasting less than five minutes were ignored. However, it remains a good example of an early study to explore the nature of the relationship between clients and staff from a socio-psychological perspective.
A number of studies in the 1970's adopted an ethological approach to the study of staff-client interactions. This emphasised the social organisation of the ward in terms of territoriality (arrangement of individuals in space), networks of interactions and the influence of the physical environment upon social interactions.

Polsky and Chance (1979) investigated the social behaviour in a hospital ward. They categorised behaviour in terms of four basic categories, assertive, altruistic, cigarette, and verbal. Clear descriptive guidelines were given for each categorisation. Using this system, observers rated clients and assigned a ranked interaction score to them. The analysis showed correlations between the four behaviour categories and rank, age, length of stay, the nearest neighbour being less than four feet away, and whether or not the focal subject's head was up. Overall, the study revealed that interaction rates were low, and that there was a large degree of variability between the group's individuals.

It was of interest that body posture, particularly head position, was related to proximity of others and hence interactions. Polsky and Chance also demonstrated that individuals who were rated as involved in high levels of interaction (top 1/3) initiated social behaviour, whilst those
with lower levels (lower 2/3) tended to be recipients and initiate less frequently.

Fairbanks et al. (1977) used an ethological perspective to investigate staff-client interactions on four hospital wards. They observed behaviour on each ward over six separate 12.5 hour periods. They adopted a random sampling method with the focal subject's age, sex, role and behaviour being recorded; similar data concerned the interactor with the subject, the distance between the two, age, sex and role of all the others within three meters, and number of staff and clients in the room. The results indicated:

- **Arrangement of individuals in space:** clients spent 40% of their time near other clients, 40% alone, and 20% near staff;

- **Social networks:** staff spent significantly more time with other staff. Clients divided their time between other clients and staff;

- **Effect of physical environment:** clients spent more time in the TV area, and near the staff office. Staff spent most time in the office or adjacent to it;
• Effect of social environment: clients' deviant behaviour was significantly higher when they were alone. Interactions were highest when staff and clients were together.

This study also had a number of methodological problems as no attempt was made to assess the reliability of the measure, or variability between observers. However, it is a good example of information available from an ethological standpoint, in particular the effect of physical and social environments on staff-client interactions. This study did clearly show, across four wards with different demographic characteristics, that clients actively sought contact with staff, that staff were for a large amount of time unavailable due to time spent in the staff office, and that clients' deviant behaviour was highest when alone. This has clear implications for ward management, and suggests that staff should be accessible to increase interaction rates and decrease deviant behaviour.

At present ethological based studies have not been reported in great numbers in the community settings, but they do offer a useful framework for analysing these environments, particularly as the change in physical and social environments is cited as a major beneficial advantage of community settings compared with hospital ones.
Behavioural Investigations of Client-Staff Interactions

More recently there have been attempts to use behavioural time sampling as a method of investigations of client-staff interactions, and the possible relationship with management practices as assessed by questionnaires.

Shepherd and Richardson (1979) attempted to explore the relationship of client-staff interactions and management practices in four day care centres. The observational schedule assessed the following:-

1. Type of interaction - staff-staff or staff-client;

2. Context of the interaction - personal problem solving or administrative;

3. Quality of the interaction - accepting or tolerating or rejecting.

Inter-rater reliability of each category was assessed and found to be high. A busy time of day was used for all observations periods (11.00 am - 12.30 pm), with each member of staff being observed for 10 consecutive 30-second periods with 30-second breaks between each observation. The investigators found that there were no differences in the context of interactions between the four day centres, but that differences
did exist in quality. Shepherd and Richardson were also able to demonstrate a relationship between management orientations of each centre and staff-client interactions. Their findings suggested a relationship between increases in client-centred practices, and a greater number of personal problem interactions and accepting interactions, and less rejecting interactions.

Sanson-Fisher, Poole and Thompson (1979) carried out an observational study of staff-client interactions in a general hospital psychiatric unit. Their observation schedule involved observers making observations in the unit twice per hour between 9.00 am and 9.00 pm over two separate six-day periods. They rated staff and clients location and behaviour pattern. Two categories of behaviour were recorded:-

1. Solitary, eg. individual tasks, egocentric behaviour, watching television;
2. Interacting, eg. individual interactions or group interactions.

Inter-rater reliability checks were carried out, and again were high for each category of observation. As with other studies reviewed this one revealed a high rate of time spent by clients in solitary activities (49%), and a low level of interactions with staff (of total interactions 78% client-client, 12% client-staff).
Staff spent most of their time interacting with other staff (41%). While low staff-client contact is usually argued to be detrimental (solitary client time being associated with an increase in deviant behaviour, Fairbanks et al. 1977), the high client-client rate of interaction seen in this study was argued to be potentially therapeutic. This draws on the work of Gelfand, Gelfand and Dobson (1967), who demonstrated that clients differentially reinforced other clients appropriate behaviour in preference to deviant, while staff did not discriminate and reinforced both types of behaviour. In Sanson-Fisher et al.'s study, as in the studies based on ethological framework, staff and clients spent most of their time in different physical areas: staff in staff areas (office, coffee room etc.) 56% of the time, and client areas 28% of the time. Clients spent 84% of their time in client areas, and 3% in staff areas. Sanson-Fisher et al. concluded that the unit was under-utilising its therapeutic potential due to the low rate of staff-client interaction, and questioned the value of hospitalising acute psychiatric clients. From a behavioural perspective they concluded staff found interactions with clients less rewarding than with other staff -but did not state what contingencies were operating to support this claim. In a second study, Poole, Sanson-Fisher and Thompson (1981) compared clients on a traditional mental hospital ward and clients on a general hospital psychiatric unit. They matched ten clients on each unit, and used a computerised keyboard system to collect observation data, which was assessed for reliability. Clients
in the ward showed more disturbed behaviour and spent less time in interaction than on the general hospital unit.

However the amount of time spent interacting with staff was equivalent on both units. They were also able to demonstrate, as had Gelfand, Gelfand and Dobson (1967), that the way "staff responded to patient's behaviour was not consistent with the application of a behavioural engineering approach to the modification or abnormal behaviour". They noted that, in the mental hospital ward, punitive styles of interaction were employed by staff. These studies demonstrate that far from being therapeutic, staff-client interactions can in some circumstances be the very reverse.

This finding is particularly negative in terms of care in the community, as general hospital psychiatric units are seen as replacements for wards on the older institutional mental hospitals. As Baruch and Treacher (1978) have suggested, this seems to represent a relocation of traditional practices of the mental hospital in new settings. Milne (1984) carried out a comparative study of two psychiatric day hospitals, which included an observational component. Whilst specific details are not given for staff-client interactions, Milne concluded that even though both units served similar clients, only one produced significant clinical improvements in terms of outcome measures, and that was due to unit programme differences. As with the previous studies of Gelfand et al. (1967) and Sanson-Fisher et al. (1979, 1981), this suggests that staff-client
contact itself is not necessarily therapeutic, but can be if part of a programmed approach to clients.

Computerised Interaction Schedules

Observation schedules derived from a variety of theoretical perspectives (Menzies 1959, Altschul 1972, Polsky and Chance 1979, Poole et al. 1981 and Garety and Morris 1984) have become increasingly complex, covering further categories, and involving new technologies such as video and event recorder. Most of this research development has not occurred within studies concerning this population, but within studies which have sought to evaluate the quality of care in services for people with learning difficulties. Studies using lap top event recorder computers and hand held PSION computers to assess interaction levels have been carried out to evaluate the move to community care (Felce 1989, Mansell and Beasley 1990, Felce and Repp 1992, Emerson, Beasley, Offord and Mansell 1992) and the influence of staff factors upon interaction level (Felce 1989; Felce, Repp, Thomas, Ager & Blunden 1991). These studies, whilst carried out with a different population, have often been concerned with very similar issues to those that face services for people with a long-term mental illness, as both services have been involved in the move over to community based settings. The methodology which allows both real time recording and momentary-time sampling would allow a more detailed analysis of interactions and the effect of changes in service delivery upon them.
The studies in services for people with a learning disability have demonstrated that interaction levels can increase in the community (Felce 1989), or remain relatively unchanged (Emerson et al. 1992) suggesting that functional features concerning the organisation of care rather than structural features concerning location are the most important factors relating to quality of care as reflected by interaction level. Studies of staff-resident ratio (Felce 1989, Felce et al. 1991) suggested that differences in staff deployment and group sizes were only marginally related to overall staff-resident ratios. There was no consistent relationship across units apart from at the extremities of low and high staff ratio in large wards and small houses. The pattern of staff-resident groupings had a larger effect, with each individual staff member working with as few residents as possible being more important than ratio. Overall the organisation of staff rather than its level appeared the most important factor in relation to interaction level.

However, even given these refinements in relation to data collection, difficulties such as generalisability, ecological validity, reliability, accuracy and reactivity remain (Foster and Cone 1980).
Assessment of Residential Community Units

As services have moved to the community there has been a developing literature concerning the assessment of residential community units. Garety and Morris (1984) assessed client-staff interactions and management practices in a new residential hospital/hostel. The study showed a resident-orientated management style, and staff-client interactions that were positive, and of a much higher rate than previous studies. The observation schedule was the same as that used by Shepherd and Richardson (1979) and similar high levels of agreement were found when the reliability of the measure was assessed.

In terms of Shepherd and Richardson's (1979) schedule the following results were obtained:

1. Type of interaction - staff-client 57%, staff-staff 12%;

2. Content of interaction - personal problem solving 83%, administrative 17%;

3. Quality of the interaction - accepting 49%, tolerating 42%, rejecting 9%.
No relationships were found between the management practices' scales and observational categories, however more educated staff were more likely to interact with clients rather than other staff.

Garety and Morris also included two further scales:-

1. Optimism-Pessimism Scale

The score on this scale developed by Moores and Grant (1977) reflected a high level of optimism (mean=27.7) concerning future outcome for the resident and staff's contribution to future outcome.

2. Perceived Involvement Scale

This scale was developed by Garety and Morris (1984) from Raynes et al. (1979) and showed that staff perceived themselves as usually involved in decisions concerning the unit (mean=1.1).

This study appeared to demonstrate that the new hospital-hostels in particular had many advantages over hospital ward based care both in terms of management practices and staff-client interactions, which led to the unit studied at Denmark Hill, London being adopted as a model for other units around the country.

44
This model of provision, outlined by Bennett (1980),
serving predominantly the new long-stay (Mann and Cree 1976)
aims to provide high quality care in non-institutional small
sized residential community care settings.

Three such "hospital hostels" have been evaluated in
detail, those at Denmark Hill, London, Manchester, and
Southampton. In evaluations of the unit for 14 residents at
Denmark Hill in London (Wykes 1982 and Garety and Morris 1984),
it was found that the clients level of functioning improved
following transfer from the hospital to the unit, and that as
already reported the unit operated an individualised model of
care which was client centred and had high levels of positive
interactions between staff and residents. In one of the few
longer term follow ups of such units (Garety, Affle, and Isaacs
1988) report on the outcome of clients who had progressed
through the unit, 11 had been successfully discharged to
independent community living, 7 readmitted to hospital, and 1
committed suicide; and 16 years after its original opening (Reid
& Garety, 1996) reported that 70% of the residents had been
discharged and duration of stay had halved despite the
population's characteristics remaining unchanged. They also
found a number of variables were associated with better outcome
following discharge. These were: planned discharges to
supported hostel accommodation; a diagnosis other than
schizophrenia and fewer behavioural problems and higher levels
of functioning at discharge.
Goldberg et al. (1985) and Hyde et al. (1987) describe and report the evaluation of a 'hospital hostel' on a similar model for 16 individuals in Manchester. A comparison of controls in a district general hospital showed that residents of the community 'hospital hostel' developed superior domestic skills, used more community facilities, and were more involved in constructive activities. These benefits were also achieved at a lower unit cost.

Gibbons (1986) and Gibbons and Butler (1987) compared clients functioning before and after the move to a community hospital hostel in Southampton and reported that the amount of time spent in the community, social interaction, activity and level of abnormal behaviour all changed in a positive direction. Controls who remained in hospital showed no comparable improvements.

The positive outcomes demonstrated as possible by these 'hospital hostel' community units have been explained in terms of the organisation of the unit and staff attitudes (Shepherd 1991, Birchwood and Shepherd 1992). Negative staff attitude has been linked to low levels of information being gathered and limited needs and intervention being chosen when related to individual care (Conning and Rowland, 1992). It has also been suggested that expressed emotion may operate in staff groups in similar ways to families (Moore et al. 1992). Low staff levels
have been linked with low levels of activity in a study of a 'new look' hospital-hostel (Allen et al., 1993).

Whilst the methodologies for assessing 'quality' are continuing to develop, evaluative work also needs to be widened as the new 'hospital hostel' community units cannot be assumed to be typical of other community units with less explicit models. This has been attempted in a study of 25 residential settings (Shepherd et al. 1995) including 20 homes in the community and 5 rehabilitation wards. This large-scale comparative study sought to compare "The physical and social attributes of the settings studied, the characteristics of the residents and key features of the organisation and delivery of care". It gave particular attention to the amount and quality of interaction between staff and residents arguing that this is central to the quality of care. It also explored levels of reported satisfaction among both residents and staff and some of the factors associated with high or low levels of satisfaction. Interactions were assessed using the Quality of Interaction Schedule (QUIS). This is a non-participatory observation method which records all interactions involving residents and staff. The categories coded are:

- Positive Social - Interactions principally involving 'good, constructive beneficial' conversation and companionship
- Positive Care - Interactions during the appropriate delivery of physical care
• Negative Protective - Providing care, keeping safe or removing from danger, but in a restrictive manner, without explanation or comfort

• Negative Restrictive - Interactions that oppose or resist residents' freedom of action without good reason, or which ignore resident as a person.

The study also looked at the residents' perceptions of their quality of life using the Lancashire Quality of Life (LQOL) Measure (Oliver 1991), based on Lehman's Schedule (Lehman 1983) (see next Chapter for discussion of this measure).

The overall findings of the study were as follows:

• Residents in the community homes generally enjoyed much better physical facilities, less restriction and staff had more autonomy in deciding on management practices;

• Hospital inpatients were not different from the community residents in terms of their age or gender, but they were significantly more impaired on all measures of functioning and dependency. Taken together with the much longer lengths of stay, this supports the idea that a 'creaming' process had taken place, whereby the more able residents had been moved to the community, leaving the more disabled people in hospital;

• The staffing picture was highly variable. Staffing ratios tended to be quite low in hospital, despite the high levels of dependency among residents. There was no apparent relationship between levels of dependency and levels of
staffing. It was also clear that the staff who remained in hospital were the most 'institutionalised' in the sense of having worked in one setting for a long period of time.

- The number and quality of interactions within settings varied considerably and these differences were not strongly associated with provider type. However, in the hospital units, a smaller total number of interactions were observed and more interactions were coded as neutral or negative.

- There appeared to be specific areas of dissatisfaction among hospital residents regarding their living situation, but they did not score significantly lower than community residents regarding their feelings of overall well-being, or general life satisfaction.

- There was a clear association between how the settings were run in terms of the choice offered to residents and feelings of general well-being. There was also an association between levels of disability and reported satisfaction and this partly explains the lower reported satisfaction among the more highly disabled residents in hospital. Better staffing ratios were associated with higher levels of satisfaction.

- There was considerable variation between staff working in the different types of providers in terms of their levels of job satisfaction and feelings of psychological well-being. In general, staff in the private sector homes appeared the most satisfied and the least stressed. Staff in hospital who were looking after the most disabled residents in the worst conditions were not apparently any more dissatisfied than
staff in the community settings. There was a small, negative correlation between reported distress and the amount of negative interactions observed.

• Information on direct care costs suggests that the hospital units were the most expensive. However, it was difficult to obtain comparable cost data and particularly difficult to collect accurate staffing costs in the private sector. Overall staffing costs per resident were probably no greater in hospital than elsewhere.

• Other professional contacts were generally more frequent in hospital, but in the community they were highest for homes in the private sector. Involvement in day programmes for residents living in the community was patchy, but over two-thirds of the residents had some access to support outside their homes.

Shepherd et al.'s findings of the realities of hospital versus community settings are relevant to the studies carried out during the closure of the hospital reported in this thesis and will be returned to in the thesis discussion.
Evaluation of Hospital Closure Programmes

Studies of hospital closure programmes are surprisingly few given the momentous nature of this policy change. The then DHSS funded a specialist project to replace the old Powick hospital in Worcester, but the opportunity to evaluate patient change was missed. A major meta-analysis (Braun et al., 1981) demonstrated both in the United States and Europe the failure to evaluate this massive shift in policy. Jones (1988) followed up two groups of people discharged from hospitals in York - a group of people with mental health problems and a group of elderly confused. The results highlighted the variety of accommodation and situations of the two groups and the varying levels of needs. The researchers suggest the need to apply a range of outcome measures to most fully reflect the experience of service recipients. While very few returned to institutional care, the researchers reflected on the on-going difficulties experienced by many and the issues of quality of life, not reflected by crude service outcome measures.

The TAPS (Team for the Assessment of Psychiatric Services) (Andersen et al. 1993, Dayson 1993, Tomlinson 1991, Leff 1997) project is a British example of an attempt to comprehensively evaluate the move to community-based care throughout the hospital closure process. The team used a range of outcome measures, encompassing administrative outcomes, social and clinical outcomes for clients and clients' views on their
accommodation. The costs of providing community care were also evaluated, and the study suggested that community care costs are marginally but significantly greater than hospital costs. This increase in cost was particularly greater for the later cohorts re-settled from the hospital rather than the earlier leavers (Leff et al. 1997).

The administrative outcomes showed that the worst fears about the consequences of hospital closures had not occurred, with no marked increase in death, vagrancy and imprisonment rates.

There were re-admissions, most often caused by mental deterioration, but most returned to the community on recovery. There were positive changes in social networks and opportunities for autonomy. Client attitudes were more positive towards community accommodation. The TAPS study (Leff et al. 1997) suggested that people living in settings which encouraged independence and offered fewer services on site, such as unstaffed group homes, tended to make greater use of community resources than people who lived in hostels, nursing, and residential homes. Clinical outcomes showed no reduction in symptomatology or level of problem behaviour following relocation. This suggests that the benefits of community care for this group are the opportunities for increased autonomy and social contact, rather than improvements in clinical state or level of functioning.
The closure of Cane Hill Hospital (Pickard et al. 1992) was also evaluated. This study found that, despite quite large differences between the districts in terms of the adequacy of reprovision facilities, most patients showed improvements in their level of functioning and increased satisfaction following the move out of hospital. Most valued the privacy and freedom of life in the community. A study conducted into resettlement of long-stay patients at the North Wales Hospital (Crosby et al. 1990) showed with a smaller sample significant improvements in negative symptoms, social functioning and reported satisfaction. As with other studies, increased satisfaction seemed to be associated with the increased sense of privacy and personal control. These studies appeared to show that positive changes in attitudes and behaviour were not immediately seen, but that they emerged gradually over the first one or two years after resettlement.

A number of studies show positive results following a move from hospital to community settings. Shields, McGuiness and Macf Flynn (1995) cited no change in mental state, but less reported problems and greater satisfaction after moving to the community for their subjects; Reda's (1994) study described some deterioration in mental state but positive improvements in social networks, hygiene and attitudes towards community living following relocation, and Holloway and Faulkner (1994) describe improvements in social functioning but no change in level of problem behaviour for those included in their study.
In conclusion, there are now studies of hospital closure which show positive outcomes usually after a couple of years. However, there is some doubt if these findings are generalisable. It is questionable if the research team assembled to conduct the TAPS study, for example, is typical the evaluation of most hospital closures, and the emphasis on evaluating outcome may have had an impact upon the results. There is a need to study non-model services and, for all hospitals approaching closure, to evaluate the change in service provision rather than assuming it will automatically be better.

**FURTHER DEVELOPMENT OF SOCIAL ENVIRONMENT MEASURES**

Quality Evaluation Process.

Ideas originating from business are starting to be adapted for health settings. Berwick (1989) has described quality evaluation as the 'theory of continuous improvement', describing how it is about improving the process on the basis of data about the process. Donabedian (1966) was one of the first researchers to apply this to the health field, using a quality assurance cycle which sought to break care into its component parts which are then assessed in terms of process and outcome. Oakland (1989) feels that this has evolved within the health service to static quality assurance programmes which are based on quality detection rather than quality control, and which lead to reactive rather than proactive change.
Assessment methodologies relating to aspects of quality of care are also evolving. Management practice scales based on the work of Goffman (1961) and developed by King et al. (1971), Raynes et al. (1979), Shepherd and Richardson (1979) and Lavender (1987) have also been included in wider schedules such as the QUARTZ schedule (Leiper, Lavender, Pilling and Clifford 1992) which also cover staffing resources, financial resources, environmental quality, community links, agency links, relationship with management, professional support, policy and procedures, team work, users lives, service utilisation, service programme, individual care and users' views.

QUARTZ is designed as an "off-the peg" quality evaluation system to be used as part ongoing clinical practice. As well as the component measures, a training process is also outlined. The measure because of its comprehensiveness may have disadvantages because of the length of time to implement, and services may feel that a framework within which they could use measures relevant to their particular concerns would be more appropriate. Smith (1992) has criticised such approaches as being prescriptive, and leading to a focus upon standard setting and monitoring. She feels there are dangers inherent in such approaches as they can lead to minimum standards being accepted as the norm, that they can lead to focusing on failure, can be perceived as irrelevant by staff and can lead staff to failing to distinguish between good and bad performance if irrelevant standards are targeted.
The Quality assurance work suggests that it is the framework that is important, and that staff and users should be involved in designing and setting the actual content of that framework. Such frameworks do exist within both service research evaluation and business which could be adapted for the evaluation of health care, and may offer one way forward. However, in the increasingly fragmentary and disparate services resulting from hospital closure programmes and the establishment of multi-agency community care services, it is arguable that an all-seeing, all-measuring quality evaluation system is not the way forward, but that one tailored to that particular service which the staff are committed to and which is based upon a shared conception of quality of care borne out of research is more likely to be practically useful.
ASSESSING NEEDS

Definition Of Need

What is a need? Drever's (1952) definition for "A Dictionary of Psychology" gives a succinct and at the same time simplistic one-sentence definition of need:

"A condition marked by the feeling of lack or want of something, or of requiring the performance of some action".

Such a definition leaves open as many questions as it answers. What condition? Whose want or lacking? What type of action needs performing? An exploration of the term as used in relation to people with enduring mental health problems has to take account of the historical, political, philosophical, definer and purpose determinants of the term, which in part have been addressed by the first chapter.

The difficulty currently facing purchasers of Health services in attempting to define the term "need" on a large scale reflects the same problem seen on a smaller scale with specific populations, such as individuals with enduring mental health problems.
Bradshaw's taxonomy of social need (1972) is one of few attempts to clarify the use made by health and social scientists of the term "need" and identifies four different types of need:—

1. Normative need
2. Felt need
3. Expressed need, and
4. Comparative need.

Bradshaw describes each of these in the following way:—

1. Normative Need

A normative need is derived by setting a required standard, and comparing how an individual or group of people compare with that set standard. If they fall short, they are seen as being in need. There are problems with such definitions, particularly as they rely on value judgements. Disputes can occur over who sets the standards, and there is the possibility of disagreement over the standard. It is imperative that normative needs should change over time to take into account better methods of defining and measuring the standard and shifts in values of society.
2. Felt Need

A felt need is derived by asking the population concerned what it feels it needs. As such, the need is related to want and limited by the knowledge of the population concerned.

Populations who are not aware of the full range of possible services available, what realistically can be achieved, and who are not informed of the costs and benefits of alternative approaches to meeting their needs, may have difficulty in expressing what they feel they need. An accurate expression of felt need relies upon a well informed population, regularly updated and consulted, which is unafraid to specify what it feels it needs.

3. Expressed Need

An expressed need is a felt need put into action. As such it is defined by the number of people who demand a service. It is limited by the bias such a derived need may produce, for example more articulate or educated groups may better express their felt needs, and large proportions of felt need identified by the majority may as a consequence not become expressed. The use of such a definition alone may skew service provision.
4. Comparative Need

Comparative need is derived by studying the characteristics of the population in receipt of a service, and identifying if there are similar individuals not receiving a service. Such individuals, if identified, are seen as in need.

This is an attempt to standardise provision and may be used as a means of ensuring the provision of equivalent services eg. by monitoring health districts to check that specific populations such as the mentally ill are not disadvantaged by living in one particular locality. However, such definitions may equally ensure an equivalent low standard of care as opposed to a high standard, and may at best only ensure a minimum level of provision and hence minimal meeting of needs.

Bradshaw further argues that these four definitions of need may inter-relate and produce combinations that are reflected in terms of different health care demands. Milne et al. (1991) further distinguished classification of need by either:-

1. the person who defines the need; or
2. the service which meets, or should meet, the need.

This distinction reflects the purchaser/provider divide implicit in the 'Working for Patients' White Paper. In addition to needs as outlined by Bradshaw, these authors introduced the concept of "professionally perceived need" defined as "health
problems for which health service professionals believe there is an effective and acceptable treatment". This is termed a 'hidden' need. This concept would be open to disagreement dependent upon the values of the professionals concerned and their interpretation of treatment effectiveness data. This relationship is described as:

Felt Needs: Health problems people wish could be improved.
Expressed Needs: Health problems people asked to be improved.
Hidden Needs: Health needs professionals believe can be effectively managed once revealed by screening.

The Role of Values.

However while the above account does show that there have been attempts to clarify the term 'need' and different definitions of need, it does not tackle the issue of obtaining agreement from various groups. Different groups such as users, professionals, purchasers, providers or the population as a whole may have different values underlying their 'need' definitions or disagree on the establishment of accurate measures that reflect the degree to which an agreed value-defined need has been met.
Values dictate the level of need perceived, and hence the amount and type of service required to meet the defined need. Bloom (1981) emphasised the importance of values in the following statement:-

"If we do not consciously impose identified values on ourselves and the world around us, then some set of values will be imposed by future events whether we like it or not."

At a service level, political decisions, philosophy of services and level of finance available will influence service provision and the amount of need met or even identified as being present. It is equally, if not more, important that such decisions are influenced by factors originating from an individual level, from users of long term services, their family members, friends and advocates, and professionals acting on their behalf. If this does not occur there is a danger that important decisions potentially affecting the quality of life of large numbers of individuals could lead to the wastage of resource via poor targeting, or the non-identification of a present need.

Kane and Kane (1982) attempt to clarify the values inherent in the field of long-term care. They argue that the values underlying long-term care are ill defined and that four
interrelated characteristics contribute to this confusion:-

a. The complexity and ambiguity of the area due to the fact that long-term care involves physical, mental and social dimensions and that services involved in care are consequently both diverse and complex.

b. The large number of people who require long-term care.

c. The high cost involved in providing long-term care.

d. The dissatisfaction with the quality of services, and the difficulty in measuring quality of care.

They define long-term care as "a range of services that address the health, personal care, and social needs of individuals who lack some capacity for self-care. Services may be continuous or intermittent, but are delivered for a sustained period to individuals who have a demonstrated need, usually measured by some index of functional dependency".

This definition highlights a further possible area of confusion, as it assumes an agreed index of functional dependency. Alternative values underlying conceptions of a required level of ability in order to be able to function would lead to different sized populations, described in different terms with different services.
To some extent this can be seen with the definition of need derived from a predominantly medical model with need being described in terms of disease and symptomatology, and services tending to be hospital based, when compared with need derived from socio-psychological characteristics with a description emphasising social, behavioural and cognitive deficit and strengths and services tending to be community based.

This may be describing two extremes but it is not dissimilar to the change in service from one polarity (hospital care) to another (community care) which is being seen this century. Even with an agreed value base, measures relating to incapacity based on observed functional incapacity may be different. Different measures may have different levels of functioning required to trigger the provision of long-term care.

The need and right to long-term care based upon financial disability may range from an inability to be able to carry out the most basic self-care activities through to a much broader range of functional impairments. Services could also range from state provided provisions through to care that informal carers provide. The latter would not be costly in terms of state provision, but could be in terms of the carer's own well being, which burden of care studies would support and groups such as the National Schizophrenia Fellowship (NSF). Equivalent disability may not necessarily predict type of care, but instead
environmental factors, such as availability of informal carers willing to support the individual, may have a greater influence.

The emphasis on reducing costs for the state may be a misleading value base, especially given the effect on the informal carers own well being of providing long term care. Kane and Kane (1982) suggest that the values underlying policies may not have been closely examined " because the high cost of any kind of care renders introspection too frightening ". This fear may partially explain the difficulties found in implementing governmental policy but is too simplistic to account for all the difficulties encountered.

Defining Needs Assessment

Brewin, Wing, Mangen, Brugha and MacCarthy (1987) underlined the importance of the assessment of need for mental health services planning at both an individual and population level. They were concerned with the development of a comprehensive assessment of all major areas of functioning for people with long term mental health problems living in the community in Camberwell, and defined a needs assessment as an instrument able to:-

"Provide an estimate of the actions appropriate to effect cure, overcome disability, prevent or reverse deterioration in functioning, and enhance subjective well being."
It was felt that a good assessment would be one that achieved this task while striking a balance between being over-inclusive (identifying numerous minor unimportant needs) and under-inclusive (identifying only a small range of possible needs). In many ways this is not a new issue, as an accurate assessment of need has always been a precursor of an appropriate service both for individuals and populations. As Shepherd (1991) points out the main "actors" have not changed but the settings or "backdrops" have. Problems of low quality institutional care still can remain even in the newer backdrops of community care as demonstrated by Shepherd and Richardson (1979) in community day care settings and by Allen, Gillespie and Hall (1989) in community residential settings (the first study reported in this thesis).

Sub-Groupings

Assessment of need is not unrelated to the "actors" or clients requiring input, or the environment. Sytema, Giel and ten Horn (1989) conceptualise need in relation to "patterns of care" with type, setting, intensity and duration of care being primary factors. The historical account of care of individuals with mental health problems and the associated legislation in the preceding chapter illustrated how the conception of the difficulties these individuals faced developed through time. Individuals with chronic mental health problems are seen as those passing through the last "filter" in Goldberg and Huxleys
pathway model (1980). Earlier filters are illness behaviour, detection of a disorder by the physician, and referral to a specialist psychiatric service.

Even within this category further differentiation has occurred. For example, differential diagnosis underpinning medical conceptions based upon symptomatology, and functioning underlying psycho-social conceptions based upon need. Hall (1978) commented on the difficulty of understanding problems in functioning for this client group due to the fact that they could be caused by numerous factors. Hall comments how the difficulties or needs can be due to a number of factors including the length of time they have had their problems, the particular difficulties they face, or exposure to unhelpful environmental conditions. Wing and Brown (1970) conceptualised these difficulties as three types of handicap:— Pre-morbid, Primary and Secondary.

Pre-morbid handicaps are seen as those factors present prior to the onset of mental health problems such as level of intelligence and personality. Primary handicaps result directly from the illness (for example delusions following a schizophrenic illness). While secondary handicaps arise as a result of reactions to the primary handicaps (for example rejection by the family).
Hall (1989) has suggested that secondary disabilities can be further differentiated as being institutional, iatrogenic or physical. Institutional handicaps result from living in an institution, (for example under-activity and lack of opportunity to make decisions).

While iatrogenic handicaps result from the side effects of medical based treatments, (tardive dyskinesia caused by the long term use of a major tranquilliser being an example). Physical difficulties can affect this population in the same way as anyone else in the community, but can be exacerbated by lack of reporting of such problems or by lack of use of prosthetic devices such as spectacles or hearing aids to overcome such problems.

Further differentiation based upon other client characteristics has also been proposed. The concept of new long-stay (Mann and Cree 1976) was discussed earlier in Chapter 1, with that of challenging behaviour (Davis 1991). Typically services in the late 1970's and early 1980's were focused upon discharging individuals who had been in hospital for long periods of time. Resettlement had been the predominant concern of services since the 1950's (Bennett 1991) with the emphasis being upon discharge of the most capable to the
community, and rehabilitation conceptualised in terms of these few individuals:—

"No rehabilitation was needed or possible for 40% of patients" (Bewley, Bland, Ilo, Walch, and Willington 1975).

Bennett (1991) and Shepherd (1984) have both argued against this narrow conceptualisation of rehabilitation. However in clinical settings it tended to be the predominant model with the more capable individuals being selected from long stay wards for placement on a rehabilitation unit prior to discharge.

In many ways clinical practice has tended to lag behind theory, whilst most practitioners today would conceptualise rehabilitation in a similar fashion to Watts and Bennett (1991):—

"We believe it will be apparent that the rehabilitation approach to psychiatric care is one that has something to contribute to a great number of those who seek help for psychiatric problems, and we would wish to see it better integrated in the general routine care of psychiatric patients".
Development of Assessment

The development of assessments did have a role in understanding the varying needs of people with chronic mental health problems. Hall (1977, 1979, 1980) in a series of articles reviewed the content of previously published scales, and evaluated their construction and administration procedure using a set of experimental criteria. Snaith (1991) in a more recent review applied the same type of criteria to a wider range of assessments covering other mental health problems.

Hall describes the history of assessments of functioning from the development of ward rating scales to be used in part or whole by nursing staff in America in the 1940's and 1950's (eg. Cohen et al. 1944, Shatin and Freed 1955). This was followed by the development of similar nurse rating scales in Britain (Venables and O'Connor 1959). In the first of Hall's (1977) review articles the five then most popular scales were analysed in terms of the areas of content that nursing staff felt to be important. Little agreement was found concerning the content of scales, with the confusion concerning criteria for the selection of items being identified as one contributing factor to this lack of agreement. In a second paper Hall (1979) reviewed every article published in the British Journal of Psychiatry involving direct assessment of people with long term mental health problems between 1945 and 1974. Two hundred and twenty
five studies were reviewed in this manner and Hall concludes that most used:-

"a very restricted range of assessment methods, with rating scales, used most frequently. Many used wholly unstandardised methods, and the description of patient characteristics was inadequate."

Hall (1980) also reviewed 29 published ward rating scales using the following minimal criteria:-

1. Has the content of the scale been pre-selected on any rational basis? Any initial pool of items will include those of little discriminative value, or low reliability or validity: unless these items have been eliminated, there can be little confidence in the scale content.

2. Is the observation period specified on which ratings are based? Since frequency is one of the most commonly used dimensions along which item content is distributed, a clear unit of observation is essential. Furthermore, repeated assessments at close intervals will be confounded and contaminate each other unless the re-assessments are further apart in time than the length of the observation period.

3. Are there any norms? A raw score is of limited value unless it can be related to the scores obtained by some clearly defined group of patients.
4. Has reliability been assessed?

5. Has validity been assessed?

Only 4 of the 29 scales reviewed in this manner met these minimal criteria. Hall felt that practical considerations and the purpose of the assessment were also key issues in the design and use of assessments of functioning for people with long term mental health problems (in a similar way to the issues raised by Brewin et al. (1988) addressed earlier in this chapter). It becomes necessary to weigh the advantage of increased amount and quality of information against the extra time and demand characteristics of gathering such information. The information required to assist carers in helping particular clients is likely to be highly individualised and as such may influence the needs assessment required.

Formal standardised assessments of functioning are likely to be only the first stage in this process, but should be able to help the carer and client focus both the further detail and information required and consequently the type and amount of input likely to lead to improved quality of life. Watts and Lavender (1987) argue that there should be a range of assessments available and that needs assessments should be wider than the individuals functioning and cover aspects such as the effect of various aspects of the environment on functioning.
Carson (1991) also reviews assessments across a number of areas in use in the area of psychiatric rehabilitation. (This type of conceptualisation covering environmental aspects was explored in the preceding chapter).

Baker and Hall (1988) identify a number of advantages of needs assessments based on observation over other assessment methodologies such as interview based ones. Advantages include the relative speed of completion, relevance of behaviour recorded to everyday living, and the fact that assessors are typically carers who are the most frequent contacts. However as Halls review papers suggested, despite the advantages of such scales, few were constructed that adhered to basic minimal criteria. A number have been developed in the 1980's to address these deficiencies and the changing format of service provision. REHAB (Rehabilitation Evaluation Hall and Baker 1983), one of the most widely known, and used at the start of this thesis, will be explored in detail in this review. REHAB tends to reflect the priorities of services at the time of its development, and the different priorities of the services at the end of this thesis show its limitations in this new setting.

A number of other assessments aimed at assessing clients' functioning have been developed in this country in the same time period, notably the Functional Performance Record (Mulhall 1985,1989), the Morningside Rehabilitation Status Scale (Affleck and McGuire 1984), the adapted Social Behaviour Scale (Wykes and
Sturt 1986, 1987), and the Community Placement Questionnaire (Clifford et al. 1991), the MRC Needs for Care Assessment (Brewin et al. 1987), and the Camberwell Assessment of Need (Phelan et al. 1995).

Rehabilitation Evaluation Hall and Baker (REHAB)

Scale Development

Hall's earlier reviews and work undertaken with Roger Baker in Leeds concerning the evaluation of an operant conditioning based token economy (Baker et al. 1974, 1977, Hall et al. 1977) had underlined the deficiencies and limitations of behaviour-based assessments of functioning then available. Baker and Hall (1988) outlined the following objectives for a new scale:

- Be used in a range of settings, so that differing units within a treatment system, or different systems, could be compared.

- Generate a measure of general disability for overall ranking or grading of patients.

- Be capable of identifying patients who had potential for living in the community.
• Identify general targets for treatment, so the most important or frequent problems of an individual or group of patients could be addressed.

• Be sensitive to change. Conventional criteria of reliability and validity do not incorporate sensitivity to therapeutic change, so this aspect of a scale requires separate examination.

• Be capable of being used repeatedly over a considerable period of time, with possibly several different raters, to evaluate long-term effects of psychological or milieu treatments or of drugs.

The scale was developed by using "source studies" available in the literature to provide a core of information on which to base item selection, and using this data compiled together to mathematically derive broad classes of behaviour. The derived scale was piloted using 168 people mainly diagnosed as suffering from chronic schizophrenia, and having being hospitalised for two years or longer (Hall 1978). Factor analysis and readability scores produced a final version of the scale which was standardised on 821 further individuals of similar diagnosis but differing chronicity and in a variety of settings.
Particular attention was paid to the reliability and validity of the scale.

A standard training procedure was outlined for training raters and a "raters guide" was produced giving extended definitions and aiding consistency of interpretation. Inter rater and item reliability checks were carried out (Baker and Hall 1988) and assessment of criterion-related validity and classification accuracy. Content validity was ensured via the method used to construct the scale.

The REHAB Scale (1984) comprises two main parts, a Deviant Behaviour and a General Behaviour section. Deviant Behaviour comprises seven items rated on a three-point frequency of occurrence scale. It includes ratings of incontinence, violence, self-injury, inappropriate sexual behaviour, absconding, verbal aggression and talking to self. The General Behaviour section has 16 items rated on a visual analogue scale with verbal descriptors underneath. These form five factors: Social Activity, Disturbed Speech, Speech Skills, Self Care and Community Skills. The scale uses different formats because of the different nature of the behaviours measured. The Deviant Behaviour subscale relates to problem behaviour likely to cause management difficulties, but typically of short duration and low frequency hence the use of a discrete three point frequency scale. The General Behaviour subscale relates to skill behaviour.
required for everyday functioning and likely to exhibited by an individual on a daily basis. As such the quality of the performance is the measured variable and hence a visual analogue scale representing a continuum of performance is used, with verbal descriptors at each end and at a point in the middle representing the mid point. The continuum is unidimensional, with the extreme right representing a standard of behaviour appropriate to living in the community and the left hand side the worst performance level. The rating period for the scale is one week.

Use of REHAB

Baker (1989) has reviewed the use of REHAB. His review highlights its extensive use in the United Kingdom in both clinical and research settings. At present it has not been widely used elsewhere, although foreign language versions are currently being developed for use in a number of European countries and a computerised version has been developed.

Clinical Psychologists and nurses are the main users of the scale but often within the context of a multi-disciplinary team. The scale has been used in a variety of psychiatric settings, largely hospital based such as rehabilitation wards (Allen, Gillespie and Hall 1989), admission wards (Linke and Taylor 1987), other wards (Quarry and Rayner 1988), and industrial
therapy units (Wojciechowski 1984), but increasingly also in community settings such as social services hostels (Allen, Gillespie and Hall 1989), hostels for the homeless (Marshall 1989), day hospitals and centres (Greig, Miller, Rollo and McGillvray 1985, and Pryce, Baughan, Jenkins and Venkatesan 1983), boarding houses (Quarry and Rayner 1988) and ordinary homes (Linke and Taylor 1987).

The scale has been used for a variety of purposes ranging from large scale evaluation projects on a national level such as that undertaken by the Personal Social Services Research Unit at the University of Kent (1985) through to the planning of individual care plans (Bluteau and Long 1986).

However perhaps the chief uses of REHAB have been the selection of individuals for specific services such as rehabilitation units, or the analysis of a whole population of individual needs to aid the reorganisation or planning of provision. This usage may have been influenced by the state of provision in the early 1980's and also the design of the scale itself.

Practice has tended to continue to emphasise rehabilitation units where rehabilitation occurs and long stay units where it does not. A scale that provides handicap bands linked to discharge potential for this population has been used to select
patients with "discharge potential" for placement on rehabilitation units. Similarly service planning has been influenced in a similar manner with the needs of a whole clinical population being assessed via use of REHAB (Quarry and Rayner 1988). Future service provision has been influenced by the handicap bands of "discharge potential" (Total General Behaviour (TGB) score 0-40), "moderately handicapped" (TGB score 41-65) and "severely handicapped" (TGB score 65+).

In many ways REHAB has been an assessment of its time period and in tune with what clinicians needed in order to develop services at the time of its development.

It has also served as an experimental measure enabling units with clients of similar level of functioning to be compared on other measures (Allen, Gillespie and Hall 1989), or to indicate the effects of other changes, such as a change in nursing appearance (Lavender 1987).

**Problems with REHAB**

However, as Hall (1989) points out, the clinical settings have increasingly changed from when REHAB was developed in the mid to late 1970's.

As individuals have been successfully discharged from hospital the residual population has increasingly become older and more disabled. A variety of sub-groups have become apparent
within this population, notably those with 'challenging behaviours'. With smaller numbers of the 'old long stay population', the 'new long stay' have become increasingly apparent and often present on rehabilitation units but with a different level and pattern of need than the former group. Services are provided in a variety of settings and increasingly in the community. These changes suggest that the norms upon which REHAB is based may no longer be applicable and that as services continue to develop in a idiosyncrastic and localised manner that the current handicap bands may be inappropriate or lack utility. With a wider conception of rehabilitation it is perhaps appropriate to question the presence of the bands at all.

Given the advent of normalisation (Wolfensberger 1972) the language used within the scale, for example "deviant behaviour", could be judged to be labelling and to have negative discriminatory attributes. The use of alternative descriptions without such connotations would be an improvement. Items also tend to relate to hospital settings, eg. "mixing on ward" which need to be adapted for community settings and some items such as "absconding" may not be appropriate in such settings. REHAB utility as a instrument to lead directly to individual care plans or indicate priorities for input is limited. It is a useful screening instrument covering a wide range of possible needs quickly and accurately and as such particularly useful for indicating areas for further investigation. This also makes it
an appropriate device for carrying out surveys of populations or as a research tool. It does indicate areas where an individual may be experiencing difficulties but not the particular details of what causes the problem or of all the needs identified which is the priority or which already actively receiving attention. In order to formulate individual care plans, it may be necessary to combine REHAB with individualised assessments or in conjunction with parts of other assessments such as the Functional Performance Record (FPR). Similarly small changes in functioning are not readily identifiable using REHAB and it may be necessary to use any repeat measurement over a long enough timescale to allow change to be identifiable or in conjunction with other measures. While REHAB is good at identifying level of functioning, it is not as strong in relation to identifying strengths which can only be conceptualised as an absence of functioning. The difficulties in using the REHAB measure in community settings became more apparent as this thesis progressed and the hospital concerned closed; this will be returned to later in the thesis.
Summary

Assessing individuals' level of functioning has been given a central role in the development of community services (Caring for People 1989). Psychologists have been instrumental in developing assessments of functioning which are relevant to this population and which are reliable, valid and have clear procedural outlines. Assessments of functioning continue to develop as both the settings change and the profile of the people requiring care changes. Conception of need has also continued to become more sophisticated, progressing from lack of ability to utility of a range of interventions to meet a skill deficit, and now to conceptualisations which attempt to combine qualitative and quantitative approaches (Hayward, Peck and Smith 1993). The latter argues for a combination of quantitative measurement with qualitative information on service pattern which is derived from a number of sources including users.
CHAPTER 4

ASSESSING USERS VIEWS

The aim of this chapter is to review the utilisation of users' views, as a means of evaluating the quality of care offered by a service for people with enduring mental health problems. The review begins with an exploration of the concept of 'user', and the background to some of the various labels used to describe recipients of mental health services and their attitudes/views concerning such service provision.

The importance of users' own views of the service they receive as part of a 'quality' assessment of service provision is discussed in relation to other forms of assessing 'quality', and the present political/legislative framework. A review of published papers including those using both qualitative and quantitative measures, and measures derived from concepts of 'quality of life' follows with an analysis of some of the methodological problems still facing researchers in this area. The chapter does not review the types of approaches employed by users as a means of achieving change in a service, for example the development of user empowerment, and advocacy (Barker and Peck 1987) as at present there has been little evaluation of such approaches. The lack of attempts to link such movements to an evaluation of their effectiveness is of concern, and future
studies will be necessary to evaluate their impact on the quality of a service.

Who are the users?

Users, patients, consumers and clients are terms that have been used interchangeably to describe recipients of mental health service provision. The Government, in its recent legislation, has discriminated between individuals receiving care from professionals employed by the Health Service "Working for Patients" largely based from hospital or family practitioner centres, and from professionals employed by the local authority "Caring for People" who are largely based in community settings, attempting in so doing to differentiate between health care and social care. Hence recipients of mental health care would be labelled in relation to the agency and type of care that was being provided.

'Patient' as a term to describe recipients of mental health care has a number of unfortunate historical connotations. In terms of power relationships, it has been used to describe passive recipients of care who are out of a lower power level than the staff group. Goffman (1961) has described the effect of this process:-

"Each time the staff deflates the patient's claims, his sense of what a person ought to be and the rules of peer group social intercourse press him to reconstruct his
stories; and each time he does this, the custodial and psychiatric interests of the staff may lead them to discredit these tales again". (p.149)

Goffman (1961) and Barton (1959) have described graphically the process of institutionalisation and the effect it has upon patients. They see the institutional process as being assisted by patients being seen not as individuals, but as part of a mass who are powerless and have an illness. Parsons (1951) has described the effect of the term 'patient' on the person's own view of themselves via their adoption of the 'sick role'. Parsons suggests that once so labelled, the person may feel that they no longer have other social-role responsibilities; that they are not responsible for their condition, but that equally they are not responsible for their own care, but are required to be passively treated by professional experts who have knowledge of their 'illness'.

