

1.0 Introduction and literature review

What is quality of life? It seems that in medicine, quality of life is an umbrella term for all human needs neglected in the health care service dominated by advanced technology (Katschnig, 1997). In medicine, the term is used to characterise quality of life from the patient's own subjective perspective. This emphasis on subjective quality of life is a response to the growing consumer dissatisfaction with medical care that had exclusively emphasized therapeutic gains with neglect of basic needs of the individuals like autonomy and subjective preferences (Katschnig, 1997).

However, the focus of quality of life on subjective assessment alone is problematic in psychiatry. Katschnig (1997) introduced the concept of psychopathological fallacies, which comprised at least 3 fallacies: affective fallacies, cognitive fallacies, and reality distortion fallacies. He believed that affective fallacy was more problematic as this is most difficult to recognize. He argued that a depressed patient would see his or her well being, social functioning and his environmental conditions as worse than they appeared to an independent observer. Reality distortion, due to delusions and hallucinations, was more obvious to the researcher. So was the situation of cognitive fallacy caused by dementia and mental retardation. This highlighted the need to assess the quality of life not only via patient but also via professional helpers and key informants – family members and friends. Barry & Crosby (1996) have shown that schizophrenic patients, when moved from a mental hospital to the community, showed no improvement in life satisfaction ratings, despite improved living conditions and increased leisure activities.

Katschnig & Angermeyer (1997) have shown that action-orientated framework for quality of life assessment is necessary as different actions are needed in accordance to the problems identified, for example antidepressant for depression, social skills training for social skills deficit and residential provision for homelessness. Research on quality of life, both in medicine and psychiatry, is still largely concerned with assessing subjective views of his or her functioning in and satisfaction with different life domains (Lehman, 1995)

In 1985, the Team for the Assessment of Psychiatric Services (TAPS) was formed to evaluate the effects of the closure of 2 psychiatric hospitals, Friern and Claybury hospitals. TAPS aimed to compare the quality of life of patients when they were cared for in Friern and Claybury hospitals with that in the community home (O'Driscoll & Leff, 1993). It was found that the benefits of the move from hospital to community care for that sample of patients outweighed the disadvantages (Leff, 1997). Patients' mental state remained stable over 5 years apart from a reduction in negative symptoms in the first year. There were improvement in social behaviour problems and daily living skills. Life in the community was much freer, to which the patients responded with increasing appreciation.

In 1993, Castle Peak Hospital established a hospital pre-discharge unit to facilitate discharge of chronic patients into the community through transition in halfway houses.

This study aimed to look at the quality of life of the first cohort of patients from hospital pre-discharge unit after 5 years of stay in the community. It also attempted to look at the quality of life from the psychopathological dimensions, social role functioning, physical health, work status, income, objective and subjective environment, social network, as well as the met and unmet needs in the community. This was a research project that combined the effort of psychiatrist, nurses and occupational therapists from Hospital Pre-discharge Unit.

There are 31 halfway houses in Hong Kong, providing 1157 places for discharged psychiatric patients and three long-stay care homes with 570 places for chronic mental patients. There are an estimated 70300 mentally ill patients in Hong Kong (Information Services Department, 1998). There is an increasing trend to treat patients in the community instead of in mental hospitals in Europe (Wiersma et al, 1994). Community care for mental patients has been developing steadily in the past few decades, usually by adapting western community care models into local practice (Mak & Yip, 1997). The problems of the patients in the community are important not only from the subjective quality of life view, but also because the public is naturally concerned about presence of homeless mentally ill people and violence related to discharged mentally ill patients (Leff, 1997)

The study aims to address the following issues:

1. What are the psychiatric, physical and social problems of the patients, 5 years after re-settlement in the community?
2. How do they find their living arrangement in the community?
3. What are the factors that distinguish those who were re-admitted from those not re-admitted into hospital after discharge to the community?
4. What are their social roles in the community? Do they find themselves a useful role in society?
5. How adequate is the mental health care in response to these problems? In other words, what are their met and unmet needs in the community? Do staff and patient agree about their met and unmet need? How satisfied are they with the need provision?
6. What are the service implications?