Hence the term 'patient' may continue to have negative connotations for both staff and user groups, and militate against users' views being listened to as a means of evaluating the service.

'Consumer' as a label also has a historical background. Barker & Peck (1987) have argued that within health services the term was originally adopted by managers and passed downwards through the system. This was due to the fact that the term had its origins in the managerial literature, particularly from the
work of Nader (1965) who first described consumerism in relation to the lack of accountability of managers in the American car manufacture industry.

Barker & Peck (1987) have suggested that within the Health Service in this country consumerism has actually operated as a form of customer relations and as such has tended to be superficial window dressing. In such a context customers have not been used as a means of assessing the quality of a service, but have only been given a voice via systems such as a complaints procedure, covering only narrow aspects of their care.

Nader (1973) envisaged consumerism as being a more active process, with consumers being in the forefront of pressures for change even when faced with monopoly situations. Nader's position is that "consumer reform cannot be separated from corporate reform"; and in a mental health context would see consumers as one of the prime forces for affecting improvements in the quality of care provided by a service. It is unlikely that it in its present form in the mental health service that this definition would be fulfilled, although services are moving towards placing greater emphasis on consumers views, and this has reinforced both by legislation and the establishment of the mental health task force.
The term 'client' originates from a legal background, used to describe a person who employs a lawyer or advocate, and as such still has connotations of an individual directly paying for a specified service from a professional. It is unlikely that a service which conceptualised individuals in this way would see user evaluation as a priority.

The term 'user' is also derived from a legal background, denoting a right established by long use, and is currently used to refer to one who uses. An organisation that conceptualises the people it serves as users would be more likely to be aware of the role of users' views as a means of evaluating the service, and the importance of involving users' views in future developments of provision.

Currently 'user' has the most positive connotations, and will be used throughout the rest of this chapter. When the studies are described, the terms used in the literature at present will be adhered to, hence 'patient' will be used for people living on hospital wards, 'resident' for people living in rehabilitation units, and 'user' for people living in non-service provided residential settings in the community.
Why look at users' views?

Why should it be important to look at users' views of a service as a means of evaluating its quality? Shield (1985) has offered three reasons for seeking users' views of their care:-

1. Moral Reason. For people with an enduring mental illness the quality of care becomes synonymous with quality of life. Other forms of quality evaluations based on provider definitions such as a reduction in symptomatology, or level of need, are irrelevant if the user remains unhappy. An assessment of quality must include components that are user defined.

2. Economic Reason. Very little data is available about what is effective in the treatment or care of people with enduring mental health problems. The users' view could be one measure of usefulness and lead to cost-effective improvements in care provision.

3. Political Reason. The whole trend in a democracy is to devolve power to citizens. It is a citizen's right to have a public service accountable to them, and to increase their participation in service delivery and evaluation.
Since Shield's (1985) review it could be argued that there are two further reasons for seeking users' views:


5. Uniqueness Reason. There is some evidence that as recipients of the service, users offer a unique perspective. Schoffer & Deiyer (1982) found that staff and patients' perceptions of change mechanisms in group psychology had low correlations.

6. Pragmatic Reason. People are unlikely to use services if they do not like them. In the long term, it may be better to develop services that meet people's needs and which they like, rather than attempting to force them to use a service which they do not value via supervision orders.

Wright and Biggs (1986), in a study seeking to evaluate staff and users' perceptions concerning changes in a rehabilitation unit, found that whilst perceptions of the staff/patient relationship did occur, they were not perceived in the same way by both groups. It was found that whilst there was agreement between the two groups about practical changes on the
ward, there was disagreement concerning the perceived roles of
the nursing staff and their relationship to patients, with the
nurses feeling that things had remained unchanged whilst users
perceived a change.

Thapa and Rowland (1989) demonstrated that in several life
domain areas concerning quality of life, staff and patients'
views were significantly different, with agreement not occurring
on what factors contributed to quality of life. Patients' views
of their life situation varied from those held by their
care-givers. This is important as Lehman (1983) has shown both
that people with an enduring mental illness can provide reliable
responses and that subjective quality of life indicators are
better predictors of global well-being than objective quality of
life indicators.

Why have users views not been sought?

Shield (1985) in his review of the literature, commented on
the fact that whilst between nineteen sixties and the mid-
eighties there had been an increase in awareness of an
individual's rights and the rise of the consumer movement, this
had not been matched by a substantial rise in research
concerning users' views of mental health services.

A review of Index Medicus by Shields produced an average of
ten papers per year, with the majority of papers being American
and qualitative in nature. Weinstein (1981) in an earlier
review also concluded that most research was qualitative, but reviewed 44 quantitative studies, mostly American.

Shield (1985) felt that two reasons may have accounted for the lack of research in this area:

1. the belief that, due to their illness, people with an enduring mental illness could not make valid comments about their care;

2. that users, when asked, tend to be highly critical of existing services and treatments, and that clinicians and managers find this threatening and hence tend not to ask.

With regard to the first of these statements, there does appear to be little evidence to support such a belief, but the fact that there has been so little seeking of users views would suggest that it may have been held regardless of such lack of evidence. In fact what research there is would tend to refute such claims. Caudill (1952) and Goffman (1961) used experiences of hospital as pseudo-patients and observations of care to show that users could express often very negative views concerning their care, and that the institutionalising process sought to suppress such views being expressed. One of the largest surveys of users' attitudes in hospital in this country conducted by Raphael & Peers (1972) covered nine psychiatric hospitals and included 2,148 patients, covering two thirds of the total
patient population. This study found that only 2% of this large group gave answers that were irrational and could not be included in their report.

Raphael & Peers (1972) concluded their report by expressing the hope that "Other psychiatric hospitals, large and small, will realise the value of finding the views of their patients". It is only more recently that their hope has been fulfilled to the extent they envisaged. A group of researchers at the Goodmayes hospital in London (Abrahamson and Brenner 1982, Abrahamson, Swatton and Wills 1989) have also sought to demonstrate that long-stay patients could express their own opinions about community and hospital care, and that the "Persistent assumption that such patients' opinions could legitimately be discounted" was misguided. A fuller account of their study is given later.

In relation to Shield's second statement, it appears that the picture may be more complicated. The overall impression is that when people only have the experience of one type of service provision and no other possible comparators, then they tend to be very uncritical, and it is difficult to obtain an evaluation of the service. However, once people have the experience of a number of types of service provision, then they can be very critical of the care provided in mental health services. Goldie's (1988) 'It Was Like A Prison' summarising the tone of a number of studies from the early 1950s. However, studies have not been uniformly critical, Weinstein's (1981) review of
quantitative research found that overall 77% of patients espoused favourable attitudes towards treatment; this being seen in 34 of the 44 studies he reviewed. However, it is noticeable that the majority of the quantitative studies he cites used provider defined terms of reference, with the use of attitude questionnaires concerning various forms of treatment offered being the preferred form. The fact that the care providers were also often responsible for the research may have made it difficult for users to be critical.

Research by Thapa & Rowland (1989) and Lehman (1985) raises questions about the narrow scope of the questionnaires used in earlier studies, and a lack of knowledge on the user's part of other available treatments. Weinstein's own content analysis of the attitude measures for treatment revealed positive attitudes towards the hospitals therapeutic value, assistance with medical problems, restrictions, activities and involvement of family members, negative attitudes towards patient government and staff-patient relations, and ambivalence towards patient freedoms and responsibilities.

Overall, studies concerning users' views of services cannot be characterised as either totally negative or positive. The belief that clinicians and managers avoid asking users their views is at present largely an untested assumption; further reasons for the lack of consultation of users' views may be, an
unclear methodology, and the lack of a managerial/administrative framework to act upon the knowledge gained. Rogers, Pilgrim and Lacey (1993) have suggested that even when users views have been gathered, they have been disregarded when they do not coincide with mental health professionals, or only given partial credence when they fit in with the expert's view.

Unclear methodology is partly founded on unclear terms. While some researchers have been concerned with quality of care, and concentrated upon users' views of the treatments offered, others have seen quality of care as a component of quality of life. Both terms have often been ill-defined.

What is quality of Life?

There are almost as many definitions of quality of life as there are papers on the topic, and hence numerous ways of measuring the concept have been developed. The concept was first coined at the end of the second world war, and was used by American economists to denote consumer affluence seen via the possession of consumer goods.

The early 1960s saw the incorporation of ideas of education, health, welfare, economics, industrial growth and defence. Ebbs, Fallowfield and Fraser (1989) argues that the social, political, and cultural changes of the later '60s led to a change from a materialistic view of quality of life to one emphasising "personal freedom, leisure, emotion, enjoyment,
simplicity and personal caring". Health is ranked by most individuals as one of the prime factors in quality of life. A study by Rokeach (1973) found that every single subject rated good health higher than any other valued state. The World Health Organisation (1947) defines health holistically, as the "physical, mental and social well-being, and not merely the absence of disease or infirmity".

Fallowfield (1990) has argued that although quality of life is a multi-faceted phenomenon rather than a unitary concept, nevertheless it is clustered around the four domains of psychological, social, occupational, physical factors. Fallowfield (1990) has also commented on the development of Quality Adjusted Life Years (QALY), a concept which has accelerated in its application in recent years given the economic constraints on the health service, but which is presently more prevalent in areas of general medicine.

Fallowfield (1990) has drawn attention to the potential danger of the application of a QALY type approach to long-term problems such as Alzheimer's Disease and Schizophrenia when life expectation is not immediately affected by treatment. This could be a problem for any person with a long-term disability when compared with other short-term disabilities, but if comparisons were made between different treatment/services for the same type of disability, then the approach may offer a way of improving care and increasing the consultation of users.
Lehman (1983) has taken the concept of quality of life and applied it to assessing the needs and outcomes of people with enduring mental health problems. He used a structured interview based on a quality of life model of the type described by Fallowfield (1990), to explore the contributory factor of various life domains to well being. His model is outlined below:

- **Personal Characteristics**
  - **Objective QOL**
    - **Objective QOL Indicators in Life Domains**
    - **Subjective QOL Indicators in Life Domains**

- **Global Well-Being**
Lehman (1983) has proposed that the sheer complexity of life difficulties encountered by people with enduring mental health problems demands a conceptual framework that integrates these factors in order to provide relevant planning and evaluation of services for them.

Lehman argued that the model could act as a means of evaluating the service and lead to suggestions for improvements based on the users views. Findings from this study suggested that improved social programs should address a number of areas such as, financial assistance, vocational training programmes and increased job possibilities, improved protection against crime, increased contact with families, better relationships with others especially co-habitees, and greater privacy.

A second study conducted by Lehman, Possidentete and Hawker (1986) compared the quality of life experiences of four groups of people suffering from chronic schizophrenia. The groups consisted of in-patients in a hospital setting and ex-users based in a supervised community setting. Results indicated that the community based residents felt that their living conditions were better, that they had more money and were less likely to have been assaulted in the previous year. The model again demonstrating its utility when evaluating alternative forms of care for individuals suffering from a long term mental illness.

Burge (1975) felt that the use of subjective measures of quality
of life "may just be an indicator of the backward state of the field of research", but increasingly work is suggesting that they offer an unique and valuable insight into quality of life, and that whilst remaining at an early stage of development a means of evaluating service provision when used in conjunction with other measures of care. A number of American and British studies have used them to evaluate services.

Sullivan, Wells & Leake (1991) compared quality of life ratings, using Lehman's scale, of people with long-term mental health problems living with their families and a group with low socio-economic status, in rural Mississippi. Overall sense of global well-being was higher for this patient group than Lehman's community samples as was satisfaction in all life domains excepting finances. Compared with the low socio-economic status group, the patient group were more satisfied, excepting finances and social life. They suggest that these relatively high reported levels of satisfaction are a consequence of living within strong family networks in a relatively stable community.

Gibbons & Butler (1987) assessed clients moving from wards in a District General Hospital to a staffed hostel in the hospital grounds. The comparison looked at ratings pre and post-move and compared the group of leavers with those who remain in hospital. Measures were an assessment of the quality of the environment based on principles derived from normalisation literature; behavioural observation whereby
individual's behaviour were time sampled; and a semi-structured interview rating subjective satisfaction with accommodation. Clients reported greater satisfaction with the hostel in both the pre-post comparison and between groups. Activity sampling showed the hostel group spending less time doing nothing and an increase in 'work' activities - domestic chores. Number of social contacts increased for the hostel group as did use of community facilities.

The hospital performed very poorly on the environmental measure. The hostel did better but retained stigmatising associations with the institution in terms of its location and size. This study used objective indicators of quality of life and self-report of satisfaction with accommodation to generate conclusions about quality of life. The authors report that hostel residents felt isolated, lonely and cut-off, suggesting they were able to report on their perception of satisfaction in a range of life areas and that subjective measures of quality of life could have been usefully applied.

Jones (1985), in a follow-up study of people discharged from hospitals in York, developed a scale to examine quality of life derived from Maslow's hierarchy of human needs. The scale groups needs into four areas: survival, safety/security, purpose, and independence. Different settings differed on which needs they met most successfully - hospitals scoring well on basic survival needs but poorly in other areas. The researchers
found that, contrary to their predictions, the majority of the sample were not capable of sustaining an interview and most of the information was derived from carers.

Turner & Dent (1989) developed a semi-structured interview format to assess the quality of life of a sample of people relocated in the community during the closure of St. John's Hospital in Buckinghamshire.

They found the majority of the sample willing to participate and able to express their feelings, differentiate between life areas and provide a wide range of opinions. Generally ratings of satisfaction were high. Areas of dissatisfaction were with finances, health, lack of leisure opportunities and disruptive and incompatible company. Participants were asked to rate their satisfaction with life in hospital retrospectively and satisfaction improved in all areas. Satisfaction was not associated with age, diagnosis, or type of accommodation. One significant finding was that those who had been out of hospital for more than two years were less satisfied than those under two years.

Simpson, Hyde and Faragher (1989) used Lehman's interview to compare quality of life ratings for people living in hospital, in a hospital hostel and in group homes run by charitable organisations. Settings were assessed using the Management Practices Questionnaire (Garety & Morris 1984) and ratings of current mental state were made. The researchers
found the MPQ unsatisfactory for the group homes since several of the items designed to reflect individualised care in other settings (eg. celebrating birthdays) were inappropriate for the level of independence in group homes. The quality of life interview generated useful data, the overall finding being and ratings were highest for the group homes, followed by the hospital hostel and lastly the hospital ward.

The three groups differed with regard to the level of psychopathology, the hospital group being more severely ill and showing more behavioural disturbance. When psychopathology was controlled for the association between setting and subjective health and social rations and social contacts outside, the facility was lost. This suggests that level of disability has some effect on quality of life independent of setting.

Barry, Crosby and Bogg (1993) undertook a longitudinal study of a resettlement programme using a quality of life schedule adapted from Lehman. Initial findings relate to the temporal stability of subjective ratings of satisfaction. The study has, to date, reported data for assessments made while in hospital only and suggests good stability over time. The majority of residents reported high satisfaction, despite the low objective qol indicated by their measures. Suggested reasons for this are a positive response bias, and a lowering of expectations and aspirations consequent upon years of hospitalisation. Clinical factors associated with high reported
satisfaction were high levels of dependency and an expressed desire to stay in hospital. Depression and thought disorder were associated with low satisfaction.

Shepherd et al. (1995) have used the Lancashire Quality of Life measure (Oliver 1991) based on Lehman's work in their evaluation of 25 residential settings across different service providers. This study reports specific areas of dissatisfaction among hospital residents about their living situation. Their overall general life satisfaction was not lower than community residents. Residents in homes provided via joint health and housing association projects were among the most satisfied. They also tended to be the oldest in the study and to have had longer periods in hospital; the authors argue that they may have been consequently more appreciative of the move, and/or the homes may have had more spent on them in terms of facilities and staff training. This study also found a strong correlation between the restrictiveness of setting and global well-being, indicating that in less restrictive settings where residents felt they had an influence, well-being tended to be higher. Qualitative responses confirmed quantitative data. People in joint homes tended to be very positive and like the company, the renewed sense of independence, and the freedom. In more staffed settings, some residents complained about some of the restrictions on things such as where people could smoke, and that staff were sometimes too noisy, etc. There was also a correlation between level of disability and satisfaction. This study suggests that there is a relationship between subjective
quality of life, social environment factors, and level of
disability. This requires further exploration, but does suggest
that services which reduce or ameliorate disability and which
have positive social environments may improve subjective well-
being.

Ehlert and Griffiths (1996) have assessed quality of life
in a study comparing in-patients and day-patients using a
different methodology. Rather than assessing subjective quality
of life, they used Hughes et al.'s (1991) measure access as
indicators of normal life based on the principles of
normalisation (Ager 1990). This study showed a consistent
difference in favour of day patients, with access to more
amenities, and control over more aspects of their lives.
However, there were no differences in levels of social activity.

In a review of the quality of life in the community mental
health field, Zautra and Goodhart (1979) suggested that measures
of psychological well-being tended to be of two types, measures
of individuals adjustment to stressful events, or measures of
the degree to which life is viewed as satisfying. However, the
latter two studies can be seen in relation to Oliver, Holloway
and Carson's (1995) more recent identification of three broad
approaches to quality of life:

- "Objective' or expert-defined, eg. Ehlert & Griffiths 1996
- "Subjective' or user-defined, eg. Shepherd et al. 1995
- "Health related' or outcome-defined.
They also describe some of the difficulties facing quality of life, conceptualisation and research. These include difficulties in agreeing "objective" indices of good quality of life and the effect of cultural and life experiences (Schwarz and Strack 1990), cognitive factors (Contek et al. 1983), temporal factors (upon subjective judgements) and, for people with mental health problems, sufficient range of experience to be able to make valid judgements.

In the context of individuals with a long-term mental illness, the measure commonly used is the latter one of satisfaction. At present quality of life in such a context is usually referring to the degree to which an individual has positive attitudes and feelings about various aspects of their life. Most measures are concerned with one aspect alone, their perspective of the mental health service provision provided, and how that affects other life aspects. Whilst such a narrow definition may not reflect other aspects of life important in an individual's appraisal of their situation, operationally at present quality of life in relation to individuals with enduring mental health problems, is the degree to which they feel their lives are benefited by the care they receive.
Studies of Users Views of Services.

Abrahamson and Brenner (1982) developed the Goodmayes Interview Schedule as a means of evaluating patients views towards leaving hospital, whilst still resident in hospital. The Goodmayes interview is a semi-structured interview covering the following, aspects of life in hospital, attitudes to leaving hospital, and knowledge of alternatives. A later development of the schedule also incorporated the social networks which patients wished to preserve. The original study demonstrated that people with a long term mental illness, even after long periods in hospital, could be realistic about the advantages and disadvantages of leaving, although they were handicapped by lack of information about the choices available. In the second study by this group Abrahamson, Swatton and Wills (1989) sought to try and inform patients about the alternatives available in the community. They found patients were aware of plans to run down or close mental hospitals, and that the proportion not wishing to live in hospital permanently (55%) was similar to earlier studies (Wing and Brown (1970) 64%). When considering alternatives to hospital care, 70% expressed a desire for a room of their own, and the majority wished to share accommodation with a small number of people in a shared flat complex. The study did find that there was a decrease in the desire to leave hospital with increasing time in hospital, but no association with diagnostic category, sex or level of disability as measured on the REHAB scale.
Weinstein's (1981) survey of 44 published articles which used quantitative measures to assess patients' views of care, concluded that, generally, the patients in the studies held positive opinions regarding the overall therapeutic value of psychiatric hospitals, and also in relation to assistance with medical problems, restrictions, activities and involvement of family members. Opinions were less positive concerning patient freedoms and responsibilities, and became negative about patient government and staff-patient relationships.

Myers, Leaky, Shoeb and Ryder (1990) sampled the views of 258 patients in four hospitals via a questionnaire and interview. They commented on both the advantages of a questionnaire and the disadvantages - "A major difficulty is that a question may appear satisfactory yet be misunderstood in quite unexpected ways", giving as an example an item where some respondents took "Same sex ward" to refer to the sex of the care staff rather than residents. They also commented on the possibility that positive results concerning care in hospital may reflect a lack of knowledge of alternatives, and that combined with the limited scope and problems in methodology of ascertaining users views that there was a need to use other measures of quality alongside measures of users views. Chamberlain, Samuel and Rogers (1990) have adopted this approach when attempting to evaluate the quality of life of people with a
learning disability living in the community. In their work they included levels of client engagement, number and range of needs being met, and adherence to philosophy and principles, alongside consumers view of services.

Gibbons & Butler's (1987) evaluation of the quality of life for new long stay psychiatric in patients also used a multi assessment approach to evaluating quality of life - and is one of the few to follow a group of patients from hospital to community placement in a hostel, also comparing with a control who remained in hospital. The study incorporated a behavioural observation inventory, alongside a residents questionnaire. While the sample was small, 15 residents being followed from wards in either a district general hospital or mental hospital to the community, it did offer the respondents the opportunity to make an informed rating of satisfaction based on the experience of two settings.

Their results indicated that once in the community residents did make more use of its resources, had higher levels of activity and had higher levels of interactions. In relation to their own subjective experiences of the change, while individuals were using community resources more, subjectively they felt lonely and cut off. However they felt the increased freedom was a benefit to their lives, and appreciated the flexibility and informality of the hostel setting when compared with the wards. No one wanted to return to hospital and six who had remained as a control in hospital throughout showed no
comparable changes on the measures and wished to live elsewhere. The study illustrated that behavioural changes, such as increased community contact; an assumed benefit, may be subjectively experienced in a different way to that expected. In this case the unexpected increase in feelings of loneliness and isolation, and this demonstrated the value of attempting to assess users views alongside other measures.

Gordon et al. (1979) evaluated the views of users once they had been discharged back to the community. The population sampled were in the main not people with enduring mental health problems; in that Gordon looked at people following their first contact with psychiatric services and who had been admitted and discharged within nine months but attempts were made to improve the methodology. Gordon ensured that the interviewers were independent from the hospital and that they were trained to obtain a satisfactory level of consistency of observation and report. The value of the information was emphasised in addition to its confidentiality.

Generally these ex-users of psychiatric services were satisfied that most of their emotional and physical needs had been met adequately, although they did feel that two aspects of care had not added to their life quality, these being loss of individual identity and poor staff patient relationships. They were not able to compare with other forms of care although three quarters stated a preference to be admitted to a psychiatric hospital rather than a psychiatric ward attached to a general
hospital. McIntyre, Farrell and David (1989) in a study carried
out ten years later found users not wishing to remain in
hospital, not finding drug based therapies useful and wishing to
have talking based therapies more widely available. More recent
studies of users views have progressed on to their opinions
regarding social services (Beresford and Croft 1986), living in
the community (Barham and Hayward 1991) and the mental health
service as a whole (Rogers, Pilgrim and Lacey 1993).

The study conducted by Rogers, Pilgrim and Lacey (1993)
involved a questionnaire survey of 516 users of mental health
services contacted by the national MIND network. This survey
led to suggestions that lay views of mental health problems were
more elaborate than traditional illness based models, and had an
emphasis on psychological conceptions, leading to "A dislike of
the aloof and cool attitude of psychiatrists during interviews
whilst in-patients, to the rejection of physical treatments as a
response to personal distress" (p.176). The study also
suggested that users satisfaction with services was linked to
the distance of a service from traditional hospital bases, and
its closeness to normal living arrangements.

Limitations of Quality of Life Measures.

Most studies do not give indications of the interpretations
placed on the questions used, and so respondents could be
replying in terms of the service they are provided with, what
they would ideally like, what they feel they should have or what
they expect to have. Similarly for rating scales or multi-choice formats, there is often no attempt to ensure that the meanings attributed to the stated definitions are commonly held by the population sample, or indeed even understood by the majority of recipients. Interview formats are often rated by the interviewers themselves, with possible interviewer bias and poor inter-rater reliabilities.

A further problem is the lack of attention paid to ensuring that the topics covered actually cover the issues of concern for the respondents, and that replies given are valid. While studies have been able to demonstrate that it is possible to gather the quality of life views of people with long-term mental illness, they remain limited by scope and the unsophisticated measures employed.

Conclusion.

There are important reasons for looking at the users' views of mental health services, and these include reasons of uniqueness, morality, effectiveness, economy, and legislative policy. A number of researchers have demonstrated that it is possible to gather the views of users, and that arguments to discount their views are not valid. However the measures used at present remain crude with few attempting to ensure the scope of areas covered are of any relevance to the respondents. Poor inter-rater reliability, inter-item reliability, level of comprehension of questions, independence of raters, and lack of
response bias are also common. The relationship of their findings to other measures of quality is unclear, and no coherent model underlies their approach. This is especially the case in relation to the concept of the quality of life. The predominant concept utilised, though often not stated, tends to be an operationally defined one of level of satisfaction with service provision. This in itself often presents difficulties in that users frequently have little information or experience of other options available to them.

A further concern in the area of users views is the incorporation of their views into planning and development of services, empowerment concerning their own care, and as a pressure group concerning care. Whilst such movements would lead from looking at users views, they have in the main not been evaluated and tended to have developed separately from the research in this area.
CHAPTER 5

STUDIES OF SOCIAL ENVIRONMENT CARE QUALITY

As part of the planned closure of St. Crispin Hospital, the following two studies were planned:

STUDY 1

A cross-sectional study (published as Allen, Gillespie & Hall, 1989) which sought to compare the care provided by a hospital and community based unit. It was planned to compare the existing hospital-based rehabilitation ward with an existing community-based unit which had a similar function. This was an important study in the context of the closure of the hospital as, prior to the transfer of units to the community, it was important to identify if existing community units were providing good quality care, and if transfer alone would provide similar benefits.

STUDY 2

The second longitudinal study sought to evaluate the care provided by the original hospital unit, evaluated in Study 1, as it moved from a hospital-based setting to a community-based setting. Given the short time periods of most evaluations of units' moves to the community, at the time of the start of the study (Reid & Garety, 1996, being a notable exception now), it
was planned to carry out the evaluation over an 18-month and 42-month post-move period in addition to the six months prior to discharge evaluation. The original measures employed in Study 1 were used throughout this period.

The first two studies initiated at the commencement of this thesis used the same methodology, replicating the measures used by Garety and Morris (1984). Due to the fact that the same methodology was used for each of these studies, this is described first prior to an account of each study.

**Measures Used in Study 1 and Study 2**

REHAB (Hall and Baker 1984) was used as a means of assessing the level of functioning of the residents. The other standard measures used replicated those adopted by Garety and Morris (1984) in their investigation of a new unit for long-stay psychiatric clients and primarily focused on staff attitudes and behaviour.

1. **Rehabilitation Hall and Baker (REHAB)**

This has already been described in some detail earlier (see Chapter 2).

Inter-Rater reliability was assessed by correlation coefficients. Hall (1974) has recommended the calculation of reliability coefficients when subjects are being observed by
raters on their units. As part of another study (Study 5) REHAB reliability data were collected from a number of other wards at the same time, with staff trained by the author. It was felt important to involve the whole professional group across social and health services in the collection of the data, thus achieving group identification with the survey. To gather the data, a multi-agency group of 13 was organised which met for a study day. The study day involved provision of background information, REHAB scale familiarisation, and training care staff to use the instrument. In the afternoon of the study day, the group was divided into pairs: one Health Service member and one Social Services member, and went to their particular wards to meet the nursing raters and to train them in the use of the scale. A total of 43 residents was rated by two independent observers. The reliability calculation was compared with the published figures. These figures show a high level of significance for the overall scale, and its individual items. Whilst many items do not achieve as high a coefficient value as the original study, only one item of the 23, that of sexual acts, did not achieve significance. This indicates that a two-tier mechanism, that of passing on skills to trainers who then train direct care staff, does not lead to any loss of reliability.

This data is described in Table 1:
TABLE 1: RELIABILITY DATA, COMPARISON OF LONG-STAY STUDY AND PUBLISHED REHAB. FIGURES

**Spearman Correlation Coefficients between Independent Raters:**

<table>
<thead>
<tr>
<th>ITEM:</th>
<th>STUDY r [n=43]</th>
<th>SIGNF LEVEL</th>
<th>REHAB r [n=47]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incontinence</td>
<td>.84</td>
<td>.000</td>
<td>.80</td>
</tr>
<tr>
<td>2. Violence</td>
<td>.64</td>
<td>.000</td>
<td>.65</td>
</tr>
<tr>
<td>3. Self Injury</td>
<td>.58</td>
<td>.000</td>
<td>-</td>
</tr>
<tr>
<td>4. Sexual Acts</td>
<td>.24</td>
<td>.115</td>
<td>.67</td>
</tr>
<tr>
<td>5. Absconding</td>
<td>.71</td>
<td>.000</td>
<td>.61</td>
</tr>
<tr>
<td>6. Verbal Aggression</td>
<td>.48</td>
<td>.001</td>
<td>.76</td>
</tr>
<tr>
<td>7. Talking to Self</td>
<td>.38</td>
<td>.010</td>
<td>.88</td>
</tr>
<tr>
<td>8. Mixing on Ward</td>
<td>.61</td>
<td>.000</td>
<td>.63</td>
</tr>
<tr>
<td>9. Mixing off Ward</td>
<td>.67</td>
<td>.000</td>
<td>.81</td>
</tr>
<tr>
<td>10. Spare Time</td>
<td>.54</td>
<td>.000</td>
<td>.62</td>
</tr>
<tr>
<td>11. Activity</td>
<td>.52</td>
<td>.000</td>
<td>.67</td>
</tr>
<tr>
<td>12. Amount of Speech</td>
<td>.48</td>
<td>.001</td>
<td>.69</td>
</tr>
<tr>
<td>13. Initiation of Speech</td>
<td>.67</td>
<td>.000</td>
<td>.80</td>
</tr>
<tr>
<td>14. Speech Sense</td>
<td>.45</td>
<td>.003</td>
<td>.72</td>
</tr>
<tr>
<td>15. Speech Clarity</td>
<td>.61</td>
<td>.000</td>
<td>.67</td>
</tr>
<tr>
<td>16. Table Manners</td>
<td>.46</td>
<td>.002</td>
<td>.62</td>
</tr>
<tr>
<td>17. Washing</td>
<td>.57</td>
<td>.000</td>
<td>.63</td>
</tr>
<tr>
<td>18. Dressing</td>
<td>.68</td>
<td>.000</td>
<td>.72</td>
</tr>
<tr>
<td>19. Possessions</td>
<td>.50</td>
<td>.001</td>
<td>.87</td>
</tr>
<tr>
<td>20. Promoting</td>
<td>.60</td>
<td>.000</td>
<td>.72</td>
</tr>
<tr>
<td>21. Money</td>
<td>.67</td>
<td>.000</td>
<td>.91</td>
</tr>
<tr>
<td>22. Transport</td>
<td>.82</td>
<td>.000</td>
<td>.92</td>
</tr>
<tr>
<td>23. Overall Rating</td>
<td>.46</td>
<td>.002</td>
<td>.65</td>
</tr>
</tbody>
</table>

*Item 3 Self Injury r not obtainable for REHAB data.*
*All REHAB data signf at .001 level.*
Management practices operating in each unit were assessed using Garety's (1981) Management Practices Questionnaire (Appendix 3). The scale is a development from King et al. (1971), who suggested that it focused on four dimensions of management:

a. social distances
b. depersonalisation
c. block treatment
d. rigidity of routine.

However, McCormick et al. (1975) factor analysed the scale and were unable to find distinctive factors along the suggested dimensions. Adaptations of the scale for other client groups have therefore used the total MPQ score rather than the subscales.

It has been modified for use with mentally handicapped adults by Raynes et al. (1979), and with chronic psychiatric clients in day centres by Richardson (1979). Garety's scale is an adaptation of these two, and consists of 28 items. For each item there are three possible answers. A score of 0-2 is allocated to each response, and summed to give the total MPQ score. There is a possible total score range of 0-56, with a high score representing institutional management orientation, and a low individually tailored management.
A second form of the MPQ (Form A) also developed by Garety (1984) was used to assess staff attitudes to management practices in relation to how they felt the unit should be organised (Appendix 4).

3. Optimism/Pessimism Scale

This was originally a 40 item scale developed by Grant (1974) and Moores and Grant (1976). They factor analysed the scale, and the present form consists of the 12 items making up the first factor.

It is suggested this reflects the expectations that staff hold concerning the potential level of achievement of their clients and the extent to which they can influence the outcome. Whilst the scale was originally used with mentally handicapped clients, Garety and Morris (1984) found it to be equally appropriate with long-stay psychiatric clients, with the exception of the final twelfth item which was excluded (Appendix 5).

A score of 0-4 is possible for each response, and summed to give the total OPS score. There is a possible range of 0-44, with a high score representing pessimism concerning potential outcome of clients and staff's effect on outcome, and a low score optimism.
Perceived Involvement - Personal Questionnaire Method (PIPO)

The strongest predictor of staff performance found by Raynes et al. (1979) was perceived involvement in matters relating to work. This was assessed by asking staff if they thought they were "usually involved" in making decisions in the following areas:-

i. resident care  
ii.  domestic work  
iii. staff schedules.

These questions were also asked in Garety & Morris' study, using Phillips' (1970) modification of the Personal Questionnaire Technique (Shapiro 1961). This modified technique was used in this study; it involves asking staff whether they feel more or less involved in a different work area as represented by a statement. These statements represented five different possible levels of involvement per item, and were then scored on score sheet (Appendix 6). Six statements are presented in total with a possible score of 0-4 for each; these are summed to give the total PIPQ score. There is a possible range of 0-24, with a higher score reflecting perceived low involvement in work matters, and a lower score a high level of involvement.
5. **Direct Observation Schedule**

This schedule was developed by Garety and Morris (1984) from the work of King et al. (1971). It focuses on staff members interactions with clients or other staff. The first verbal interaction occurring within a set 30s observation period is categorised in terms of its type, content and quality. These categories are allocated in the following way:

a. **type**: staff-staff (S-S) or staff-resident (S-R)

b. **content**: personal problem solving (PPS) or Administrative (AD)

c. **quality**: accepting (A), tolerating (T) or rejecting (R).

Definitions for each classification were those given by Garety and Morris (1984) whose classification guidance sheet was replicated (Appendix 7). Recordings were also made of the activity the staff member was involved in when the interaction was observed, the number of residents in the room at the time, and whether no interaction occurred.

Inter-rater reliability studies with two independent raters were carried out for 110 observations, 16% of the total. This was a lower proportion than originally intended, as the hostel did not give permission for a second rater to enter the unit. The Kappa correlation coefficient was used to assess inter-rater reliability. The reliabilities are given in Table 2, and all
were significant at the $P<0.001$ level. No figure is given for $R$ (rejecting) as a rejecting observation was not made during reliability data gathering.

### TABLE 2: Inter-Rater Reliabilities on Direct Observation Schedules

<table>
<thead>
<tr>
<th>Observational Category</th>
<th>Activity</th>
<th>Number of Residents</th>
<th>No Interaction</th>
<th>S-S</th>
<th>S-R</th>
<th>PPS</th>
<th>AD</th>
<th>A</th>
<th>T</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kappa</td>
<td>0.89</td>
<td>0.99</td>
<td>0.98</td>
<td>0.98</td>
<td>1</td>
<td>0.92</td>
<td>0.92</td>
<td>0.88</td>
<td>0.87</td>
<td>-</td>
</tr>
</tbody>
</table>
STUDY 1 - A COMPARISON OF STAFF ATTITUDES AND PRACTICES IN A COMMUNITY RESIDENTIAL SETTING AND A HOSPITAL SETTING

The hostel ward studies (Chapter 2) have demonstrated the potential effectiveness of new residential community units, but have not reflected how an established residential setting in the community would compare with an established hospital ward. With a new unit, it may be expected that staff morale would be high, management practices client-orientated prior to perhaps slipping and the outlook in general positive. However this does not reflect how the unit may change over time, or act as a comparison to previous studies of established hospital wards.

It was the intention of this study to compare an established community hostel for the long-term mentally ill, with an established hospital ward serving the same type of population. With the increasing move to the community, it is of importance to assess how community units already in existence compare with hospital units, to assess if such units suffer from the same types of difficulties, and hence act as guidance in the future development of new residential community units. This was important for the service concerned as it was also planned to move the existing hospital unit to the community shortly after this evaluation.

It was decided to replicate the study measures of Garety and Morris (1984), as their study had also looked at a residential community unit, used a number of adapted measures
for this population, and at the time appeared the most appropriate methodology to use. The measures concerning management practices and staff-client interactions had also been used by a number of previous authors (see Chapter 2).

Doubts were expressed concerning some of these measures (Conning 1986), but they have been assessed for reliability, clear descriptions of their contents and administration are available, and they then appeared superior to most others in the area. In addition, the REHAB Scale (Baker and Hall 1983) was used to assess level of functioning of clients, and compare the two populations.

Hypotheses

Given the favourable findings of the hostel-ward studies (see Chapter 2) the following hypotheses were generated concerning this study:-

1. The residential unit in the community would have more client orientated management practices than the hospital setting.

2. Staff in the community unit would have attitudes that were more client orientated in management practices, would be more optimistic about client outcome, and would feel they were more involved in the running of the unit than the hospital staff.
3. Staff in the community setting would have higher levels of interactions with their clients, and these would be of a personal rather than an administrative nature compared with the hospital staff.

The Residents

The residents included in the study at both units were designated 'rehabilitation' clients. To be designated as such indicated that the future plan for such clients was to move to re-integrate in the community, so the ward or hostel was not seen as a permanent residence. There were 12 residents on the hospital ward (n=12) and 17 residents at the hostel (n=17). The demographic details of the residents in the two units are represented in Table 3 overleaf:
The median age of the ward residents was 44 years (range 20-65), and of the hostel residents 41 years (range 22-59). The length of stay in the particular unit and the total period of time in contact with services were not significantly different for the two groups of residents. The average length of stay on the ward was 0.98 years, and in the hostel 3.39 years (u=59.5, p>0.055). The average total period of contact with services for ward residents was 9.31 years, and for hostel residents 5.10 years (u=77, p>0.268). Twelve of the 17 hostel residents had previously resided in the hospital.
The Staff

The staff included in the study at both units were the direct care staff. These were the staff who had day to day dealings with residents. In the ward setting this excluded other staff such as Occupational Therapists, Psychiatrists, and Psychologists. In the hostel setting it excluded kitchen and domestic staff. The details of the two staff groups are summarised in Table 4 below:

**TABLE 4: DEMOGRAPHIC DETAILS OF STAFF IN HOSPITAL WARD AND HOSTEL**

<table>
<thead>
<tr>
<th></th>
<th>Hospital Ward (n=13)</th>
<th>Hostel (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>26.85 years</td>
<td>41.44 years</td>
</tr>
<tr>
<td>Median</td>
<td>25 years</td>
<td>35 years</td>
</tr>
<tr>
<td>Age Range</td>
<td>19→45 years</td>
<td>19→60 years</td>
</tr>
<tr>
<td>Males</td>
<td>3 (23%)</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Females</td>
<td>10 (77%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>Average Time on Unit</td>
<td>2.81 months</td>
<td>6.77 years</td>
</tr>
<tr>
<td>Median Time on Unit</td>
<td>2 months</td>
<td>4 years 4 months</td>
</tr>
<tr>
<td>Range of Time on Unit</td>
<td>2 weeks→1½ years</td>
<td>6 months→10 years</td>
</tr>
</tbody>
</table>

The ward staff consisted of 13 individuals: a senior charge nurse, a sister, a staff nurse (RMN), a state enrolled nurse and nine student nurses. The hostel day staff consisted of nine individuals: an officer in charge, a deputy officer in charge, two assistant officers in charge, a residential social worker, and four care assistants. Both units employed a shift system.
Three ward staff and two hostel staff were male. There was no significant difference between the ages of the staff or their level of education (in terms of number of 'O' levels etc.), but there was a significant difference between length of time staff had worked on the units. For the ward staff this was 2 months, and for the hostel staff 4 years 4 months \((u=2, p<0.001)\). The full-time staff on the ward were relatively new to the unit, as well as the student nurses on their short-term attachments. Professional training of the staff having nursing qualifications (RMN, SEN) and the hostel staff having social work qualifications (CQSW, CSS).

**The Units**

The ward was situated in the grounds of a large psychiatric hospital. It was in a separate building from the main block which had been built at the same time. The ward itself was a large building which had at one point contained more residents than it did at present. It consisted of large rooms, half the residents still living in a partitioned dormitory rather than having their own rooms. The atmosphere was not homely.

The hostel was situated in a village located between the hospital and the outskirts of a nearby town. It was a large purpose built building opened in the 1970's. Residents had either shared rooms or had their own. However there were large kitchen, lounge and dining areas and the building stood out from its surroundings.
Procedure

Each member of the care staff at each unit was then interviewed individually and the four questionnaires were completed. This replicates the protocol of Garety and Morris (1984), apart from the fact that the MPQ related to the management practices actually being carried out was completed by all staff rather than just the senior staff. It was felt that this was an improvement on the original study as senior staff do not always reflect the practices actually being adopted by all grades of staff, and that differences in the perception of actual practices may occur.

Prior to the study being carried out, practices had been confirmed at each unit by the author working a number of shifts to get to know staff, and this experience reflected the general trends seen in the management practices questionnaires. The observations were also made at the same time as the original Garety and Morris study, between 3.45 pm and 5 pm based in the sitting rooms of each unit. This was the time in these units that residents and staff returned from industrial and occupational therapies. A number of the residents on the two different units attended the same industrial therapy activities.

Data was collected on 23 occasions (Ward=11, Hostel=12) over a period of four months. Each staff member on duty was observed for five consecutive 30 second periods, with 30 second
gaps between each observation for recording. The total number of observations (n=695) represented an overall median of 30, range 10-45 for each staff member. (Ward median = 25, range 10-40; Hostel median = 35, range 15-45.)

Results

The Statistical Package for the Social Sciences (SPSS+) software package (Nie et al. 1975) was used to carry out statistical comparisons. For comparative purposes non-parametric procedures were adopted as normal distribution of the data could not be assumed. To enable comparison with the study by Garety and Morris (1984) means, medians and ranges are reported.

Rehabilitation Evaluation Hall and Baker (REHAB)

The first assessment carried out by trained members of the direct care staff, had been to assess residents using Rehab. This was to establish the level of functioning of clients in both units, and see if any differences were apparent in terms of client characteristics. The medians for each unit were calculated for each Rehab item. They were compared using the Mann Whitney statistic.
Overall there were no significant differences between the two groups as reflected in the comparison of total deviant behaviour items, and total general behaviour items (median = 48 hospital and 54 hostel). This also applied for 21 of the 23 individual scale items, apart from spare time (U=52.5 p<0.05), and amount of speech (U=52.5 p<0.05) indicating that ward staff had less skill deficits in relation to their ability to use their spare time (interestingly the hospital at this stage still operated a number of activities on site including a shop, cafe, and a range of other activities), and more skill deficits in the amount of speech they used when compared with hostel residents. It can be assumed that the client groups in each setting were not significantly different (as judged by the overall scores). Any differences found in the staff attitude questionnaires and observational schedules were not likely to be due to big differences in the client groups of the two units.

Management Practices Questionnaire

The median scores for the actual management practice (MPQ Form B) for each unit were 8 (hospital) and 19 (hostel). These scores do represent a significant difference in the actual practices between both units as represented by a Mann Whitney U=1.5 which is significant at the 0.0001 level. This difference in scores was reflected by the experience of the author in both units.
The notable difference was that the residents in the hostel did not all have detailed individual programmes, and did not have free access to all areas in the unit such as the kitchen. A reverse trend was the wearing of uniforms by staff in the hospital setting, but not in the hostel. The procedure of administering the MPQ (Form B) was different to the Garety and Morris (1984) study, who only used senior staff to assess actual management practices.

A significant correlation between actual practices and staff attitudes to practices ($r=0.887$ signf $p<0.001$) suggests that there is an interaction between staff perception of actual practices and their views of what they feel practices should be. The range of scores in both units also suggests that actual practices can be differently perceived by staff carrying out different roles and having different responsibilities.

**Attitudes concerning Management Practices**

The median score for the hostel unit was 14 ($\text{S.D}=3.28$) (mean = 14.33), and for the ward unit six ($\text{S.D}=3.50$) (mean 6.62). These scores reflect a significant difference between staff attitudes concerning management practices as represented by a Mann Whitney U value of 4.5 which is significant beyond the $p<0.001$ level.
There was also a significant correlation for management orientated practices with the number of months staff had spent working on the unit \((r=0.65 \ p<0.001)\). This was the reverse of Garety and Morris' (1984) correlation, which had shown a correlation between resident orientated attitudes and length of time on the unit, rather than management orientated practices.

The correlation in this study would suggest that a shorter period on the unit was correlated with resident orientated attitudes, and a longer time spent on the unit with institutional orientated attitudes. As with Morris and Garety (1984), no significant relationships were found between MPQ(A) scores and other staff characteristics such as age, sex, grade, education or nursing experience.

**Optimism-Pessimism Scale**

The median score for staff at the hostel was 20 (SD=4.02) \((mean=21.22)\), and for staff at the ward 10 (SD=4.80) \((mean=11.31)\). A lower score on the OPS represents greater optimism. The difference in scores is statistically significantly different \((U=5 \ p<0.0001)\), with the hospital staff being more optimistic about the outcome for their clients. Both scores were lower than that found by Garety and Morris (1984) in their study \((mean=27.7 \ SD=4.4)\).
In their study no relationship was found between this scale and any staff characteristics, however in this study a relationship was found between the scale score and length of time on the unit ($r=0.61 \ p<0.0001$).

This suggests that the longer staff spent on their units the more pessimistic they were likely to become about clients outcome. A significant relationship was also found between the scores on the OPS and both forms of the MPQ (MPQ Form B-OPS $r=0.702$, MPQ Form A-OPS $r=0.753$ both $p<0.0001$). This indicated a link between level of pessimism and institutionally orientated management views.

**Perceived Involvement (PIPO)**

The median score for staff at the hostel was 11 (SD=4.01) (mean=11.89) and at the ward was 11 (SD=4) (mean=10.85). The possible range of scores in this scale was 0-24, a lower score indicating greater involvement. There was no significant difference between the scores for the staff at both units. The scores are not directly comparable with the Garety and Morris (1984) study as the staff in this study were presented with more options per item and hence the scoring is dissimilar. Garety and Morris found a relationship between the score on this scale and length of time staff had spent on the unit, and number of years of experience. These correlations were not replicated in
this study, but correlations were found between OPS score and seniority \((r=0.53 \ p<0.01)\) and sex of the staff \((r=0.57 \ p<0.01)\) which indicate that the more senior staff and males feel more involved with decision making on the units. These two factors may be confounded as the senior staff at both units tended to be male, and the rest of the staff female.

**Staff-Resident Interactions**

A total of 695 observations were made for this study. The overall mean number of observations for each staff member (31) \(\text{median}=30\) is similar to that of Garety and Morris (27). In relation to staff-staff interactions, these made up 32% of the ward total, and 47% of the hostel total respectively.

Of the total number of observations in each setting, 41% of the total in the ward setting and 29% of the total in the hostel setting involved staff-resident interactions. In the ward setting, 22% of the staff-resident interactions were of an administrative nature and 35% in the hostel setting. Interactions of a personal nature made up 78% of the ward staff-resident interactions and 65% of the hostel staff-resident interactions.
For the quality of the interaction distinction between staff and residents, the following was found for each unit:-

<table>
<thead>
<tr>
<th></th>
<th>Ward %</th>
<th>Hostel %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting</td>
<td>75</td>
<td>67</td>
</tr>
<tr>
<td>Tolerating</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Rejecting</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

No significant differences were found between quality of interaction factors.

In relation to staff characteristics, a relationship was found between "accepting" interactions and grade of staff \((r=-0.667 \ p<0.0001)\): the more senior a member of staff the smaller the proportion of "accepting" interactions with residents. No association was found between the majority of other staff characteristics and observational data.

The following associations were found between observation categories and scores on the attitude measures:-

a. "Accepting" interactions and PIPQ score \((r=0.58 \ p<0.01)\). This means that staff who rate themselves as being less involved in decision making had a greater proportion of "accepting" interactions.
b. Staff-staff interactions and MPQ(A) \( (r=0.71 \ p<0.01) \), MPQ (B) \( (r=0.68 \ p<0.01) \) and PIPQ \( (r=0.52 \ p<0.01) \). This means that staff who felt the unit should be run along institutional management lines and staff who were less involved in decision making tended to have a higher proportion of interactions with other staff.

c. Staff-resident interactions of an administrative nature and PIPQ \( (=-0.57 \ p<0.01) \). This means that staff who felt less involved in decision making had a lower proportion of interactions of an administrative nature with residents.

d. Staff-resident interactions of a functional nature and OPS \( (r=0.5 \ p<0.01) \). This means that staff who felt pessimistic about outcome for the clients tended to have a higher proportion of functional interactions with residents.

e. No interaction occurring and PIPQ score \( (r=0.49 \ p<0.01) \). This means that staff who felt less involved in decision making had a greater proportion of no interactions with either residents or staff.
A number of correlations were also found between various observational categories. These were:

i. Activities of a socialisation nature, and activities of an administrative nature \( (r=0.7 \ p>0.0001) \). This means that staff who were more often involved in activities of an administrative nature were less likely to be involved in socialisation activities.

ii. Functional activities and administrative activities \( (r=0.57 \ p>0.01) \). This means that staff who spent a greater proportion of their time carrying out administrative duties also spent a larger proportion of time in functional activities.

**Staff Characteristics**

For most aspects of staff characteristics there were no significant differences between the two groups. There was a significant difference for length of service, with the hostel staff on average having worked for 6.77 years at their unit, and the hospital staff on average 2.81 months \( (u=2 \ p>0.0001) \).
Discussion

In relation to the major hypotheses the following conclusions can be drawn:

1. **Management Practices.**

   There was a significant difference in the management practices of the two units, but this was in the opposite direction to the hypothesised one. The hospital ward had more client orientated management practices than the social services hostel. Both of these established residential units had a higher score on the MPQ(B) than the new residential unit, described by Garety and Morris (1984). As such the findings suggest that these two units are less client orientated in their management practices than the latter's unit.

   The findings of this study suggest that old practices can be transferred to community units if residents are simply relocated or, if the unit is moved with institutional practices in place, that these are likely to be replicated in the community. This was of particular concern as the hospital unit in this study was about to relocate to the community, and suggested the need to evaluate such a move to study the effect on practices of such a move.
This concern has been discussed by Bachrach (1980) who suggested that the term "community" has been indiscriminately applied to any place that is not a hospital, and cosmetic moves may not bring any improvements.

It would be important to assess such new units, and to establish what has helped a successful one such as that described by Garety and Morris (1984) avoid institutional management practices. Community units do have the advantage of easier access to community facilities, and offer the potential of integration into the local area, but these types of issues were not addressed in this study.

The results suggest that existing community residential units can contain features of traditional hospital institutions, and that these may even be more institutional than some of the hospital units they are planned to replace.

Administering the MPQ(B) to all direct care staff did show that scores could be quite variable across staff when assessing actual practices, and likely to be influenced by the individual's role in the unit.
2. **Attitudes of Staff**

It was hypothesised that staff in community units would be more client orientated in their attitudes to management practices, more optimistic about client outcome, and feel more involved in their unit's organisation than in a hospital unit. None of these hypotheses were proven. Again the significant differences were in the opposite direction, with the hospital staff proving to be more client orientated and optimistic about outcome. Hospital staff also felt more involved in decision making than hostel staff, but this difference was not significant.

The average score of the hospital unit was comparable to that found in Garety and Morris' study indicating that both these units had staff who were resident orientated. The hostel staff's score is indicative of staff with a less resident orientated attitude. The original Garety and Morris study however reflected attitudes that were closely related to actual management practices whilst in this study both units produced attitudes that were more resident orientated than the actual practices occurring in the units. This may suggest that the environment the staff are operating in is restricting them from putting their attitudes into practice. Garety and Morris found a relationship in their study between length of time on the unit and attitude, with a longer period of time on the unit correlating with an increase in resident orientated attitudes.
The reverse was found in this study with a longer period on the units being correlated with a decrease in resident orientated attitudes. The Garety and Morris unit, being new, may have encouraged the operation of the resident orientated attitudes the staff held. The units in this study had established management practices; it may have been that new staff arriving with resident orientated attitudes became more assimilated into this culture. Certainly the OPS results indicated that with an increasing length of time on the unit, staff became more pessimistic about the outcome for their clients. There was also a relationship between staff who held institutional attitudes having a greater chance of also being pessimistic about client outcome.

3. Differences in Staff Variables

There were differences in the staff groups which may have contributed to the results of this study. Hostel staff had a significantly longer period of employment in their jobs. The lack of other suitable job alternatives in this area compared with London (the location of Garety and Morris' study) may be a further factor in the difference in attitudes found between staff groups, with staff being less motivated to do this type of work but not having other options. It may be that hostel managers also have a less able group of potential employees than in the larger London setting.
Length of service may also have an effect upon training, although there were no significant differences between the two groups in terms of educational attainments in terms of number of 'O' and 'A' levels, but the professional training certainly was different. It was of note that many of the hostel staff had trained for a number of years prior to the hospital group, and in social service rather than nursing qualifications, and many had no appropriate community residential care training. There may be an argument for retraining or "topping-up" training for such staff, in order for community residential units to become more effective. The current Sainsbury's Inquiry into training of staff to work in community units would be of relevance; one of the suggestions leading to the inquiry was that staff have largely been inappropriately trained in more institutional-type settings.

The difference in attitudes was apparent to the researcher, with the hospital staff being inquisitive as to the nature of the study and wanting to use the information to change their unit, and the hostel staff appearing threatened by the study and worrying about too close a scrutiny of their unit. The kitchen staff not actually being observed as part of the study, at one point had to be reassured that they were not being observed, but that staff and residents (who were discouraged from entering the kitchen) were. This is also apparent in the hostel staff's refusal to allow access for a second rater for the behavioural schedule.
4. Staff-Resident Interactions

There were no significant differences between the observational categories concerning staff-resident interactions at the two units. However, the difference tended to be in the opposite direction of that predicted, with staff-resident interactions in the ward setting accounting for 41% of observational periods, and 29% of such periods in the hostel setting. This compares with 57% of observational periods in the unit surveyed by Garety and Morris.

It is an assumption held by many researchers that high staff-client interactions are beneficial for clients. Some writers notably (Wing and Brown 1970) have suggested the reverse, but most (eg. Fairbanks et al. 1977) have noted that maladaptive behaviour tends to be higher when staff-client interactions are low. It is also of note that staff-staff interactions follow a reverse trend with the hostel level being the highest (47%) and ward lower (32%) rather than there just being a lot of no interactions. Again Garety and Morris' study was lower still (12%). These levels of staff-client interaction compare favourably with levels of 7-13% found by Oppenheim (1955) and Poole et al. (1981).

The quality of staff-resident interactions was defined by Garety and Morris, and Shepherd and Richardson (1979) in terms of "accepting", "tolerating", and "rejecting". There were no
significant differences in quality of interactions between the ward and hostel. The level of "accepting" interactions compares favourably with the previous studies.

The ward level of "accepting" interactions was 75%, the hostel 67%, Garety and Morris' figure for their unit was 49%, and the units studied by Shepherd and Richardson (1979) using this method ranged from 22-46%. Richardson (1977) felt the proportion of "accepting" interactions was of primary importance, and that units should aim to maximise these types of interactions. There was no difference in the proportions of different kinds of interactions in this study. Garety and Morris (1984) argue that some level of "rejection" might be desirable in the process of resocialising severely socially disabled residents.

The rates of "rejecting" interactions in this study were 2% (Ward) and 3% (Hostel) respectively. This compared with 9% (Garety and Morris) and 2-35% (Shepherd and Richardson).

It is important to assess the "quality" of interactions as well as quantity. In this study it was felt that a further aspect of the nature of interactions, that of content, would have also added useful information. The "content" of interactions did appear to differ between the two units. An example illustrates this: "You are a good boy; did you bring that back for me?" is an example of a conversation overheard at the hostel between a staff member and a resident. It would be
classified as an "accepting" interaction under the defined classification, as being socially pleasant, friendly, warm, attentive, accepting and encouraging, although implying an inappropriate adult-child relationship. Similarly the following conversation overheard at the ward would be classified "accepting": "What have you bought at the shops?" However, on a classification of content a distinction could be made between these two interactions, on the basis that one deals with the individual as an equivalent adult, and the other as a child. A classification relating to power roles and age appropriateness would thus distinguish the two statements.

Garety and Morris found a relationship between "accepting" interactions and staff seniority. A relationship was also found in this study, but in the opposite direction to the one they found. Senior staff in this study tended to have a smaller proportion of "accepting" interactions. A number of correlations were found by Garety and Morris (eg. Education level of staff - staff/staff interactions, age of staff - "rejecting" interactions) which were not replicated in this study. A number of correlations were found in this study, but not in theirs (eg. "accepting" interactions and PIPQ score, staff/staff interactions and MPQ(A), MPQ(B) & PIPQ scores). This is not surprising as different units, run along different lines, with different staff, are unlikely to produce the same correlations.
Conclusions

The Garety and Morris (1984) paper was optimistic about the development of new community residential units for the psychiatrically disabled. They found such a unit to be resident-orientated both in practices and staff attitudes, to have staff with optimistic opinions about their clients potential and to consider themselves involved in decision making. They also found high levels of positive interactions with residents.

This study replicated their protocol and sought to compare an established hospital ward and established community hostel for a similar psychiatrically disabled population. The findings did not reflect such an optimistic position as Garety and Morris' paper. They reflected the established community unit as having less client orientated practices and staff attitudes than the hospital ward setting. The study also found the community staff to be less optimistic about outcome for their clients than the hospital staff. Overall the impression was more than found by Carter and Edwards (1975) and Shepherd and Richardson (1979) concerning established community day services. Both pairs of authors concluded that it was not the location of the service that was of primary importance but the nature of that service. Both these established units compared unfavourably on these measures with Garety and Morris' 'model' unit.
In the context of the concerned hospital's closure, it seemed important to conduct a second study longitudinally evaluating the ward in this study as it moved to the community. This would highlight the impact of relocation on the quality of care of the unit on these measures.
The previous study comparing the unit in this study, when operating as a hospital ward, with a community based hostel, indicated that on a number of measures the community unit exhibited more institutional practices and that the staff there had attitudes that were more institutional in nature than the hospital unit. This work suggested that relocating services to the community would not automatically overcome some of the difficulties associated with institutional care. The danger of creating small institutions or ghettos in the community has been noted (Shepherd 1991), and it would appear important to monitor the relocation of units from hospital to community settings over a period of time to ensure that this had not occurred.

Most of the studies evaluating the relocation of ward based units to community residential units have been concerned with "ward in a house" or "hospital hostels". This model of provision, outlined by Bennett (1980), serving predominantly the new long-stay (Mann and Cree 1976) aims to provide high quality care in non-institutional small sized residential community care settings and was reviewed in Chapter 2. It was of note that few of these studies had evaluated the units longitudinally, most concentrating on the period after opening.
The protocol used to assess the unit in this earlier comparison (Allen, Gillespie & Hall 1989) was used longitudinally to assess the impact of transferring the unit to a community setting.

The unit was evaluated six months prior to its closure (as part of the previous study), at 18 months and also 42 months after its relocation to ordinary houses in the community.

The present study sought to answer the following two questions:

1. How are aspects of quality of care in a unit affected by transfer from a hospital to community setting?

2. How does the unit continue to function over a period of time?
The Unit

The ward prior to its move was described in the previous study. The community unit opened in July 1987 consisted of a row of terraced houses on a modern housing estate. The maximum capacity of each house was three with each resident having their own bedroom, and sharing kitchen, living room and bathroom facilities. Four such adjacent houses gave the unit a maximum capacity of 12 residents.

A nearby day-care facility on the same estate was available and utilised by some of the residents as appropriate in addition to others in the locality who required such a facility. The unit was 10 miles from the original hospital campus, which was on the opposite side of the town.

The Residents

The unit continues to operate as a rehabilitation unit. As such it does not offer permanent residential care but is seen as a preparatory stage to more independent functioning in the community.

The six-months-prior-to-closure ward population consisted of 12 residents (4 male and 8 female) with a median age of 44 years (range 20-65); the population after 18 months of the house
unit consisted of 6 residents (5 male and 1 female) with a median age of 29 years (range 20-59); and the 42 months' population consisted of 6 residents (4 male and 2 female) with a median age of 29 years (range 20-45).

There is a significant difference in the age of residents of the unit from the ward assessment and to both 18 months ($u = 15$ $p > 0.05$) and 42 months ($u = 8.5$ $p > 0.02$), but not between the latter two periods. The average length of stay on the unit was 1.98 years, 0.41 years, and 0.56 years respectively. Total average length of contact with psychiatric services was 9.31 years, 7.43 years, and 2.57 years respectively.

The resident populations were different at each evaluation point with no resident appearing in the unit at more than one point.

**The Staff**

All staff covering the active day of the patients (7-9am) were included. The ward staff consisted of 13 individuals, four qualified staff and nine student nurses; the 18 month staff 12 individuals, four qualified and eight student nurses; the 42 month staff 8 individuals, seven qualified and one student nurse.
The reduction in total staffing complement has taken place alongside an increase in the proportion of qualified staff. The average age of staff had increased significantly from 25 years to 33 years at 18 and 42 month follow ups (u = 23 p>0.04).

The cumulative effect of both the residents and staff groups average change in age was to move from care being provided by a younger generation on the ward to carers and residents being of the same generation by the end of the study.

Twenty eight different qualified staff worked in the unit over the time period of the study.

One individual appeared in two different evaluation periods at 18 and 42 months. Of the 22 staff who had left the unit, 15 had transferred within the health district and 7 had left for personal reasons such as further studies, child rearing or jobs in other parts of the country.

The Measures

This study used the measures described at the start of this chapter:

REHABILITATION EVALUATION - HALL AND BAKER (REHAB)
MANAGEMENT PRACTICES QUESTIONNAIRE (MPQ A & B)
OPTIMISM/PESSIMISM SCALE (OPS)
PERCEIVED INVOLVEMENT-PERSONAL QUESTIONNAIRE (PI PQ)
DIRECT OBSERVATION SCALE
In relation to this final assessment the first verbal interaction occurring within a 30 s observation period was again categorised in terms of its type, content and quality. The observations took place between 3.45pm and 5.00pm, the time when residents returned to the units from their daily activities. Data was collected on 11 occasions on the ward, 9 occasions at 18 months' follow-up, and 7 occasions at 42 months' follow-up, each time over a number of weeks. The average number of ratings per staff member was 28 (range 10-45), 53 (range 30-65) and 35 (range 15-65) respectively.

Results

Rehabilitation Evaluation Hall and Baker

The residents' level of functioning was assessed using REHAB during each evaluation period. This would indicate if the population had changed in any way over time in relation to the residents' overall level of need. The median total general behaviour (TGB) (Table 5) showed a significant reduction in the level of need of the residents between 1987 and 1989 (u=15.5 p<0.05) and 1987 and 1992 (u=9 p<0.03). In 1987 the average TGB was within the "moderate disability" category of the REHAB scale, but in 1989 and 1992 the average is within the "discharge potential" category.
There were also significant differences in the level of self care skills (u=11 p<0.04) and level of community skills (u=7 p<0.01) between the 1987 and 1992 populations. Between 1987 and 1989 these changes had not been significant but the trend indicated by the scores for these two periods had been in the same direction which indicated residents had become increasingly skilled in these areas (Table 5).

### TABLE 5: COMPARISON OF STAFF AND CLIENT VARIABLES IN THE UNIT IN SIX MONTHS PRIOR TO MOVE, AND 18 MONTHS AND 42 MONTHS AFTER THE MOVE TO THE COMMUNITY

<table>
<thead>
<tr>
<th>-6 Months</th>
<th>18 Months</th>
<th>42 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>n=12</td>
<td>n=6</td>
<td>n=6</td>
</tr>
</tbody>
</table>

#### Client Variables:

| Age       | 50.17 | 16.36 | 20-65 | 31.67 | 17.1 | 20-59 | 30.4 | 6.73 | 20-45 |
| REHAB     |       |       |       |       |      |       |      |      |       |
| Total Deviant | 1.92 | 1 | 1.56 | 0-6 | 1.33 | 1 | 1.86 | 0-6 | 1.4 | 1 | 2.19 | 0-6 |
| Social Activity | 22.42 | 20 | 13.01 | 5-35 | 14 | 14 | 8.74 | 6-25 | 14 | 14 | 11.18 | 4-26 |
| Speech Disturb. | 2.33 | 2 | 2.39 | 0-6 | 1.33 | 1 | 1.96 | 0-6 | 2 | 2 | 2.45 | 0-6 |
| Self Care | 11.42 | 11 | 7.4 | 5-20 | 6.17 | 6 | 5.81 | 0-15 | 3.2 | 3 | 3.7 | 0-9 |
| Comm. Skills | 9.42 | 9 | 5.48 | 5-15 | 5.33 | 5 | 4.37 | 0-11 | 1.4 | 1 | 2.19 | 0-5 |
| Overall Rating | 4.83 | 4 | 1.75 | 2-6 | 2.83 | 2 | 2.64 | 2-6 | 2.2 | 2 | 2.68 | 2-5 |
| Total General | 49.08 | 49 | 21.75 | 18-85 | 28.67 | 28 | 20.57 | 6-65 | 23.8 | 22 | 18.38 | 5-55 |

#### Staff Variables:

| Age       | 26.85 | 7.55 | 19-45 | 27.14 | 8.09 | 20-50 | 34.13 | 7.04 | 21-45 |
| MPQ(B)    | 8.84 | 8 | 2.48 | 4-14 | 5.72 | 4 | 3.35 | 1-10 | 3.88 | 3 | 2.75 | 0-8 |
| MPQ(A)    | 6.62 | 6 | 3.50 | 2-12 | 2.43 | 2 | 3.65 | 0-10 | 2.38 | 2 | 1.85 | 0-6 |
| OPS       | 11.31 | 11 | 4.80 | 2-20 | 11.57 | 11 | 6.58 | 0-23 | 9.13 | 9 | 9.08 | 0-25 |
| PIPQ      | 10.85 | 9 | 4.00 | 0-18 | 10.71 | 9 | 8.64 | 0-22 | 5.88 | 5 | 5.44 | 0-15 |
Following the unit's move to the community it is serving a resident group that is more capable. This may be due to the new demand characteristics of the house, compared with the ward, with residents having to be more able to function in the new setting. A further possible explanation is a change in the population source, this being seen in the change of the profile of the hospital population whose old long stay population had declined both in terms of actual numbers and as a proportion of the total population, which had also seen a proportionate increase in the new long stay population (Mann and Cree 1976) which had increased from 15% to 24% between 1987 and 1993 (Allen et al. 1993).

MANAGEMENT PRACTICES QUESTIONNAIRES

The scores for the actual management practices (MPQ Form B) (Table 5) were significantly different between the evaluations in 1987 and 1992 \( (u=23 \ p<0.05) \) reflecting an increased individual orientation. This appeared to be reflected in the actual practices observed in the unit. Resident orientated attitudes were significantly correlated with the number of months staff had spent working on the units \( (r=-0.47, p<0.01) \) an association also seen in Garety & Morris' study. The MPQ score once the unit became a community based facility is similar to the mean score of 6 found by Garety and Morris (1984).
ATTITUDES CONCERNING MANAGEMENT PRACTICES

There is a significant reduction in the scores (Table 5) between both 1987 and 1989 (u=16 p<0.01) and 1987 and 1992 (u=16.5 p<0.01). As found in the earlier study (Allen et al. 1989) the scores obtained for attitudes concerning management practices at each point in time are lower than the scores for actual practices.

OPTIMISM-PESSIMISM SCALE

There was no significant change in the average scores for this scale (Table 5).

PERCEIVED INVOLVEMENT

There is a significant difference in the average scores (Table 5) obtained between 1987 and 1992 (u=22 p<0.03). This perception of increased involvement in decision making regarding work decisions appeared to be reflected in practice and may have been in part related to organisation change. Such organisational change may well lead to improvements in staff functioning, as Raynes et al. (1979) found that the strongest predictor of staff performance was perceived involvement in decision making.

155
STAFF-RESIDENT INTERACTIONS

Interaction type, content and quality were evaluated and compared. In the earlier hostel-ward comparison (Allen et al. 1989) whilst significant differences had been found when comparing staff questionnaire data no significant differences were found for observational categories between the two units.

A comparison of observation data between 1987 and 1989 indicated a number of significant differences. 'Nil' interactions had significantly decreased ($u=6689 \ p<0.0002$) as had staff-staff interactions ($u=6597 \ p<0.0002$). Staff-Resident interactions had significantly increased ($u=4774 \ p<0.0001$) as had the level of personal problem solving interactions ($u=6527 \ p<0.0005$) and accepting interactions ($u=7330 \ p<0.05$). By the time of the follow up in 1992 staff-resident interaction levels had declined when compared with 1989 when the unit had been new ($u=16882.5 \ p<0.0001$) but had not fallen to the level seen on the ward in 1987 ($u=13986 \ p<0.001$). Similarly there was evidence of an increase in staff-staff interactions ($u=18476.5 \ p<0.0001$) between 1989 and 1992.

In terms of the type of interactions seen on the unit more interactions of a personal problem solving nature were evident in both 1989 and 1992 than in 1987 ($u=6527 \ p<0.0005$, $u=13373 \ p<0.0001$) with no significant difference seen between 1989 and 1992. The level of administrative interactions was not
significantly different between 1987 and 1989 or 1987 and 1992, but there was a significant decrease in interactions of an administrative nature between 1989 and 1992 (u=20506.5 p<0.05).

The quality of interactions had also showed patterns of change over the lifetime of the unit. Levels of accepting interactions had continued to increase throughout the units lifespan showing significant increases between 1987 and 1989 (u=7330 p<0.05), 1987 and 1992 (u=11670 p<0.0001) and 1989 and 1992 (u=18268.5 p<0.0001). The level of tolerating interactions had not significantly altered between 1987 and 1989, but had significantly decreased when 1987 and 1992 (u=14179 p<0.0005) and 1989 and 1992 were compared (u=17129 p<0.0001). The level of rejecting interactions had not altered throughout the study.

Discussion.

As the policy of community care has progressed and the large psychiatric hospitals continue to decline in size and number, alternative community based facilities have developed but with little information concerning their effectiveness or functioning over a longer period of time.

The new "hostel-ward" facilities have proved to be effective (Birchwood and Shepherd 1992) but may not be typical of hostels in less well resourced areas and in the main have been evaluated when relatively new. Other studies concerning
both day units (Shepherd and Richardson 1979) and residential units (Allen et al. 1989) have suggested some evidence of institutional practices being relocated to community settings. This study sought to evaluate aspects of quality of care, and the needs profile of residents over a five year period, which included the period prior to its relocation from a hospital to community setting, the period immediately following its relocation and a period following its operation for a number of years. An earlier study (Allen et al. 1989) had established that prior to its move the unit had been operating well.

In relation to the two questions posed in the introduction this longitudinal study suggested:

1. With respect to quality of care, on the questionnaire measures the unit had improved over time. This particularly followed its relocation to smaller community based houses. A number of factors may have had an influence in accounting for the changes noted. These include greater access to community facilities, and an improvement in the physical and social environment. These different demand characteristics may have led to different admission criteria, which may have led to a reduction in demands upon staff and allowed consequent improvements in care.

2. While questionnaire measures have continued to reflect improvements in quality of care as assessed by those measures, this has not been the case for the interaction level measure,
were the pattern has been more complex. There was a fall in overall interaction levels when data from 42 months was compared with data from 18 months, but this reduction was not back to the levels seen on the ward. This may indicate a "honeymoon" period when the unit was relatively new. The level of accepting interactions has continued to increase, in spite of a high level of staff turnover and its possible effect on consistency of care.

It is difficult to extract many clear findings from this study due to the major changes in care provision occurring during its duration. These changes and their effect on the studies undertaken are more fully discussed in the final chapter. However a number of factors would be worth considering in relation to their effect upon quality of care.

Effect of Relocation

A number of studies show positive results following a move from hospital to community settings. Shields, McGuiness and Macflynn (1995) cited no change in mental state, but less reported problems and greater satisfaction after moving to the community for their subjects, Reda's (1994) study described some deterioration in mental state but positive improvements in social networks, hygiene and attitudes towards community living following relocation, and Holloway and Faulkner (1994) describe improvements in social functioning but no change in level of problem behaviour for those included in their study.
Change in Physical and Social Environment

One of the largest changes observed was in relation to interaction levels, with levels increasing following the relocation to community setting. These changes may be explained by the effect the houses had on the staff group, effectively breaking them into smaller groups, staff were often observed working individually with clients in the community rather than part of a larger group with other staff as on the ward.

The more homely physical and social environment may have also contributed to lessening the distance between staff and client groups, as might the increasing age similarity.

Change in Base Population

The impending closure of the hospital or origin and the reduction in the population of the continuing care wards from 11 wards and 144 in-patients at the start, to 3 wards and 62 in-patients at 42 months follow-up and subsequent closure one year later, did have an effect upon the community based rehabilitation unit.

Residents' length of stay decreased and length of contact with psychiatric services was shorter at each evaluation point, the impression was of people being pushed through the care
system at an increasingly faster rate, Reid and Garety (1996) also note that duration of stay on the unit they evaluated decreased by almost fifty percent over 16 years.

Client Selection

There is also some evidence that new community services may select the more able (Repper and Perkins 1995) and there are ongoing concerns about the ethical issues surrounding the provision of domestic style, community based accommodation for those with severe long term mental health problems (Dilks 1995).

Client Needs

It was not possible to control for the needs of the clients in the unit and this may had had an influence upon the quality of care offered. As the hospital population decreased and the proportion of new long-stay clients increased, the population served by the rehabilitation unit became less homogenous. The impending hospital closure could have affected staff morale and this may, in part, account for the high level of staff turnover, also seen.
This study also raised questions concerning the utility of current methods of assessing quality of care in community settings:—

**Limits of Measures: Reactivity**

The measures were in some respects at the limits of their utility in small community settings. Reactivity effects when using the observational measure were more of a concern in the smaller settings.

The definitions and classification sheet of Garety and Morris were used at each evaluation period. Inter-rater reliability studies were carried out for the ward evaluation and reported in Allen, Gillespie and Hall (1989), all were significant at the p>0.001 level. Inter-rater reliability checks were not repeated for the community follow-ups, but the same rater was used for all three evaluations and it was felt that the presence of a second rater might increase the likelihood of reactivity occurring, as typically observations were taking place with 2-4 other people present in addition to the observer in the community, whilst in the ward setting typically 4-12 other people may have been present. Two observers in the house settings could have represented 50% of the total population present. Using permanent unmanned video cameras would be an alternative way of collecting data but could be intrusive in attempts to create homely settings and would have to be agreed with residents.
Limits of Questionnaires: Inappropriate Items

The questionnaires developed for use in larger settings had a number of items that were inappropriate in smaller community settings. For example, on the MPQ scales, items referred to use of the grounds, visiting times, waiting in line prior to breakfast, bathing of residents and access to the kitchen, and on the OPS scale an item referred to possible functioning if living in ordinary houses.

To some extent staff were increasingly aware of the concepts underlying attitude questionnaires and may give acceptable or desirable answers. In this context it is important to use a behaviour based assessment which ascertains how staff actually operate rather than how they say they do.

Use of Appropriate Language

In this study it was important to continue with the assessments utilised in the first evaluation in 1987 to aid a longitudinal comparison.

However, the REHAB scale uses language that some staff considered to be labelling, and negatively discriminatory such as "deviant behaviour", and also included items no longer
considered relevant in community settings such as 'absconding'. Alternative assessments such as the Camberwell Assessment of Need (Phelan et al. 1995) may be more appropriate in community settings.

Problems with Concept of Quality

Concepts concerning "quality" and its measurement have continued to develop since this study was started. A notable absence in this paper is an assessment of the residents' own views of quality of life. A number of studies have emphasised the importance of listening to users (Barnes and Wistow 1994, Brown 1992) and have attempted to look at service quality via users views and quality of life measures. Studies including such methods in this country include Ehlert and Griffiths (1996) who used quality of life indices to compare day and inpatients experiences, Holloway and Faulkner (1994) who looked at users views as a means of evaluating moving to the community and Wykes and Carroll (1993) who looked at the provision on an intensive care ward. Carson and Sharma (1994) have also emphasised the importance of staff views in addition to users views. Articles concerning methodological issues (Barry, Crosby and Bogg 1993) and concepts underlying quality of life (Oliver, Holloway and Carson 1995) suggest that the field is still in a relatively early stage of development and that the approaches underlying qualitative and quantitative methods require bringing together (Hayward, Peck and Smith 1993). Following the use of the Goodmayes interview schedule (Abrahamson, Swatton and Wills
1989) in other mental health units in the health district concerned (Allen, Clarke and Tanker 1991) this assessment was used in the 'houses' setting to ascertain residents' views. This helped to identify a number of practices that still created difficulties for residents, but that were not covered in the measures used in this study. These included attitudes of night staff, access to notes, and the style of interaction of particular staff members rather than the staff en masse. Similarly assessments covering other aspects of the units functioning, covered by new measures such as QUARTZ (Leiper et al. 1992) could have usefully identified other changes in care following the relocation.

Summary

This study suggests that it is possible to relocate a hospital based rehabilitation unit to a community setting whilst continuing to maintain a high level of quality of care. The measures used suggested that such house based units offered distinct advantages in terms of increased interaction levels and more individualised care practices. These improvements occurred despite high staff turnover, changing clients' needs and the changing pattern of service provision typical of many health trusts facing the closure of a large psychiatric hospital.
It was also apparent that work in the following three areas would be important to understand the impact of hospital closure and the effect on the unit studied:—

1. An understanding of users views of their quality of life both in hospital and community settings.

2. Given that change of profile of the units population over time, and evaluation of the hospital population over the same time period to help understand the reason for the changes seen.

3. The interaction schedule appeared from this study to be one of the more robust methods of evaluating quality of care, further studies to improve this measure by the addition of categories and the use of modern technology to use the schedule in 'real time' to test assumptions regarding duration appeared worthwhile.

Studies in these three areas are reported next, commencing with two in the latter area which are briefly outlined below.
STUDY 3

A study which sought to further develop a measure of interactions and use the measure with a different population to assess change in practice on a unit.

This study added further categories to the interaction measure to give a fuller picture and used the measure to evaluate changes in practices on a ward for older people.

STUDY 4

A study which further develops the measure described in Study 3 and explored some of the assumptions the original measure was based upon.

This study added further categories to the interaction measure and by the use of a computerised event recorder used the measure in real time rather than via time sampling. This measure was then used on a continuing care ward to evaluate some of the assumptions underlying interaction measures.
This study sought to further develop the measure of interactions used in studies 1 and 2, and then to use the measure to evaluate the effect of programme interventions focused upon staff education and extra ward activities on levels of interaction on a ward for older people (Published as Allen and Turner 1991).

Developing the Interaction Measure.

Observational methods have been strongly recommended for studying quality of care in residential environments (Shepherd et al. 1995, Clark and Bowling 1990). The Garety and Morris (1984) measure used in the previous study had the following limitations:

1. It does not address resident-resident interactions. Poole et al. (1981) and Gelfand et al. (1967) have both questioned the emphasis placed upon staff-resident interactions, they both argued that resident-resident interactions may be better predictors of care quality, and an environment which encouraged such interaction as offering good quality care.
2. Content category lacks specificity. In practice, interaction that are not administrative are categorised as personal problem solving as no other category is available. This assumes that any interaction that is not administrative is of a therapeutic nature. To some extent this is an assumption underlying the observational measure, however some interactions may be seen as more therapeutic than others, eg. counselling in relation to an emotional upset could be argued to be more therapeutic than discussing the weather.

3. Quality category ignores age-appropriateness. An example cited in Study 1 concerning going to the shops, eg. "You are a good boy" versus "What have you bought?", both categorised as accepting, indicated that paternalistic age-inappropriate interactions are not separately identified from other interactions.

Quality of Care in Settings for Older People

Since Townsend (1962) a number of authors have noted that the lack of activity, lack of interactions with others and lack of opportunity for participation in activities are often the most distinctive features of institutions caring for the elderly mentally infirm. Armstrong-Esther and Browne, (1986) noted that, typically on geriatric wards, patients had no active role with little involvement in their own care, and appeared to sit day after day waiting to die. Spence (1985) has suggested that part
of the reason for the low level of interactions between staff and residents may be due to the absence from nurse education of adequate communication skills training. Havinghurst (1968) has emphasised the importance of communicating with others, and Knapp (1977) the need to engage in meaningful activities.

Bromley (1978) suggests that communicating with older people is different from communicating with younger age groups. He argues that in particular "social signalling" is affected with a marked decrease in mobility, responsiveness and use of body language, such as, eye contact, gesture, posture and expressiveness. Hence, due to such differences in response, a young carer and an older patient may experience a failure to communicate unless such differences are taken into account.

The findings of a study by Tobin and Neugarten (1961) using the Life Satisfaction Ratings and Interaction Index, indicated that social interaction is positively associated with life satisfaction for those of all ages who participated in their study.

Interaction level, as measured by engagement, has been used as an indicator of the quality of care of older people in institutional settings (McFadyen, 1982). Blunden and Kushlick (1975) have defined engagement in the following way:- "A person may be said to be engaged... if he is reacting with materials or with people in a manner which is likely to maintain or develop his status and abilities".
Armstrong-Esther and Browne (1986) have found that nurses interact significantly less with confused and dependent patients when compared with lucid patients.

Studies aimed at decreasing institutional aspects of the environment (Hitch and Simpson, 1972; Gupta, 1979; Adams et al, 1979) have been shown to lead to increases in activity. It can be argued from this that while increased engagement does not ensure a better quality of life improved quality of life would normally involve increased engagement.

Studies by Jenkins et al. (1977); Powell et al. (1978) and McCormack & Whitehead (1981), have shown the beneficial impact on level of engagement of introducing various materials and activities. Allen and Bennett (1984) also describe a number of interventions which may be of use in improving the quality of life of older people on continuing care wards. Recent research regarding residential care for older adults suggests quality of care (measured by the quality and quantity of staff-resident interactions) may be higher in newly developed community units compared with traditional long-stay wards (Bond & Bond 1990, Clarke & Bowling 1990, Lindesay et al. 1991, Skea & Lindesay 1996). Generally, these newer units appear to be associated with higher levels of job satisfaction in direct care staff, suggesting that this improvement in quality of care may not be detrimental to staff (Philp et al. 1991, Lindesay et al. 1991).
Levels of stress and job satisfaction in direct care staff appear to vary considerably between different residential units for older people (Lindesay et al. 1991, Baillon et al. 1996, MacPherson et al. 1994). Not much is known about the causes of stress in direct care staff, although it appears to be linked to both organisational factors and resident behaviours (MacPherson et al. 1994, Baillon et al. 1996). One additional possible cause of stress is the impending closure of a unit. Long-term care for older people is increasingly being provided via nursing homes and residential homes in the private sector. The unit in this study faced closure as the Trust concerned withdrew from providing long-term care. The unit has since closed. Faced with closure and evidence that staff-resident interactions are higher in new residential units, an intervention programme was designed with an emphasis on staff training (e.g., communication skills) and the introduction of additional activities. Based on these earlier studies the following hypotheses were generated:

1. That staff training should increase knowledge and understanding of the needs of the patients in their care and lead to greater interaction levels.

2. That the provision of additional activities should result in an increase in the level of interaction of patients.
The study was also seen as an opportunity to further develop the assessment of interactions (Garety and Morris 1984) used in Studies 1 and 2, and to look at its applicability with another population.

**Method.**

**Setting.**

The study was conducted on a continuing care ward for elderly women. The ward was situated on the first floor and accommodated nineteen patients. Ward facilities consisted of two nightingale-type dormitories with curtains between each bed, and a common dayroom. The main part of the hospital was built in the nineteenth century, but additions including this ward's dayroom have been added more recently. Although the dayroom is well-lit being on the first floor there is not much of interest to see. Within the confines of such a setting attempts are made to make the ward as homely and personal as possible. It was planned to close the unit and this did occur two years later.

**Patients.**

Demographic variables and level of dependency was collected for the patients pre and post intervention. This is summarised in Table 6.
### TABLE 6: COMPARISONS OF PATIENT VARIABLES PRE- AND POST- INTERVENTION

**n=19**

<table>
<thead>
<tr>
<th>Resident demographic and scale information</th>
<th>Pre Intervention Median</th>
<th>Post Intervention Median</th>
<th>Mann-Whitney U</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age CAPE</td>
<td>81</td>
<td>83</td>
<td>152.5</td>
<td>0.418</td>
</tr>
<tr>
<td>IO</td>
<td>8</td>
<td>10</td>
<td>8.5</td>
<td>0.93</td>
</tr>
<tr>
<td>MA</td>
<td>7</td>
<td>7</td>
<td>15.0</td>
<td>0.523</td>
</tr>
<tr>
<td>PD</td>
<td>6</td>
<td>7</td>
<td>112.5</td>
<td>0.046*</td>
</tr>
<tr>
<td>AP</td>
<td>7</td>
<td>7</td>
<td>151.0</td>
<td>0.401</td>
</tr>
<tr>
<td>CD</td>
<td>1</td>
<td>1</td>
<td>148.5</td>
<td>0.354</td>
</tr>
<tr>
<td>SP</td>
<td>0</td>
<td>0</td>
<td>179.5</td>
<td>0.977</td>
</tr>
<tr>
<td>BRS</td>
<td>14</td>
<td>15</td>
<td>137.5</td>
<td>0.212</td>
</tr>
<tr>
<td>Faces</td>
<td>3</td>
<td>3</td>
<td>19.5</td>
<td>0.943</td>
</tr>
</tbody>
</table>

*Statistically significant at the 0.05 level.

IO = Information  
MA = Mental Ability  
PD = Physical Disability  
AP = Apathy  
CD = Communication Difficulties  
SP = Social Problems  
BRS = Behaviour Rating Scale (PD+AP+CD+SP)

The median age of the patients pre-intervention was 81 years. The age range was from 60 years to 97 years. The median age post intervention was 83 years. The age range was from 63 years to 98 years. There were 19 patients on the ward on both occasions, nine of whom were in both pre and post groups. The length of stay on the unit and the total period of time in
contact with hospital services, were not significantly different for pre and post intervention groups. The average length of stay on the ward for the pre-intervention group was 0.487 years, and for the post-intervention group was 0.349 years. The average total period of contact with hospital services was 1.297 years for both pre and post intervention groups. The Clifton Assessment Procedures for the elderly (CAPE); Pattie and Gilleard (1981), was used to assess level of dependency. The CAPE consists of two subparts: a cognitive assessment scale (CAS) and a behaviour rating scale (BRS) which, when combined, measure each individual's dependency level. The cognitive assessment scale measures the patient's orientation, mental ability and psychomotor skills. The behavioural subsection is conducted with a member of staff familiar with the patient, usually a nurse. It consists of a set of questions which, when scored, gives an overall picture of how the patient is functioning. It scores in four categories: physical disability, apathy, communication failure and socially irritating behaviour. The psychomotor assessment was not used due to a number of the patients physical disabilities. The patients' level of dependency was compared pre and post intervention. There were no significant differences between the two groups of patients in overall dependency level or on category subscales apart from level of physical disability (U=112.5  P<0.05), indicating a greater level of physical dependency in the post intervention group. This did reflect greater demands for physical care on the staff. There were no significant differences in the scores of the 9 individuals on the ward on both occasions.
Staff.

The staffing complement of the ward is comprised of a ward manager, a staff nurse, two state enrolled nurses, six full-time nursing auxiliaries and two part-time nursing auxiliaries. There is a vacancy for a part-time enrolled nurse and the money from this is used to employ Bank Nurses when the need arises to help provide safe 'cover' for the ward. The night staff generally consists of one state enrolled nurse and one nursing auxiliary with a night sister providing administration for two or three wards. Day nursing staff remained the same throughout.

The Measure.

Direct Observation Schedule.

The schedule was a development of that used in Studies 1 and 2. This schedule focused on interactions of staff members with patients or other staff. Whilst the schedule was originally used with a different client group; people with an enduring mental illness, it was felt that both client groups having long-term disabilities have traditionally been offered services in similar settings with the danger of institutionalisation and low interaction levels resulting.

This adaptation also covered interactions between patients, and also patient interaction with others (eg. visitors). It was felt important to include interactions other than staff-patient,
as findings such as those of Gelfand, Gelfand and Dobson (1967) have suggested that interactions with others may be as therapeutic as with staff. Recent surveys, for example Rogers, Pilgrim and Lacey (1993) of users, have produced ratings of other patients as the second most useful resource to help with their problems. A further category of social/environment was introduced as it was felt that in the previous studies, that any interaction not classified as administrative had been classified as personal problem solving. Social setting and age appropriateness were introduced to give a fuller picture of interactions.

The first verbal interaction occurring within a set 30-second period is categorised in the following way:

a. Type: Staff-resident, resident-resident or resident-visitor and also interaction initiator.

b. Content: Personal problem-solving, administrative or social/environment.

c. Quality: Accepting, tolerating or rejection.

d. Social setting: Solitary, with one other or in a group.

e. Age-appropriateness: Age appropriate or non age appropriate.
A classification guidance sheet was followed precisely by raters. Recordings were also made of the activity that the patient was involved in when the interaction was observed and whether no interaction occurred. The observations were carried out throughout the day, with a grid being devised to ensure residents were all observed at similar points during the day. In total over 12,000 observations were made. Each resident was observed for 5 consecutive 30s periods with 30s gaps between each observation for recording. As the schedules were different from the original inter-rater reliability studies were carried out for 400 observations, approximately one-third of the data.

The Kappa correlation coefficient was used to assess inter-rater reliability. The reliabilities are given in Table 7 and all were significant at the p<0.001 level. This suggested that the original scale could have categories added to it without this compromising reliability, and the schedule could be used to evaluate quality of care in a variety of residential settings, eg. for people with enduring mental health problems, people with learning difficulties, and older people. This had been the main aim of this study.
**TABLE 7: INTER-RATER RELIABILITIES ON DIRECT OBSERVATION**

<table>
<thead>
<tr>
<th>Observational Category</th>
<th>Activity</th>
<th>Social setting</th>
<th>Interaction initiation</th>
<th>Type of response from other</th>
<th>Content of interaction</th>
<th>Age appropriateness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correlation coefficient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First set of raters</td>
<td>0.95</td>
<td>0.99</td>
<td>0.96</td>
<td>0.95</td>
<td>0.95</td>
<td>0.96</td>
</tr>
<tr>
<td>(pre-intervention)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second set of raters</td>
<td>0.97</td>
<td>0.98</td>
<td>0.98</td>
<td>0.99</td>
<td>0.99</td>
<td>1.00</td>
</tr>
<tr>
<td>(post-intervention)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**View of life on the ward.**

The patients were all asked to rate their subjective experience of life on the ward via a simple seven point visual analogue scale. This consisted of seven statements on a continuum ranging from very happy to very sad. This was accompanied by seven illustrations of simple faces with different expressions to match the appropriate statement, which were used for people who had difficulty reading.

**Interventions.**

The interventions had two main focuses:-

- To increase staff's knowledge of the psychological factors of health care via a series of staff education sessions.
- To stimulate the patients' interest by an increase in the number of activities, variety of choices available, and opportunities for conversation. Interventions were typical of
the type used with this client group, eg. music sing-along sessions, low-key physical activity sessions, bingo, reminiscence sessions etc.

The Roper, Logan and Tierney (Roper et al. 1980) model of the Nursing Process is used on the ward, and the interventions were integrated into this model of nursing care. The multi-disciplinary team were fully involved in the project and gave it their backing. A small core team consisting of ward manager, occupational therapist, health promotion facilitator, clinical psychologist and the hospital manager met regularly to monitor and advise. The ward manager was responsible for implementation and co-ordination at the ward level.

Numerous studies have attempted to improve patients quality of care, most, for example (Allen and Bennett 1984), have described the problems inherent in ward settings where little stimulation is present and gone on to enthusiastically describe interventions, changes to routine and staff education assuming any such changes must be positive, but with little evidence to back up their assumptions.

Results.

Direct Observation Schedule.

The measure was used pre-intervention and post-intervention four months later. The results of the two periods of time sampling were then compared. For the majority of observation
categories there were no significant differences pre and post-intervention. Differences were found for the following observational categories using the Mann-Whitney statistic at the p<0.0001 level. These were time spent solitary (u=28519), overall level of interactions (u=38517) and level of responses (u=39448.5). They were in the opposite direction to those predicted with residents spending more time solitary, being involved in less interactions and having less responders post-intervention. An inspection of the data suggested that whilst the level of staff-client interactions had dropped post-intervention, that client-other interactions had risen - but that this accounted for only a small part of the time in the day room.

A correlation was found between an increase in the number of people a patient sat with and the likelihood of them being engaged in an interaction. There was also a correlation between engagement in an activity and level of interactions indicating that those patients who were engaged in an activity were more likely to also interact with others.

Own view of life on the Ward.

The average rating was three which represented not happy or sad both pre and post intervention. This represented no significant difference in how patients were viewing their life on the ward (Mann-Whitney u=19.5 p < 0.943) using this measure.
Discussion.

The results of this study indicated that the original hypotheses could be rejected. These were that staff training would increase knowledge and understanding of the needs of patients and lead to greater interaction levels, and that the provision of additional activities would result in an increase in the level of interactions between patients.

A number of possible factors may account for this:-

Whilst there were no significant differences between the two groups of patients in overall dependency level, there was a significant difference in the level of physical disability with the post-intervention group being more dependent. The study of Armstrong-Esther and Browne (1986) demonstrated that nurses interacted significantly less with confused patients, it may be that nurses in this study were less likely to interact with physically dependent patients when compared with those more physically able.

The increase in ward activities involving extra input from sources additional to the ward team may have led to the staff disengaging from activities in the dayroom. A staff attitudes measure might have been able to ascertain how staff had reacted to this input, as it may have been seen as an opportunity for staff to leave the dayroom and attend to other duties.
Relying upon interactions alone as an outcome measure in relation to quality of care is too narrow. The use of other outcome measures such as staff attitude questionnaires, number of patient needs met, and staff knowledge of and adherence to objectives of training may have given a clear impression of the effect of interventions. The targeting of specific measures to appropriate specific interventions would perhaps offer a more accurate impression than an overall measure of interaction. Particularly as it remains an assumption that an increase in interaction level is directly linked with improved care.

A further problem in interpreting the results was the sheer number of interventions and staff training used. A more sensible approach may have been to limit the changes made on the ward which would have led to a clearer understanding of the effectiveness of specific changes. The study as undertaken gave no firm indication of which patients were likely to benefit from it, in what way they would be helped, and whether changes seen would be transient or lasting.

The period between the observations pre and post-intervention may not have been long enough for the interventions used to have an effect on staff behaviour. A follow-up study would have been useful in judging the long-term effects of the intervention but a hospital re-organisation has made this impossible.
Although attempts were made to integrate teaching with clinical practice greater efforts to ensure active use of knowledge gained may have improved intervention results.

The ward operated using the nursing process. A change to a key-worker or primary nursing system could have enabled the interventions to be more successfully adopted. However there is still a need to evaluate such approaches and demonstrate that they do lead to the benefits often assumed.

This study suggests that it is naive to assume that interventions on their own will automatically lead to improvements in care as measured by interaction level. Producing change is a complex issue and this project would suggest that an understanding of the process of change is as important as the use of techniques assumed to produce change.

In relation to the interaction measure used this study demonstrated that additional categories giving a fuller picture of interactions could be added to the schedule without affecting reliability, and that the measure did have some utility in evaluating care for individuals with long term mental health problems such as people with learning disabilities, chronic mental health problems and disabled older people. However the study would suggest caution in using interaction level as the single indicator of care quality.
STUDY 4: INTERACTION CONTENT, QUALITY, DURATION AND RESPONSE:
The Use of an Event Recorder on a Unit for People with Long Term
Mental Health Problems:

The quality, content and frequency of interactions have been correlated with management practices and have been cited as evidence in favour of one psychiatric care setting over another [King et al, 1971, Garety and Morris, 1984]. However, as Shepherd [1984] has pointed out these positive correlations are of little utility unless their effect upon residents can be demonstrated. In the previous three studies, time sampling has been the method used to evaluate interactions and it has not been possible to evaluate some of the assumptions concerning interaction categories. The use of an event recorder allowed the possibility of studying interactions in real time and the testing of some of these assumptions. The study reported here tested the following hypotheses based on these assumptions.

Hypothesis 1.

The duration of "personal problem solving" interactions are predicted to be longer than other content types, owing to their greater emphasis on the individual.
Hypothesis 2.

The duration of interactions will vary as a function of the quality of an interaction. "Accepting" interactions are predicted to last longer than "tolerating" or "rejecting" ones, on the assumption that residents will be more responsive to warm, encouraging styles of interaction.

Hypothesis 3.

The level of staff training is expected to be associated with the proportion of "accepting" interactions between the staff and residents. The direction of association is not specified since Garety and Morris [1984] and Allen et al. [1989] report conflicting findings: the former finding a positive correlation and the latter a negative one.

Hypothesis 4.

The duration of interactions will vary as a function of residents' responses. Positive responded interactions lasting longer than neutral or negative ones.

The hypothesis is based on the assumption that residents will maintain interactions that they are more satisfied with.

186
Hypothesis 5.

It is hypothesised that residents will respond with higher levels of "positive" responses to staff members who use a high proportion of "accepting" interactions.

Residents will find "accepting" styles of interaction more satisfying than "tolerating" or "rejecting".

Hypothesis 6.

Staff using higher proportions of "personal problem solving" interactions will be associated with higher proportions of "positive" responses.

The assumption is that residents will find the more personal interactions more satisfying and pleasing.

Method.

The Setting:

The ward where the study was carried out was within a large brick building of classic Victorian architecture. Big rooms, long corridors and a central clock tower were a feature of this building.
The ward accepted both male and female clients between the ages of 20 and 65.

Its aim is to provide as normal an environment as possible, given the constraints of hospital provision, and to maximise residents' level of functioning within a supportive setting.

Furnishings on the ward were the usual hospital standard with one room carpeted, that is the no-smoking area, and the remainder of the floor is covered in lino. Although this is an open ward, there were still locked doors to the kitchen, bath area, office and on occasions, the bedrooms. Meal times were set and dinners brought up from the hospital kitchens. Cooking facilities were available and some of the residents did occasionally cook their own meals.

Each day the clients followed programmes which they had agreed with the staff. Generally this consisted of occupational therapy in the mornings and afternoons. A few of the residents make use of other options that include industrial rehabilitation work, attendance at a day care centre and community visits. Despite staff efforts there remained a few that did not participate in any organised activities except on an infrequent basis.
**Staff:**

Staff comprised of a ward manager, two staff nurses, two RMN and 3 SEN/M qualified staff, and two student nurses. The length of time that they each had been employed on the ward varied considerably with a range of nineteen months, to just four weeks in the case of the student nurses.

The day was organised on a shift system. Members of staff worked a variety of early [7.30 am to 2.00pm] and late [1.30 pm to 8.30 pm] shifts during each week. At the times of observation, there were generally three members of staff on duty, though the mean number was slightly above this at 3.15. The staff to resident ratio was approximately 2:9.

**Residents:**

The residents consisted of ten male and three female clients. Their mean age was 47 years with a range of 29 to 68. The amount of time had been in contact with the psychiatric services, varied from two years to 28 years, with an average of 15 years. The majority [11] had been diagnosed as suffering from schizophrenia whilst two were classified as exhibiting affective disorders.
The Measure:

The measure used for studying interactions is a further development of that used by Garety and Morris [1984] and Shepherd and Richardson [1979] which was developed further in the previous study [Allen and Turner 1991]. Interactions are recorded on two main categories, those of content and quality.

The measures describe the onset of staff and residents interactions, and in what manner the staff communicate with the residents. Information is also collected to determine whether each interaction is between staff and staff or staff and residents. "Staff-resident" will be used to describe any interaction between staff and residents, and is not meant to give an impression that the staff member initiates interaction.

The response of the resident and the initiator of interactions were also recorded in the study which is a development on the previous measure [Allen and Turner 1991], although resident-resident interactions were not recorded as in that study. The data was collected in ten minute sessions using a staff member as a focal subject. Interactions were categorised and their duration recorded simultaneously to their occurrence using an event recorder.
The Content:

Previous studies [Shepherd and Richardson, 1979, Garety and Morris, 1984, Allen et al, 1989 and Allen and Turner, 1991] have utilised two classifications, those of "administrative" and "personal problem solving". Both of these measures are retained in the present study, but added to them are categories of "social/environment" and "demands/prompts". It was thought necessary to include the latter categories to achieve a fuller picture of the interactions. With only the two classifications used in previous studies there is a danger that any interaction not "administrative" is going to be labelled "personal problem solving", whether or not it fits the category code. The definitions are given below:

Definitions Categories for Content:

1. Administrative:
   Functional interactions, giving instructions or information about work, clothes etc.

2. Personal Problem Solving:
   "Personal interactions", dealing with the individual's problems, recognising individual needs.
3. Social/Environment:
Interactions concerning events in hospital, in papers, television, occupational therapy etc. Conversation relating to things the interactors have been doing or done, to clothes, dinner, the weather etc.

4. Demands/Prompts:
Any demand other than related to nursing responsibilities or clients' programmes. Requests from residents not administrative in their nature.

The "administrative" and "personal problem solving" definitions are taken directly from Garety and Morris [1984].

The "social/environment" category is not a completely new measure. Altschul [1972] used a similar classification of "social chat" in her work on interactions in acute psychiatric wards.

The category of "demands/prompts" is also based upon work by Armitage [1986] who observed that typical resident-nurse interactions were of a supplicatory nature.
Quality of Interactions:

The measures for quality of interactions were taken directly from definitions given by Garety and Morris [1984]. These were as follows:

1. Accepting:
   Socially pleasant, friendly, warm, attentive, accepting and encouraging interactions.

2. Tolerating:
   Neutral, functional interaction or paying less than full attention.

3. Rejecting:
   Rejecting, ignoring, disapproving, perhaps critical and remaining distant, not encouraging interaction.

The Resident Response:

This was a new category used to give an indication of how residents responded to interactions. The resident's response was categorised using three behavioural codes. These were "positive", "neutral" and "negative". Definitions are as follows and are based broadly on those used by Poole et al. [1981].

193
1. Positive:
   Approval, agreement, acceptance, compliments, laughter, smiles, encouraging further elaboration. In general to be considered happy.

2. Neutral:
   No response, blasé', blank expression, not noticeably positive or negative.

3. Negative:
   Disapproval, disagreement, rejection, denial, discouraging continuation of interaction. Derogatory comments, frown, disgruntled or upset expression. Shouting, inappropriate or bizarre behaviour.

Other Behavioural Categories:

As well as the three major classifications of an interaction [content, quality and response], there were four other behavioural categories recorded.

Type of interaction:

Staff-staff or staff-resident interactions.

Initiator of Interaction:

Staff or resident initiated interaction, either by the first verbalisation or by physical approach of staff or resident.
Off the Ward:

Keyed during time that the focal subject is out of view of the observer. Either off the ward living areas or in a room with the door closed, eg. kitchen or office.

Two plus Residents:

Used to record nurse interactions with more than one resident or whilst interacting with two or more simultaneously.

For "staff-staff" and "two plus residents" the content quality and response were not classified.

Reliability:

Intra-observer reliability studies were not carried out, but inter-rater reliabilities were assessed using two independent observers, using two Epson event recorders. Co-rating consisted of 23, 10 m sessions over 5 days and included a total of 54 staff-resident interactions. A Kappa coefficient of concordance was obtained for the behavioural categories of content, quality and response. The obtained values are given below in Table 8.
TABLE 8: OBSERVATIONAL CATEGORY COEFFICIENT AND CONCORDANCE

<table>
<thead>
<tr>
<th>CONTENT QUALITY</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>KAPPA</td>
<td>0.973*</td>
</tr>
</tbody>
</table>

* Significant at the 0.001 level.

Reliability of calculations for occurrences of staff-staff and staff-resident interactions consisted of simple indices of concordance, as no chance element existed. These indices together with that for "off the Ward" and given in Table 9, and are all of an acceptable level.

TABLE 9: INTERACTION CATEGORY INDEX OF CONCORDANCE

<table>
<thead>
<tr>
<th>STAFF-STAFF</th>
<th>STAFF-RESIDENT</th>
<th>OFF THE WARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index of Concordance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.95</td>
<td>0.92</td>
<td>0.97</td>
</tr>
</tbody>
</table>

For the duration of interactions a Spearman's rank order correlation was obtained. Given below are the coefficients obtained for "staff-staff" interactions, "staff-resident" interactions and "off the ward".

TABLE 10: DURATION OF INTERACTION SPEARMAN'S COEFFICIENT

<table>
<thead>
<tr>
<th>STAFF-STAFF</th>
<th>STAFF-RESIDENT</th>
<th>OFF THE WARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman's Coefficient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.97*</td>
<td>0.95*</td>
<td>0.99*</td>
</tr>
</tbody>
</table>

* Significant at the 0.0001 level
Two measures were unacceptably low: Those of "initiator" and "two plus residents". The latter was recorded on only three occasions and on one of these, both observers coded it, one lasted less than five seconds and was thus not included in the analysis. The Kappa coefficient for "initiator" of staff-resident interactions was surprisingly low at 0.49. This poor reliability was thought to result from the key of behaviour being less attended to than the other behavioural codes. This category was subsequently not involved in further analyses.

Recording Medium:

Data were collected using an Epson HX20 event recorder. This is a lightweight portable computer, with a typewriter keyboard, an LCD display screen and a printout facility.

Each behavioural code was designated by a certain key on the keyboard. The Epson programme "behaviour" was used, storing each key depression in memory. The first press of a key corresponded to the start of an observational code and a second press on the key represented the termination of the behaviour. Whilst the key was in "action" its character was displayed on the screen, Output from the computer at the end of a session took two forms. Firstly the sequence of behaviours and the duration in seconds of each code were written on to a micro cassette, and secondly a printout of the same information was made.
Procedure:

As the presence of a portable computer on the ward and two for the reliability checks was likely to cause reactivity effects, prior to the onset of the study two weeks were spent on the ward throughout the day by an observer. During this time the observer recorded behaviour and stood in the ward with the Epson HX20. This period served to habituate both staff and residents to the observer's and the computer's presence. It also functioned as a pilot study phase enabling the observers to become proficient at discriminating between the categories of behaviour.

It was decided that observations would take place on the ward's "day areas" between the times of 3.30 pm and 5.00 pm replicating the times used by Garety and Morris [1984] and the studies reported earlier in this chapter. The times represent the period between which residents return to the ward after attending various activities, such as occupational therapy. As with the earlier studies, nursing staff served as focal subjects. Each day three staff subjects were observed for two, ten m sessions. On average, each staff member was recorded for eleven, ten minute sessions with a range of eight to fourteen sessions. These were controlled for the time period, thus each focal subject's sessions came from differing times across the whole observation period.
Results.

Observations were made over a total of eighteen hours. Each staff member served as a focal subject for an average of one hundred and ten minutes, with a range of being eighty to a hundred and forty minutes.

Table 11 shows the frequencies, total durations and median interactions times of staff-staff and staff-resident interactions.

TABLE 11: FREQUENCIES, DURATIONS, AND MEDIANS OF INTERACTION CATEGORIES

<table>
<thead>
<tr>
<th>Interaction Type</th>
<th>Frequency</th>
<th>Total Duration [seconds]</th>
<th>Median Time [minutes]</th>
<th>Range</th>
<th>Median Time [seconds]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff-staff</td>
<td>248</td>
<td>249</td>
<td>40</td>
<td>5-600</td>
<td></td>
</tr>
<tr>
<td>Staff-resident</td>
<td>280</td>
<td>145</td>
<td>10</td>
<td>3-320</td>
<td></td>
</tr>
</tbody>
</table>

Duration of Interactions:

Staff-staff and staff-resident interactions showed a marked disparity in terms of their relative durations. Staff-staff interactions were significantly longer than staff-resident ones [p<0.001, Wilcoxon].
Correlations of Duration and Frequency with other Factors:

There was no correlation between staff training and duration or frequency of interactions with other staff. However, staff level of training did correlate the frequency of staff-resident interactions [$r=0.75 \ p > 0.01$] but not with $[r_s=-0.19]$ duration of interactions.

There was not a significant correlation between length of staff employment on the ward and frequency of staff-resident interactions [$r_s=0.29$] or with the duration of interactions [$r_s=0.18$] with residents.

Results for Content of Interaction:

Table 12 shows the total frequencies, durations and median interaction times for each content category of staff-resident interactions.

**TABLE 12: FREQUENCIES, DURATIONS, AND MEDIANS OF CONTENT CATEGORIES**

<table>
<thead>
<tr>
<th>Content Category</th>
<th>Frequency</th>
<th>Total Duration [mins]</th>
<th>Median Interaction Time [secs]</th>
<th>Range [secs]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/ Environment</td>
<td>135</td>
<td>63</td>
<td>20</td>
<td>8-180</td>
</tr>
<tr>
<td>Personal Problem Solving</td>
<td>50</td>
<td>40</td>
<td>35</td>
<td>10-320</td>
</tr>
<tr>
<td>Administrative</td>
<td>49</td>
<td>30</td>
<td>25</td>
<td>5-210</td>
</tr>
<tr>
<td>Demands/Prompts</td>
<td>46</td>
<td>13</td>
<td>5</td>
<td>3-140</td>
</tr>
</tbody>
</table>
Comparisons between categories for average interaction times were carried out by means of a "Friedman two-way analysis of variance by ranks test". This indicated a significant difference between the content categories \( X^2 = 11.64 \ p > 0.05 \). There were no significant correlations between the content categories and staff demographic factors. Further analysis indicated that the duration of demands/prompts were significantly shorter than each of the other categories and that personal problem solving category was significantly longer.
Results for Quality of Interaction:

Accepting interactions were more common and in general lasted longer than those classified as either "tolerating or "rejecting". Total frequencies, durations and median interaction times are given below in Table 13.

### TABLE 13: QUALITY OF INTERACTION, FREQUENCIES, DURATIONS AND MEDIANs

<table>
<thead>
<tr>
<th>Quality of Interaction</th>
<th>Frequency</th>
<th>Total Duration [mins]</th>
<th>Median Interaction Time [secs]</th>
<th>Range [secs]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting</td>
<td>183</td>
<td>106</td>
<td>35</td>
<td>10-320</td>
</tr>
<tr>
<td>Tolerating</td>
<td>63</td>
<td>30</td>
<td>25</td>
<td>5-210</td>
</tr>
<tr>
<td>Rejecting</td>
<td>34</td>
<td>9</td>
<td>10</td>
<td>3-45</td>
</tr>
</tbody>
</table>

Duration of Interactions:

There was a significant difference between categories of quality in terms of average interaction time \(X^2_T=7.39 \ p>0.05\). Accepting interactions were significantly longer than rejecting interactions but not significantly longer than tolerating interactions. There were no significant correlations between quality of interaction categories and staff demographic factors.
Results for Resident Response:

The most common response of residents was one characteristic of the "neutral" category. "Negative" responses were rare whilst "positive" responses were fairly common. Table 14 shows the frequencies, durations and median interaction times for response coded interactions.

**TABLE 14: TYPE OF RESPONSE, FREQUENCIES, DURATIONS AND MEDIANS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutral</td>
<td>190</td>
<td>87</td>
<td>16</td>
<td>5-210</td>
</tr>
<tr>
<td>Positive</td>
<td>74</td>
<td>50</td>
<td>39</td>
<td>10-320</td>
</tr>
<tr>
<td>Negative</td>
<td>16</td>
<td>9</td>
<td>25</td>
<td>3-60</td>
</tr>
</tbody>
</table>

Duration of Interactions:

There was a significant difference in the interaction times for different types of response. Positive interactions were significantly longer than both negative and neutral interactions [Wilcoxon p>0.02]

The frequencies of staff-staff and staff-resident interactions were found to be very similar. Staff divided their attention equally between staff and residents. It is suggested that "staff resident distance" as described by King et
al. [1971] plays an important role in this behaviour. The staff and residents are perceived as two distinct groups of people, and attention is divided between them. If correct, measures taken to decrease "social distance" would be associated with an increase in the frequency of interactions between staff and residents.

It was observed that staff-staff interactions lasted considerably longer than staff-resident ones. Armitage [1986] suggests that such findings are a result of residents' inabilities to maintain interactions, as a consequence of, a short concentration span, lack of eye contact and minimal responses. However, in this study it was noticeable that other factors outside of the residents' abilities may influence the duration of interactions. Staff-resident interactions were almost always dyadic and usually occurred as staff moved from one area of the ward to another. Rarely did staff actually sit together with residents. It was also evident that staff and residents had certain "territories" within the ward. This apparent territoriality represents a large "social distance" [King et al. 1971] between the two, and tends towards minimising opportunities for staff and resident interactions, [Fairbanks et al., 1977]. It could be argued that the increase in interactions seen in Study 2 resulted from a decrease in social distance by the move to ordinary homes.
Content of Interactions:

Evidence from the present study suggests that the content is an important factor in the maintenance of interactions between staff and residents. "Personal problem solving" interactions proved to last longer than "administrative" ones, and although not quite significant, tended to last longer than "social/environment" interactions.

This suggests that "personal problem solving" interactions are functionally different to other less "resident oriented" interactions such as "administrative" or "social/environment" ones. The residents and staff appear to be more motivated to talk when conversation concerns the resident in a more intimate or personal manner.

The proportion of interactions that were of a "personal problem solving" nature [18%] was considerably lower than the proportions quoted in earlier studies: Garety and Morris [1984], and Allen et al. [1989] (Study 1), both of whom found such interactions to account for over 65% of those observed. It is very unlikely that the discrepancy is a result of difference between the environments or the subjects, as these were not drastically dissimilar. The introduction of two additional content categories for the classification of an interaction is almost certainly responsible for such a significant finding.
In the previous studies there were possible difficulties in the definition of "personal problem solving". There is a danger that when only two categories are used, that one can become an "anything else" category. Some interactions in previous research are likely to have been coded as "personal problem solving" when really they did not fit the definition. As a result of such a misuse of categories an artificially high figure is arrived at for interactions of a supposedly "personal problem solving" nature.

If "personal problem solving" interaction rates are to be used as a measure of ward quality then it is useful to include at least a third category of content, for example, "social/environment" interactions. Otherwise there is a very real possibility that evaluations and comparisons of care units are merely examining the frequency of "administrative" interactions that occur. [Assuming that these are indeed easier to classify and less likely to be mixed up with interactions of a more social nature.]

It was hypothesised that "personal problem solving" interactions, because of their emphasis on the individual would be associated with a positive response from residents. However, staff using the highest proportion of such interactions were not responded to more positively than other members of staff. Some "personal problem solving" topics were on
occasions distressing to the resident, and it is probable that they were responding to the content of the specific interaction rather than the staff member.

Quality of Interactions:

Significant differences were found between the durations of "rejecting" and "tolerating" and "rejecting" and "accepting" interactions. Physical actions often accompanied "rejecting" interactions, such as closing a door or walking away from the resident.

Thus it was not surprising to find they were shorter than "tolerating" or "accepting" ones. The duration of "accepting" and "tolerating" interactions did not differ significantly. Therefore there was no evidence to suggest that there is a functional difference between the two types of interaction.

However, staff that used the highest proportion of "accepting" coded interactions received the highest proportion of positive responses from residents. This provides limited support to Richardson's [1977], cited by Garety and Morris [1984], advancement of "accepting" interaction styles. Richardson argued that residents would not be happy in an atmosphere of rejection. In this study residents were happier, or at least showed a more positive response, to staff that were generally encouraging, warm and supportive in their interactions with residents.
This latter finding provides some validation to support the use of quoting frequencies of "accepting" interactions in assessments of the quality of care in hospital or community based facilities.

**Resident Response:**

The duration of positively responded interactions lasted significantly longer than "neutral" or "negatively" responded ones. These differences are hardly surprising, as it is clear that residents will remain in interactions they are showing signs of enjoying. Positive responses from residents also encourage staff to maintain their interactions.

**Effects of Staff Training:**

It was hypothesised that staff training would be associated with frequencies of staff-staff and staff-resident interactions. It was also postulated that more highly trained staff would show higher proportions of "personal problem solving" and "accepting" interactions, as well as spending more time in each of their interactions.

The only significant association was between higher level of training and higher frequency of staff-resident interactions. The causes for increased staff-resident interactions are not entirely clear. Firstly, it is possible that the increase is
due to some factor related to the staff. Perhaps those that complete a higher level of training may have a high sense of responsibility. Secondly, it could be an influence directly related to the training received.

Thirdly, the rates of interaction might be higher as a result of the residents' behaviour. They may be acting in such a way as to interact selectively with higher trained, and subsequently higher ranking staff members.

Nonetheless, more frequent staff-resident interactions are associated with some aspect relating to staff who have been trained to a higher level. If the cause can be teased apart in future research, it might be possible to raise the levels of staff-resident interactions.

In a previous study, Garety and Morris [1984] found a positive association between the proportion of "accepting" interactions used, and higher level of training. In their study there was included a number of care assistants who had received minimal training or no training. Study 1 found the converse to be true. However, the subjects were quite different, with a large proportion of student nurses involved in the study. It could be that the findings are due to the non-institutionalised attitudes and behaviours of the student nurses who have been trained more recently than other staff.
Drawing from all three studies it appears that the association between the proportion of "accepting" interactions used by staff and their training level is not clear cut.

It is more pronounced at the extremes with differences between those staff with qualifications and those with no training or qualifications. Further research is necessary to clarify the situation.

Similarly in the present study there was no association between the proportion of "personal problem solving" interactions used by staff and their training level. Thus staff are equally attentive to individuals, and use their counselling skills in roughly the same proportions as other staff members, regardless of training.

In conclusion, it is apparent that more highly trained members of staff do not show higher proportions of "resident oriented" interactions, but they do exhibit higher overall frequencies of staff-resident interactions.

If training alone is not responsible for accounting for differences in interaction levels, then other factors will require exploring: burnout and tendency to high EE etc. would appear areas worth exploring.
Effect of Staff's Length of Employment on the Ward:

It was thought that staff length of employment on the ward would be associated with better relationships with residents, as had been suggested by Freeman et al. [1958], Ullman [1967] and Altschul [1972]. It was hypothesised that a longer length of employment on the ward would be associated with higher proportions of "personal problem solving" and "accepting" interactions, as well as higher proportions of "positive" resident responses.

It was also hypothesised that higher frequencies and longer durations of staff-resident interactions would be associated with a longer length of staff employment on the ward. None of these hypotheses were supported by the results of the study. Two conclusions can be drawn from this finding.

Firstly, it can be concluded that the length of staff employment on the ward is not a factor in the formation of good relationships between staff and residents. Secondly, the findings can be said to provide support for Diers [1966] hypothesis that relationships are not necessarily linked to interactions. Thus concluding that the interaction measures used were not subtle enough to assess staff and resident relationships. If the latter conclusion is accepted then doubts are cast on the validity of using such methods to assess hospital and community based care units.
At present this study does not have the scope to distinguish between the two possible outcomes. However, interviews with both staff and residents concerning aspects of their relationships would help to clarify the situation.

Summary.

The study provides evidence that "personal problem solving" and "accepting" interactions are significantly longer than other interactions in their categories. If you accept that longer interactions are more likely to lead to the formation of relationships between staff and clients, and that this leads to improved quality of care (as most observation schedules assume) then this is a positive result. However, the assumption that `duration leads to quality' alongside `frequency leads to quality' are both crude conceptualisations which merit further investigation. Further studies in the following areas would be of use:

- Do clients in units where interactions are more frequent and of longer duration show significantly more clinical improvement, or rate their quality of life as significantly better than similar clients in units where interactions are less frequent and less long?
• Are staff who engage in longer and more frequent interactions with clients more effective therapeutically? What factors would lead staff to behave in this way?

• Are there client factors which make them less or more likely to be recipients of interactions?

• Which social and environmental factors encourage or discourage social interactions?

The successful use of event recorders suggest that the above questions can be answered, and some of the assumptions underlying observational methods, tested.

In this study staff training and length of time employed on the ward appeared to make no difference in relation to the quality or content of interactions, although staff training was linked with a higher frequency of interaction. The measures used in this study do provide information about the quality of interactions in care units, but they fail to evaluate the role of staff-resident relationships.
STUDY 5: WHICH PATIENTS LEAVE THE ASYLUM FIRST?
A LONGITUDINAL COMPARISON OF PATIENT OUTCOME IN RELATION TO
THEIR LEVEL OF FUNCTIONING

The longitudinal study (Study 2) reported earlier demonstrated that, as the hospital closure progressed, this led to a changing population in the unit. This occurred over a period of four years. This effect of the transition of care presented difficulties in evaluating the quality of care offered by the unit, as differences seen could have been due to the changing profile and needs of the population. The fact that the base hospital population, which provides clients for the unit, was changing is of interest in itself. It had been assumed that, although the locality of care and the type of provision was changing, the population requiring care would remain the same. This did not appear to be the case. Repper and Perkins (1995) have argued that community-based services can tend to 'cream off' the more able people who consequently do better than those who refuse care or are rejected by the service.

A survey of the hospital population as a whole had been carried out prior to the smaller units' (Study 2) move to the community (-6 months). This had been done to identify accurately the functioning of the population served in order to attempt to meet needs, introduce interventions to prevent or reverse deterioration in functioning, and plan appropriate services. This type of activity in similar hospitals has led to the developing literature concerning need definition and
assessment described earlier (Chapter 3) and attempts to clarify the concept of need and improve assessments. Attempts have been made to utilise needs assessments to evaluate and improve care on a number of levels. For example REHAB (Baker and Hall 1983) has been used in the following ways, as reviewed by Baker and Hall (1993):-


2. To select individuals as a way of targeting services or interventions (Carson et al. 1988, Nicholl 1989).


4. To plan individual interventions (Bluteau and Long 1986).

The REHAB assessment was used when the hospital population was initially surveyed, because at the time of writing it was one of the most frequently used needs assessments with this population in the United Kingdom, has a clearly described development history (Hall 1977, Hall 1978, Baker and Hall 1980), and has data available relating to its reliability, validity and sensitivity (Baker and Hall 1983, Croucher, Abrahamson and
Carson 1989, Conway, Wojciechowski, Leroux and Ludlow 1989). Additionally, independent reviews of needs assessments had tended to be positive about REHAB (Wallace 1986, Barker 1985, Liberman 1988) when this survey was undertaken.

It was decided to re-evaluate the remaining hospital population six years' later when Study 2 had been completed. The same measure (REHAB) was utilised as this would allow a comparison of the profiles of the two populations. This would allow the following questions to be answered:-

1. When the hospital population is compared over the six year period had the level of functioning differed?

2. Are the individuals who were discharged over the six year period different from those who remained in hospital?

3. What abilities distinguished the two populations and which factors were particularly important in determining the outcome of people over the six year period?
The Hospital.

The hospital is a large Victorian building opened in 1871 to provide mental health care for the people of Northamptonshire. It was built on a hill outside the town in a heavily wooded rural setting. The village of Duston is nearby and, as Northampton has developed, housing estates have now been built on the hospital's boundaries. The hospital was closed in 1996 and the site will be redeveloped as a housing estate.

At the commencement of this study in 1987 the continuing care directorate consisted of 11 wards, and the hospital additionally had wards designated as psychogeriatric, acute and rehabilitation. Six years later the continuing care directorate consisted of three wards and the psychogeriatric wards had been relocated to another hospital. In 1987, whilst the wards consisted of large rooms with dormitories and minimal furnishings, there was an air of activity and the hospital was busy. By contrast in 1993 large parts of the hospital had been closed, including all the upper floors, one complete wing and most of the satellite villas. The physical fabric of the hospital had been allowed to deteriorate, with only minimal maintenance being carried out, and the grounds had become overgrown.
Continuing Care Population.

The original population consisted of 144 individuals, 88 men and 56 women. Their mean age was 60.3 years with a standard deviation of 16.46, median age 62, and a range from 22 to 89 years. The mean length of stay was 19.66 years with a standard deviation of 16.52, median length of stay 21, and a range of one to 62 years.

The population six years later consisted of 62 individuals, 39 men and 23 women. Their average age was 50.05 years with a standard deviation of 14.01, median age 52, and a range of 24 to 76 years. The mean length of stay was 12.11 years with a standard deviation of 12.88, median length of stay 7, and a range from one month to 58 years.

The population is significantly younger six years later ($u=2705, p<0.0001$). The original population had only 8% of the population under 35 years of age and 37.5% aged over 65 but, by the latter period, this had changed to 21% of the population being aged under 35 years of age and only 16% over 65. The latter population also has a significantly shorter length of stay in hospital than the original population ($u=3141, p<0.002$) and the new long-stay group (length of stay under two years) had increased from 15% to 24%.
TABLE 15: COMPARISON OF THE AGE AND LENGTH OF STAY OF THE TWO HOSPITAL POPULATIONS SIX YEARS' APART (figures in years)

<table>
<thead>
<tr>
<th>POP</th>
<th>MEAN AGE</th>
<th>S.D.</th>
<th>MEDIAN</th>
<th>RANGE</th>
<th>MEAN LOS</th>
<th>S.D.</th>
<th>MEDIAN</th>
<th>RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSP POP</td>
<td>60.3</td>
<td>16.46</td>
<td>62</td>
<td>22-90</td>
<td>19.66</td>
<td>16.52</td>
<td>21</td>
<td>1-61</td>
</tr>
<tr>
<td>N=144</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOSP POP</td>
<td>50.05</td>
<td>14.01</td>
<td>52</td>
<td>24-76</td>
<td>12.11</td>
<td>12.88</td>
<td>7</td>
<td>1 mth-58</td>
</tr>
<tr>
<td>N=62</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Needs Assessment.

The REHAB scale has been described in some detail earlier (Chapter 3). Due to the number of individuals being assessed, rather than the author directly training all assessors, a study day was held to train trainers who then trained the direct care staff with the author acting as a consultant. Twelve trainers were trained in this manner in the original survey, and two six years' later. As this training method is in effect at one step removed, it was important to assess the reliability of this method of gathering data. Consequently 43 individuals were rated by two independent observers over the same time period for this purpose. The reliability calculation was compared with the published figures (Baker and Hall 1983), and are presented in Table 1 (Chapter 5). Spearmans rho comparisons indicate a high level of significance for the overall scale, and its individual items.

Whilst many items do not achieve as high a coefficient value as the original study, only one item of the 23, that of sexual acts, did not achieve significance. This indicates that a
two tier mechanism, that of passing on skills to trainers who then train direct care staff, does not lead to any loss of reliability and that the needs assessment can be used reliably.

1. **Comparison of Two Populations.**

The continuing care population of the hospital had changed between the two time periods. Numerically it was smaller and based on fewer wards as the hospital approached its closure. As discussed earlier, its client group was also significantly younger and had a significantly shorter length of stay.

Table 16 indicates the patterns for the two populations in terms of age and category on the REHAB needs assessment. In terms of the REHAB categories, 70% of the population had fallen into the severe disability category in both surveys, 80% of the original population also scored in terms of having at least one identified problem behaviour on the deviant behaviour scale. In terms of the discharge potential category in the original population, 18 individuals (12.5%) had been in this category, whilst six years' later only 5 individuals (8%). This also reflects the fact that, as the total population falls, there are fewer people with a similar pattern of needs and it therefore becomes increasingly difficult to plan services for a homogenous group. This was also reflected in the increased proportion of the new long-stay group (Table 17) from 24% to 32%. This group tended to have the most varied profile in terms of overall REHAB score (varied levels of ability in activities of daily living) and deviant behaviour score (presence of problem behaviours).
TABLE 16: COMPARISON OF THE TWO HOSPITAL POPULATIONS' REHAB PROFILES SIX YEARS' APART BY AGE

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Original Discharge Potential</th>
<th>Moderate Disability</th>
<th>Severe Disability</th>
<th>Overall</th>
<th>Age &amp; Rehab Profile Six Years' Later</th>
<th>Moderate Disability</th>
<th>Severe Disability</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>25-34</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>35-44</td>
<td>5</td>
<td>3</td>
<td>9</td>
<td>17</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>45-54</td>
<td>3</td>
<td>3</td>
<td>11</td>
<td>17</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>55-64</td>
<td>2</td>
<td>9</td>
<td>34</td>
<td>45</td>
<td>1</td>
<td>1</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>65-74</td>
<td>5</td>
<td>2</td>
<td>13</td>
<td>20</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>75+</td>
<td>3</td>
<td>4</td>
<td>27</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18</td>
<td>25</td>
<td>101</td>
<td>144</td>
<td>5</td>
<td>13</td>
<td>44</td>
<td>62</td>
</tr>
</tbody>
</table>

TABLE 17: COMPARISON OF TWO POPULATIONS' REHAB PROFILE SIX YEARS' APART BY LENGTH OF STAY (LOS)

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Original Discharge Potential</th>
<th>Moderate Disability</th>
<th>Severe Disability</th>
<th>Overall</th>
<th>Los &amp; Rehab Profile Six Years' Later</th>
<th>Moderate Disability</th>
<th>Severe Disability</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Long-Stay under 3 years</td>
<td>4</td>
<td>9</td>
<td>21</td>
<td>34</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Old Long-Stay over 3 years</td>
<td>14</td>
<td>16</td>
<td>80</td>
<td>110</td>
<td>3</td>
<td>6</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>25</td>
<td>101</td>
<td>144</td>
<td>5</td>
<td>13</td>
<td>44</td>
<td>62</td>
</tr>
</tbody>
</table>
A comparison of the needs profile of the two populations on every item of the REHAB scale indicated that there were some significant differences between the two populations. The later population exhibited a significantly higher level of absconding \((u=3613 \ p<0.004)\) and verbal aggression \((u=3373 \ p<0.008)\), while the original population had a higher level of self-injury \((u=3917.5 \ p<0.03)\). The later population were more able to look after their own possessions \((u=3564.5 \ p<0.05)\), had better money skills \((u=3354 \ p<0.01)\), and generally were more capable in the community skills category \((u=3290 \ p<0.007)\). As with Conning and Brownlow's (1992) study concerning a population of 53 people, both populations showed deficits in a number of areas.

2. Differences between those Discharged and those Remaining in Hospital.

Of the original population, by six years later, 36 were still in the hospital, 23 had been discharged to less supported community settings (own homes, hostels and lodgings), 33 had been discharged to supported community settings (nursing homes and elderly persons' homes) 35 were dead, and 17 people's subsequent history could not be traced.

The means, medians, standard deviations and range of each group age and length of stay at the original assessment period is described in Table 18:
TABLE 18: COMPARISON OF THE OUTCOME OF THE ORIGINAL HOSPITAL GROUP

<table>
<thead>
<tr>
<th></th>
<th>MEAN AGE</th>
<th>S.D.</th>
<th>MEDIAN</th>
<th>RANGE</th>
<th>MEAN LOS</th>
<th>S.D.</th>
<th>MEDIAN</th>
<th>RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY GRP N=23</td>
<td>46.70</td>
<td>17.74</td>
<td>46</td>
<td>22-82</td>
<td>11.71</td>
<td>12.77</td>
<td>5.33</td>
<td>1-44</td>
</tr>
<tr>
<td>HOMES GRP N=33</td>
<td>71.61</td>
<td>8.59</td>
<td>68</td>
<td>57-88</td>
<td>30.08</td>
<td>16.73</td>
<td>30</td>
<td>1.4-61</td>
</tr>
<tr>
<td>DEAD GRP N=35</td>
<td>68.31</td>
<td>10.85</td>
<td>70</td>
<td>43-89</td>
<td>22.14</td>
<td>16.58</td>
<td>27</td>
<td>1.67-51</td>
</tr>
</tbody>
</table>

Comparing those who had remained in hospital with those who had been discharged to more independent settings in the community, it was found that there were a number of significant differences in relation to their original REHAB scores. Those that stayed in hospital had significantly higher total deviant behaviour scores (u=285.5 p<0.04) and total general behaviour scores (u=225.5 p<0.003). They also had significantly higher scores in relation to the items concerning verbal aggression, mixing with others on the ward, level of activity, initiating speech, table manners, dressing skills, care of possessions, and use of public facilities indicating greater needs in all these areas, and suggesting that for this population it may have been possible to predict outcome in relation to REHAB needs data. There were fewer differences when these two groups were compared with the group who moved to nursing and old people's homes, who were unsurprisingly significantly older and had significantly longer lengths of admission. However, they also had a
significantly higher general behaviour score (u=260 p<0.05) than those who had been discharged to less supported settings, and a significantly lower deviant behaviour score (u=435.5 p<0.05) than those who stayed in hospital.

3. Which Factors Distinguished the Two Populations, and Which were Important in Determining the Outcome of the Original Group?

Needs assessments of total populations are often utilised by care planners to make both immediate and future predictions about service provision. This was the case with both of these surveys, with the information being utilised to plan future care and secure resources to enable this to take place.

Conning and Brownlow (1992) suggested that placement decisions should not be based on REHAB scores alone and, clinically whilst this is sensible advice in relation to individuals, service planning often does occur on the basis of such figures.

The availability of two sets of data concerning the hospital populations at different points in time, and the knowledge of the outcome of the original population, allowed the following questions to be posed:-

i. Which abilities distinguished the two hospital populations?
ii. Which abilities were likely to influence the outcome of the original hospital population, and likely to discriminate between those who stayed in hospital and those who successfully transferred to the community?

i. A discriminant analysis of the two hospital populations revealed that use of cash, level of prompting and ability to care for possessions, were the factors most likely to discriminate population membership. The discriminant function $y = a + b_1x_1 + b_2x_2$ using standardised canonical discriminant function coefficients was:

$$y = 0.877 \times \text{care of possession score} - 1.222 \times \text{level of prompting score} + 0.778 \times \text{use of cash score}.$$  

This is in line with the significant differences found between the groups earlier and suggests that members of the later hospital population were likely to have more abilities in relation to their use of money and care of possessions, but were more likely to require more prompting. These are the features that are likely to discriminate them from the original group.

ii. Of more interest is what discriminates the outcome of the original population. This is of interest as it may indicate for current populations the factors which are predictive of future outcome, either because those factors are important in determining outcome, or because staff who evaluate abilities believe that they are. Any extrapolation in this manner would
have to be done cautiously as the discrimination analysis performed may only apply for this particular population, group of staff, and measure.

The two groups that were of particular interest were the group that remained in hospital, and the group that successfully transferred to an independent life in the community. The discriminant analysis indicated three factors were particularly important in discriminating between these two groups on their original REHAB data. These were: verbal aggression; level of activity; and ability to use public facilities. The discriminant function \( y = a + b_1x_1 + b_2x_2 \), for these two groups was \( y = 0.90 \times \text{verbal aggression} + 0.54 \times \text{level of activity} - 0.66 \times \text{ability to use public facilities} \). This would indicate that individuals who were verbally aggressive, had high levels of activity and who had fewer difficulties in using public facilities, were likely to remain in hospital. Similar studies in other hospitals approaching closure would indicate if these factors were important in other settings. Further work would also indicate if intervention programmes targeted upon reducing verbal aggression and low levels of activity aided the likelihood of successful discharge to the community. It may be that these difficulties, combined with an ability to use public facilities, make staff particularly wary of discharge to the community due to the perceived potential of difficulties arising; this would also indicate the need to work explaining
staff attitude to discharge of clients and work to evaluate if these combination of factors are more likely to lead to difficulties.

The determining factor for the original hospital residents going to a home or dying, appeared to be age, with both groups significantly older than the hospital or community groups. Having details of outcome of the original hospital population six years' later was important as it gave a more accurate picture of what, for this group in terms of REHAB profiles, had been important in potentially determining outcome. This information six years previously would have enabled more accurate predictions concerning likely service provision demands. When the original hospital population survey had been carried out, attempts were made to identify sub-groups of the population, and plan for their care, and also to plan for future provision a number of years into the future.

The details of the recommendations made then are detailed below:-

"a. Immediate priority should be given to drawing up detailed individual care plans for community living for the 18 residents identified as having "discharge potential"."
b. Within the "severe disability" category, high priority should be given to the 14 residents showing no deviant behaviour (special problems of care) and arrangements made for residential and day care facilities within the community.

c. To ensure closure of the hospital, there are long-term resource implications for managing the number of residents in the "severe disability" category.

It is estimated, for Northampton District, that two-thirds of the 1994 predicted occupation of long-stay beds will be "severely disabled" (approximately 55 of 82 : RHA. attrition rate). This indicates that 55 beds would be required in a highly supported environment.

d. The group identified as "moderate" disability would most benefit from a community-based rehabilitation scheme, preferably within the context of a jointly funded-managed community Mental Health Centre with adjacent domestic-style residential accommodation."

Attempts were made to plan for particular subgroups of the population. Hence, in relation to the recommendation, the 18 individuals in the discharge potential category were transferred to the rehabilitation unit, the 14 individuals who had high level of needs but who presented few management difficulties
were discharged as a group to a nursing home, and the rehabilitation ward was relocated to a community setting (Study 2) in an attempt to meet the needs of the individuals in the moderate disability category. Attempts were also made to predict the needs of the residual population group in 1994 using attrition rates (Table 19). The actual 1993 figures based on the continuing care population are closer to the RHA. predicted rates once the EMI predicted figure (64) is removed" (Table 20).

A similar exercise was carried out six years later:-

"a. The five individuals in the discharge potential category should be further assessed to ascertain their suitability for discharge to the community.

b. Given the number and range of needs present it is unlikely that the continuing care population can be accommodated in current community provision in Northampton. Such provision should be developed urgently, in the interim the current wards at St Crispin Hospital should be closed and the patients moved to the physically superior wards at Princess Marina Hospital.

c. Service provision should be more closely matched to client need. It is unlikely that the 15 'new long stay' clients will require the same sort of services as the 10 65+ year olds, and varying services should be available accordingly.
d. Social aspects of care should be looked at in detail alongside any physical relocation of the continuing care population, staff re-training should be a priority.

e. A survey of clients in the acute and rehabilitation services should be carried out due to their potential impact upon continuing care services.

It is of note that, as the overall continuing care population has decreased between 1987 and 1993, consequently the number of people with similar needs is smaller, forcing the directorate to make plans for services that are based on small numbers of people."

The tables were used as a way of attempting to predict future numbers of patients and therefore resources necessary in discussions concerning funding between the district and regional health authorities. The district preferred its formula as it predicted larger numbers in the short-term, and therefore the need for more money to support the care of these individuals.
### TABLE 19: LONG-STAY BED REQUIREMENTS USING DHA ATTRITION RATES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>.437</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>.293</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>35-44</td>
<td>.21</td>
<td>17</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>45-54</td>
<td>.129</td>
<td>17</td>
<td>15</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>55-64</td>
<td>.131</td>
<td>45</td>
<td>39</td>
<td>34</td>
<td>30</td>
<td>26</td>
<td>23</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>65-74</td>
<td>.168</td>
<td>20</td>
<td>17</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>75+</td>
<td>.308</td>
<td>34</td>
<td>24</td>
<td>17</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>144</strong></td>
<td><strong>115</strong></td>
<td><strong>93</strong></td>
<td><strong>76</strong></td>
<td><strong>62</strong></td>
<td><strong>52</strong></td>
<td><strong>43</strong></td>
<td><strong>36</strong></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 20: LONG-STAY BED REQUIREMENTS USING RHA ATTRITION RATES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MI ALL AGES</td>
<td>.03</td>
<td>90</td>
<td>87</td>
<td>84</td>
<td>81</td>
<td>79</td>
<td>77</td>
<td>75</td>
<td>73</td>
</tr>
<tr>
<td>EMI LONG-STAY</td>
<td>.17</td>
<td>20</td>
<td>17</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>65-74</td>
<td>.31</td>
<td>34</td>
<td>24</td>
<td>17</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

4. **Discussion.**

There are a number of limitations of using needs based assessments at the hospital/institution level in the manner described above.
The New Long-Stay

A narrow vision of the service can result with, as in this example, plans being focused on predictions concerning the current population, but omitting developments for new users.

In this particular case it was assumed that the development teams based in primary care setting would cater for new clients with long-term mental health problems. Over the six years, this proved not to be the case, and with a hospital albeit reduced in size still in existence it is understandable that referrals continued to be made to its services. This may have been because the services available in the hospital were better suited to meet the needs of the new long-stay, or other factors such as the changing financial administration of the Health Service. Whilst clients remained in primary care settings, fund holding general practitioners were responsible for the funding of their care, once they had been referred to the hospital. This responsibility then passed to the Local Health Authority. Attrition rates based on national/regional norms do not take into account these financial/policy influences, or how in reality services in a particular area may operate. The effect in this service was to underestimate the size of the remaining hospital population, due to the influx of the new long-stay population.
Overall Level of Functioning or Pattern of Functioning?

Services were planned and continue to be planned based upon clustering people together who have similar levels of functioning. However, the discriminant analysis results looking at outcome six years apart suggest that it is the particular profile of functioning and need that may be more important in deciding outcome than the overall level of functioning. Identifying particular skills which will be essential to survive in the community (eg. use of money) or particular problems which if still present will cause difficulties in the community (eg. aggression) may be more important than attempting to raise or hold skills generally. This would suggest that any service should be seeking to evaluate its population at ongoing points, be aware of the outcome of people passing through its service, and determine which factors have been important in influencing outcome.

Service Provision

Service provision can lag behind the requirements of the people being provided for. The hospital concerned had been providing a static service for a number of years, probably since it reached capacity in the 1950's. This was when the large hospital wards, satellite villas, and hospital farm had been in operation. The developments in pharmaceuticals and social psychiatry had led to the introduction of rehabilitation wards
Special Note

Page 234 missing from the original
management, medical, professions allied to medicine, and nursing staff. Such turnover may have been related to the huge turmoil involved in closing a hospital. The difficulties this presents are in relation to continuity of care, relationships with patients, and in relation to the overall planning of a new service.

Care Recipients

One of the few stable groups were the recipients of care. Thirty six individuals had remained in hospital over the six year period, 56 had progressed onto community settings either independently or to homes. New care recipients had joined the population over the six years, and were progressing through the system. What were their impressions of this huge change in care provision? How did the impending closure of the asylum affect them? What were their impressions of hospital vs community care? These appeared pertinent questions. The next two studies sought to address the recipients of care's views of their lives as they had been affected by changing care provision.
STUDIES 6 AND 7: STUDIES OF USERS' VIEWS OF CARE

There has been an increasing emphasis upon the importance of users' views which has been reflected in legislation (Caring for People 1989), an increasing literature concerning their views of care, and the development of user pressure groups and advocacy.

Assessing users' views of their lives appeared particularly important as the hospital approached closure. Two studies were undertaken:

Study 6 - A relatively quick cross-sectional study which sought to compare the quality of life of hospital residents, and individuals in the community who have recently passed through the hospital unit concerned. This would provide information quickly as to the impact of community living, but is likely to be confounded by differences in the two populations.

Study 7 - A longitudinal study which would follow the original hospital ward population until they had been discharged to the community and reassess their views of their subsequent quality of life for comparison with their views when hospitalised.

The measure employed for both studies, The Lehman Quality of Life schedule (1983), was selected as its development has been described, and it has been used in a number of published
studies. The Lehman schedule attempts to assess quality of life over a number of domains using a semi-structured interview schedule which is rated by the interviewer. In the studies reported here, the Lehman is used as a means of comparing quality of life in hospital and community settings.

As such, it is utilised as a means of looking at different systems of care and the transition from one to the other from the recipient's perspective.
It was the intention of this study to compare a group of people with long-term mental health problems discharged to the community from the rehabilitation ward of St. Crispins Hospital in Northampton with a group currently resident on the ward. The aim was to evaluate the quality of life (QoL) of both groups as an indicator of how people experienced these different settings, as a possible way of judging care provision and as a means of evaluating the success of placements. A range of outcome measures were identified as useful of both quality of life and other factors concerning the individuals - objective indicators of QoL; subjective ratings of satisfaction; an environmental measure for settings; an assessment of level of functioning; and level of psycho-pathology. The assessment of level of functioning selected was that used as part of clinical practice on the ward - REHAB (Baker and Hall, 1983). Data for this assessment exists for the discharged group thus making a comparison between current functioning and functioning at the time of discharge possible. The REHAB assessment is completed by professionals involved in the person's care. For the community group it was realised that some would be in their own homes, or living with landladies. It was therefore planned to complete the assessment using the person in most face to face contact - landlady, friend, professional or family member.
Community Group.

Potential participants were identified from records of discharges kept on the ward. Those individuals transferred to other wards or hospitals were excluded. Others were inappropriate, being resident on the ward for a brief period only due to bed shortages on the acute units. A potential 23 participants were identified, discharged over a two and a half year period.

An information sheet explaining the purpose of the study and the procedure should they wish to take part was sent to each at the address recorded at time of discharge. Enclosed was a consent form and a pre-paid envelope. Three people responded and indicated their consent. As no reply, positive or negative had been received from the remainder, they were followed up in the following manner. Client lists of local day-care facilities were checked and attenders approached personally. The remainder were sent another letter. There were no replies. Phone numbers were found for some and these were contacted by phone. For a summary of reasons for non-participation see Table 21.
TABLE 21: REASONS FOR NON-PARTICIPATION  n=14

<table>
<thead>
<tr>
<th>No.</th>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Currently in hospital</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Too disturbed</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Untraceable</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Refused</td>
<td></td>
</tr>
</tbody>
</table>

The reasons given for refusal were that people wished no further contact with anyone connected with St. Crispins, were tired of being assessed, or were too busy.

The remainder were interviewed, six in their own home and three in day-care settings, giving a total of nine in the community group. The demographic detail of this group and the hospital group are detailed later in Table 22.

The failure to contact those clients untraceable through day services and the high level of refusal suggest that a selection bias is operating, and it may be that those who did participate had a more positive view of their experiences in hospital than those who refused, and suggested a longitudinal study would be one way of overcoming these difficulties.
At interview participants were asked to name the person who had most contact with them and who knew best, how they were functioning. REHABs were completed with these named people. See Table 22 for summary of relation to participant.

**TABLE 22: ASSESSOR AND RELATION TO PARTICIPANT**  

<table>
<thead>
<tr>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landlady</td>
</tr>
<tr>
<td>Social Worker</td>
</tr>
<tr>
<td>Head of Home</td>
</tr>
<tr>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Psychologist</td>
</tr>
<tr>
<td>Not possible</td>
</tr>
</tbody>
</table>

One client was re-admitted two days after being interviewed (due to deterioration in his physical health) making the required week observation impossible. One carer was unavailable at the required time. In total, seven were re-assessed on the REHAB measure.

Rates of re-admission, death and loss to follow-up.

From a potential 23 individuals identified at the planning stage, four were currently resident in hospital. One participant was re-admitted shortly after being interviewed, and two had been briefly re-admitted since discharge from the rehabilitation ward. For participants in this study reasons for re-admission were deterioration in mental state for the two
brief re-admissions, and deterioration in physical state for the third. He had developed emphysema and was living in a very hilly town. The circumstances of the other re-admissions is not known. This suggests that either the process of selecting placements is insufficiently tailored to individuals' needs, or there is a failure in the services provided in the community to monitor and support individuals. At present there is no community based multi-disciplinary team to support individuals once they have left hospital.

Two individuals had died since discharge: both were aged over 60 years. Natural causes were assumed as neither had committed suicide. The death rate in this study appears high, but given the small sample size, comparison is difficult. Two individuals remained untraced after contact with the CPN department and day-care facilities. Jones reports that the York study succeeded in tracing all but two of fifty individuals, but comments that this was achieved through eliciting the help of a range of professionals, as circumstance often bore little relation to hospital discharge plans. Oliver (1993) reports that 17% of the sample his researchers followed up after discharge had changed address within a nine-month period. With greater resources it may have been possible to trace all individuals to check they had not become vagrant. In this regard it was striking how little systematic monitoring of people's whereabouts was undertaken. It is not possible to make
any comments on the likely social circumstances of the untraced individuals. This must be of concern given that these individuals have long-standing mental health problems.

Hospital Group.

Potential hospital participants were identified as those currently resident on the rehabilitation ward, and who had been resident for more than one month, giving 17 potential participants. The ward was sited in a separate building close to the main hospital building, was a large building without a homely atmosphere, and consisted mostly of large rooms, half the residents still living in a partitioned dormitory rather than having their own rooms. Individuals were referred from long-stay and acute wards. All residents were those who showed potential for discharge given the range of community facilities currently available.

Individuals were given an information sheet to take away and read. Two were excluded due to being too disturbed to be interviewed, and one excluded due to the interviewers' judgement that he was not capable of giving informed consent. Ten agreed to participate and four refused. Most did not give a clear reason. The others stated that they were too busy, or did not want to talk.
Demographic Details.

Community Group.

Of the nine people in this group, six were men and three women. All six men had a diagnosis of schizophrenia, two of the women were diagnosed as depressed, and the remaining women had a diagnosis of manic depression. None were married, six being single, two divorced and one widowed. Table 22 details their ages and time since first episode.

All but one were living at the address they were discharged to. Two had been re-admitted to hospital, one for three days and one for a week. In both cases, this was due to a deterioration in mental state. One was returned to their previous accommodation in a nursing home, and the second did not return to his previous bed-and-breakfast, but was placed in a staffed private hostel. See Table 23 for a summary of placement type.

TABLE 23: COMMUNITY GROUP DEMOGRAPHIC DETAILS

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Time since first Episode (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
</tr>
<tr>
<td>n=3</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>57.7</td>
<td>66</td>
</tr>
<tr>
<td>Men</td>
<td></td>
</tr>
<tr>
<td>n=6</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>55.2</td>
<td>53.5</td>
</tr>
<tr>
<td>TOTAL:</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>56.0</td>
<td>54</td>
</tr>
</tbody>
</table>
TABLE 24: PLACEMENT TYPE  

<table>
<thead>
<tr>
<th>No.</th>
<th>Own home</th>
<th>Bed &amp; Breakfast</th>
<th>Staffed private home</th>
<th>Nursing home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

The four in the staffed private home were resident in the same facility, which has strong links with the discharging ward. The three participants living in their own home all lived alone. The length of time that community participants had lived in their current setting and the length of time of their previous admission is summarised in months in Table 25:

TABLE 25: TIME IN SETTING AND ADMISSION DATA  

<table>
<thead>
<tr>
<th></th>
<th>Mean (years)</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time in setting</td>
<td>14</td>
<td>16</td>
<td>2-31</td>
</tr>
<tr>
<td>Length of last admission</td>
<td>29.8</td>
<td>25</td>
<td>9-128</td>
</tr>
<tr>
<td>Time on REHAB. ward</td>
<td>14.3</td>
<td>12</td>
<td>7-39</td>
</tr>
</tbody>
</table>

The Hospital Group.

The hospital group consisted of five women and five men. Four men and two women had a diagnosis of schizophrenia. One of the men had an additional diagnosis of psychopathic personality and had been admitted to the unit from a special hospital. The remaining four were diagnosed as depressed, one in addition to
borderline personality disorder (female) and one in addition to anorexia (male). None of the group were married, five were single, four divorced and one separated. The age and time since the first episode of illness is summarised in Table 26.

<table>
<thead>
<tr>
<th>TABLE 26: AGE AND TIME SINCE FIRST EPISODE</th>
<th>n=10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>Time since first Episode (years)</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Women n=5</td>
<td>41.6</td>
</tr>
<tr>
<td>Men n=5</td>
<td>41.0</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>41.3</td>
</tr>
</tbody>
</table>

The time spent on the rehabilitation ward and the length of time in hospital in months is summarised in Table 27:

<table>
<thead>
<tr>
<th>TABLE 27: TIME IN SETTING AND ADMISSION DATA, HOSPITAL GROUP</th>
<th>n=10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Time on REHAB ward</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>6.5</td>
<td>5</td>
</tr>
<tr>
<td>Length of current admission</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>58.8</td>
<td>9</td>
</tr>
</tbody>
</table>

246
Measures.

Quality of Life.

Lehman's (1983) Quality of Life assessment was used; it has been used in previous studies described in Chapter 4. It consists of a structured interview lasting between 30 minutes and an hour. Subjective data are obtained in eight life domains: living situation, family, social relations, leisure activities, work, finances, personal safety and health. Scores are obtained by the participant rating their satisfaction on a seven-point scale, from "terrible" to "delighted" for a series of items within each domain. A measure of general well-being is obtained on a similar scale. Objective data are obtained by asking direct questions about people's lives and their self report on physical and emotional well-being (see Appendix 8). Internal consistency has been shown to be adequate, reliability using the Chronbach alpha method ranged from 0.69 to 0.28 and test/re-test reliability correlations have been stable (Lehman 1988).

Level of Functioning.

The REHAB scale (Baker & Hall 1983) was used to assess level of functioning. This was described in detail in Chapter 2. It is used as part of routine assessment on the ward. Scores were therefore available for the hospital group,
and for the community group prior to discharge. A current assessment was completed for the community group by the person identified as being in closest contact.

Psychiatric Symptomatology.

The Present State Examination (Wing et al. 1974) was used to assess the level of current psychiatric symptomatology. Ideally a training course should be attended prior to the use of this measure. Due to practical limitations training was given by a medical colleague. A total symptom score is obtained, plus a rating of presentation made by the interviewer. The scale rates both the number of symptoms reported and their severity.

Environmental Quality.

The environmental measure from the QUARTZ assessment package (Leiper et al. 1992) was used to provide a measure of the quality of the facility. QUARTZ is a package designed to assess the quality of a service. The environmental component is based in part on ideas derived from the normalisation literature. It provides a measure of the quality of the accommodation relative to normative community standards, the facilities proximity to community facilities and the degree to which residents are integrated into the community. Ratings are made by the interviewer based on observations of the settings and questions asked of the participant or carer (see Appendix 9). A further measure has been developed and used in the TAPS
study - the Environmental Index (EI) (O'Driscoll and Leff 1993), which combines the sort of elements measured in this aspect of QUARTZ (the availability and access of amenities) with elements of Garety & Morris (1989) schedule (degree of autonomy available).

Results.

Demographic Details.

There was a significant difference in the ages of the hospital and community groups (u=15 p>0.01). A comparison of needs data also found a significant difference on the overall item (Table 28). A possible explanation was that the ward population had changed with the "old long-stay" group being over-represented in those discharged, and the current hospital group being predominantly made up of the "new long-stay" group; this being reflected in different profiles of demographic characteristics and level of functioning (as described by Mann and Cree 1976). A significant difference was not found for the global level of functioning measure, the total general behaviour score, or any of the other subscales.

Two of the hospital group were ex-special-hospital residents. It was felt that they might have biased the hospital group as they had remained in hospital due to legal factors, the remaining ward population might be a different group. The analysis was repeated excluding these two participants. It was
found that the time since first episode was now significant at the 0.05 level. No new significant differences were found. Age remained significant at the 0.01 level. The REHAB overall item was now significant at the p=0.05 level.

### TABLE 28: DEMOGRAPHIC DETAILS AND WARD REHAB

<table>
<thead>
<tr>
<th>Hospital Medians n=10</th>
<th>Community n=9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 41</td>
<td>54</td>
</tr>
<tr>
<td>Time since first episode 13</td>
<td>25</td>
</tr>
<tr>
<td>REHAB:</td>
<td></td>
</tr>
<tr>
<td>Deviant behaviour 0</td>
<td>0</td>
</tr>
<tr>
<td>Social activity 15.5</td>
<td>15</td>
</tr>
<tr>
<td>Speech disturbance 0</td>
<td>1</td>
</tr>
<tr>
<td>Self-care 9</td>
<td>5</td>
</tr>
<tr>
<td>Community skills 8</td>
<td>5</td>
</tr>
<tr>
<td>Overall 4</td>
<td>1</td>
</tr>
<tr>
<td>Total General Behaviour 32.5</td>
<td>30</td>
</tr>
</tbody>
</table>

In summary, the community group were significantly older. The exclusion of the ex-special hospital residents resulted in the community group having significantly longer psychiatric histories. There were no significant differences between the scores on the Total General Behaviour score. A significant difference was found for one REHAB subscale, overall rating, on which the community group scored significantly lower, indicating a higher level of functioning. This indicated that, whilst the groups were comparable in terms of most areas of functioning, the community group was significantly older and had been more able on one item - overall rating.
Quality of Life.

Subjective ratings.

Only three participants worked, two in the hospital group and one in the community group. This measure relating to work was therefore excluded from the analysis. One participant was unable to answer on two items, from the domains of activity and health. A second had no family and was unable to rate satisfaction in that domain. These individuals were therefore excluded from analyses in those domains. Table 29 summarises medians of reported levels of satisfaction for the two groups. The medians were higher for the community sample on all domains, and a number were significantly higher.
### TABLE 29: SUBJECTIVE RATINGS OF SATISFACTION:

**HOSPITAL vs COMMUNITY GROUPS**

<table>
<thead>
<tr>
<th></th>
<th>Out of Total Score</th>
<th>Hospital N=10 Medians</th>
<th>Community N=9</th>
<th>U</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Satisfaction</td>
<td>14</td>
<td>7.5</td>
<td>11</td>
<td>19.0</td>
<td>0.017*</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>42</td>
<td>27</td>
<td>38</td>
<td>14.0</td>
<td>0.006**</td>
</tr>
<tr>
<td>Community Activity</td>
<td>42</td>
<td>28</td>
<td>31</td>
<td>33.5</td>
<td>0.175</td>
</tr>
<tr>
<td>Activity</td>
<td>42</td>
<td>23</td>
<td>32</td>
<td>13.0</td>
<td>0.007**</td>
</tr>
<tr>
<td>Family</td>
<td>28</td>
<td>16.5</td>
<td>20</td>
<td>21.0</td>
<td>0.047*</td>
</tr>
<tr>
<td>Social Relations</td>
<td>42</td>
<td>25</td>
<td>30</td>
<td>31.5</td>
<td>0.13</td>
</tr>
<tr>
<td>Money</td>
<td>28</td>
<td>10</td>
<td>18</td>
<td>24.0</td>
<td>0.044*</td>
</tr>
<tr>
<td>Safety</td>
<td>35</td>
<td>23</td>
<td>30</td>
<td>16.5</td>
<td>0.009*</td>
</tr>
<tr>
<td>Health</td>
<td>42</td>
<td>26</td>
<td>32</td>
<td>21.5</td>
<td>0.048*</td>
</tr>
</tbody>
</table>

*p<0.05; **p<0.01

**Objective Indicators.**

For three objective indicators very few participants scored and the ranges were small: work, victim of crime, and perpetrator of crime. These were not therefore included in the statistical analysis. Three participants had some sort of work. One community participant worked in a voluntary capacity part time. One hospital resident worked full-time in sheltered employment, and one did part time voluntary work. No community participants reported being the victim of crime, or being
arrested. One hospital resident reported being arrested in the past year for breaking and entering a property while homeless. This occurred immediately prior to the current admission. Three hospital residents reported being the victim of crime: one had his house vandalised and two suffered from theft.

Medians and U values for Mann Witney U test are given in Table 30. A significant difference was found for two measures: self-report and feelings. The trend for all medians was as for subjective indicators with community residents tending to always be more satisfied apart from family and limits categories.

**TABLE 30: OBJECTIVE QOL - HOSPITAL vs COMMUNITY GROUPS**

<table>
<thead>
<tr>
<th></th>
<th>Out of Total</th>
<th>Hospital n=10 Medians</th>
<th>Community n=9 Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>16</td>
<td>6.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Self-Report</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Family</td>
<td>10</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Social Relations</td>
<td>32</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Money</td>
<td>12</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Health</td>
<td>30</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Limits</td>
<td>42</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Feelings</td>
<td>60</td>
<td>30</td>
<td>44</td>
</tr>
<tr>
<td>Pain</td>
<td>11</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

A significant difference was found for two measures, self report (μ=13 p<0.01) and feelings (μ=23 p<0.05). The trend for
means was in the expected direction for other measures, apart from family and limits.

Level of Functioning.

Between Groups Comparison.

Mann Witney U tests, were carried out on all sub-scales of the REHAB assessment, comparing current REHAB scores for both groups. A significant difference was found between two subscales, community skills ($\mu=17.5 \ p<0.05$) and the overall measure ($\mu=14 \ p<0.02$), indicating that the hospital group had greater needs in these areas.

Between Subjects Comparison: Community Group.

Wilcoxon paired comparisons, were carried out on all subscales of the REHAB to compare the current scores of individuals living in the community with their scores while in hospital. For two participants there were no current REHAB scores. They were therefore excluded from this analysis. No significant differences were found between individuals scores now and when they were resident on the ward. People's needs appeared to have remained unchanged regardless of setting.
Dependency Profiles.

It was hypothesised that there might be clinical differences between the hospital and community groups not picked up by this overall analysis. Looking at dependency profiles appeared to be useful, as hospital participants seemed to have higher incidences of problem behaviours which may make community placement difficult. The items on the deviant behaviour subscale were looked at for each group, and for both assessments for the community group, to see if this theory was useful, and are shown in Table 31. The table shows the sum of scores for each category, and the figure in brackets shows how many individuals contributed to this score. By inspection of the data, there was a different pattern in items scored between the hospital group and the community group, both for current assessment and ward assessment. Three of the ward residents score on the self injury category versus none of the community residents, currently or at time of discharge. This is clinically suggestive rather than statistically significant, but does suggest that particular problems may be more likely to cause an individual to remain in hospital rather than their overall dependency level, which was borne out by the discriminant analysis performed on the hospital population data in the previous study.
No significant differences were found for the global level of functioning measure (total general behaviour) between community participants and a.) hospital participants, and b.) their own scores while in hospital. Two subscales only showed a significantly lower score for the community group compared with the hospital group: overall measure and community skills.
TABLE 31: ITEMS SCORES ON DEVIANT BEHAVIOUR SCALE, HOSPITAL AND COMMUNITY, CURRENT AND WHEN ON WARD.

<table>
<thead>
<tr>
<th></th>
<th>HOSPITAL</th>
<th>COMMUNITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sum of Scores</td>
<td>Current</td>
<td>Ward</td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td>1 [1]</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Self-Injury</td>
<td>6 [3]</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Sexually Inappropriate</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Absconding</td>
<td>0</td>
<td>0</td>
<td>1 [1]</td>
<td></td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>0</td>
<td>0</td>
<td>2 [1]</td>
<td></td>
</tr>
</tbody>
</table>

[] reports no. of individuals with problems in this area.

Psychiatric Symptomatology.

Mann Witney U-tests were carried out for the four scales derived from the PSE. No significant differences were found for any scales, indicating that the hospital and community groups had similar levels of symptomatology.

Environmental Quality.

A Wilcoxon paired comparison was performed on the environmental scales derived from QUARTZ to compare current setting with hospital for community participants (see Table 32). Community settings scored significantly higher than the hospital.
on measures of location and facilities. Community facilities were more blended in with their surroundings, had better access to facilities and internal facilities were of a higher standard. For the integration subscale there was no significant difference.

**TABLE 32: QUARTZ MEASURES, HOSPITAL vs COMMUNITY GROUPS**

<table>
<thead>
<tr>
<th></th>
<th>Hospital Medians</th>
<th>Community Medians</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>34</td>
<td>46</td>
<td>0.0</td>
<td>0.004**</td>
</tr>
<tr>
<td>Facilities</td>
<td>9</td>
<td>20</td>
<td>0.0</td>
<td>0.004**</td>
</tr>
<tr>
<td>Integration</td>
<td>18</td>
<td>17</td>
<td>4.0</td>
<td>0.97</td>
</tr>
</tbody>
</table>

** p<0.01

 Associations with Subjective Quality of Life.

A number of significant correlations were found with subjective ratings of satisfaction. Results are presented for all participants in Table 33.
<table>
<thead>
<tr>
<th>GENERAL RATING</th>
<th>SPEARMAN R</th>
<th>DEGREES OF FREEDOM</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.68</td>
<td>17</td>
<td>0.001**</td>
</tr>
<tr>
<td>Time in Setting</td>
<td>.68</td>
<td>17</td>
<td>0.008**</td>
</tr>
<tr>
<td>Time since First Episode</td>
<td>.69</td>
<td>17</td>
<td>0.0009**</td>
</tr>
<tr>
<td>Objective Self-Report</td>
<td>.64</td>
<td>17</td>
<td>0.003*</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>.52</td>
<td>17</td>
<td>0.02*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.45</td>
<td>17</td>
<td>0.049*</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-.58</td>
<td>17</td>
<td>0.008**</td>
</tr>
<tr>
<td>Objective Feelings</td>
<td>.52</td>
<td>17</td>
<td>0.02*</td>
</tr>
<tr>
<td>Objective Pain</td>
<td>.46</td>
<td>17</td>
<td>0.43*</td>
</tr>
<tr>
<td><strong>Living Arrangements:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Facilities</td>
<td>.57</td>
<td>17</td>
<td>0.009**</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>.53</td>
<td>17</td>
<td>0.019*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.45</td>
<td>17</td>
<td>0.050*</td>
</tr>
<tr>
<td>Support in Setting</td>
<td>.56</td>
<td>17</td>
<td>0.11*</td>
</tr>
<tr>
<td><strong>Community:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.47</td>
<td>17</td>
<td>0.039*</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-.58</td>
<td>16</td>
<td>0.010*</td>
</tr>
<tr>
<td>Support in Setting</td>
<td>.47</td>
<td>16</td>
<td>0.045*</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>.57</td>
<td>16</td>
<td>0.012*</td>
</tr>
<tr>
<td><strong>Family:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.64</td>
<td>16</td>
<td>0.004**</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-.70</td>
<td>16</td>
<td>0.001**</td>
</tr>
<tr>
<td>Time since First Episode</td>
<td>.45</td>
<td>16</td>
<td>0.044*</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>.53</td>
<td>16</td>
<td>0.012*</td>
</tr>
<tr>
<td><strong>Social Relation:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSE Neurotic Symptom</td>
<td>-.59</td>
<td>17</td>
<td>0.012*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.54</td>
<td>17</td>
<td>0.015*</td>
</tr>
<tr>
<td><strong>Money:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time since First Episode</td>
<td>.75</td>
<td>17</td>
<td>0.0002**</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-.53</td>
<td>17</td>
<td>0.018*</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>.49</td>
<td>17</td>
<td>0.031*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.49</td>
<td>17</td>
<td>0.031*</td>
</tr>
<tr>
<td><strong>Safety:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.57</td>
<td>17</td>
<td>0.009**</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-.57</td>
<td>17</td>
<td>0.010**</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>.57</td>
<td>17</td>
<td>0.010**</td>
</tr>
<tr>
<td>Time since First Episode</td>
<td>.49</td>
<td>17</td>
<td>0.031*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-.53</td>
<td>17</td>
<td>0.018*</td>
</tr>
<tr>
<td><strong>Health:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time since First Episode</td>
<td>.69</td>
<td>16</td>
<td>0.001**</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-.58</td>
<td>16</td>
<td>0.011*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-0.53</td>
<td>16</td>
<td>0.023*</td>
</tr>
</tbody>
</table>

**p<0.01 *p<0.05**
Because of the number of comparisons made, it would be expected that approximately 13 would correlate at the p<0.05 level by chance alone. Correlations significant at this level should therefore be treated with caution. Higher subjective ratings of satisfaction are associated with being older, having a longer psychiatric history and having a low level of symptomatology. Amongst the objective qol indicators, self report of higher level of functioning, not being in pain and reporting positive feelings are associated with higher reported satisfaction (the latter two at the p<0.05 level only). Level of functioning was not associated with reported satisfaction. Marital status and many of the objective indicators do not show a significant association with reported satisfaction. Level of support in setting was associated with higher reported satisfaction in the domains of living arrangements and activity. Those living in less supportive environments report higher satisfaction. This is at the p<0.05 level only however. For the community group alone, satisfaction across the domains is additionally associated with objective money, a low reported level of limitation on activity, and good health. No significant association was found with level of support in setting, the number of professionals in contact or the level of day-care received. Associations with the environmental measures were not significant in this analysis. The associations between age, time since first episode and neurotic symptoms and general satisfaction were lost. Longer time in setting remained
associated with high reported general satisfaction, but at
p<0.05. High scores on PSE scales were associated with low
reported satisfaction in the domains of family and social
relations.

One subscale of REHAB, namely speech disturbance,
correlated with satisfaction with living arrangements, at the
p<0.01 level. Individuals with more disturbed speech reported
lower satisfaction. For the hospital group alone satisfaction
for different domains was associated with high scores on some
objective measures, activity, family, feelings, money and
limitation on activity. The association between age and high
reported general satisfaction was lost. Low satisfaction in the
domains of community and safety was associated with high scores
on the PSE.

Type of residence was associated with reported satisfaction
with living arrangements and activity. Individuals living in
less supported settings reported greater satisfaction. This was
significant at the p<0.05 level only and must therefore be
treated with caution. This association was not found for the
community group only.

Environmental quality was associated with higher reported
satisfaction. People in settings with good facilities report
greater satisfaction with their living arrangements. Those in
settings scoring high on location were happier with their
perceived safety. Other associations were significant at the p<0.05 level only.

Level of functioning was not associated with reported satisfaction. For the community group only higher levels of disturbed speech is associated with lower reported satisfaction, perhaps indicating that, due to this difficulty, they felt isolated.

Level of psychopathology, as measured by the PSE scales, was associated with reported satisfaction. Individuals reporting larger numbers and more severe neurotic and total symptoms were less satisfied.

Few objective measures correlated with reported satisfaction. Only objective self report correlated at the p<0.01 level. Individuals who rated their level of functioning higher, reported greater satisfaction.

Summary of Results.

The two groups differed with regard to age, the community group being significantly older. Community participants reported higher levels of subjective satisfaction than hospital residents. This was particularly so in the areas of living arrangements, activity, and safety. Community participants scored higher on a self rating of level of functioning and on reporting positive feelings.
No significant difference was found for the overall level of functioning (REHAB total general behaviour) between the two groups. However, two subscales indicated significantly better functioning for the community group, overall, and community skills. No significant differences were found between the community group's current REHAB scores and their scores whilst in hospital. An analysis of items scored on the deviant behaviour scale suggested that hospital participants had particular problems that made them more likely to stay in hospital. This was a pattern also seen in the previous study of the hospital population, when a discriminant analysis of the factors influencing outcome suggested that particular problems may be more predictive of staying in hospital rather than scores. No significant differences were found between the two groups on level of psychiatric symptomatology.

Community settings scored significantly higher on two subscales of the measure of environmental quality, location and facilities. Higher scores on the measure of integration were not found.

High reported satisfaction was associated with being older, living in settings with good facilities and in good locations, and having a low level of psychiatric symptomatology.
Discussion.

Quality of Life.

The main finding from this study was that participants living in the community reported greater satisfaction with life in general and within different domains than those living in hospital. Lehman et al. (1982) report that for a sample of people with long-term mental health problems living in board and care homes, 56% rated general life satisfaction as "mostly satisfied" or above. Barry et al. (1993) report that for hospital residents 61% rated general life satisfaction as "satisfied" or above (using a five point scale). In this sample 7 of the 19 participants (36%) rated general life satisfaction as "mostly satisfied" or above. By groups, this means that 55% of the community group were satisfied, and 20% of the hospital group. (For the domain-specific ratings it was unclear how the researchers had treated ratings with several items, so no comparison is made). Satisfaction for community residents appears to be comparable to Lehman's sample. For hospital residents reported satisfaction in this study appears to be lower than for Barry et al.'s participants. In the latter study high satisfaction is associated with high dependency. Reasons given are possible limited range of experience and low expectations and aspirations. Unfortunately the authors do not cite REHAB scores so a comparison between the groups studied is not possible. Another explanation might be that there are differences in the quality of the two hospital environments that
account for differences in reported satisfaction. It would be interesting to examine factors associated with qol across different hospital environments.

Satisfaction correlated with three demographic measures, age, time since first episode, and time in setting. The association with age is lost for within group correlations, suggesting this association is an artefact of the underlying difference between groups. Another explanation is that the association with age rather than setting is responsible for the group difference found. No other studies report an association with age for this population. However, studies of the general population suggest that older people report higher subjective life satisfaction (Campbell et al. 1976). Time since first episode is confounded by age. The association found may be explained by the association with age. Alternatively, it may reflect a real association. Longer psychiatric histories may mean individuals have found personal adaptations to their situation and be less subjectively dissatisfied.

The association between subjective qol and the objective indicators was limited in this study. This is in accordance with other findings, eg. Barry et al. (1993). Barry et al. suggest that this is due to individual factors associated with having long term mental health problems, such as a limited range of experiences and low expectations. This may lead to individuals being relatively satisfied with living conditions that raters would find intolerable. Alternatively, the
objective measures selected may not be those that contribute to feelings of well-being and satisfaction for this group. The measures may be insufficiently sensitive to experiences that enhance life satisfaction.

For this study there were strong associations between expressed satisfaction and two measures of environmental quality, location and facilities, for the analysis involving all participants. However this association was not found for community participants only, perhaps because of the narrow range of scores.

Expressed satisfaction was negatively correlated with the PSE scales of psychotic symptoms, neurotic symptoms and total symptoms. This is in accordance with findings from other studies eg. Simpson et al. (1989), Barry et al. (1993) and Lehman (1983). There is a need to control for symptomatology in research designs, however the level of symptomatology was not significantly different between the hospital and community groups. Clinically the finding highlights the importance of symptoms for quality of life and the need to monitor individual's mental state.

There were few significant differences found on the objective indices. No evidence was found for community participants having a higher level of social contact, activity, contact with family, financial security or health. The TAPS project suggests that gains for community living are shown in
the number of contacts named as friends rather than degree of
social contacts. The measure of social contact in the Lehman
schedule concentrates on the frequency rather than the quality
of contact. A more fine grained assessment of individuals'
social networks might pick up qualitative differences. Equally,
the activity measure is a simple checklist of common activities.
Areas like family situation and health are unlikely to be
altered by community placement.

Significant differences were found for self report, and
reporting positive feelings. Both these measures are based on
individual self assessment and may thus be influenced by factors
such as self esteem and positive attitudes. They may therefore
be tapping into differences in subjective attitude and therefore
behave similarly to subjective satisfaction ratings.

Level of Need and Symptomatology.

A longitudinal analysis of REHAB scores indicated that
there were no significant changes in level of functioning since
discharge. This finding must be treated with caution given the
small numbers and issues of inter-rater reliability (see below
for fuller discussion of limitations). Similarly there were
few significant differences between current REHAB scores between
groups. Community participants showed better level of
functioning on community skills, as would be expected given that
this measure in part measures use of community facilities, and
the overall measure. Ratings on this latter scale refer to
judgements as to the ability of the assessed to live outside hospital. Given the community group were doing so a significant difference would be expected. The overall level of functioning scale (total general behaviour) did not show significantly better functioning for community residents. The level of functioning of the community group is comparable with residents in ordinary houses supported by staff in Northampton (See Study 2). Conning and Brownlow (1992) suggest that the REHAB scale is not an ideal tool for deciding on placement. In a survey of long-stay patients they found a number whose scores on the REHAB total general behaviour scale suggested potential to live in the community.

Factors associated with continued hospital residence were fluctuating mental state, adverse reaction to change, and items scored on the deviant behaviour scale. This present study found no significant difference on the total general behaviour score between groups. This suggests that decisions about discharge are not made solely on the basis of level of functioning, and is in line with the findings of the previous study which suggested particular difficulties may be more predictive of outcome. Similarly there was no significant difference between deviant behaviour scores. A closer analysis suggests that it is the type of behaviour that predicts discharge. Three of the hospital group score on self injurious behaviour. This behaviour may be seen as particularly difficult for community settings to manage. There is a need for units that can manage and treat behaviours such as self-injury within the community to
allow these individuals the benefits of community residence. Similarly, there were no significant differences between levels of psychiatric symptomatology between the two groups.

The cross-sectional nature of the design means that conclusions cannot be drawn as to the effects of community living on level of functioning or symptomatology. This is in accordance with outcomes cited for the TAPS project (Anderson et al. 1993). They report no significant changes in social behaviour (as measured by the Social Behaviour Schedule: Stuart & Wykes, 1986) or mental state (measured using PSE) for hospital leavers. The one year data suggest that the psychiatric status of discharged long-term mentally ill individuals remains stable. Gains for the TAPS cohorts were in experiencing less restrictive environments, more positive attitudes towards their accommodation and an increase in the number of social contacts named as friends. This study suggests that community living may enhance subjective quality of life, but it is confounded by the differences in the two populations, and the self-selection of the community group which suffered from a high refusal rate.

Individuals with relatively high needs can survive in the community, given the right settings. This suggests that the aim of services for people with long-term mental health problems should be to provide care rather than to improve functioning (Hall 1989). There is a suggestion that community residence
enhances quality of life, although the results of this study do not permit conclusions to be drawn as to which factors are responsible due to the differences in the two groups.

**Environmental Quality.**

Community settings were shown to be better integrated into the surroundings, have better access to community facilities, and have a higher standard of facilities than the hospital. On the measure of integration no significant difference was found. Scores for the community settings were lower than the hospital. Individuals on the ward have input aimed at increasing their level of activity and use of community facilities. Nursing and O.T. staff regularly accompany residents on trips to local facilities as part of rehabilitation programmes. For the residents in the private home basic shopping and cooking was catered for. There was therefore no need for these individuals to make use of shops etc. on a regular basis. One item of the scale relates to the extent to which community facilities were used as an active intervention. None of the staffed settings did so and this item was inappropriate for people living in their own homes. One individual did score, having an activity schedule as part of a psychological intervention. This scale may therefore be inappropriate for use across a range of settings. However this may suggest a lack in community provision settings of intervention to maintain skill levels of
people once they are discharged. In addition, it is interesting that one of the community settings, a staffed private home, was in some ways more institutional in its practice than the ward.

Methodological Difficulties.

Design.

The cross sectional design of the majority of analyses does not permit conclusions to be drawn about causal relations between community living and improved quality of life. A longitudinal design, assessing people while on the ward and at intervals during residence in the community, would enable stronger conclusions to be drawn as to the impact of residence upon quality of life. An improvement would be to follow-up the hospital participants as they are discharged, and this was undertaken as the next study. Allocation into groups is not random. This reflects the reality of undertaking research in clinical settings but may introduce biases into the results. Discharged clients tend to have higher levels of functioning and express a desire to leave hospital. In this study, level of functioning while in hospital did not appear to differ for the two groups. However, there is a suggestion that the hospital group showed particular features which may account for their continued residence. Three scored for self-injurious behaviour and two were on Home Office sections; this differential pattern had been seen in the previous study of hospital population.
Attitude to hospital was not assessed. Those discharged may have had more negative attitudes to living in hospital. They may therefore be inclined to rate their current accommodation higher.

The small sample size is a major limitation of this study and severely curtails the degree to which conclusions may be drawn about this population. The high rate of attrition due to various factors may bias these findings. The untraceable group may represent those who are functioning well and do not require continued contact with services. Alternatively, they may be lost to follow-up due to placements having broken down. It is not possible to determine which.

There was a high refusal rate for both groups. For the community group a frequent reason given was a desire to have no contact with anyone associated with the hospital and to do no more assessments. Those individuals with particularly negative experiences of hospital may be those who refuse to take part. For the hospital group few reasons were given. It was felt that the refusing individuals were those pre-occupied with current difficulties or holding negative attitudes to staff. They may therefore hold more negative views of quality of life in hospital.
The Quality of Life Schedule.

There may have been a repose bias as individuals may have been unwilling to express dissatisfaction with life in hospital to someone perceived as being involved in their care. Together with the bias introduced by the refusal rate, this suggests that biases operate in the direction of higher ratings of satisfaction for the hospital group. A similar bias may have operated for community participants, particularly as those who refused expressed a desire to have nothing more to do with the hospital, suggesting they made this connection. For those interviewed, many expressed a desire not to return to hospital. The connection of the interviewer with that facility may have made them rate current circumstances higher. Training an ex-user to carry out this part of the research would be an improvement which could reduce bias due to the perception of the interview.

Two participants were illiterate. Care was taken to explain the principle behind the scale fully and it was adapted to show feelings pictorially, using faces. The impression was that these two participants were making satisfactory, graded judgements. However, the implications of this adaptation are not clear.
Needs Assessment (REHAB).

This measure was not designed for use in a range of community settings. It was used as its regular utilisation on the ward allowed comparisons of community residents' current REHAB scores with their assessments when they had last been on the ward. The implications of using un-trained raters is not clear. No inter-rater reliability checks were carried out as often there was not more than one person in regular contact with the individual concerned. For trained raters, most were in face-to-face contact for a small proportion of the designated assessment week. Raters were requested to make judgements on their knowledge of the client. This may result in low incidence behaviours, such as those coded on the deviant behaviour scale, being under-reported.

The overall measure describes a high score as indicating that the person would be able to function adequately in the community. For community participants this is clearly the case. Raters may be making judgements on this scale without reference to actual behaviour. Other items seemed to bear questionable relevance to community settings, for example absconding on the deviant behaviour scale. REHAB may not have been the most suitable measure of level of functioning, and measures such as Camberwell Assessment of Need (Phelan et al. 1995), may have been more appropriate. REHAB was used because it allowed for a longitudinal comparison. The extent to which conclusions may be
drawn from this comparison is limited due to factors affecting rater reliability outlined above. In addition, the comparison is confounded by there being differing time intervals between ratings for different participants.

Level of Symptomatology Measure (PSE).

This scale covered a wide range of possible symptoms in some detail, many of which were not relevant to the client, and some clients felt the length of time to administer the scale aversive. More suitable measures might have been the Brief Psychiatric Rating Scale (Overall & Gorham 1962), or the Krawiecka rating scale (Krawiecka et al. 1977).

Measure of Environmental Quality (QUARTZ).

No data on the reliability or validity of this measure were available. It is in the stage of being used as a research tool (Pilling 1993). The full assessment's length and training requirements may discourage routine clinical use.

Community Service Implications.

Community residence in this study was associated with higher ratings of satisfaction. This positive finding is set against methodological difficulties, clinical impressions gained in the course of this study and some qualitative data. There was little variability in the range of settings available, four
people being in one private care home. This may be an artefact of the recruitment process. People in this home were also in day care and in contact with the ward. The establishment houses people, all previously resident at the local psychiatric hospital. Practice was felt to be group oriented, with little planning for individual needs. The setting scored relatively well on the QUARTZ measure, since it was clean and comfortable. However it had an institutional feel to it, with one residents' lounge and large numbers of fire doors. Study one has already demonstrated that locating facilities within the community did not automatically result in a change in staff and organisational practice. Equally, private facilities may acquire institutional type practices, such as over-meeting needs. There is a need to evaluate and monitor practice in private establishments. Five of the nine community participants had some sort of day care programme. All went to specialist faculties. The discharging ward provided just under half of all day care received by the community group. Time spent on the ward ranged from one session to two full days a week. This suggested that there was a lack of facilities based in the community for day care as the hospital approached closure. Alternatively, the lack of individual planning for care after discharge may mean there is little creative use of community possibilities. As one participant observed, "What kind of care in the community is that?!".
The use of the ward to provide day-care does allow for continuity of care for these individuals. There is a need for community based services to provide support and continuity in more normative settings. Only one participant had any kind of employment, part-time voluntary work, no analysis of the effect of employment status on quality of life was therefore possible. However, it is felt that this reflects the low level of integration with the community in general, and that when job opportunities are low that this group in particular tend to suffer.

One client had no contact with any psychiatric professional. She was resident in a nursing home. Three saw a psychiatrist for review at six monthly intervals. The remainder had professional contacts in addition to the psychiatrist, with social worker, O.T., CPN or psychologist. Although this was not systematically investigated, the impression gained was that some individuals with a relatively high level of symptoms received infrequent contact only. The level of re-admission within this service suggests that there is a need for monitoring of individuals' mental state to predict relapse, and avoid people requiring re-admission (Birchwood et al., 1989). In addition, given the finding that higher levels of symptomatology are associated with lower subjective ratings, this might be an effective target for intervention to improve quality of life. Interventions might include more regular review of medication
and psychological approaches to emotional adaptation and psychotic symptoms.

Conclusions.

Despite the methodological difficulties of this study there was a suggestion that people with long term mental health problems can be relatively satisfied with life in the community. This appeared to be independent of level of functioning or the objective measures of life quality used in this study, but not symptomatology. Individual factors such as raised self esteem consequent on no longer being a psychiatric hospital resident may also be important. A longitudinal study to investigate whether quality of life is sensitive to changes in residence and circumstance would offer a way round some of the difficulties found in this study, although it would involve waiting for a sufficient number of people to be discharged from the current ward population to allow a comparison. This was undertaken as the next study.

This study suggested that subjective quality of life is an important component when assessing hospital closure, particularly if the benefits of community care are to be demonstrated. Clinical outcomes concentrating on need and symptom level may reveal no benefits for community residence. Studies that concentrate on these alone may fail to assess the impact of community residence on perceived satisfaction with life.
STUDY 7: A LONGITUDINAL STUDY COMPARING USERS VIEWS OF THEIR QUALITY OF LIFE WHEN IN HOSPITAL AND WHEN DISCHARGED TO THE COMMUNITY.

Given the methodological difficulties of the previous study - selection bias and differences between the hospital and community groups which may have occurred possibly for the results obtained, a further study was undertaken which involved waiting for the original hospital group to be discharged and, once they had been in the community for six months, to reassess them and compare with their original assessments. This would overcome the difficulties of the two original groups being different. The same outcome measures were utilised to enable a comparison with the original set of data. The timescale of this study was longer as it involved waiting for a sufficient number of the original group to be discharged to allow a comparison to be made.

Participants

The ten people who originally took part in the initial study whilst in hospital were approached to take part in this second study. None refused to take part; this may have been because people on the ward who had not wished to be included had already refused during the initial study (4). The study was undertaken over a two year period after the initial study, assessments being undertaken after people had been in the community for six months. This was the case for 8 of the original 10 residents, two after this period remained in
hospital, one on the original rehabilitation ward, and the other was transferred to a long stay ward. They were also reassessed at the end of this two year period. Since the hospital's subsequent closure one of these has transferred with the other residents of the rehabilitation ward to a large house in the community with the staff, and the other individual on the long stay unit died prior to the hospital closure.

**Placement Type**

Table 34 lists the type of placement of the group when they were re-assessed:

**TABLE 34: PLACEMENT AT REASSESSMENT**

<table>
<thead>
<tr>
<th>Type of Placement</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home</td>
<td>2</td>
</tr>
<tr>
<td>Own/Rented Flat</td>
<td>2</td>
</tr>
<tr>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>Shared Rental House</td>
<td>1</td>
</tr>
<tr>
<td>Social Services Hostel</td>
<td>1</td>
</tr>
<tr>
<td>Supported</td>
<td></td>
</tr>
<tr>
<td>Health Services Supported House</td>
<td>2</td>
</tr>
<tr>
<td>Hospital REHAB Ward</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Long Stay Ward</td>
<td>1</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
</tbody>
</table>
In comparison with the nine community residents in the previous study, more had progressed onto independent living facilities: five (50%) compared with three (33%). However, two were still in a hospital setting after two years.

Demographic Details

The age and time since first episode of the total group, group discharged to community, and group remaining in hospital is detailed in Table 35.

<table>
<thead>
<tr>
<th></th>
<th>Age (Years)</th>
<th>Time Since First Episode (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Total Group n=10</td>
<td>42.3</td>
<td>43</td>
</tr>
<tr>
<td>Discharged Group n=8</td>
<td>41.4</td>
<td>43</td>
</tr>
<tr>
<td>Hospital Group n=2</td>
<td>46</td>
<td>--</td>
</tr>
</tbody>
</table>

Of the total group five were men and five women; of the discharged group four men and four women; and a man and a woman remained in hospital. The discharged group consisted of three men and two women with a diagnosis of schizophrenia, one man with a diagnosis of depression and anorexia, and two women with a diagnosis of depression. The two who remained in hospital were a man with a diagnosis of schizophrenia and psychopathic personality who had been admitted from a special hospital, and a woman with a diagnosis of depression and
borderline personality disorder; both had histories of self-injury. None of the participants were married, and two had a job. The time in the unit prior to discharge is summarised in Table 36.

**TABLE 36: TIME ON UNIT PRIOR TO DISCHARGE (months)**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged Group n=8</td>
<td>7.75</td>
<td>8</td>
<td>1-19</td>
</tr>
</tbody>
</table>

**Measures**

The measures were as described in the previous study:-

- Level of functioning - Rehab (Hall and Baker 1987)
- Quality of Life assessment - (Lehman 1983)
- Psychiatric Symptomology - PSE. (Wing et al. 1974)
- Environmental Quality - Quartz (Leiper et al. 1992)

**Results**

**Level of Functioning.**

The REHAB assessment was completed by a named person, who had most contact with the individual and knew them best. Their relationship to the participant is summarised in Table 37.
A comparison of the REHAB assessment for the eight individuals discharged to the community indicated the following:

**TABLE 38: COMPARISON OF REHAB ASSESSMENTS FOR INDIVIDUALS IN HOSPITALS AND COMMUNITY**

<table>
<thead>
<tr>
<th>REHAB</th>
<th>HOSPITAL Medians</th>
<th>COMMUNITY Medians</th>
<th>Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deviant Behaviour</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Activity</td>
<td>21.5</td>
<td>16.5</td>
<td>0.98</td>
<td>0.33</td>
</tr>
<tr>
<td>Speech Disturbance</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Self Care</td>
<td>10.5</td>
<td>9.5</td>
<td>0.91</td>
<td>0.37</td>
</tr>
<tr>
<td>Community Skills</td>
<td>8.5</td>
<td>0</td>
<td>2.77</td>
<td>0.01*</td>
</tr>
<tr>
<td>Overall</td>
<td>4.5</td>
<td>0</td>
<td>2.17</td>
<td>0.03*</td>
</tr>
<tr>
<td>Total General Behaviour</td>
<td>46.5</td>
<td>36</td>
<td>1.19</td>
<td>0.24</td>
</tr>
</tbody>
</table>

This comparison using the Wilcoxon matched pairs test suggested that since discharge there had been a significant improvement in community skills, and overall rating. It is difficult to know if this first improvement had allowed discharge, or if it had been the effect of discharge allowing.
people to make more use of their skills. The previous study had found a difference between the two groups on overall rating but not community skills. It may have been that the ward group had been more able in terms of community skills, and the group that had been previously discharged to the community had only improved to this level after discharge.

Quality of Life

Subjective Ratings.

A comparison of the subjective ratings of quality of life in hospital and community settings using the Wilcoxon matched pairs test is given in Table 39. This shows only two significant results, for general satisfaction, and living arrangements compared with seven ratings show significant difference in the previous cross-sectional study when the two groups were referred. This would suggest that the previous findings may have been a result of group differences. The other difference in results of note, in that in the previous study all the findings that were significant suggested that the community groups subjective quality of life was greater.
TABLE 39: SUBJECTIVE RATINGS OF SATISFACTION

HOSPITAL vs COMMUNITY AFTER DISCHARGE (n = 8)

<table>
<thead>
<tr>
<th></th>
<th>MAX SCORE</th>
<th>HOSPITAL n=8 Medians</th>
<th>COMMUNITY n=8 Medians</th>
<th>Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Satisfaction</td>
<td>14</td>
<td>7.5</td>
<td>4.5</td>
<td>2.11</td>
<td>0.03*</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>42</td>
<td>27</td>
<td>31.5</td>
<td>1.89</td>
<td>0.05*</td>
</tr>
<tr>
<td>Community</td>
<td>42</td>
<td>28</td>
<td>34</td>
<td>1.68</td>
<td>0.09</td>
</tr>
<tr>
<td>Activity</td>
<td>42</td>
<td>23</td>
<td>27.5</td>
<td>1.36</td>
<td>0.18</td>
</tr>
<tr>
<td>Family</td>
<td>28</td>
<td>16.5</td>
<td>19</td>
<td>1.82</td>
<td>0.07</td>
</tr>
<tr>
<td>Social Relations</td>
<td>42</td>
<td>27.5</td>
<td>28</td>
<td>0.63</td>
<td>0.53</td>
</tr>
<tr>
<td>Money</td>
<td>28</td>
<td>9</td>
<td>12</td>
<td>0.34</td>
<td>0.74</td>
</tr>
<tr>
<td>Safety</td>
<td>35</td>
<td>23</td>
<td>20</td>
<td>1.01</td>
<td>0.31</td>
</tr>
<tr>
<td>Health</td>
<td>42</td>
<td>26</td>
<td>26.5</td>
<td>0.67</td>
<td>0.50</td>
</tr>
</tbody>
</table>

This is the case in this longitudinal study for living arrangements. Perhaps unsurprisingly, given the conditions on an old Victorian ward, compared with their current experience of the community where all had their own rooms and more independent living circumstances. However general satisfaction was in the reverse direction with the results suggesting that people in this study felt generally more satisfied with their life when in hospital rather than when later in the community. The Lehman is not an additive scale with subscales being summed to produce overall general satisfaction. This result may suggest that, whilst subjects were more satisfied with living arrangements, other important components in their estimation of general life satisfaction not measured by the Lehman scale have, in their perception, worsened with a move to the community.
One possible explanation of this based upon the experience of the interviewers, was the different time period in which the study was undertaken and the previous impact of the hospital's closure on the respondents' views of their own lives. The previous study had been carried out three years prior to the hospital's final closure. At this time, although people were aware that the hospital would close, this was not an immediate plan. The hospital was still fairly active and busy, the main block still being open, and the hospital still had its own shop, cafe and social activities. The median length of stay of the community group on the Rehabilitation ward had been 12 months.

In the longitudinal study, by the time the original ward group had reached the community, they had done so in the last few months prior to the hospital's final closure and the rehabilitation unit's relocation to a large house in the community. The main block closed during this period, and the hospital site was inactive, their median length of stay on the rehabilitation ward was 8 months. There also, for some people, appeared to be a different attribution concerning their move to the community, with a feeling that this had been hurried due to the hospital's impending closure and related to external factors, rather than due to their choice, at a time of their choosing, to a place they wished to go to. It would be of interest to look at the effect of attributions upon life satisfaction ratings, a perceived lack of control of one's own future this study would suggest may be worth further
exploring, and may be a factor in hospital closure. These factors may also play a role in staff turnover. On a personal note my own decision to leave the hospital at the point just prior to above was in part related to an impression of lack of influence on the process, and a perception of hospital closure being the priority rather than the provision of a good quality community service.

Objective Indicators

Areas relating to work, victims of crime and perpetrator of crime were not included in the analysis due to few participants reporting events in these areas. The median for hospital and community living are reported in Table 40, along with a Wilcoxon matched pairs comparison.
**TABLE 40: OBJECTIVE Q of L - HOSPITAL vs COMMUNITY EXPERIENCE**

<table>
<thead>
<tr>
<th>MAX SCORE</th>
<th>HOSPITAL n=8 Medians</th>
<th>COMMUNITY n=8 Medians</th>
<th>Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>16</td>
<td>6</td>
<td>8.5</td>
<td>1.69</td>
</tr>
<tr>
<td>Self Report</td>
<td>4</td>
<td>2</td>
<td>2.5</td>
<td>1.60</td>
</tr>
<tr>
<td>Family</td>
<td>10</td>
<td>5</td>
<td>5.5</td>
<td>1.21</td>
</tr>
<tr>
<td>Social Relations</td>
<td>32</td>
<td>8</td>
<td>8</td>
<td>0.33</td>
</tr>
<tr>
<td>Money</td>
<td>12</td>
<td>8.5</td>
<td>10.5</td>
<td>2.03</td>
</tr>
<tr>
<td>Health</td>
<td>30</td>
<td>18</td>
<td>28.5</td>
<td>0.94</td>
</tr>
<tr>
<td>Limits</td>
<td>42</td>
<td>37</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Feelings</td>
<td>60</td>
<td>36</td>
<td>39</td>
<td>1.12</td>
</tr>
<tr>
<td>Pain</td>
<td>11</td>
<td>8</td>
<td>8.5</td>
<td>0.21</td>
</tr>
</tbody>
</table>

Although most indicators were higher in community settings, indicating greater quality of life, only one achieved significance, the factor relating to money. In the previous cross-sectional group comparison only two factors had been significantly different; those relating to feelings and self-report. In this longitudinal study more individuals were living independently and eligible for benefits themselves, rather than those passing to landlords or statutory services. This would mean that objectively they would have a greater income when in the community compared with hospital, but would also be responsible for their own feed, household purchases etc., which would explain perhaps why they did not feel significantly more subjectively satisfied with their monetary income.
Psychiatric Symptomatology

There were no significant differences between the scores for individuals on the four scales derived from the PSE when comparing ward and community settings. This indicated that individuals' level of symptomatology had not changed between the two time periods.

There were no significant differences between the scores for individuals on the four scales derived from the PSE when comparing ward and community settings. This indicated that individuals' level of symptomatology had not changed between the two time periods.

Environmental Quality

Community settings scored significantly higher than the hospital setting on measures of location, facilities and integration. See Table 41 for a comparison of the scores in the two settings.

<table>
<thead>
<tr>
<th>TABLE 41: QUARTZ MEASURE. COMPARISON OF WARD SETTING AND SETTINGS GROUP WERE DISCHARGED TO IN THE COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Location</td>
</tr>
<tr>
<td>Facilities</td>
</tr>
<tr>
<td>Integration</td>
</tr>
</tbody>
</table>
This was in line with the previous study which also suggested that community settings that the community group had been discharged to were better blended into their surroundings, had better facilities, and were of a higher standard. The settings in this study were also better integrated into the community, whilst in the previous study there had been no significant difference between the two settings. This may have been because this group had been discharged in more independent settings and were therefore making greater use themselves of local facilities.

Associations with Subjective Quality of Life

Correlations were carried out for subjective quality of life with the other measures used. For significant correlations, the Spearman (R) and level of significance are shown in Table 42. In comparison with the previous study, it is notable that there are less significant correlations: 28 compared with 36, and only 5 at the p≤0.01 level compared with 12.

General Satisfaction

For general satisfaction, association with age, time since first episode, objective self-reports, feelings and pain, and environmental location, are no longer found. However, ratings with time in setting, total symptom and neurotic symptoms
remain, and for this population there is an association with objective finances. These differences between the studies may be accounted for by the differences between the two original groups. This group were significantly younger and had gone to more independent settings than the original community group. There was an association between less support in a setting and general satisfaction level. However, they underline in these studies the link of time in setting and lack of symptoms with ratings of general satisfaction, suggesting either that those generally satisfied are symptom-free and settled, or that symptom freedom and time in setting can lead to symptom reduction. Given the upheaval surrounding hospital closure, these associations are worth keeping in mind.

Living Arrangements

Satisfaction with living arrangements was again associated with environmental factors as measured by the QUARTZ measure. This was for all three environmental features: facilities, location, and integration. There were also associations between satisfaction with living arrangements and level of support and objective finances. Although the latter was in the reverse direction, with people with less income tending to be more satisfied, perhaps this was because they had fewer demands on that income.
Community

Satisfaction with community living was associated with two areas: environmental factors as measured by the QUARTZ, and lower symptom level as measured by the PSE.

Activity

Satisfaction with activity level was associated with symptom level, environmental integration and overall rating (REHAB). This appears to suggest that satisfaction with activities is linked to low levels of symptoms, good access to facilities, and a staff rating that you can do well.

Social Relations

As for the last study, there was an association between satisfaction with social relations and lower symptoms, but in this study there were also associations with two REHAB measures: deviant behaviour and overall rating. This suggests that those individuals who were satisfied would tend to have lower symptoms, less problem behaviour, and be seen as more likely to do well overall by staff.

Money

Associations were found between satisfaction with money and time since first episode and lower level of symptoms. This might suggest that, as time progresses since the onset of
mental health problems and symptoms become less severe, individuals adjust to their relatively low incomes.

**TABLE 42: CORRELATIONS WITH RATINGS OF SATISFACTION - LONGITUDINAL STUDY n=16**

<table>
<thead>
<tr>
<th>AREA OF SATISFACTION</th>
<th>SPEARMAN R</th>
<th>SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Satisfaction:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time in Setting</td>
<td>0.54</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td>Objective Finances</td>
<td>0.72</td>
<td>p≤0.0003**</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-0.46</td>
<td>p≤0.04*</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-0.58</td>
<td>p≤0.007**</td>
</tr>
<tr>
<td>Support in Setting</td>
<td>-0.48</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td><strong>Living Arrangements:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Facilities</td>
<td>0.62</td>
<td>p≤0.004**</td>
</tr>
<tr>
<td>Environmental Location</td>
<td>0.58</td>
<td>p≤0.008**</td>
</tr>
<tr>
<td>Environmental Integration</td>
<td>0.47</td>
<td>p≤0.04*</td>
</tr>
<tr>
<td>Objective Finances</td>
<td>-0.48</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td>Support in Setting</td>
<td>0.47</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td><strong>Community:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Location</td>
<td>0.49</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td>Environmental Facilities</td>
<td>0.50</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td>PSE Psychological Symptoms</td>
<td>-0.51</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-0.48</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-0.48</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td><strong>Activity:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Integration</td>
<td>0.45</td>
<td>p≤0.05*</td>
</tr>
<tr>
<td>Overall Rating (REHAB)</td>
<td>-0.52</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-0.56</td>
<td>p≤0.01**</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-0.54</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td><strong>Social Relations:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deviant Behaviour (REHAB)</td>
<td>-0.49</td>
<td>p≤0.03*</td>
</tr>
<tr>
<td>Overall Rating (REHAB)</td>
<td>-0.53</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td>PSE Neurotic Symptoms</td>
<td>-0.54</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td>PSE Negative Symptoms</td>
<td>-0.65</td>
<td>p≤0.002**</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-0.52</td>
<td>p≤0.02*</td>
</tr>
<tr>
<td><strong>Money:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Since First Episode</td>
<td>0.68</td>
<td>p≤0.001**</td>
</tr>
<tr>
<td>PSE Total Symptoms</td>
<td>-0.45</td>
<td>p≤0.04*</td>
</tr>
<tr>
<td><strong>Health:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Since First Episode</td>
<td>0.59</td>
<td>p≤0.007**</td>
</tr>
</tbody>
</table>

** * p≤0.05  ** p≤0.01
Conclusions

This longitudinal study suggested that some of the findings of the previous study may have been due to the differences between the two groups. However another important factor may have been the relative closeness of the final closure of the hospital compared with the earlier study.

This study suggested that for this group, that whilst their symptoms remained unchanged following discharge to the community, that some of their skills did improve, particularly in the areas of community skills, and overall rating as assessed by REHAB. It is difficult to know if this is because they have discharged to relatively independent settings and were having to develop such skills as a consequence, or if improvements in there areas allowed them to be discharged to such settings. A combination of the two is the more likely. The settings they were discharged to were better blended into their surroundings, had better facilities, and better integrated into the community than their original ward setting, as measured by QUARTZ.

The most significant difference when compared with the preceding study was the reduction in perceived changes in the area of subjective quality of life as measured on the Lehman scale. On most factors there were no significant differences; however people were significantly more satisfied with their
living arrangements once in the community, but their general satisfaction levels were significantly lower. This is in contrast to the result of the preceding study when the result was in the opposite direction. As suggested above it is difficult to know if this is due to differences in the two groups in the original study, or other factors such as the closer proximity of the closure of the hospital.
STUDY 8: A STUDY IN A COMMUNITY-BASED UNIT TO EXPLORE THE RELATIONSHIP BETWEEN INTERACTION LEVELS AND MANAGEMENT PRACTICES IN STAFF AND QUALITY OF LIFE, LEVEL OF DISABILITY AND SYMPTOM LEVEL IN CLIENTS

The previous studies had evaluated various aspects of care in a system undergoing massive change as a hospital closed. This final study was conducted in a nearby hostel. It aimed to establish:

1. The utility of measures previously used in hospital settings;
2. The inter-relationship of these measures;
3. Pointers for future directions for research in such settings;
4. Users' views concerning care in such a setting and their impressions of such changes in care.

Setting

The unit was a Social Services hostel operating in a village close-by to the hospital. It was a purpose-built building which had undergone recent building changes to allow each resident to have their own room, and had also attempted to break the environment into group living settings rather than large communal living. All staff and clients in the unit were approached to take part in the study, and all agreed to participate.
Staff

All 12 of the day staff of the unit took part in the study. Their average was 35.75 years, median 34.5 years, range 24-47 years. They had an average length of time working on the unit of 6.25 years, median 3.9 year, range 2 months-20 years. One of the staff had worked on the unit since it opened. This was also the longest time period that any of them had worked for Social Services. The average length of time spent working for Social Services was 10.66 years, median 8 years, range 2-20 years. Of the 12, four had professional qualifications, 3 'A' levels, and 8 'O' levels. Four had no qualifications. There were three males and nine females. See Table 43 for staff and resident details.

Residents

All 17 of the residents took part in the study. Their average age was 46.82 years, median 48, and range 29-64 years. They had an average length of stay on the unit of 3.64 years, median 1.33 years, and range 2 months-10.42 years. All had previously resided at the nearby psychiatric hospital which closed during the completion of this study. There were 10 females and 7 males.
### TABLE 43: DEMOGRAPHIC DETAILS OF STAFF AND RESIDENTS OF UNIT

<table>
<thead>
<tr>
<th></th>
<th>Staff n=12</th>
<th>Residents n=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>35.75</td>
<td>46.82</td>
</tr>
<tr>
<td>Median Age</td>
<td>34.5</td>
<td>48</td>
</tr>
<tr>
<td>Range</td>
<td>24-47</td>
<td>29-64</td>
</tr>
<tr>
<td>LOS Average</td>
<td>6.25</td>
<td>3.64</td>
</tr>
<tr>
<td>Median</td>
<td>3.9</td>
<td>1.33</td>
</tr>
<tr>
<td>Range</td>
<td>2 mths-20 years</td>
<td>2 mths-10.42 years</td>
</tr>
</tbody>
</table>

This unit was unusual when compared with the previous health service units studied, in that the staff were more stable and had been on the unit longer than the residents.

**Measures**

A range of measures were used. For the staff these were:-

**Staff Assessments**

- Management Practices Questionnaire (A) \*All Garety
- Management Practices Questionnaire (B) \& Morris (1984)
- Perceived Involvement Personal Questionnaire \(\)as described
- Method \(\) in Study 1
- Optimism Pessimism Scale
- Observation Schedule
Resident Assessments

REHAB (Hall & Baker 1983) - See Study 1
PSE (Wing et al. 1971) - See Studies 6/7
Quality of Life Schedule (Lehman 1983) - See Studies 6/7
Experience Sampling Form (Delespaul and DeVries 1987)
Goodmayes Interview Schedule (Abrahamson & Brenner 1982)

All assessments have been used and described in previous studies apart from the latter two resident assessments.

Experience Sampling Form

This measure developed by Delespaul & DeVries (1987) (see Appendix 10) asks residents to self-rate their activity on a pre-determined basis. In this study residents were asked to self-rate every half-hour during the same time period as the observational schedule was being used to observe staff (3-6pm). On the half-hour residents were asked to complete the form which involves describing:-

- What they were thinking about
- Where they were
- What they were doing.
Then rating on 10-point visual analogue scales:

- How well they were concentrating
- The degrees of self-consciousness experienced
- How they felt about themselves
- How much they felt in control of the situation
- If they felt they were living up to others and their own expectations.

Followed by 13, 7-point visual analogue scales related to mood state, a description of number of other people present, and eight further 10-point visual analogue scales rating how they felt about the activity they had been engaged in. Delespaul and DeVries (1987) report that this self-rating form can be successfully used with patients with a chronic mental illness in their studies in Holland. The measure appeared to offer the advantage of a description of the behaviour combined with a rating concerning its importance and effect upon mood.

It was included as a means of gathering information about residents' activity and interaction levels, as the direct observation schedule focuses upon staff interactions. It was planned to explore the relationship between interaction levels, subjective life quality, level of ability and symptom level.
Goodmayes Interview Schedule

The Goodmayes Interview Schedule described in Chapter 4 is a schedule devised to evaluate patients' views towards leaving hospital whilst still resident in the hospital. In this study it was adapted to look at residents' views of the hostel and previous life in hospital (see Appendix 11). It covers the following in a semi-structured interview:-

- Aspects of life in the hostel
- Attitudes to leaving the hostel
- Knowledge of alternatives
- Social networks.

The Goodmayes had been added to the resident assessments as a means of illuminating the impact of current residence and the movement out of hospital upon subjective assessment of life assessment as measured by the Lehman (1983) schedule.

Results

Questionnaire Based Measures

In comparison with the earlier studies carried out in settings with similar purposes (Studies 1 and 2) which included the following units: a rehabilitation ward prior to closure, staffed houses in the community and a Social Services community
hostel, this unit's profile on the questionnaire measures is similar in profile to the rehabilitation ward (see Table 44).

**TABLE 44: RESULTS OF STAFF ASSESSMENTS IN COMMUNITY HOSTEL**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPQ (B)</td>
<td>11.5</td>
<td>12.17</td>
<td>8-18</td>
</tr>
<tr>
<td>MPQ (A)</td>
<td>6</td>
<td>6.75</td>
<td>4-10</td>
</tr>
<tr>
<td>OPS</td>
<td>13</td>
<td>12.08</td>
<td>4-19</td>
</tr>
<tr>
<td>PIPQ</td>
<td>7</td>
<td>7.25</td>
<td>0-12</td>
</tr>
<tr>
<td>None</td>
<td>18</td>
<td>22.72</td>
<td>0-80</td>
</tr>
<tr>
<td>SS</td>
<td>55</td>
<td>62.53</td>
<td>11.58-78.57</td>
</tr>
<tr>
<td>SR</td>
<td>25.5</td>
<td>26.68</td>
<td>0-68.42</td>
</tr>
<tr>
<td>AD</td>
<td>60.5</td>
<td>52.43</td>
<td>0-75.51</td>
</tr>
<tr>
<td>PPS</td>
<td>43.5</td>
<td>47.57</td>
<td>24.49-100</td>
</tr>
<tr>
<td>All</td>
<td>43</td>
<td>48.57</td>
<td>9.09-100</td>
</tr>
<tr>
<td>TOL</td>
<td>48</td>
<td>51.43</td>
<td>0-90.91</td>
</tr>
</tbody>
</table>

With similar management practices profile (Rehab Ward MPQB=8 MPQA=6) and less institutionalised practices than the hostel in Study 1 (MPQB=19 MPQA=14), but less individualised practices than the community homes (MPQB=3-4, MPQA=2). Staff also had similar optimism levels to the ward (Ward OPS=10) which again were more optimistic than the hostel (OPS=20) and similar to the community houses (OPS=9-11). However, involvement in decision making was closer to the level seen in community houses (PIPQ=5-9) rather than the ward (PIPQ=9) or hostel (PIPQ=11).
Interaction-Based Measures

The interaction levels were evaluated at the same time period as in the previous studies of wards, hostels and community homes (3.30-5.00). The level of no interactions seen in this unit (18%) is lower than in the units evaluated in Studies 1 and 2 (ward=27%, hostel=24%). The level of no interactions also compares favourably with other published studies (eg. Garety & Morris 1984 -31%). However, in the study the level of staff-staff interactions was higher (55%) than in all these studies (32%, 47%, and 12% respectively) suggesting that, whilst residents were not just sitting with little going on about them, they were often the passive spectators to staff interchanges. The higher level of staff-staff interactions may also partially account for the higher levels of administrative interactions seen (60.5%) compared with earlier studies (ward 22%, hostel 35%). Overall, the results suggested a unit where there was activity in terms of interaction levels, but where this was often between staff members at the time period measured.

Correlation's Between Measures

There were a number of correlations between the various measures, and also between the measures and demographic variables. In relation to demographic variables, associations were found between age and tolerating interactions ($r=-0.63$ $p\leq 0.05$) and age and accepting interactions ($r=0.63$ $p\leq 0.05$)
suggesting older staff were more likely to interact in an accepting manner and less likely in a tolerating manner. Length of time on the unit was associated in a similar way with these two factors with tolerating interactions ($r=-0.62$ $p\leq0.05$) and accepting interactions ($r=0.62$ $p\leq0.05$). There was also an association between number of 'O' levels and score on the PIPQ scale ($r=-0.75$ $p>0.01$), years on the unit and PIPQ scale ($r=0.61$ $p>0.05$) and level of professional qualification and PIPQ scale ($r=-0.65$ $p>0.05$). This suggests that those staff who have more 'O' levels and a greater level of professional training are more likely to feel involved in decision making, and those staff who have been at the unit longest are less likely to feel involved in decision making. There was also an association between no interactions and MPQ(A) score ($r=0.63$ $p\leq0.05$) suggesting that those staff who were more likely not to be seen interacting were also more likely to favour institutionalised practices. There were some associations between interaction measures suggesting that in this unit they were clustering in particular patterns, for example there were associations between accepting and personal problem solving interactions ($r=0.65$ $p\leq0.05$), administrative and staff-staff interactions ($r=0.61$ $p\leq0.05$), administrative and accepting interactions ($r=-0.65$ $p\leq0.05$), administrative and tolerating interactions ($r=0.65$ $p\leq0.05$) and personal problem solving and staff-staff interactions ($r=-0.61$ $p\leq0.05$).
It is of note that the pattern of associations seen in this study is different to that seen in earlier studies, suggesting that there are not common universal patterns across units, but different patterns operating in different units.

Results of Resident-Based Assessments

Level of Functioning

The residents' mean/median level of functioning (see Table 45) is in the moderate disability range on the REHAB scale. Compared with the populations in the previous studies, the group has a lower level of functioning (total general behaviour) than the individuals who moved on to more independent settings in the previous study (32.5). They have average higher scores on each of the sub-scales, and most have some problematic behaviour which may require addressing (deviant behaviour items). They also have higher than average scores than the residents living in supported community houses in Study 2 (25-33), but lower scores than the ward and hostel (Study 1, 48-54) and the hospital units (Study 5). This suggested that the unit was dealing with people who were more able than those seen in hospital, but less able than those in less supported community settings.
**Level of Symptomatology**

The residents of the hostel had a similar level of symptomatology (see Table 45) to the individuals in the previous longitudinal study of Quality of Life (12), and had a higher level of symptomatology than the group that had been discharged in the original study of Quality of Life (8).

**TABLE 45: RESULTS OF RESIDENT ASSESSMENTS IN COMMUNITY HOSTEL**

**LEVEL OF FUNCTIONING AND SYMPTOMS n=17**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REHAB:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deviant Behaviour</td>
<td>2</td>
<td>1.88</td>
<td>0-7</td>
</tr>
<tr>
<td>Social Activity</td>
<td>25</td>
<td>21.35</td>
<td>0-33</td>
</tr>
<tr>
<td>Speech Disturbance</td>
<td>5</td>
<td>4.88</td>
<td>0-14</td>
</tr>
<tr>
<td>Self Care</td>
<td>11</td>
<td>10.82</td>
<td>0-27</td>
</tr>
<tr>
<td>Community Skills</td>
<td>6</td>
<td>7.35</td>
<td>0-14</td>
</tr>
<tr>
<td>Overall</td>
<td>3</td>
<td>3.18</td>
<td>0-9</td>
</tr>
<tr>
<td>Total General Behaviour</td>
<td>42</td>
<td>47.12</td>
<td>20-75</td>
</tr>
<tr>
<td><strong>PSE:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSE Psychotic</td>
<td>4</td>
<td>3.58</td>
<td>0-6</td>
</tr>
<tr>
<td>PSE Neurotic</td>
<td>6</td>
<td>6.23</td>
<td>0-10</td>
</tr>
<tr>
<td>PSE Negative</td>
<td>1</td>
<td>0.59</td>
<td>0-2</td>
</tr>
<tr>
<td>PSE Total</td>
<td>12</td>
<td>10.35</td>
<td>0-18</td>
</tr>
<tr>
<td>PSE Presentation</td>
<td>1</td>
<td>1.18</td>
<td>0-3</td>
</tr>
</tbody>
</table>
Quality of Life

The unit's subjective and objective quality of life profile (Table 46) is similar to that of the group in the previous longitudinal study, and is lower in a number of areas than the group which had been discharged earlier in the preceding study. The group would have left the closing hospital and entered the community at a period between the two groups in the previous two studies.
TABLE 46: RESULTS OF RESIDENT ASSESSMENTS IN COMMUNITY HOSTEL

QUALITY OF LIFE  n=17

<table>
<thead>
<tr>
<th>Scale</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lehman's Quality of Life Schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective Ratings:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Satisfaction</td>
<td>7</td>
<td>7.35</td>
<td>2-14</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>22</td>
<td>21.77</td>
<td>6-40</td>
</tr>
<tr>
<td>Community</td>
<td>26</td>
<td>23.29</td>
<td>6-40</td>
</tr>
<tr>
<td>Activity</td>
<td>22</td>
<td>33.41</td>
<td>4-38</td>
</tr>
<tr>
<td>Family</td>
<td>18</td>
<td>17.24</td>
<td>4-36</td>
</tr>
<tr>
<td>Social Relations</td>
<td>23</td>
<td>21.88</td>
<td>6-40</td>
</tr>
<tr>
<td>Money</td>
<td>10</td>
<td>12.18</td>
<td>4-25</td>
</tr>
<tr>
<td>Safety</td>
<td>19</td>
<td>18.53</td>
<td>4-35</td>
</tr>
<tr>
<td>Health</td>
<td>22</td>
<td>21.58</td>
<td>6-40</td>
</tr>
<tr>
<td>Objective Ratings:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>8</td>
<td>8.35</td>
<td>5-14</td>
</tr>
<tr>
<td>Self-Report</td>
<td>2</td>
<td>1.88</td>
<td>1-3</td>
</tr>
<tr>
<td>Family</td>
<td>5</td>
<td>5.35</td>
<td>2-9</td>
</tr>
<tr>
<td>Social Relations</td>
<td>14</td>
<td>14.59</td>
<td>6-28</td>
</tr>
<tr>
<td>Money</td>
<td>8</td>
<td>8</td>
<td>4-12</td>
</tr>
<tr>
<td>Health</td>
<td>17</td>
<td>17.59</td>
<td>12-28</td>
</tr>
<tr>
<td>Limits</td>
<td>28</td>
<td>28.41</td>
<td>25-40</td>
</tr>
<tr>
<td>Feelings</td>
<td>30</td>
<td>31.59</td>
<td>15-50</td>
</tr>
<tr>
<td>Pain</td>
<td>8</td>
<td>8.11</td>
<td>3-11</td>
</tr>
</tbody>
</table>
Experience Sampling Form

Attempts to use this form did not meet with success. Residents found the form difficult to understand, and following a residents meeting seven of the 17 agreed to use the form on a trial basis with staff support as a pilot group. Staff were used to prompt the appropriate time to complete the form and also to act in an advisory form in filling it in. The introspective natures of the form proved particularly difficult for the residents to grasp. For one of them this proved particularly difficult and staff felt was partially responsible in re-triggering a psychotic episode, as attempts to fill in the form prompted delusional thoughts apparently correlated to the events the resident had just been involved with, which he was then unable to stop. It appeared that the form had interfered with the residents particular strategy for coping with delusional thoughts which was to avoid introspection and deal with the here and now, rather than reflecting upon it when access to such thoughts was more likely. Other residents left large sections of the form blank despite prompting from staff, and failed to fill the form in at the required time. Following the incident with one resident becoming psychotic, staff support for using this instrument was also a problem and further attempts to use it were discontinued.
Whilst this form has been successfully used with residents in Holland, the following difficulties arose trying to use it with this population:

- Complexity. Residents found it hard to understand and levels of reading and comprehension expected by the measure were greater than the residents' abilities.

- Motivation. The measure requires a degree of motivation on the part of the recipient to fill in the form at the appropriate time and completely. This proved difficult for this group even with staff support.

- Ability to Introspect. The form requires an ability to be able to introspect upon emotional state. This is a relatively sophisticated psychological skill which the residents found difficult to do, or in some cases, distressing when they were able to do given the fragility of their mental state.

- Stressful Nature. The residents reported finding the form stressful to complete. One found it so stressful that it appeared to re-trigger delusional thought.

Given these problems it appears likely that resident groups using the form in Holland were more capable and were less troubled by the symptoms of severe mental illness. This may be due to the fact that the Dutch have not pursued a
hospital closure programme to the same extent as in Britain and that residents in their hospitals and hostels would be in community settings in this country.

**Attitude towards the Hostel.**

The Goodmayes scale was included in order to gather qualitative data which, whilst subjective, qualitative and categorical, would help give a clearer sense of the residents' experience prior to hospital, in the hospital, the process of closure and their understanding of their life in the hostel and hopes for the future.

**Goodmayes Scale Feedback from Hostel Study.**

Prior to going into hospital, eight residents had been living with family or partners, six on their own, and two with friends. Six people reported feeling that they had no friends prior to admission, although 12 in total reported being lonely.

Only four people had been employed, with two others attending training schemes. Only two people felt that they had been reasonably settled prior to admission to hospital but no-one reported living both a full and settled life during that time.
People described their life before hospital in the following manner: "It was awful", "Not a nice life", "It was a living hell; I had a jealous mother", "I was in a hotel for a few months with my baby before he was taken into care", and "I was at home with my boyfriend - difficult to cope". A picture emerges therefore of a group who were, in the main, lonely, unemployed and unsettled prior to going into hospital, already experiencing a number of life difficulties.

- Things that Residents miss about Life before Hospital:

  Replies to this question included: home comforts (8), freedom (6), family and friends (6), money (4), privacy (2). Only one resident who had been unhappy and unsettled reports missing nothing at all. Comments such as, "I feel that my personal possessions have been taken away", are more typical.

- Reasons for going into, and staying in, Hospital:

  Twelve people had a clear idea of the reason why they were admitted to, and stayed in, hospital. These included depression (8), breakdown (2), and compulsive nervous disorder (2). These people all felt that they had been too ill to cope at home all the time: "Too ill to look after myself with the voices", "Can't manage".
The remaining four people were unsure about the reason for their stay in hospital. Examples given were: "It was something to do with having a Clause 3 - I was hoping to leave sooner than I did but the doctors wanted me there", "Other people [relations] thought I was sick but I didn't think there was anything wrong".

- The best things about the Hostel:

Residents cited the staff: "Staff help you", "Being looked after", "More organised than hospital", "Staff here are more caring than at Crispin's", "They are interested in you".

Other replies included the increased freedom (6), the other residents, ie. "Having people around" (8), money (2), having one's own room (2), the social activities (2), and it being tidy, clean and quiet (2). Others recognised the need for a step between hospital and the community, "To get used to the outside world after being in hospital for 14 years".
• The worst things about the Hostel:

The replies were varied and included:

Money: (4)
   "Lack of money"
Boredom in the Evenings: (4)
   "There's nothing to do"
Social Environment (too quiet/too noisy/too many people/lack of privacy): (6)
   "People around all the time - I feel like a rat in a barrel"
Smoking: (4)
   "I don't like it"
   "People are always asking for cigs"
Domestic/Environment: (2)
   "I'm the only one to tidy up - can't the staff tell them to do it?"
   "Bedroom is a dump - wall plaster is gone".
Homesickness: (2)
Future: (2)
   "Having to leave"
   "I'm always having to go"
Self-Care: (2)
Getting up: (2)
• Satisfaction/dissatisfaction with living at the hostel:

Six people reported being very satisfied living at the hostel, three were fairly satisfied, one was indifferent - "It's a bit of both", and one felt it was too early to say. Four were fairly dissatisfied and one very dissatisfied.

• Changes that would improve quality of life at the hostel:

The type of suggestions made included:

"We need a rota for the cleaning"

"More money"

"I'd like to see my kids more"

"More young people and a bit of life"

"More entertainment"

"Less rushing around and more rest"

although one felt it was too late:-

"I've given it up as a bad job".

Desire to leave the Hostel.

The issues covered:

- Desire to live at the hostel permanently

- Knowledge of what living outside the hostel involves

- What would they do during the day?
- Had any of the residents they have known here left?
- where did they go?
- how did they get on?
- Knowledge of alternative types of accommodation
- Type of accommodation preferred
- Skills for daily living
- Things that residents would miss about the hostel
- Would they be lonely?
- What would be gained by leaving the hostel?
- Preferred living area/part of town.

• Desire to live at hostel permanently:

Twelve out of the 16 residents expressed quite clearly that they would not like to live at the hostel permanently. Although four people expressed a desire to stay permanently, two of these were aware that this was out of the question.

All but one person had thought that they would like to live somewhere else, and that they would leave the hostel if their keyworker advised them to. One added, "I'd have to, wouldn't I? - It's not up to me". The person who said he would not leave if advised, explained that, "I still wouldn't want to leave if I wasn't less tired and more stable".
Knowledge of what living outside the hostel involves:

Twelve residents said that they understood what living outside the hostel involved. The four who did not know what this would involve had all been in hospital/residential care for longer periods than the others.

When asked where they would get their money from if they were discharged, the large majority said Social Security or Invalidity Benefit. One resident knew that he had a book and would have to go to the Post Office, but this was the extent of his understanding. No-one mentioned the possibility of a job.

The residents were asked who would give them their tablets/injections if they left the hostel. Six people reported being happy and confident about handling their own medication, four would go to their GP's, and four said they would expect to go back to a hostel for this. One resident did not know what would happen with regards medication. When asked if they would still be able to see a social worker/doctor/nurse, four replied 'yes' and two felt this would not be necessary.
• What would you do during the day?

All residents had some idea of what they would do if they left the hostel: eight people mentioned domestic chores, and six felt that these would keep them busy most of the time. Two would go to college part-time, and four said they would attend day care. Only six people mentioned leisure activities, hobbies or visiting other people and this was usually when prompted. One person said that, "Apart from attending day care, there would be nothing to do". Interestingly, no-one mentioned trying to get a job.

• Had any of the other residents they have known left the hostel?

Everyone interviewed reported that they had known others who had left the hostel: four of them had no idea where they had moved to; others mentioned hospital (2); flat (8); bedsit (2).

As far as how these people were getting on, there seemed to have been very little contact or feedback. Only two people had a clear idea of how the ex-residents were getting on. One
person was reported to be getting on 'okay' but was rather lonely, another was reported to be doing well, and one other had to go home to his mother's due to an unsuccessful placement.

• Knowledge of alternative types of accommodation:

Residents were asked what sorts of accommodation would be available to them if they left the hostel. This proved a difficult task for six people, whose next placement seemed to be pretty much decided. The difficulty was in considering or imagining other possible options. No-one expressed a desire to return to their family, and only one person suggested more than one option, "I could have a flat or go to a group home". Other replies were own flat (6), group home (6), and one person was unsure about the options available.

Other questions about types of accommodation included the following:

- Do you know what a group home is?

<table>
<thead>
<tr>
<th>Replies</th>
<th>Number of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
</tr>
<tr>
<td>Yes (inaccurate)</td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
</tr>
</tbody>
</table>
Sample replies:
"It's a shared house"
"People with similar problems living together"
"three or four people in a house with some helpers"

- Do you know what a hostel is?

<table>
<thead>
<tr>
<th>Replies</th>
<th>Number of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>Yes (Inaccurate)</td>
<td>4</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
</tr>
</tbody>
</table>

Sample replies:
"Where I am now more or less"
"Like Lindfield"
"It's temporary - they help you to find a new home"

- Do you know what a sheltered flat is? - Describe.

<table>
<thead>
<tr>
<th>Replies</th>
<th>Number of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
</tr>
<tr>
<td>Yes (Inaccurate)</td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
</tr>
</tbody>
</table>
Sample replies:
"It's adequate"
"Warden controlled"
"People to assist if necessary"

These replies suggest that residents, in such settings, may need to be given more information about available accommodation.

• Type of accommodation preferred:

All but one of the residents interviewed had a clear idea regarding choice of accommodation. Six people wanted to go to a group home; four to their own flats; four to sheltered flats; and two people with a large number of people (due to a fear of being left alone in the house). Everyone expressed a preference for their own bedroom.

• Skills for daily living:

All residents were asked whether they would be able to cook/shop/launder for themselves, whether they would prefer help with these tasks, or whether they would prefer them to be done for them.
Cooking: Twelve residents would prefer to do their own cooking, two of these with occasional help. The remaining four residents would like their cooking to be done for them.

Shopping: Six residents would prefer to do their own shopping, six would like some help with this, and the remaining four would prefer their shopping to be done for them.

Laundry: Six residents reported that they would prefer to do their own laundry, six felt they would need some help in this area and four said they would prefer this to be done for them.

• Things that residents would miss about the hostel:

Half of those interviewed said that they would miss the staff (and other residents), six people could not think of anything that they would miss. Other replies include the peacefulness (1), the atmosphere (1), their doctor (1), the security (2), and doing their own meals and being able to choose what they want to eat (1).

• Would you be lonely?

Eight residents thought they would be lonely when they left, four weren't sure, and four didn't think loneliness would be a problem.
• What would be gained by leaving the hostel?

Increased independence and freedom was mentioned by eight of the residents. Other replies included more confidence (1), meeting new people (1), "The change" (1), "Seeing my family more often" (1). Four residents could not think of anything they would gain by leaving.

• Preferred living area/part of town:

Eight people expressed specific areas preferred. These were usually to be either close to family or day-care. Eight people had no particular preference.

Social Networks.

This section relates to residents' social contacts both on and off the unit, and the quality of these contacts. It concerns not only other residents at the same unit, but also in other units and in hospital. In addition to this, it looks at relationships with staff and contacts/friends outside, including relatives.
Issues covered:

- People you know
- Reasons that make you satisfied/dissatisfied with these people
- Is there anyone you would like to leave with?
- Is there anyone you would like to leave behind?
- Dependency
- Giving
- Is there anybody else you could mention that matters to you, affects, or upsets you?

• People you know:

  This question certainly seemed to be one of the most difficult for many interviewees. The replies were very variable both in terms of quantity and quality of contacts. Some people needed prompting to think of anyone at all, and even then only mentioned relatives. Three categories of contacts were mentioned, these being relatives, other residents, and professionals. It was noticeable that, with regard to professional contact, only staff at the hostel were mentioned. Also, although the other residents were mentioned,
only two did so by name and only one saying that they were friends as opposed to acquaintances. Excerpts from the interviews with regard to social contacts were as follows:

"When I go to see my mum and dad we just watch the telly"
"I've go no close friends"
"The people at the hostel are just people I'm living with"
"When they come to visit me they never stay for long"
"My best friends have all left"
"We help each other out".

• Reasons that make you satisfied/dissatisfied with these people:

There were a range of comments from six of the twelve interviewees concerning their satisfaction with their social contacts. Most of these were about their relatives, ie.:

"My mum's good company"
"They're easy to get along with"
"They're pretty supportive".

The other positive remarks were about other residents and can be summed up in the following excerpt:

"They worry about you the same way as you worry about them".
Only two interviewees could think of any reasons for dissatisfaction with their social contacts. These were both concerning relatives and were as follows:

"My family nag and don't always understand me"

"I don't get on with my family - I don't want to know them".

• Is there anyone you would like to leave the hostel with?

Only one interviewee felt there was anyone they would like to leave the hostel with, and this included one co-resident and two staff members.

• Is there anyone you would like to leave behind?

Nobody could think of anyone they would particularly like to leave behind, and comments were made such as:

"No, I like them all here"

"No, I wish everyone well".
• Dependency:

Residents felt that they were dependent in the following areas:

Financial = 2
Domestic skills = 6
Company/emotional = 8
Problem solving = 1
Medication = 2

When asked whether anybody depended on them, only three interviewees replied 'yes'. Two of these felt they were depended on for domestic tasks, ie. "Doing odd jobs" and only one person felt they were depended on to give emotional support to others.

• Giving:

When asked whether they gave anything to others, two people reported that they did not give anything to anybody. Six spoke of the money they give to others, although one added:

"But they didn't pay it back so I've stopped now".
Six people reported that they give presents to people, and four spoke of the emotional support they give to relatives and friends.

When asked whether anyone else gave them things, only one person could think of nothing at all. Twelve people referred to the material items given to them, mainly presents; two mentioned the emotional support they receive; and only one person spoke of any financial support.

- Is there anybody else you could mention that matters to you, affects, or upsets you?

Replies to this question were mainly 'no' (10). The remaining said the following:

"My mum ... even though she's dead"

"A policeman I fell in love with"

"My keyworker. I have counselling with him and it's the best thing about being here".

Overall Impression

The overall impression was of a group of individuals whose lives in many ways had deteriorated and became more limited following the onset of their particular problems, whose passage through the hospital system had been marked by an increasing sense of lack of control over their lives and who now tended to judge their quality of life based upon their current situation,
surroundings, state of health and material possessions, but who had little concept of what potential life outside the hostel would be like, or a sense of choice available to them.

Discussion

This study used all the measures together which had been separately used in the earlier studies. An additional measure also helped to give some insight into residents views of their life in a community hostel and their experience of life in the psychiatric hospital as it approached closure. In relation to the questions posed at the beginning of this study the findings suggested:

1. Utility of measures:

The study suggested as had the previous ones, that a number of the measures derived in hospital settings had limited utility in community settings. Their validity was questionable (REHAB) or they were based upon concepts derived from the institutional literature (MPQ, OPS, PIPQ, Interaction schedule).

These measures may help to show that institutional practice and low interaction levels are not present, but they say little about the presence of good practice in a community setting. There is an assumption that the absence of bad institutional practices is enough. This study suggested that whilst for example interaction levels may be higher in this
setting. There is an assumption that the absence of bad institutional practices is enough. This study suggested that whilst for example interaction levels may be higher in this community setting, they were often higher due to an increased level of staff-staff interactions. Looking at what has replaced low interaction levels and institutional practices is important, and is not possible in the degree of sophistication necessary.

The measures are all based to what staff and researchers feel is important in such settings, often observable events such as skills, interactions, evidence of symptoms, and staff practices. There is little from a client's perspective of what is seen to be important, even the Lehman quality of life schedule is to some extent rating areas of life defined by researchers as being important. Clients make ratings in each area, but do not have an input into also evaluating if they feel this particular category has any importance in their life. The measures as such ignore individual variation, and are unable to make weightings based upon this and may not reflect individual's views. The Goodmayes did illustrate the restricted life experience and aspirations of many individuals following the onset of a long term mental health problem and the additional effect of the experience of hospitalisation. The context of this experience occurring during hospital closure appeared to have reinforced a sense of lack of control, and the lack of options or knowledge of options for the future.
appeared to have magnified the potential debilitating effects of residual symptoms. This was seen in the strong correlation between symptoms severity and subjective life quality rating.

Even with the limiting experiences of severe mental health problems and hospital closure there was still a great deal of variability between residents ratings of their experience of life in the hostel, and in their responses to the questions.

This questionnaire itself remains qualitative in nature relying upon the interviewers recording and rating of responses to the probe questions. Tape recording the interviews would allow procedures such as content analysis to be used.

An attempt to use the Experience Sampling Form proved difficult with this group of residents. It suggested that the client group it had been used with in Holland had been more able, less troubled by symptoms, and had the ability to introspect. Attempting to use the scale with this group still experiencing severe mental illness could prove damaging for some individuals. However, developing a simpler form with residents that gave an account of how they spend their time and what they found particularly useful would be worth pursuing.

In conclusion at present the measures currently available are useful for checking for the absence of institutional practice and low interaction levels.
They can evaluate level of functioning, level of symptomatology ratings of life quality and experience of living in a care environment. However, they are less good at identifying the conditions for higher quality care, or the process of change in a person's self-perception within a care environment.

2. The inter-relationship of the measures:

As in the previous studies there were inter-relationships between the measures used. For the staff based measures there were interesting relationships between the interaction measures and the staff questionnaires. An example being the relationship between level of no interactions and raised institutional attitude score, suggesting that staff who are more likely not to be seen interacting are also more likely to have institutional attitudes.

These relationships suggested that there was a link between staff attitudes and patterns of interaction seen in units, but this was not a replicated pattern across all the different units looked at prior to this study. This would suggest that different patterns of relationship are operating in different units, and that it would be important to understand the factors underlying these differences. One of the difficulties of studies of residential units is the lack of consideration of factors outside the immediate environment.
The unit in this study, established in the community for a number of years had a stable staff group and was attempting to evolve and improve care. The pressures on the staff group are likely to have been different from those in the previous studies, were staff had been involved in a hospital closure programme with units closing or just being established in the community. Units do not have impervious boundaries and understanding how factors outside the immediate unit have an influence upon staff attitudes and interactions could be one way of so understanding the different relationships seen in these studies.

The pattern of relationship of the resident measures did repeat the type of pattern seen in the previous studies. The relationship between the quality of life measure and level of symptomatology was magnified, suggesting that in this setting presence or lack of symptoms was closely related to perceived quality of life. The Goodmayes questionnaires qualitative data suggested that whilst there was a lot of individual variation in response to the experience of becoming ill, hospitalised and then living in a hostel, there were some commonalties. The most startling were the way peoples lives started to become much more limited prior to hospitalisation after the development of a long term mental health problem. This suggested that apathy, inactivity and dependency may commence before admission, whilst the person is still in the community, and become more marked as they pass through the system of care. It may be that the impact is strengthened when the hospital
they receive their care from is itself closing, and recipients of care may in such a situation more prone to attributing decisions about their future care to external factors such as the closure rather than internal factors such as their own abilities. It seems likely that a person with lowered competencies and function's, faced by on going symptoms may be more likely to be vulnerable to such environmental contingencies.

3. Pointers for future directions for research in such settings.

Using all the measures together in one study was useful in highlighting areas of potential development. These will be explored more fully in the final thesis discussion. Briefly areas that emerged from this study were:-

- Interventions aimed at alleviating symptoms. Particularly given the strong association seen between symptomatology and subjective quality of life.

- Assessments which were sensitive to individuals evaluation of their relative importance. This would appear to be particularly appropriate for quality of life assessments but also for level of functioning and symptomatology measures.
• Improving the rigour of qualitative methods. Although schedules such as the Goodmayes provide a wealth of information, evaluating their reliability and improving the analysis of such information would be important developments.

• Establishing appropriate comparators. Rather than comparing with previous hospital settings it may be more appropriate to compare community residential settings for the long term mentally ill with bed and breakfast, ordinary homes, small hotels etc.

• Broadening the scope of factors looked at in understanding quality of care. Units in the community are not impervious to outside influences exploring sources of staff stress would appear important.

• A greater emphasis on understanding how change occurs. More work needs to be undertaken in understanding how improvements in care occur.
DISCUSSION AND CONCLUSION

Care for people with long term mental health problems is undergoing massive changes in this country. The closure of asylums and the establishment of community care is the biggest change in care provision since the asylums themselves were opened in the last century. This major change in service provision was seen on a small scale in the closure of St. Crispin's Asylum in Northampton which occurred during the course of this thesis. This closure created the opportunity to study the process of closure, the effects upon clients and staff, and allowed the researcher to compare the qualities of care in hospital and community settings, and to evaluate methods of assessing such changes in provision.

The Review Chapters

The review chapters of this thesis examined the reasoning behind changes in care provision and the different approaches that had been used to evaluate care. In relation to the history of care and legislation relevant to this population, the literature suggested that generally there had been attempts to define more clearly who the people with long term mental health problems were, and improve services.
The review of attempts to assess quality of care based on measures of the social environment suggested that concerns about bad practices in institutions had been central to the concepts used in this area. Measures of management practices, staff attitudes, and interaction levels had emerged as the main measures (with most assuming a continuum between good and bad practice) and these were used to assess the new community based units, and hospital-hostels in particular. An examination of the existing literature highlighted the fact that, in these new settings, the measures used would require adapting, that the assumption of a continuum was questionable, and that comparisons with other community settings (such as lodgings) might be more salient rather than with large old asylums. Finally it was suggested that the quality evaluation process, largely developed in the area of business, had some utility in this field.

A review of the literature related to needs assessment highlighted how these had been used to identify the problems faced by people with long term mental health problems, and how this initiative had led to attempts to define the concept of need and to produce measures that were accurate, reliable and valid. One of the most commonly used assessments was examined in some detail as it was then employed in the later studies, and the argument was put forward that, as services continued to change, new measures would be required.
Finally, the more recent development of user based evaluations of quality of care was reviewed, and the reasons for the relative lack of attention to this area explored. It was suggested that users' views had previously been discounted for a number of reasons, and that to a lesser extent this remained a difficulty. Measures based on the concept of quality of life, and users' own evaluations of services, were examined and it was concluded that, although measures currently in use were at an early stage of development, nevertheless they held promise as a means of evaluating services from the recipient's point of view.

The Legislative and Economic context of the Studies.

One of the tensions apparent in the historic and legislative overview undertaken in Chapter 1 concerned the attempts to improve care for such people, alongside a desire to protect the rest of the population from them (although these aims are not always mutually exclusive). Although the establishment of asylums was seen as a way of improving care for people with mental health problems, later the Lunacy Act of 1890 and the creation of much larger asylums led to some of the problems of institutionalisation (described by Barton (1959) and Goffman (1960)).

The move to community care initiated in the 1960s, and continuing to the present, represents a further change in the location of services, again with the underlying assumption that care will thereby be improved. Findings from some of the studies
undertaken as part of this thesis would question that assumption. The tension between protecting the public and improving services remains (as seen in the recent Clunis (1994) inquiry), as reflected in the continuing support for community care alongside the changes in monitoring serious mentally ill people in the community and the introduction of the supervision register. The ongoing Sainsbury Centre's inquiry (1995) has also suggested that staff are not appropriately trained to provide care in community settings, and that changes in training at pre and post qualification levels would be needed to provide appropriate care and public protection.

The state of the national economy also appeared to have some impact on the process of closure. As the asylum at St. Crispin started to move towards closure in the mid 1980s, services and future models for potential service developments had an emphasis on improving care; by the late 1980 and early 1990s the emphasis had moved firmly towards financial considerations. By the early 1990's, the cost for each remaining asylum had become more expensive as it grew smaller and, with the fall in land prices and the recession, the capital to be released by the sale of the land had diminished, affecting plans for future service development and slowing planned closure.

The hospital did finally close as the economy showed signs of recovery and land prices recovered enabling the site to be sold as land for housing.
Taken together, the review chapters suggested that there was some consensus emerging about good quality care in terms of management practices, staff attitudes and level and type of interaction. However measurements in these areas where still evolving, as was the assessment of level of functioning and the rapid changes of care provision and closure of asylums had perhaps outpaced these developments. Attempts to include care recipients views were still at an early stage and there was also some evidence of increased concerns about the balance of patients rights and protection for the public.

What the Studies suggested:

Comparing a Hospital and Community Based Unit

Study 1 demonstrated that it was possible to use measures of social environment to compare quality of care in two units. These measures were based upon questionnaires (completed by staff) concerning attitude and management practices and behavioural observations of interactions. The measures can be traced back to the work of Goffman (1960) and Barton (1959) and they assume that good quality care is the opposite of institutional care (the expectation being that high interaction levels, individual management practices, and staff with positive attitudes, reflects good quality care). The first study's comparison of hospital and community-based residential units (and an earlier study by Shepherd & Richardson (1979) concerning
community day centres) questioned the assumption that relocating services to the community will automatically improve them and illustrated the importance of looking at how care is provided, as well as its location.

Following a Unit into the Community

The period of change and unpredictability associated with the closure of St. Crispin's, offered an opportunity to conduct studies while a whole system of care was altering, but also led to unforeseen difficulties. Longitudinal studies were affected by changes in the wider system of care which made it difficult to control factors, such as rapid turnover of both staff and residents and problems such as these were especially apparent in the second study of the thesis. At the start of the study, it was assumed that, although the location of the unit was moving from a hospital to a community base, nevertheless its purpose as a rehabilitation unit would remain unchanged, that the type of client group would be similar in demographic and need profile, and that the staff group would remain relatively stable. Given these assumptions, the intention was to carry out a study examining the effect of a change of location on the quality of care. In reality none of the three assumptions held and it was therefore difficult to ascertain which factors had influenced the changes in care seen. The client group changed because of a reduction in the pool of potential clients in the asylum as it reduced in size, and an increasing referral route from the community and acute wards of a group termed "The new long stay"
(Mann & Cree 1976). The presence of this latter group of patients had been under-estimated, and plans had not been made for their care. As a consequence the unit's demographic and needs profile changed, forcing a change in unit function. The staff group also changed more than anticipated, although it is of interest that Felce (1989) experienced similar high levels of staff turnover in the move to community settings of a service for people with learning difficulties. These unplanned changes, the possible reasons for them, and the effects they had on care quality, became the focus of the study. The amount of turmoil created by hospital closure is of interest in itself. This study suggested that closure programmes could have dramatic effects upon staff and client profiles increasing the amount of additional change prompted by re-location and highlighting the difficulties this may cause for continuity of care.

The study, in effect, changed from a planned experimental one where some factors remained constant, to one that described the Unit's evolution through a period of rapid change, and has greater impact as an account of the possible factors responsible for these changes in a clinical setting. With the benefit of hindsight, it would have been useful, in addition to tracking the Unit through time, to also have tracked some of the individuals in the systems of care as it changed. Exploring the pathways that both the clients and staff followed would have aided an understanding of the impact of the changes of the unit as a whole, and would also have given an understanding of what it felt like to be in a system where major changes were
occurring. Rogers, Pilgrim and Lacey (1993) attempt to do exactly this via the Mind network, but their individuals' comments are difficult to place in the context of the particular changes in services that they experienced.

The Experience of Living in an Asylum during the Process of Closure.

During the course of this thesis, one of the most noticeable changes in emphasis has been the greater focus on user views, together with the development of user groups and user services such as advocacy. In 1988 there was a relative paucity of literature concerning user views and few attempts to utilise users as a way of evaluating care (Lehman 1983 and Abrahamson et al 1982 being notable exceptions). However, over the last eight years there has been a huge growth in the literature (Black 1992) with researchers increasingly paying attention to users' views (eg. Bogg et al. 1993). In addition to tracking users through the system, the longitudinal study (Study 2, following a unit into the community) would have benefited from taking into account the users' views of these experiences. An attempt was made to address this in Study 8 when users' views of passing through the system of care were sought, and revealed that many people who passed through the hospital as it approached closure felt they had little control over their own lives. To some extent this had been their
experience since their mental health problems commenced, but the
sense of lack of control became more pronounced during their
experience of hospital closure.

An earlier study (Study 6) sought to evaluate the different
experiences of life of users in hospital, and those who had
passed through the same unit from the hospital to the community.
As had been the case for the first study, this was a cross-
sectional design, and again it was assumed that the users
concerned would be similar in terms of demographic profile and
needs. However this study was carried out after an interval of
five years, and it was then found that the users currently in
the unit were different to those who had been discharged in the
past. It was not possible to compare like with like in the way
intended; the decrease in the old long-stay population in the
hospital and the increasing prominence of new long-stay users
from the community and acute settings again appearing to account
for the younger age and different needs' profile of the later
unit population. As the population had shrunk it had become
less homogenous, and the pattern of need more complex. The 'new
long stay' as a description of this group is a simplification
for a group whose highly variable needs make them difficult to
place, and they present a substantial challenge to carers. This
study did suggest that subjective quality of life was improved
in the community, but it was difficult to disentangle the effect
of difference in setting from the differences in populations.
A subsequent longitudinal study (Study 7) was conducted in an attempt to overcome some of these experimental design difficulties, and in this intervention the original hospital group was followed until the patients involved had been discharged to the community. Findings suggested that some of the differences seen in the previous study may indeed have been due to the different populations. The earlier study had suggested that subjective quality of life was higher in the community. It is difficult to know if the lack of such a strong finding in the longitudinal study was due to cohort effects, or other factors such as the nearness of asylum closure.

**Development of an Interaction Measure**

Measures used to evaluate interactions in large units when also employed in smaller community settings appeared to have a number of drawbacks. In the small house settings (evaluated in Study 2) it was difficult to use the behavioural observation schedule because of the small number of people present, and also the greater likelihood of the observer affecting the interactions seen. This concern about reactivity also prevented inter-rater reliability checks being performed. For larger wards or hostels the behavioural observation measure did not present the same difficulties and it did appear to have utility for other client groups such as older people in similar care settings (demonstrated in Study 3) where similar concerns about quality of care applied. It has been argued (Shepherd et al
that amount and quality of interaction between staff and residents is central to quality of care. Certainly such behavioural measures appear to have advantages over questionnaire based measures, when answers may not always reflect actual practice. Even given some of the difficulties found in using the interaction measure in smaller community units, a further development of the interaction measure seemed worthwhile, and this formed the focus of both studies 3 and 4.

In Study 3, further categories of observation were added concerning resident-resident interactions (in addition to staff-resident interactions) without adversely affecting reliability. This measure itself was then transferred to a computerised event recorder in study 4 allowing real time observations rather than time sampling. The use of two event recorders also showed that this more detailed measure could also be used reliably. The observation schedules quality categories are based on the assumption that accepting interactions are more rewarding for residents than neutral or rejecting interactions and may encourage interactions of longer duration due to this assumed superiority. The transfer to an event recorder allowed this assumption underlying the quality category of the observation schedule to be tested, enabling a comparison that demonstrated that accepting interactions were indeed more likely to be of longer duration than tolerating or rejecting ones. Replacing observers with a wall-mounted video recorder and analysing the video using an event recorder would overcome some of the difficulties experienced in the small house settings in Study 2,
and may be a further development. This would answer some of the research concerns but there would still be some ethical concerns about the acceptability of video monitoring in ordinary houses, cost issues, and practicality concerns given the amount of data generated.

Study 2 also demonstrated a large increase in staff-resident interactions after the unit had moved from a hospital ward to ordinary community houses. In institutional settings 'concern had focused on low interaction levels and the effect this had on residents. The community settings had overcome this difficulty by breaking staff and residents into smaller groups, thereby denying opportunity for staff-staff interactions and increasing the likelihood of staff-resident interactions. This leads to a requirement to consider the optimal level of interaction in such settings. Due to the low level of interactions seen in institutions, a good quality service has been assumed to be one that offers high level interactions. The new smaller settings in the community may bring this assumption under scrutiny as interaction levels could eventually be too high, and staff interfere unnecessarily with users' lives and cause stress. There will be a need to compare with interaction levels in similar settings, ie. ordinary houses, rather than with institutions to evaluate how these services are operating. Studies of interaction levels in ordinary family homes and board and lodgings settings may be necessary to act as a more appropriate comparator. The hostel evaluated in Study 8 also demonstrated that, whilst overall interaction may be higher in a
community setting, the significant increase may be in interactions between staff, rather than between staff and residents. Taken alongside the results seen in Study 2, this would suggest that in larger settings there is always the danger that, given the choice, staff members will talk to other staff members. In smaller units where the opportunities are decreased, they then are more likely to talk to residents.

However other aspects of this interaction may be worthy of study, Moore et al.'s (1992) study suggests that interaction styles more typically seen in family settings where expressed emotion is a concern, can also be present in some smaller staffed community settings. This would suggest that greater concern needs to be paid to interaction style and type rather than just sheer quantity of interactions, and would be worthy of further investigation. It is limiting to use only one measure as a way of assessing quality of care; this is particularly the case when quantity of interactions is used. In Study 3, there was an attempt to judge the effectiveness of an intervention programme via quantity of interactions. The intervention consisted of staff training and ward activities, and there was an overall drop in the level of interactions post-intervention.

One possible explanation for this result was that the effect of the extra ward activities may have focused staff-resident interactions into those periods. As interaction level was the major outcome measure used, it was difficult to assess if staff attitudes had changed due to the training component,
and the residents' views were not gathered concerning the intervention, although their view of life on the ward remained unchanged. Focusing on interaction as the only quality measure may have affected how staff interacted with residents by making them more conscious of interactions but only during the additional activity periods. Finally, as Shepherd et al. (1995) have noted, at present there is no clear evidence of a link between high levels of positive staff-resident interactions and improved resident care.

**Difficulties with Measures Developed in Hospital Settings**

Doubts about the transferability to community settings of both the measures and the assumptions that these were based upon were more pronounced with the questionnaire measures. A number of items on the management questionnaires used in the studies were less appropriate in community settings. For example, the question, "Do they wait in line before coming into breakfast?" is obviously inappropriate in a community setting where residents make their own breakfasts in their own kitchens. The measures, due to the inappropriateness of a number of items, are prone to a floor effect with some questions tending to always score zero. Conning (1986), using Maxwell's (1961) criteria that an item should be dropped when it scores zero 80% of the time, suggests that a number of items should be dropped for this reason. Conning (1986), has also argued that the bi-polar
continuum of client orientation to management orientation which underlies the management practice scales, is questionable. Conning suggests that there are, in fact, separate overlapping concepts. This would make some sense from clinical observations as it could be argued that too much emphasis on individualised non-restrictive practices might eventually be harmful both to the functioning of a unit and the individuals within it. A unit that gave individuals complete free choice to perhaps spend all day in bed, or not to feed themselves, could potentially score well on a scale that presumed that institutional practices were at one end of the continuum and individuality at the other, but it would be difficult to argue that this was in the user's best interest and represented good quality care. This suggests that in the new settings, a balance between structure and choice will be necessary, and that the continuum, rather than being linear, may actually be U-shaped, with problems and poor care being associated with the extremes at each end.

Quality of care assessment based upon social environment measures are useful. However most measures and the assumptions upon which they were based are derived from poor care seen in large institutional settings and new measures derived from new experiences in community settings need to be developed, and these may lead to different assumptions about quality of care.
Which Patients leave the asylum first?

Study 5 used assessments of levels of functioning as a way of determining the current needs of the population, predicting the likely service required in the future, and enhancing understanding of the pattern of outcome over time.

This study was undertaken in an attempt to understand the changes in the base hospital population over a six year time period, these changes had a noticeable impact on studies carried out over a period of time (Studies 2 and 5) when population profiles were found to have changed. For this particular asylum, a clear pattern did begin to emerge. The older patients in the population if they had not died, were likely to be discharged from the asylum to a home for the elderly. However, younger patients were more likely to progress to a community setting, provided they did not have problems with verbal aggression, or high levels of activity, and rather surprisingly were less able to use public facilities. It may have been the presence of these three factors together which caused staff members particular concern. The ability to be able to get into public setting, and when there to be seen by staff as likely to be active and verbally aggression may explain why such individuals were less likely to be discharged. The impression from this study was that clients presenting with the least difficulties were more likely to be discharged to the community - a "creaming off" process - leaving the most problematic clients in the asylum.
This in itself could represent a failure in planning as a good quality system should provide a range of alternative services to meet the varying needs of all. A number of interventions have been shown to be helpful and include, relapse prevention systems (Birchwood et al 1989), cognitive behavioural interventions for psychosis (Chadwick and Birchwood 1994), integrated mental health care systems providing input in peoples own homes (Fallon and Fadden 1993) and hospital hostels (Garety and Morris 1984) which should be available rather than relying either hospital beds or independent community settings, with only a limited number of beds in supported houses or hostels.

Needs information was found to be helpful in indicating when care is succeeding or failing, but it was less helpful in any attempt to understand the process which is causing this to happen.

With hospital closure pending, there can be a pressure to reduce patient numbers. For individuals this sometimes can mean discharge to an inappropriate setting where their needs are not met, their problems worsen, and their actual individual needs increase, or they are lost to the service and at risk. There is a need to track such individuals across services, and to monitor if there needs are being met. This may be the thinking behind the supervision order, although it could be argued that the responsibility is upon the service to keep in contact and provide appropriate care rather than the onus to be upon the
individual to maintain contact. Widening the number of factors looked at from just information concerning functioning may have given a clearer impression of who goes where when an asylum closes. The later studies (Studies 6, 7, and 8) suggest level of symptomatology should have been included as high levels of symptoms appeared to have a marked debilitating effect. The pattern seen in the study with verbal aggression, activity and ability to use public settings could have been caused by still active symptoms.

Developing User View Measures

Measures such as the Goodmayes Interview Schedule which seek to evaluate users' views of services also rely to some extent on a well-informed user group who are able to make informed choices about the options of care available to them. Unfortunately, in reality, this information has often not been available to users, and it is only with the comparatively recent emphasis on users' rights that this situation has started to change. Current measures of users' views are somewhat limited, most being devised by clinicians or researchers to answer specific questions. This non-involvement of the user in the design of the instrument that seeks to discover their views obviously may bias the assessment away from the user's actual concerns. Similarly, employing users to gather users views appears to be an important way of overcoming biases inherent in using staff for this task. Rogers, Pilgrim, and Lacey (1993) also comment how it may constrain critical responses as the
researchers/clinicians are often associated with the service and/or premises involved in providing the care the users receive. Even the measure used in the People First MIND survey which Rogers, Pilgrim and Lacey undertook can be criticised on this basis, although they did attempt to use responses by users to media programmes in the measure's development. Their instrument, like the Goodmayes interview schedule, attempts to use a combination of quantitative and qualitative methods. The Lehman and Goodmayes schedules both have a further difficulty in that the interviewers both carry out the interview and rate the schedule. This method raises doubts about the reliability of the schedules. The Lehman's Schedule (1983) used in Study 7-8, while comprehensive, is more suited to use as a research instrument than a clinical instrument because due to its comprehensiveness, it is relatively long, causing users to become tired, and particularly as not all of the sections may be seen by them to reflect their particular concerns. Being able to weigh the importance of factors and would seem a way of more accurately reflecting users' views of their life quality and making it more clinically relevant.

Users' views are an important component of any attempt to measure quality of care. However since at present users are not well informed about service alternatives and are not used to being consulted, together with the early state of the development of such measures, findings have to be interpreted with some caution.
Systems of Care

At the time when work on this thesis commenced, the asylum of St. Crispins was a closed system. It had a large number of wards and operated its own shop, bank, cafe, church, activity centre and industrial unit. If they left their own wards, patients often stayed on site as there was no need to go outside the asylum. Indeed unless you had your own transport it was physically difficult to leave the site, requiring a bracing walk to the nearby village and main road to catch a bus. Similarly many of the staff also stayed on site; there was a nursing residence, doctor's house, a number of houses for families, and a hospital club. Understanding the quality of care in such a closed setting via measures that concentrated upon the activities, interactions, and attitudes of staff and patients towards the place seemed sensible. However, as the asylum closed, facilities shut, and individuals and units transferred to the community, and the system of care changed from a closed to an open one. This may partially explain the difficulties and inadequacies of the measures when applied in the community based settings. In an open system factors outside the immediate environment became increasingly important. It is not just how the staff think about, behave towards, and interact with the residents in a setting, but also how the corner shop owner does, or how the local community reacts towards someone with mental health problems. Boundaries are less distinct and a full analysis of quality of care in the community may need to move
beyond management practice, interactions in the units and clients' views about the unit, towards measures of integration, tolerance of local community, and uptake of local amenities. Other individuals with high contact rates with residents, such as shopkeepers, may have as much impact as the residential workers upon a person's self-esteem, their ability to cope with mental health problems, and their level of functioning. Quality of life indices may also have to be broadened to take account the impact of broader community influences. Taking into account such an 'open system' may help explain some apparently contradictory findings, for example as in Study 7 when participants' subjective quality of life appeared to significantly decrease following their move from a hospital unit to the community. Individuals can seem particularly satisfied in what appears to be an institutional setting when they have low expectations and little experience of alternatives. In a community setting which appears less institutional they may be less satisfied because they are more aware of other alternatives, have greater expectations and may chose to compare their setting with their potentially more affluent neighbours rather than with the asylum setting they have left.

Similarly, staff may be more prone to being affected by outside influences in an open system. The performance of staff may be more prone to stressors outside the work setting. Like the residents they may have lower expectations of what can be provided in an asylum setting. In the community, higher expectations may be triggered, and hence frustrations when these
Special Note

Page 357 missing from the original
ordinary community settings (Study 7) and are more able to cope with their symptoms. To understand quality of care it would seem to be important that features of the settings: the clients, the staff, and the interaction between them, are examined. It may be that particular patterns of interactions are typical across particular types of units, this would make it more sensible to compare findings across like settings eg. supported houses with other supported houses rather than across different settings eg. supported houses with hospital wards. The low interaction levels seen in ward settings (eg. Study 2) are typical; such a finding in another setting (supported house) where they are less typical, would be more important.

Associations found in other studies such as Shepherd et al. (1995) were not replicated in the studies in this thesis, for example the association between level of disability and reported satisfaction reported in their study was not seen (although there were associations between some disabilities and areas of satisfaction, eg. deviant behaviour and satisfaction with social relations and health (Study 7)). Comparisons across studies are made more difficult due to the different assessment measures being used. Patterns do begin to emerge across the studies in this thesis: the association between symptomatology and subjective life satisfaction appears strong in units where more staff support is provided and perhaps there is less contact with the community than there is in less supported settings which
perhaps are less insular (Study 8 compared with Study 7). There also appears to be an association between institutional attitudes in staff and a likelihood to interact less with residents (Study 8). The degree of generalisibility of such findings though remains open to question.

Conclusion: Ways Forward

The final study identified a number of areas where further work could usefully develop an understanding of how community care was functioning now that asylums are closing. These are areas that would lead on from this thesis, or would be considered if such a project was being undertaken again:

- Interventions aimed at alleviating symptoms. Given the strong association between subjective quality of life ratings and symptomatology, developing interventions that helped individuals cope with their symptoms appears particularly important. This has indeed been a developing field since the commencement of this thesis, particularly in the use of cognitive behavioural approaches to cope with psychosis. Evaluating changes in perceived quality of life may be one way of judging the effectiveness of cognitive behavioural approaches.

- Developing assessments which reflect individuals' weighting of the importance of the problem/area of enquiry. This may be particularly pertinent in the area of quality of life were it
may be important to ascertain which factors a client feels are more important to their quality of life. However, it could be a principle which is useful across other issues such as level of functioning and symptomatology. Do lack of abilities in a particular area, or presence of symptoms, impact on a client in a significant way to them? Some developments have taken place in the area of symptomatology, for example in the assessment of delusions (Brett-Jones, Garety and Hemsley 1987) which assess the impact the individual feels such a symptom is having upon them.

Improve ways of gathering users' views. An important way of evaluating a care system is to ask its recipients what they think. The measure used in this study had a number of drawbacks. The Lehman Quality of Life schedule asked clients to make numerous ratings, often of areas of life which appeared to be of little significance to them, while although the Goodmayes provided a wealth of information, the validity and reliability of this was questionable and the experiences life schedule was experienced as distressful and intrusive by many patients. Involving users in the design and administration of measures would be a step forward, and qualitative methods such as semi-structured interviews, focus and nominal groups may help open up meaningful clinical hypotheses which then could be evaluated. Marshall, Powell and Lloyd (1996) have also argued that qualitative methods add a
human dimension' when explaining the results of quantitative studies, and the Goodmayes schedule used in the final study helped serve this function.

- Broadening the scope of the view of care. Systems theory may be a useful way forward in considering care in the community. Boundaries are less marked in the community than when care is promoted in asylums. Assessing which other aspects of community life impact upon people with long term mental health care and evaluating their effect could be of use, concentrating solely on what occurs within units may be less meaningful in the community.

- Recognising good quality care. Historically most studies have concentrated upon identifying institutional practices particularly those carried out in hospital settings. It has been assumed that good care is the absence of such practices. Fewer studies have evaluated this assumption or sought to establish the constituents of good quality care.

- Using appropriate comparators for community care settings. Comparisons are often made between new community settings and asylums. This is no doubt due to the fact that most of the evidence about care practices is derived from institutional settings ad that with time comparators with appropriate similar settings would become increasingly available. Further research concerning practices in bed and breakfast settings, ordinary homes, small hotels etc., would also act as a means
of establishing appropriate comparators for community based settings for people with long term mental health problems and assist in defining good and average practices.

- Studies to Evaluate how Change Occurs. Although many studies have concentrated upon evaluating care, few have attempted to effect change in care quality of a training and intervention programme and demonstrated that effecting change is likely to be a complex process and that such simplistic training and education programmes are unlikely to be successful. Studies looking at methods of improving care quality would be useful, involving users, staff based interventions which effect attitudes and practices, and methods of evaluating care which involve immediate feedback and re-adjustments would be potential ways forward.

The asylum evaluated in these studies has closed, other asylums have closed or are in the process of closure, however, the long term mental health problem of clients and the secondary handicaps of apathy, inactivity and dependence remain. It still is important to identify the conditions for higher quality care and the means of achieving this in the community. People with long term mental health problems and lowered competences and functioning remain more likely to be shaped by and vulnerable to environmental contingencies.
It is likely that, in achieving high quality care, a great deal can be learned from the studies of asylums, and asylum closures, although it is also important not to be too narrow in the approaches adapted and to realise that some of the issues that were addressed in asylums are less of a concern in the community, and other avenues may require exploring. Evaluating care quality in community settings is likely to be an even more complex task than it was in the asylums due to the dispersal of services and closer links with other community based factors. It will require input at many levels, but is not a task that should be abandoned because of its complexity. Services will need to be understood in terms of their structure, process and outcomes. Structure is best understood in terms of the physical environment, eg. type of facility, demographic variables etc. Structure may need to be seen in broader terms than it has been and include degree of integration and acceptance by the community. Understanding Process will need to cover the form of care provided, and hence traditionally would have focused upon staff based measures, such as staff attitude, management practices, and interaction measures. However, in community settings these will also require a broader focus and need to also cover attitudes and interactions of importance to others who have higher levels of contact with people with long-term mental health problems. Essentially there is also a need to demonstrate a clearer link between such process measures and the outcome of care settings, which sort of factors are important in producing good quality care, and what this means in terms of
outcomes such as residents' ability to deal with their problems, level of functioning, and quality of life. For example, it would be important to demonstrate that reducing staff stress, improving staff knowledge or other methods focused upon staff, would actually alter staff behaviour and hence quality of care. It is often assumed that they do without clearer evidence. Monitoring aspects of structure, process and outcome systematically on a regular basis would provide a framework to enable the nurturing of positive attitudes and interactions, encourage creativity, support staff in their endeavours, and recognise each resident and staff number as an individual within the context of the wider community. Evaluating asylum closure is one step forward in this process. The lessons learnt from such closure need to be built upon. The over-riding aim of service provision should be to improve the quality of life of individuals with long-term mental health problems.
REFERENCES


Allen, C.I. (1993). Clients' Views: I mentioned it once and they didn't do anything about it - that's wrong isn't it?


Refs: Page 2 of 21


Department of Health: Caring for People: Community Care in the Next Decade and Beyond, HMSO 1989.

Department of Health: County Asylums Act, 1828. HMSO 1828.


Department of Health: Better Services for the Mentally ill. HMSO 1975.

Department of Health: Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. HMSO 1996.


Refs: Page 8 of 21


Refs: Page 13 of 21


Refs: Page 14 of 22


Mulhall, D. (1989). The Functional Performance Record. NFER,


Refs: Page 16 of 21


Refs: Page 17 of 22


Refs: Page 18 of 21


Sawtell, R. (1989). Assessment of the needs for care of a group of 'new' long-stay psychiatric patients, as viewed by staff and the patients themselves. Leicester: British Psychological Society Diploma.


Tukey, S. (1813). A Description of York Retreat. York,


LIST OF APPENDICES

Appendix 1  - REHAB Assessment

Appendix 2  - REHAB Raters Guide

Appendix 3  - Management Practices Questionnaire (B)

Appendix 4  - Management Practices Questionnaire (A)

Appendix 5  - Optimism Pessimism Scale

Appendix 6  - Perceived Involvement in Decision Making Scale

Appendix 7  - Direct Observation Schedule

Appendix 8  - Lehman Life Satisfaction Scale

Appendix 9  - QUARTZ Environment Scale

Appendix 10 - Experience Sampling Form

Appendix 11 - Goodmayes Interview Schedule
ASSESSMENT FORM

Part 1. Deviant Behaviour

Instructions
These next questions are all concerned with particular types of deviant or disturbing behaviour. Each question is followed by three possible answers, please place a tick by the answer which best describes the behaviour. Begin by tick ing the ONE box which best describes the patient’s behaviour last week. Take account of any reports of incivility, etc., which happened when you were not with the patient during the week.

1. Was the patient involved in
   □ Incivility (e.g., leave the ward without permission, etc.)
   □ Incivility in the ward
   □ No incivility

2. Was the patient physically violent?
   □ Verbal, (e.g., shouting, threatening, etc.)
   □ Violent acts in the ward
   □ No violence

3. Did the patient hurt or maltreat himself/herself?
   □ Self-injury (e.g., self-biting, etc.)
   □ Self-injury in the ward
   □ No self-injury

4. Was the patient sexually offensive in any way?
   (Judge-offensiveness as a stranger would)
   □ Offensive acts more than once in the week
   □ Offensive acts in the ward
   □ No offensive behaviour

5. Did the patient have the word or hospital without arrangements?
   □ Left without arrangements for the week
   □ More than once in the week
   □ No word or hospital without arrangements

6. Did the patient threaten or swear at others?
   □ Threatened or swore at another patient or any staff during the week
   □ No threats or swearing

7. Did the patient talk to himself/herself?
   □ Talked to himself/herself
   □ No talk to himself/herself

8. Apart from the deviant behaviour that occurred last week, what else has occurred during the last four weeks? Tick the box concerned and write alongside approximately when the behaviour occurred.

   □ [Space forwrite]

   When did the behaviour last happen?

   □ [Space for write]
### Part 2. General Behaviour

<table>
<thead>
<tr>
<th>Instructions</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructions: Each question is followed by a list. Read each list at three. The statements range from the worst possible standard of behaviour at the top, to the standard of behaviour expected from normal patients at the bottom.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. How much did the patient mix with others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Off the ward or not.</td>
<td>On the ward or ward.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. What did the patient do with his/her spare time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occasionally paced in the area.</td>
<td>Normally normal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. How active was the patient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Periods of inactivity not abnormal varied.</td>
<td>Normal amount and speed of activity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. How many words did the patient use when he/she spoke?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Told for a normal length of time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. How much did the patient initiate conversation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, tick box.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. How sensible was the patient’s speech?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, tick box.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. How clearly did the patient speak?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, tick box.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. How good were the patient’s table manners?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If not, tick box.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Overall Rating

23. How good was the patient’s general everyday behaviour last week?

- Taking everything into account, your patient’s behaviour during the past week would be: 
  - Better than usual
  - About the same as usual
  - Worse than usual

Please add any comments that you wish to make about the patient’s behaviour: 

---

**Note:** The document contains a series of questions and observations related to a patient’s general behaviour, including their interaction with others, activities, speech, and table manners. Each question is followed by a list of possible responses ranging from the worst to the best standard of behaviour.
Introduction

REHAB is a rating scale which can be used to assess psychiatric patients/clients/residents. It is especially useful for people who have become long stay. It can be used to rate patients living in hospital, those attending a day hospital/centre or those living in a hostel or residential home. It measures the most important type of behaviour of patients. It can be used:

1. to pick out patients who have potential for living outside hospital.
2. to pick groups of patients with a similar problem e.g. self-care problems, or to pick patients at a similar level e.g. grading them into high, medium and low levels.
3. to measure patients before, during and after treatment to see if they change. This refers to drug treatments, psychological treatments e.g. Token Economy, or changes in the living environment e.g. introduction of new activities.
4. to pinpoint problem areas — this might be problems in individuals, e.g. what are the important behaviour problems of William Smith, or in whole wards or units e.g. what is the most common problem found in Ward 9.

To rate, the person doing the rating has to observe the patient (or group of patients) over the period of one week. At the end of the week the rater fills in one of the ASSESSMENT FORMS, remembering back how the patient was during that last week. The forms will then be collected by the person in charge of the ratings, who will score them.

If you are not in a hospital set up .........

Note that the ASSESSMENT FORMS refer mainly to 'patients' and 'wards'. This is because the scale was developed in hospitals. REHAB can be applied as well in other settings — please translate 'patients' or 'wards' into the correct terms for your set up. For instance where the ASSESSMENT FORM talks about the patient 'leaving the ward or hospital without arrangement' (item 5) translate this to hostel or centre etc.
possible for a psychiatric patient

18. Dressing

Does not attempt to dress or attempts are very poor in every way, such as pulling shirt or blouse on back to front, clothes inside out, buttons undone, shoes on the wrong feet, stockings hanging right down etc. If a staff member has to dress the patient rate here. This is really referring to having to help the patient with most aspects of dressing. If just one or two things need help such as doing up shoe laces, you probably wouldn't rate at the extreme left, but nearer the mid-point statement.

19. Looking after his/her own things

This refers to how well the patient makes his/her bed and what the space around the bed or in the bedroom looks like. To rate at this end the bed might be unmade or in a mess and there might be cigarette ends, dust and paper around the bed area, clothes slung in locker and hanging out etc. If the patient makes the bed well enough, but the area around the bed is very untidy (in other words one part of it is O.K. and the other isn't), rate around the middle point.

20. Prompting

This does not refer to how well a patient does a task, but how much the staff have to tell the patient to do it, prod, prompt, remind, or actually have to do it for the patient.

How Rating Starts

The ratings can be used in a lot of different ways. It may be that the staff want to split patients up into groups, such as high, medium, and low level groups. It could be that a rehabilitation team wants to know which patients would benefit most from a pre-discharge unit. It could be that a psychiatrist wants to carry out a drug trial and needs to measure the effect of the drug. There are many different reasons for wanting to carry out the assessment and also many different people who might start up the idea. Whichever way it starts there will have to be full discussion with the nurse in charge of a ward (or warden if in hostel), at the beginning. Questions have to be answered, like why do we need to do the ratings, who will be rated, which staff will do the ratings, how long will it take?

After these first discussions, the staff that are picked to do the ratings will have to be trained to do it properly. Reading the assessment form and this booklet helps, but a proper training is important to get it really accurate. If only one or two patients are going to be rated it's not worth carrying out a special training programme. But if a lot of patients are to be rated, or if the ward/hostel/day hospital is going to use the scale regularly, special training will be necessary.

Training involves the raters observing two trial patients for a week. This is followed by a 'training session' with the person in charge of the rating. After this the raters go away and fill in an assessment form on one of the trial patients by themselves. The person in charge of the rating will then collect and score up the assessment forms, bringing them back for a 'feedback session' a few days later. This session is to iron out any problems the raters had, things they didn't understand etc. That finishes the training, and the raters can now be expected to give an accurate assessment of the patients they observe.
General Behaviour

In the General Behaviour part of the scale the left hand statement is 'worst possible standard of behaviour' and the right hand statement is 'normal'. What follows now is a description for each item as to what we mean by 'worst possible standard of behaviour' and 'normal'. We haven't tried to explain the statement at the mid point of each line; this simply refers to a standard midway between the right and left hand statements.

Left hand side: worst standard possible for a psychiatric patient
Right hand side: standard expected in the community

8. Mixing on the Ward

The patient keeps contact with others to the absolute minimum. He/she may seek solitude e.g. sitting alone, hiding in empty rooms or deserted parts in the grounds. The patient may move away when others approach or show that he/she doesn't want their company.

9. Mixing off the Ward

No social contact outside of the ward. The patient never goes to see patients on other wards or goes off the ward to see any other person. If the patient goes out of the ward for a walk in the park alone, and not to meet anybody particularly, he/she would still score at this site (bad) because this is not mixing socially outside.

Seek information about hospital socials which the patient visited. If the patient goes to a hospital social, and mixes with others there it would be ticked at the mid point. If the patient goes to a hospital social, but sits in a corner isolated, this could not be said to be mixing socially outside the ward, and you would have to rate much further towards the left hand side of the item.

N.B. — If you are rating in a hostel or unit this item would refer to whether the patient mixes only with patients or staff closely connected with the hostel/unit or whether with people outside the hostel/unit.

Guide to Individual Items

If you are not clear about any particular item the following guide is meant to help.
13. Initiation of Speech

Never starts speaking first to patients or staff even though he/she might answer when spoken to. A patient who answers every question but never asks any questions would count here. A patient would score here if it is you who have to make all the effort to keep a conversation going.

14. Sense of Speech

This refers to what a patient says. If the patient's sentences are all mixed up (word salad) so that you don't know what the patient is talking about, rate here. If the patient's speech is so delusional or absurd as to make no sense or if he/she continually wanders off the point, or uses his/her own words (neologisms), then rate here.

15. Clarity of Speech

Speech totally unclear. Impossible to make out what is said, because the patient either speaks too slow, or too fast, or too mumbled, or too soft, or too loud, or too slurred. When you get to know a patient you 'tune in' to unclear speech, and so you might tend to rate the patient better than he/she really is. Try to imagine the patient from the day before.

General Behaviour

This section is filled in differently to the Deviant Behaviour section. Each question is followed by a line, as below.

9. How much did the patient mix with others

Went to hospital socials and mixed, or went to see patients on other wards.

10. What did the patient do with his/her spare time?

Occasionally joined in games and activities. Occasional interest in news and events.

Remember

* The right hand side refers to 'normality'.
* Only put one tick or mark for each question.
* Only mark on what the patient did last week.
* Check that you have marked every question.
* Check to see if you have filled in the patient's name, ward etc.
The following image type has poor quality text due to the nature of the material.

Image quality is best available.
QUESTIONNAIRE N° 1

1. DO THE RESIDENTS GET UP AT THE SAME TIME ON WEEKENDS AS THEY DO DURING THE WEEK?

   Different time for all on 2 days
   Different for some, on 1 day only
   Same time

2. DO THE RESIDENTS GO TO BED AT THE SAME TIME ON WEEKENDS AS THEY DO DURING THE WEEK?

   Different time for all on 2 days
   Different for some, on 1 day only
   Same time

3. DO THEY USE THE SHEETS AT BED TIME?

   Yes, whenever they like
   Under various conditions
   No, not used at all

4. ARE THERE ANY RULES THAT VISITORS ARE GIVE BY THE STAFF?

   Yes, some (specify what)
   No rules at all
   Tell me a story

5. ARE ANY OF THE RESIDENTS CAPABLE OF WALKING ALONE?

   Yes, some (specify what)
   No one at all
   Tell me a story

6. DO ANY OF THE RESIDENTS NEED SOME ATTENTION?

   Yes, some (specify what)
   No one at all
   Tell me a story

7. ARE THERE ANY RESIDENTS ON SPECIFIC DIAETARY

   Yes, let me know
   Tell me a story

8. ARE THERE ANY RESIDENTS CHANGIN THEIR MINDS?

   Yes, let me know
   Tell me a story
HOW MANY RESIDENTS HAVE PERSONAL POSSESSIONS?

- 67-100%
- 34-66%
- 0-33%

ARE THE RESIDENTS ALLOWED PICTURES OR PIN-UPS IN THEIR ROOMS?

- Yes, in all rooms
- Yes, in some rooms
- No

HOW ARE THE RESIDENTS' BIRTHDAYS CELEBRATED?

- Individual presents or parties
- Mixed presents
- Joint parties or no recognition

HOW ARE BREAKFASTS Laid FOR MEALS?

- Whole meal for all
- Half meal for some
- No meal, either cooked or eaten

HOW MANY RESIDENTS CAN USE THE KITCHEN?

- 67-100%
- 34-66%
- 0-33%

DO THE RESIDENTS HAVE PRIVIES OR ELOI AT THE OPTION?

- Yes, in 100% of cases
- Yes, in some cases
- No

HOW DO OTHER MEALS PREPARED OR SERVED HERE?

- Whole meal for all residents
- Half meal for some
- No meal

DO CARS OR SMOKING MATCHES GO WITH THE RESIDENTS? What next?

- Yes, at least sometimes
- Some visits or visits allowed
- Strictly forbidden and supervision only

DO OTHERS OR KIN PAY FOR MEALS AND MENDING WITH THE RESIDENTS? What next?

- Someone usually pays
- Someone sometimes pays
- A specific payment or supervision only

HOW MANY RESIDENTS HAVE BEEN ON EXCURSIONS IN THE LAST 6 MONTHS?

- 0-33%
- 34-66%
- 67-100%
Thank you for taking part in this research. All information gathered will be confidential.

Please tick the appropriate box per question to represent your view.

1. SHOULD RESIDENTS GET UP AT THE SAME TIME ON WEEKENDS AS THEY DO DURING THE WEEK?
   - Different times for all on 2 days
   - Different for some, or on 1 day only
   - Same time

2. SHOULD THE RESIDENTS GO TO BED AT THE SAME TIME ON WEEKENDS AS THEY DO DURING THE WEEK?
   - Different time for all on 2 days
   - Different for some, or on 1 day only
   - Same time

3. SHOULD THEY USE THE GROUNDS AT SET TIMES?
   - No, whenever they like
   - Under various conditions
   - Yes, at set times only

4. SHOULD THERE BE SET TIMES WHEN VISITORS CAN COME TO THE UNIT?
   - Any time (except specified times)
   - Any day but set times
   - Certain days only

5. SHOULD THE RESIDENTS BE ROUTINELY TOILETED AT NIGHT?
   - None some only once
   - Some more than once
   - All once or more

6. SHOULD THEY USE THEIR BEDROOMS AT SET TIMES?
   - No, whenever they like
   - Under various conditions
   - Yes, set times only

7. WHAT SHOULD THE RESIDENTS DO BETWEEN DRESSING AND BREAKFAST?
   - All occupied
   - Some wait doing nothing
   - All wait doing nothing

8. SHOULD RESIDENTS WAIT IN LINE BEFORE COMING IN FOR BREAKFAST?
   - None wait
   - Some wait
   - All wait

(Continued ........)
Questionnaire No. 2/Continued

9. Should staff members help residents to milk and sugar in tea etc?
   - Never
   - Sometimes or some residents
   - Always

10. Should staff members control the radio or television?
    - Never
    - Sometimes
    - Always

11. When lunch is called, should residents go into the dining room together as instructed by the staff?
    - No, individually
    - In groups
    - All together

12. How long should residents wait at table after the meal is finished?
    - Less than 7 minutes
    - 8-14 minutes
    - 15 or more minutes

13. What should be done with the clothing a resident brings?
    - Kept and used by the resident
    - Used only on special occasions
    - Not used or not allowed

14. What should be done with the personal possessions a resident brings with him/her?
    - Kept and used by the resident
    - Kept for a time but become communal
    - Not used or not allowed

15. How many of the residents should possess all of the following items of clothing: shirt or blouse, trousers or skirt, dress or jacket, jumper, top coat, shoes, dressing gown, slippers.
    - All
    - Some
    - None

16. Where should the residents' clothes be kept?
    - In private provision
    - In shared provision, supplied weekly
    - In communal provision supplied daily

17. How many of the residents should have personal possessions?
    - All
    - Some
    - None

Continued ............
19. SHOULD THE RESIDENTS BE ALLOWED PICTURES, PIN-UPS, PHOTOS IN THEIR ROOMS?

- Yes, in all rooms
- In some rooms
- No

20. HOW SHOULD THE RESIDENTS' BIRTHDAYS BE CELEBRATED?

- Individual presents or parties
- Mixed pattern
- Joint parties or no recognition

22. HOW SHOULD TABLES BE LAID FOR MEALS?

- Tables laid for all
- Tables laid for some
- Not laid, cutlery handed out by staff

23. HOW MANY RESIDENTS SHOULD BE ALLOWED TO USE THE KITCHEN?

- All
- Some
- None

24. SHOULD THE RESIDENTS HAVE ACCESS TO THE OFFICE?

- Yes, no restrictions (except specified times)
- Sometimes, under certain conditions
- No, door kept locked

25. HOW SHOULD STAFF ASSIST RESIDENTS AT BATH TIMES?

- One staff member per resident
- Mixed pattern
- "Conveyor-belt" system

26. SHOULD STAFF ON DUTY EAT WITH THE RESIDENTS? (Main meal)

- All staff (at least sometimes)
- Some staff, or sit but don't eat
- Stand, serve and supervise only

27. SHOULD STAFF ON DUTY SIT AND WATCH T.V. WITH THE RESIDENTS?

- Someone usually should
- Someone sometimes should
- Sporadic supervision only

28. HOW MANY RESIDENTS SHOULD HAVE BEEN ON OUTINGS IN THE LAST 3 MONTHS?

- All
- Some
- None

29. SHOULD STAFF HAVE THEIR OWN CROCKERY AND CUTLERY?

- Neither crockery or cutlery
- Only crockery
- Both crockery and cutlery

Continued ............
28. SHOULD THERE BE STAFF-RESIDENT MEETINGS TO DISCUSS THE RUNNING OF THE UNIT?

Regularly  
Occasionally  
Never  

-------50-------
In hostels, all one can do effectively at the present time is to look after the residents' basic physical needs such as toileting, feeding and dressing.

For those residents able to undertake industrial therapy, the simple repetitive type of work is most appropriate.

Most severely handicapped residents respond so slowly to treatment that there is little point in making repeated assessments of their development.

Very few residents who participate in work programmes could cope comfortably with a 40 hour working week.

Given the current shortage of money it would be shortsighted to provide residents with more personal possessions as they would not look after them properly.

It is doubtful whether most residents could really understand and value the money they might earn doing work in the community.

The provision of individual programmes having any real value for residents is too expensive for hostels.

Very few hostel bound residents could develop a sense of identity with life outside the hostel from going on trips and visits.

Continued ...............
<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Strong Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Unreasonable to expect that the quality of life of more than a few chronic residents will be improved if they were housed in lodgings in the community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Only a few of the least handicapped residents could ever hope to hold down a job in the community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Despite the problem of incontinence residents should always wear their own personal underclothing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thank you for taking part in this research. All information gathered will be confidential.

Please circle one point per question to represent your view.

1. Most hostel staff feel that they are not included enough when plans for the residents are being made.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
</table>

2. Officers in charge of this hostel rarely ask for information about particular residents from other staff.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
</table>

3. One of the major problems here is that people making all the plans just don’t know the residents as well as they should.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
</table>

4. There are too many hostel bosses here telling you what to do and not enough people to do the work.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
</table>

5. You don’t get enough recognition here for all the work you do.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
</table>

6. In this hostel the opinions of staff who work alongside residents are rarely sought when decisions are made to transfer residents to other departments.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strong Agree</th>
</tr>
</thead>
</table>
QUALITY OF LIFE INTERVIEW
CORE VERSION

Lehman 1/15/91

INTRODUCTION

I am interested in what your life is like, your health, what you do from day-to-day, and how you feel about things. I have some questions about different parts of your life. There are no right or wrong answers, so please relax and take your time in answering.

Before we start, do you have any questions?
SECTION A: GENERAL LIFE SATISFACTION

Please look at this card. (HAND SUBJECT THE DELIGHTED-TERRIBLE SCALE.) This is called the Delighted-Terrible Scale (D/T Scale).

The scale goes from terrible, which is the lowest ranking of 1, to delighted, which is the highest ranking of 7. There are also points 2 through 6 with descriptions below them. READ POINTS ON THE SCALE.

During the interview we'll be using this scale from time to time to help you tell me how you feel about different things in your life. All you have to do is tell me what on the scale best describes how you feel. For example, if I ask, "how do you feel about chocolate ice cream" and you are someone who loves chocolate ice cream, you might point to "delighted." On the other hand, if you hate chocolate ice cream, you might point to "terrible." If you feel about equally satisfied and dissatisfied with chocolate ice cream, then you would point to the middle of the scale.

Do you have any questions about the scale? Please show me how you feel about chocolate ice cream. Let's begin.

The first question is a very general one.

1. How do you feel about your life as a whole? D/T SCALE: __1__
DK = 8

Now, set the scale aside. I'll let you know when we need it again.
TERRIBLE UNHAPPY MOSTLY MIXED MOSTLY PLEASED DELIGHTED DISSATISFIED (ABOUT SATISFIED EQUALLY SATISFIED AND DISSATISFIED)
SECTION B: LIVING SITUATION

Now I am going to ask you some questions about your living situation.

1. What is your current living situation?
   (IF PATIENT IS CURRENTLY IN THE HOSPITAL, LIVING SITUATION = LIVING SITUATION JUST PRIOR TO HOSPITALIZATION)

   01 Hospital
   02 Skilled nursing facility -- 24 hour nursing service
   03 Intermediate care facility -- less than 24 hour nursing care facility
   04 Supervised group living (generally long term)
   05 Transitional group home (halfway or quarterway house)
   06 Family foster care
   07 Cooperative apartment, supervised (staff on premises)
   08 Cooperative apartment, unsupervised (staff not on premises)
   09 Board and care home (private proprietary home for adults, with program and supervision)
   10 Boarding house (includes meals, no program or supervision)
   11 Rooming or boarding house or hotel (includes single room occupancy, no meals are provided, cooking facilities may be available)
   12 Private house or apartment
   13 Shelter
   14 Jail
   15 No current residence (including the streets, bus stations, missions, etc.)
   99 No information

   IF HOMELESS (CODES 13 OR 15), SKIP TO 3

2. How long have you lived there? _____ (code in months)

3. Have you lived any place else during the past year?
   (including a psychiatric hospital)
   0 - No (Go to 6)
   1 - Yes (Go to 4)
   9 - No information (Go to 6)
4. List in order the places you have lived during the past year, including psychiatric hospitalizations, beginning with your current living situation. (USE CODES IN Q.1 ABOVE)

<table>
<thead>
<tr>
<th>Type code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td></td>
</tr>
</tbody>
</table>

Total number of different, non-hospital residences (during past year)? ___ ___

5. Which of these was your usual residence during the past year? (use codes in Q1 above) ___ ___.

6. During the past year how often did you sleep in each of the following locations: never, a few times, many times, or most of the time?

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>NEVER</th>
<th>A FEW TIMES</th>
<th>MANY TIMES</th>
<th>MOST OF THE TIME</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. outside without shelter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>b. inside an empty building</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>c. in a public shelter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>d. in a church</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

(Don't know/Refused = 9)

7. Do you currently have a regular place to live where you spend at least 5 out of 7 nights on the average?

- Yes 1
- No 0
- DK 9
I would like to know about the facilities and appliances available to you where you live now. (RATE FOR RESIDENCE CODED IN Q1. IF CURRENTLY HOSPITALIZED, RATE FOR LAST RESIDENCE PRIOR TO HOSPITALIZATION).

SKIP TO NEXT SECTION IF SUBJECT IS HOMELESS.

A. Is there a(n) (FACILITY/APPLIANCE) for your use? (not necessarily private, exclusive use) (FOR EACH ITEM, IF "YES" TO A, ASK B)

B. Is it usually in good (working) condition?

<table>
<thead>
<tr>
<th>FACILITY/APPLIANCE</th>
<th>AVAILABILITY</th>
<th>WORKING CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>flush toilet</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>b. toilet door that closes and locks</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>c. bathroom door that closes and locks</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>d. wash basin</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>e. kitchen sink</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>f. range and cooking stove (not a hot plate)</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>g. refrigerator</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>h. telephone</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>i. electrical outlet in your bathroom</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>j. electrical outlet in your sleeping area</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>k. room where you can go if you want to be alone</td>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
9. Now look again at the D-T Scale and answer the following. (HAND SUBJECT THE D-T SCALE). (QUESTIONS REFER TO MOST RECENT RESIDENCE IF PATIENT IS CURRENTLY IN THE HOSPITAL.) {SKIP IF HOMELESS}
   How do you feel about:
   
   A. The living arrangements where you live? .... _____
   B. The food there? .......................................... _____
   C. The rules there?  ....................................... _____
   D. The privacy you have there?  ........................... _____
   E. The amount of freedom you have?  .................... _____
   F. The prospect of staying on where you currently live for a long period of time? ... _____

10. Still using the D-T Scale, answer the following: {SKIP IF HOMELESS}
    How do you feel about:
    
    A. The people who live in the houses, apartments near yours? ............... _____
    B. People who live in this community? ..... _____
    C. The outdoor space there is for you to use outside your home? .......... _____
    D. The particular neighborhood as a place to live? ........................... _____
    E. This community as a place to live? ..... _____
    F. How safe you feel in this neighborhood? ____
### SECTION C: DAILY ACTIVITIES AND FUNCTIONING

1. Now let's talk about some of the things you did with your time in the past week. I'm going to read you a list of things people may do with their free time. For each of these, please tell me if you did it during the past week. Did you...(READ OPTIONS A-P)?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Go for a walk?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>B. Go to a movie or play?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>C. Watch television?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>D. Go shopping?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>E. Go to a restaurant or coffee shop?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>F. Go to a bar?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>G. Read a book, magazine or newspaper?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>H. Listen to a radio?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>I. Play cards?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>J. Go for a ride in a bus or car?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>K. Prepare a meal?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>L. Work on a hobby?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M. Play a sport?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>N. Go to a meeting of some organization or social group?</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Overall, how would you rate your functioning in home, social, school, and work settings at the present time? Would you say your functioning in these areas is excellent, good, fair or poor?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EXCELLENT</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOOD</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAIR</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POOR</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DK</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Now please look at the delighted/terrible scale again. How do you feel about (READ OPTIONS A-F)?

A. The way you spend your spare time?

B. The amount of time you have to do the things you want to do?

C. The chance you have to enjoy pleasant or beautiful things?

D. The amount of fun you have?

E. The amount of relaxation in your life?

F. The pleasure you get from the television or radio?
SECTION D: FAMILY

The next few questions are about your relationship with your family including any relatives with whom you live.

1. In the past year, how often did you talk to a member of your family on the telephone? Would you say at least once a day, at least once a week, at least once a month, less than once a month but at least once a year, or not at all?

   AT LEAST ONCE A DAY ...............5
   AT LEAST ONCE A WEEK ............4
   AT LEAST ONCE A MONTH ...........3
   LESS THAN ONCE A MONTH .........2
   NOT AT ALL ......................1
   NO FAMILY. (GO TO SECTION E) ....9
   RF ..................................7
   DK ..................................8

2. In the past year, how often did you get together with a member of your family— at least once a day, at least once a week, at least once a month, less than once a month but at least once, or not at all?

   AT LEAST ONCE A DAY ...............5
   AT LEAST ONCE A WEEK ............4
   AT LEAST ONCE A MONTH ...........3
   LESS THAN ONCE A MONTH .........2
   NOT AT ALL ......................1
   NO FAMILY .........................9
   RF ..................................7
   DK ..................................8

3. Please look at the delighted/terrible scale again. How do you feel about (READ OPTIONS A-D)?

   A. Your family in general?.................... |___|
   B. How often you have contact with your family?.................... |___|
   C. The way you and your family act toward each other?.................. |___|
   D. The way things are in general between you and your family?........... |___|
SECTION E: SOCIAL RELATIONS

Now I'd like to know about other people in your life, that is, people who are not in your family.

1. Do you have any close friends who are not family members?
   
   NO........(GO TO 3)...........0
   YES.............................1
   RF........(GO TO 3)...........7
   DK........(GO TO 3)...........8

   A. Do any of these friends live outside of your home?  
      NO............................0
      YES............................1

2. In the past year, how often did you do things with any of these close friends? Would you say at least once a day, once a week, once a month, less than once a month, or not at all?
   
   AT LEAST ONCE A DAY.............5
   AT LEAST ONCE A WEEK............4
   AT LEAST ONCE A MONTH...........3
   LESS THAN ONCE A MONTH...........2
   NOT AT ALL......................1
   RF.............................7
   DK.............................8

3. Still talking about friends, about how often do you do the following? Would you say, at least once a day, once a week, once a month, less than once a month or not at all?
   
   AT LEAST ONCE A DAY.............5
   AT LEAST ONCE A WEEK............4
   AT LEAST ONCE A MONTH...........3
   LESS THAN ONCE A MONTH...........2
   NOT AT ALL......................1
   RF.............................7
   DK.............................8

   A. Visit with someone who does not live with you? ....................
   B. Telephone someone who does not live with you?......................
   C. Write a letter to someone?....................
   D. Do something with another person that you planned ahead of time?........
   E. Spend time with someone you consider more than a friend, like a boyfriend or girlfriend?........
4. Look at the delighted/terrible scale again. How do you feel about

A. The things you do with other people?..............|___|

B. The amount of time you spend with other people?.................................................|___|

C. The people you see socially?.................|___|

D. How you get along with other people in general?.................................................|___|

E. The chance you have to know people with whom you really feel comfortable?.............|___|

F. The amount of friendship in your life?.... |___|
SECTION F: FINANCES

A few questions about money.

1. In the past have you had any financial support from the following sources?

<table>
<thead>
<tr>
<th>Not Known</th>
<th>Yes (1)</th>
<th>No (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Earned income
2. Social Security Benefits (SSA)
3. Social Security Disability Income (SSDI)
4. Supplemental Security Income (SSI)
5. Armed Service connected disability payments
6. Other Social Welfare benefits---state or county (general welfare, Aid to Families with Dependent Children (AFDC))
7. Vocational program (Comprehensive Employment and Training Act (CETA), Vocational Rehabilitation, sheltered workshop, Goodwill,
8. Unemployment compensation
9. Retirement, investment or savings income
10. Rent supplements (including HUD, Section 8 certificates, living programs receiving public support)
11. Alimony and child support
12. Food stamps
13. Family and/or spouse contribution
14. Other source(s) (SPECIFY):

2. How much money did you receive during the past month from all of these sources?

--- --- --- ---

9999 - DK,RF

2A. Was this a usual month in terms of the amount of money you received?

1 - Yes (Go to Q3)
0 - No (Go to Q2B)
9 - DK,RF (Go to Q2B)
2B. Would you say that the amount of money you received during the past month was more than or less than usual?

1 - More than usual
2 - Less than usual
9 - DK, RF

2C. How much would you say that you have usually received per month during the past year?

--- --- --- ---
$9999 - DK, RF

3. On the average, how much money do you have to spend on yourself each month, not counting money for room and meals?

9999 - DK, RF

INTERVIEWER RATING
HOW RELIABLE DO YOU THINK R'S RESPONSES WERE TO Q1,

VERY RELIABLE ............. 4
GENERALLY RELIABLE .......... 3
GENERALLY UNRELIABLE ........ 2
VERY UNRELIABLE ............ 1

4. Is there anyone who handles your money for you?

NO ........ (GO TO 5) ........ 0
YES ......................... 1

A. Are your checks mailed directly to this person?

NO ......................... 0
YES ......................... 1

5. During the past year, did you generally have enough money each month to cover (READ OPTIONS A-F)?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>SOMETIMES</th>
<th>YES</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>C.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>F.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>
Now, I’d like you to use the card for the delighted/terrible scale again. In general, how do you feel about (READ OPTIONS A-D)?

A. The amount of money you get?.........................

B. The amount of money you have to cover basic necessities such as food, housing, and clothes?

C. How comfortable and well-off you are financially?..

D. The amount of money you have available to spend for fun?..................................................
SECTION G: WORK AND SCHOOL

1. Have you worked during the last year, that is since (DATE)? Are you working now?
   No (Q13) ............0
   Yes, currently .........1
   Yes, formerly (Q6) ......2
   RF ..................7
   DK ..................8

   PROBE FOR ANY PAID WORK

2. What kind of work do you do at the present time?
   DESCRIBE: WORK: [ ]
   PROBE: WAS THIS AT A SHELTERED WORKSHOP, OR WITH A JOB COACH?
   No ................0
   Yes ................1
   RF ................7
   DK ................8
   SPECIFY: NA ............9

3. About how many hours a week do you usually work?
   HOURS: [ ]
   RF ..................97
   DK ..................98
   NA ..................99

4. About how much do you earn per week at this job?
   $:
   $996 ..........996
   RF ...............997
   DK ...............998
   NA ...............999

   ROUND TO DOLLARS

5. Is this the only job you have had in the past year, that is since (DATE)?
   No (Q7) .............1
   Yes (Q14) ............2
   RF ..................7
   DK ..................8
   NA ..................9

6. You said you were not working at present, but have worked in the past year. How many weeks has it been since you worked?
   WEEKS:
   RF ..................997
   DK ..................998
   NA ..................999
7. Please describe each job that you’ve had in the past year, that is since (DATE) other than the one we’ve talked about. What was the job you had before the job at which you currently work?

<table>
<thead>
<tr>
<th>JOB:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RF ..........</td>
<td>97</td>
</tr>
<tr>
<td>DK ..........</td>
<td>98</td>
</tr>
<tr>
<td>NA ..........</td>
<td>99</td>
</tr>
</tbody>
</table>

ASK IF R WORKED FORMERLY IN PAST YEAR, ASK what was the most recent job you have had?

SPECIFY:

PROBE: WAS THIS AT A SHELTERED WORKSHOP OR WITH A JOB COACH?

8. About how many hours a week did you usually work?

<table>
<thead>
<tr>
<th>HOURS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RF ......</td>
<td>97</td>
</tr>
<tr>
<td>DK ......</td>
<td>98</td>
</tr>
<tr>
<td>NA ......</td>
<td>99</td>
</tr>
</tbody>
</table>

9. About how much did you earn per week at this job?

<table>
<thead>
<tr>
<th>$:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$996+</td>
<td>996</td>
</tr>
<tr>
<td>RF ......</td>
<td>997</td>
</tr>
<tr>
<td>DK ......</td>
<td>998</td>
</tr>
<tr>
<td>NA ......</td>
<td>999</td>
</tr>
</tbody>
</table>

ROUND TO DOLLARS

10. What was the job before that?

<table>
<thead>
<tr>
<th>JOB:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RF ..........</td>
<td>97</td>
</tr>
<tr>
<td>DK ..........</td>
<td>98</td>
</tr>
<tr>
<td>NA ..........</td>
<td>99</td>
</tr>
</tbody>
</table>

SPECIFY:

PROBE: WAS THIS AT A SHELTERED WORKSHOP OR WITH A JOB COACH?

11. About how many hours a week did you usually work?

<table>
<thead>
<tr>
<th>HOURS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RF ......</td>
<td>97</td>
</tr>
<tr>
<td>DK ......</td>
<td>98</td>
</tr>
<tr>
<td>NA ......</td>
<td>99</td>
</tr>
</tbody>
</table>

12. About how much did you earn per week at this job?

<table>
<thead>
<tr>
<th>$:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$996+</td>
<td>996</td>
</tr>
<tr>
<td>RF ......</td>
<td>997</td>
</tr>
<tr>
<td>DK ......</td>
<td>998</td>
</tr>
<tr>
<td>NA ......</td>
<td>999</td>
</tr>
</tbody>
</table>

ROUND TO DOLLARS
13. If S claims no work at all during the past year, ask:

Why are you not working at this time?

PROBE: PSYCHIATRIC PROBLEMS
PHYSICAL PROBLEMS
LAID OFF
LOOKING, (CAN'T FIND, ETC.)
WHAT IS THE MAIN REASON?

REASON: ______ ______
RF......................... 7
DK........................ 8
NA........................ 9

14. During the past year, that is since (DATE) have you done any type of work such as yard work or painting over a few days time that you got paid for?

No (Q16).................. 0
Yes........................ 1
RF......................... 7
DK......................... 8
NA......................... 9

15. If so, about how much did you earn doing this?

$:

$996+....................... .996
RF.......................... .997
DK.......................... .998
NA.......................... .999

16. Have you done any kind of volunteer work such as working at a hospital or a school in the past year that is since (DATE)?

No (Q18)................... 1
Yes........................ 2
RF......................... 7
DK......................... 8

17. About how many hours per week do you do volunteer work?

HOURS:
RF.......................... 97
DK.......................... 98
NA.......................... 99
18. Have you done any other type of work in the past year?

No.........................1
Yes.........................2
RF..........................7
DK..........................8

19. About how much did you earn per week?

$:

$996+..................996
RF.........................997
DK..........................998
NA..........................999

20. JOB SATISFACTION (Use D-T Scale) (SKIP IF UNEMPLOYED)

How do you feel about:

A. Your job? ......................................................
B. The people you work with? ......................
C. What is it like where you work......
   the physical surroundings? ......................
D. The number of hours you work? ...................
E. The amount you get paid? .......................

21. Have you been a student during the past year?

No ...... 0 (go to next section)
Yes ...... 1 (go to 22)
DK, RF ... 9 (go to next section)

22. At what level was the schooling?

1 ... High School (grades 9 - 12, including GED)
2 ... Adult Education
3 ... College (Undergraduate)
4 ... Graduate school
5 ... Vocational/technical school
6 ... Job Training
7 ... Other (Specify)............................

23. Are (did) you carry a full-time load of studies?

0 ... No
1 ... Yes
9 ... DK, RF

24. Are you attending now?

0 ... No
1 ... Yes
9 ... DK, RF
25. Using the Delighted-Terrible Scale again, how do you feel about:

A. Being a student? ................................ ....
B. Your school? .......................................... ...
C. The other students at your school? ...... ....
SECTION H: LEGAL AND SAFETY ISSUES

1. In the past year, have you been picked up or arrested for any of the following types of crimes (READ OPTIONS A-E)?

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Alcohol or drug offense?</td>
<td>0</td>
</tr>
<tr>
<td>B. Shoplifting?</td>
<td>0</td>
</tr>
<tr>
<td>C. Loitering?</td>
<td>0</td>
</tr>
<tr>
<td>D. Public nuisance?</td>
<td>0</td>
</tr>
<tr>
<td>E. Other crime (SPECIFY)?</td>
<td>0</td>
</tr>
</tbody>
</table>

2. How many times have you been arrested or picked-up for any crimes in the past year?

   # ARRESTS __ __

3. In the past year, how many nights did you spend in jail?

   # NIGHTS __ __

4. In the past year, were you a victim of
   A. Any violent crimes such as assault, rape, mugging, or robbery?

   No.....................0
   Yes, once..............1
   Yes, more than once...2
   RF......................7
   DK.....................8
   NA.....................9

   B. Any nonviolent crimes such as burglary, theft of your property or money, or being cheated?

   No.....................0
   Yes, once..............1
   Yes, more than once...2
   RF......................7
   DK.....................8
   NA.....................9

5. Please look at the delighted/terrible scale again. How do you feel about (READ OPTIONS A-E)?

   A. Your personal safety?................................. [__] |
   B. How safe you are on the streets in your neighborhood?.... [__] |
   C. How safe you are where you live?........................ [__] |
   D. The protection you have against being robbed or attacked?........................... [__] |
   E. Your chance of finding a policeman if you need one?.... [__] |
SECTION I: HEALTH: MEDICAL OUTCOME STUDY QUESTIONNAIRE

NOW I'D LIKE TO ASK YOU ABOUT YOUR HEALTH.

1. In general, would you say your health is:

   Excellent .................. 1
   Very Good .................. 2
   Good ........................ 3
   Fair .......................... 4
   Poor .......................... 5
   RF ............................. 7
   DK ............................. 8

2. Compared to six months ago, how would you rate your health in general now?

   Much better now than six months ago ..................... 1
   Somewhat better now than six months ago ................... 2
   About the same .................................................. 3
   Somewhat worse now than six months ago ................. 4
   Much worse now than six months ago ..................... 5
   RF ............................................................... 7
   DK ............................................................... 8

3. The following questions are about activities you might do during a typical day. Does your health limit you in these activities and, if so, how much?

   Yes, Limited
   Yes, Limited
   No, Not Limited
   A Lot
   A Little
   At All

A. Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports?
   1  2  3

B. Moderate activities, such as moving a table, pushing a vacuum cleaner, painting a wall, bowling or riding a bike?
   1  2  3

C. Lifting or carrying groceries?
   1  2  3

D. Climbing several flights of stairs?
   1  2  3

E. Climbing one flight of stairs?
   1  2  3

F. Bending, kneeling, or stooping?
   1  2  3

G. Walking more than a mile?
   1  2  3

H. Walking several blocks?
   1  2  3

I. Walking one block?
   1  2  3

J. Bathing or dressing yourself?
   1  2  3
4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

As a result of your physical health, have you:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

- Cut down the amount of time you spent on work or other activities?
- Accomplished less than you would like?
- Were limited in the kind of work or other activities?
- Had difficulty performing the work or other activities (for example, it took extra effort?)

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

As a result of your mental health, have you:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

- Cut down the amount of time you spent on work or other activities?
- Accomplished less than you would like?
- Didn't do work or other activities as carefully as usual?

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely
- RF
- DK

<table>
<thead>
<tr>
<th>Extent</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
<tr>
<td>Slightly</td>
<td>2</td>
</tr>
<tr>
<td>Moderately</td>
<td>3</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>4</td>
</tr>
<tr>
<td>Extremely</td>
<td>5</td>
</tr>
<tr>
<td>RF</td>
<td>7</td>
</tr>
<tr>
<td>DK</td>
<td>8</td>
</tr>
</tbody>
</table>
7. These questions are about how you feel and how things have been with you during the past month. For each question, please indicate the one answer that comes closest to the way you have been feeling.

How much of the time during the past month,...

(circle one number on each line)

<table>
<thead>
<tr>
<th></th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>A Good Bit of the Time</th>
<th>Some of the Time</th>
<th>A Little of the Time</th>
<th>None of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. did you feel full of pep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c. have you felt so down in the dumps that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. have you felt calm and peaceful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e. did you have a lot of energy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. have you felt downhearted and blue?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g. did you feel worn out?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>h. have you been a happy person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>i. did you feel tired?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>j. has your health limited your social activities (like visiting with friends or close relatives)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
8. How much **bodily** pain have you had during the past 4 weeks?

None........................1
Very mild....................2
Mild.........................3
Moderate.....................4
Severe.......................5
Very severe..................6
RF............................7
DK............................8

9. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all...................1
A little bit..................2
Moderately..................3
Quite a bit..................4
Extremely....................5
RF............................7
DK............................8

10. Please chose the answer that best describes how **true** or **false** each of the following statements is for you.

<table>
<thead>
<tr>
<th></th>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Not Sure</th>
<th>Mostly False</th>
<th>Definitely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I seem to get sick, easier than other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I am as healthy as anybody I know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. I expect my health to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. My health is excellent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
11. How do you feel about: (USE THE D/T SCALE)

A. Your health in general? ..............................................
B. The medical care available to you if you need it? ...
C. How often you see a doctor? .....................................
D. The chance you have to talk with a therapist? ........
E. Your physical condition? ...........................................
F. Your emotional well-being? .................................
External Features and Location

Does the physical structure and state of repair of the building clash or blend with the buildings in the immediate neighbourhood?

Score

Very strong clash with neighbourhood. Three or more major features of the building clash with neighbouring buildings.

Moderate to strong clash with neighbourhood. Two features of the building clash with neighbouring buildings.

Mild clash with neighbourhood. One feature or several minor features clash with neighbouring buildings.

Building blends with neighbourhood with no features indicating or leading citizens to see the occupants as different.

Does the location of the building provide easy access by foot or public transport to the following community facilities?

Key

Easy access: less than 10 mins.
Moderate easy access: 10-20 mins.
Rather difficult access: more than 20-40 mins.
Very difficult access: more than 40 mins.

Score

i) Shops (general grocers and/or supermarket) 4 3 2 1
ii) Shops (newsagents) 4 3 2 1
iii) Cafe 4 3 2 1
iv) Public House 4 3 2 1
v) Church 4 3 2 1
vi) Sports facility 4 3 2 1
vii) Library 4 3 2 1
viii) Cinema 4 3 2 1
ix) Bank 4 3 2 1
x) General Practitioner 4 3 2 1
xi) Post Office 4 3 2 1
Does the name or past history of the building indicate that the people attending the facility are different from ordinary?

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building has strong association with marginalised groups.</td>
<td>1</td>
</tr>
<tr>
<td>Building has some association with marginalised groups.</td>
<td>2</td>
</tr>
<tr>
<td>Building is neutral and does not indicate the users to be marginal.</td>
<td>3</td>
</tr>
<tr>
<td>Building has positive connotations which enhance the value of the user group.</td>
<td>4</td>
</tr>
</tbody>
</table>
How appropriate are the design (size and features), furnishings and fixtures to the intended function of the room? Note that attention should be given to all of the significant functions that a bedroom is likely to serve: not only sleeping, but also private recreation and personal socialising. (For the purpose of this rating the least appropriate aspects of the average room should be chosen.)

Score

The design (size and features), furnishings and fixtures are extremely inappropriate for the intended functioning of the room (e.g. no mirror; very limited or no space to hang clothes; no chest of drawers; inappropriate bed; no chair; lack of personal effects (photographs, pictures, toiletries etc.)

The room has some serious shortcomings in terms of the appropriateness of design, furnishings and fixtures.

The room has no obvious shortcomings and has a design, fixtures and fittings appropriate to the intended functioning of the room.

The design, fixtures and furnishings are clearly ideal for the intended functioning of the room (careful positioning of the mirrors, ample space to store clothes, easy chair and hard chair, high quality personal effects).

What could be done to improve the bedrooms in physical comfort; and in design, fixtures and furnishings so that they would be more appropriate to the intended functioning of the room?
 Integration with Community

Please use the following scale:

<table>
<thead>
<tr>
<th>Key</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/K</th>
</tr>
</thead>
<tbody>
<tr>
<td>frequently</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>regularly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sometimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>occasionally</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not known</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To what extent do some clients of this setting use local, community facilities as a normal part of their lives on a regular basis?

1. Recreational facilities (such as leisure centres, sports and games facilities, parks, adult education etc.)

2. Social facilities (such as pubs, clubs, etc).

3. Occupational facilities (such as paid jobs or volunteer work).

4. Facilities for daily living needs (such as shops, post office, public transport etc).

5. To what extent does the setting use these community facilities as part of an active rehabilitation intervention to support clients' integration?

6. What proportion of clients generally use these community facilities? Approximately:

   20%
   20 - 40%
   40 - 60%
   60 - 80%
   80%

7. Do clients of the setting know of the existence, availability and location of the above community facilities?
Experience Sampling Form

Date: __________  Time __________  am/pm  Time Filled out __________  am/pm

What were you thinking about? ____________________________________________

Where were you? _________________________________________________________

What was the MAIN thing you were doing? __________________________________

What other things were you doing? _________________________________________

WHY were you doing this particular activity?

☐ I had to  ☐ I wanted to do it  ☐ I had nothing else to do

How well were you concentrating? _________________________________________

Was it hard to concentrate? _______________________________________________

How self-conscious were you? _____________________________________________

Did you feel good about yourself? _________________________________________

Were you in control of the situation? _______________________________________

Were you living up to your own expectations? ________________________________

Were you living up to the expectations of others? _____________________________

Describe your mood as you were __________________________________________

very  quite  some  neither  some  quite  very
alert  0  o  .  -  .  o  0  drowsy
happy  0  o  .  -  .  o  0  sad
irritable  0  o  .  -  .  o  0  cheerful
strong  0  o  .  -  .  o  0  weak
active  0  o  .  -  .  o  0  passive
lonely  0  o  .  -  .  o  0  sociable
ashamed  0  o  .  -  .  o  0  proud
involved  0  o  .  -  .  o  0  detached
excited  0  o  .  -  .  o  0  bored
closed  0  o  .  -  .  o  0  open
clear  0  o  .  -  .  o  0  confused
tense  0  o  .  -  .  o  0  relaxed
competitive  0  o  .  -  .  o  0  cooperative

Did you feel any physical discomfort as you were doing ______________________

Overall pain or discomfort none slight bothersome severe
0  1  2  3  4  5  6  7  8  9

Please specify: ___________________________________________________________

Who were you with?
☐ alone
☐ friend(s)  How many? __________________
☐ mother  female ☐ male
☐ father
☐ sister(s) or brother(s)
☐ other

Indicate how you felt about your activity:

very  quite  some  neither  some  quite  very
Challenges of the activity  0  1  2  3  4  5  6  7  8  9
Your skills in the activity  0  1  2  3  4  5  6  7  8  9
not at all  very much
Was this activity important to you?  0  1  2  3  4  5  6  7  8  9
Was this activity important to others?  0  1  2  3  4  5  6  7  8  9
Were you succeeding at what you were doing?  0  1  2  3  4  5  6  7  8  9
Do you wish you had been doing something else?  0  1  2  3  4  5  6  7  8  9
Were you satisfied with how you were doing?  0  1  2  3  4  5  6  7  8  9
How important was this activity in relation to your overall goals?  0  1  2  3  4  5  6  7  8  9
If you had a choice . . .
Who would you be with?
What would you be doing?

Since you were last has anything happened or have you done anything
I am conducting a survey to find out how people feel about living in hostels. I would like to ask you how you feel about your life in hostels, and if you have any suggestions for how it could be improved – how we might make it better for yourself and for other people you know.
A. **ATTITUDES TOWARD HOSTELS**

1. How long have you been in hostel?

   0 - 0 - 3 years
   1 - 3 - 4 years
   2 - 5 - 9 years
   3 - 10 - 14 years
   4 - 15 - 19 years
   5 - 20 +
   8 - Unknown/No response

2. Can you remember anything about your life before you came to the hostel?

   ..............................................
   ..............................................
   ..............................................
   ..............................................
   ..............................................
   ..............................................
   ..............................................
   ..............................................

   - Were you living with your family/alone?
   - Did you have a job?
   - Did you have any friends?

   Code:  1 - Settled, full life.
          2 - Settled, but lonely existence.
          3 - Unsettled, but not lonely.
          4 - Unsettled and lonely.
          5 - Don't remember anything.
          8 - Unknown/No response.
3. Is there anything you miss about your life before you came into the hostel?

CODE: 1 - Privacy
2 - Family
3 - Work
4 - Freedom
5 - Social Life
6 - Having Money
7 - Nothing
8 - Unknown/No Response
9 - Other

4. Why do you think you stayed in the hostel?

CODE: 1 - Too ill
2 - Unable to cope
3 - Nowhere to go
4 - Feel too old now to move out
5 - Doctors wanted it
6 - Liked the hostel
7 - Other .......................  
8 - Unknown/no response
5. What is the BEST thing about being in hostels?
Are there any (other) advantages?

Code: 1 - Somewhere to live 7 - Nothing
2 - Social Life 8 - Unknown/No response
3 - Organised Entertainments 9 - Other
4 - Get looked after
5 - Other
6 - Having Work

6. What is the WORST thing about being in hostels?
Are there any (other) disadvantages?

Code: 0 - Lack of privacy
1 - Bad food
2 - Interference from other residents
3 - Interference from staff
4 - Boredom e.g. not enough leisure activities
5 - Boredom e.g. work activities uninspiring
6 - Insufficient money
7 - Other .........................
8 - Unknown/No response
7. Would you say you are satisfied or dissatisfied with living here? (Is that very or fairly (dis)satisfied?).

Code: 1 - Very satisfied
2 - Fairly satisfied
3 - Indifferent/ambivalent
4 - Fairly dissatisfied
5 - Very dissatisfied
8 - Unknown/no response

8. What changes would help you?
(are there any further changes that would help you?)

........................................
........................................
........................................

Code: 1 - Different staff
2 - Different staff attitudes
3 - More activities/work
4 - Different residents
5 - Better food
6 - Move to a different ward
7 - Other .........................
8 - Unknown/No response
9 - None
8. DESIRE TO LEAVE HOSTEL

1. Do you feel you might like to live here permanently?
   
   CODE: 1 YES 3 Uncertain
   2 NO 4 No response

2. Do you ever think you would like to live somewhere else?
   - If you had a suitable place to live would you like to leave the hostel?
   
   CODE: 1 YES 3 Uncertain
   2 NO 4 No response

3. If your keyworker advised you to leave the hostel - would you?
   
   CODE: 1 YES
   2 NO
   3 Uncertain

4. Do you know what living outside the hostel involves?
   - Do you know what arrangements could be made to help you outside hospital?
   
   CODE: 1 YES
   2 NO
   3 No response

5. If you lived in the community where would you get your money from?
   
   CODE: 1 - Benefits 8 - No response
   2 - Work 9 - Other
   3 - Savings
   4 - Don't know

6. Who would give your tablets/injections?
   
   CODE: 1 - Chemist
   2 - G.P./C.P.N.
   3 - Wouldn't need them
   4 - Do them myself
   5 - Don't know
   8 - No response
   9 - Other
7. Would you still be able to see doctors or hostel staff?

CODE: 1 - YES   3 - Uncertain   8 - No response
2 - NO   4 - Wouldn't need to

8. What would you do during the day?

................................. CODE: 1 - Get a job
................................. 2 - Domestic chores
................................. 3 - Visit friends/relatives
................................. 4 - Hobbies & leisure
................................. 5 - Nothing, sit around, sleep
................................. 6 - Don't know
................................. 7 - Variety
................................. 8 - No response
................................. 9 - Other

9. Have any of the residents you have known ever left the hostel?

CODE: 1 - YES
2 - NO

10. If yes, where did they go? (a)
How did they get on? (b)

.................................................... CODE: (a) CODE (b)
.................................................... 1 - Group Home 1 - Well
.................................................... 2 - Hospital 2 - Badly
.................................................... 3 - Flat 3 - Alright
.................................................... 4 - Unknown 4 - Unknown
.................................................... 5 - Preparation 5 - No response
.................................................... House
.................................................... 6 - To Family
.................................................... 8 - No response
.................................................... 9 - Other
....................................................
1. If you left the hostel what sort of places do you think might be available?
   - Is there anywhere you could go?
   - What about your family?

   CODE: 1 - Could go to family
   2 - Could return to own home
   3 - Group home
   4 - Hospital
   5 - Flat
   6 - Nowhere to go
   7 - Don't know
   8 - No response
   9 - Other

12a. Do you know what a group home is?

   CODE: 1 - Yes
   2 - No
   8 - No response
   10 - YES(inaccurate)

b. Do you know what a hospital is?

   CODE: 1 - Yes
   2 - No
   8 - No response
   10 - YES(inaccurate)

c. Do you know what a sheltered flat is?

   CODE: 1 - Yes
   2 - No
   8 - No response
   10 - YES(inaccurate)

13. What type of place would you prefer to live in?

   CODE: 1 - Group Home
   2 - Hospital
   3 - Sheltered Flat (209 type complex)
   4 - Stay in hospital
   5 - Own home
   6 - Don't know
   7 - An ordinary flat (on your own)
   8 - No response
   9 - Flat within sheltered scheme(warden, meals)
   10 - Other
14. How many people would you prefer to live with?

CODE: 1 - A few
     2 - A few within a larger group
     3 - A large number of people
     4 - On my own
     8 - Unknown/No response

15. Would you like to sleep on your own or in a room with other people?

CODE: 1 - Alone
     2 - With one other person
     3 - With a few other people
     4 - With a lot of people; like in a dormitory
     8 - Unknown/No response

16 a. Would you be able to cook for yourself?

CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

b. Would you prefer help with cooking?

CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

c. Would you prefer your cooking done for you?

CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

17 a. Would you be able to do your own shopping?

CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

b. Would you prefer help with shopping?

CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

c. Would you prefer your shopping done for you?

CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response
18 a. Would you be able to do your own laundry?
    CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

b. Would you prefer help with your laundry?
    CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

c. Would you prefer your laundry done for you?
    CODE: 1 - Yes  2 - No  3 - Sometimes  8 - Unknown/No response

19. What do you feel you might miss?
    CODE: 1 - Security  
    2 - Meals  
    3 - Provisions  
    4 - People  
    5 - Activities  
    6 - Nothing  
    7 - Don't Know  
    8 - No response  
    9 - Other

20. Do you feel you might be lonely if you left the hostel?
    CODE: 1 - Yes  
    2 - No  
    3 - Don't Know  
    8 - No response

21. What do you feel you might gain by leaving the hostel?
    CODE: 1 - See family  
    2 - Health  
    3 - Freedom  
    4 - Self respect  
    5 - Money/job  
    6 - Nothing  
    8 - No response  
    9 - Other

22. If you were discharged which area would you like to go to?
    ..........................................................
SOCIAL NETWORK

Can you tell me something about some of the people you know.
(Residents / IRW / Day Unit / Staff / Outside hospital / Visitors / Family)

How long have you known them / How often do you see them / What do you do / Where do you go / What do you talk about / How do you help each other / Friend or Acquaintance / Would you miss / Best – Worst thing / Does he / she upset you in any way?

CODE

C - COMMUNITY
1. PROFESSIONAL
2. PARAPROFESSIONAL (orderly, domestic)

H - HOSTEL
3. RESIDENT
4. EX-RESIDENT
5. RELATIVE
6. RELATIVE OF ANOTHER RESIDENT
7. SERVICE CONTACT (shop keeper, bar person)
8. UNKNOWN
9. OTHER
Is there any reason you have not mentioned that makes you satisfied with the people you have mentioned?


Is there any reason you have not mentioned that makes you dissatisfied with the people you have mentioned?


Is there anyone you would like to leave the hostel with?


Is there anyone you would like to leave behind?


Do you depend on anybody?
For What?

CODE: 1 - Financial
2 - Domestic Skills
3 - Company/Emotional
4 - Problem solving/Advising
5 - Other
8 - Unknown/No response

Does anybody depend on you?
For what?

CODE: 1 - Financial
2 - Domestic Skills
3 - Company/Emotional
4 - Problem solving/Advising
5 - Other
8 - Unknown/No response

Do you give anybody anything?
What

CODE: 1 - Financial
2 - Emotional
3 - Material

Does anybody give you anything?
What?

CODE: 1 - Financial
2 - Emotional
3 - Material
20. Is there anybody else you could mention – anybody that matters, affects or upsets you?