from the real problems of unmet need and lack of community resources.

RICHARD NEWTON
JOHN GEDDES

Royal Edinburgh Hospital,
Edinburgh EH10 5HF

References

GEORGE, S. L., SHANKS, N. J. & WESTLAKE, L. (1991) Census of single homeless people in Sheffield. *British Medical Journal*, **302**, 1387–1389.

HRH PRINCE OF WALES (1991) Lecture to the Royal College of Psychiatrists. *British Journal of Psychiatry*, **159**, 763–768.

MELTZER, D., HALE, A., MALIK, S. *et al* (1991) Community care for patients with schizophrenia, one year after hospital discharge. *British Medical Journal*, **303**, 1023–1026.

DEAR SIRS

I wish to comment on the article by Drs Double & Wong about long-stay patients who were in-patients in 1982 (*Psychiatric Bulletin*, 1991, **15**, 735–736). They are to be congratulated on their persistence in finding all the patients on the register at that time. It is a pity that they were unable to assess the quality of life issue as this would have made the article far more meaningful.

The Psychogeriatric Service in Sheffield has to deal with patients in Part III homes and it has become obvious that the chronic psychotic mentally ill people are not in a suitable environment. Part III homes in Sheffield have become mini-nursing homes as between 60 and 80% of the residents have not got a degree of dementia. Over the past few years some of the chronic new long-stay and old long-stay have been admitted. At a recent meeting with principal social workers who deal with the elderly, the principals of homes and the home care organisers came to the conclusion that they were unable to cope with the chronic mentally ill.

It is therefore very worrying that increasing numbers are being sent to the part III homes, with a top-up from the hospital service. The patients are in homes where there are two care staff for 40 residents. There is no stimulation whatsoever and they become more disturbed. On my own list, I have approximately 20 chronic psychotic patients who, in my opinion, could, and should, be in hospital, but of course, there is nowhere for them to go.

An even greater worry and an absolute heartbreak are those patients who are now in the private nursing homes for the mentally ill. Here there is no doubt that the standard of care is deplorable. The argument runs, however, that it is no longer our responsibility; if the registration officer does not think the standard is correct, he should close the homes. However, the registration officer is unable to do so when there is nowhere for them to go. Over the past year, when there was some suggestion that perhaps one of the homes might be closed, we were asked, in the hospital service, if we could admit approximately 40 chronically ill people, but our wards had been closed.

Before the mental hospitals are closed, I think some measure of quality will have to be defined. We all know the adage that it is very easy to close a hospital, but it is what you put in its place that is the real test of successful policy.

J. V. CONWAY

Northern General Hospital
Sheffield S5 7AU

DEAR SIRS

I appreciate the interest shown in our study in Sheffield, particularly by someone who works here (Dr Conway) and someone who used to work here (Dr Geddes). Perhaps the essential message is that, contrary to popular impression, long-stay patients are not being discharged to live in large numbers "on the streets".

I agree that it would be valuable to have information about the quality of life of patients, although this was not the point of our study, and I would maintain, as we did in our article, that it is not an easy question to answer because of methodological problems. It may be of interest to compare the results of our study with that of Professor Eve Johnstone (1991) (now in Edinburgh, of course, where Drs Newton and Geddes are) which traced 93.6% of 532 patients with schizophrenia discharged from Harrow services over 10 years. Almost all of them had permanent homes, and only one was in prison. Not all patients fared badly, but unemployment, social difficulties and a restricted life-style were found to be common. Poor outcome is generally a defining characteristic of schizophrenia whether patients are in hospital or the community.

Dr Conway is rather sweeping in his condemnation of Part III homes. I do agree, though, with the implication of his argument that resettlement of long-stay patients should be for clinical reasons and not for the financial expediency that both health and local authorities gain because of the arrangements about "top-up". There is also a real problem about what registration authorities should do when homes do not meet adequate standards. It may be of benefit to inspect long-stay psychiatric wards by the same procedures.

I hope we did not seem complacent in our article. Sheffield Hostels (previously Sheffield hostel for homeless men) is a voluntary organisation, supporting several people in houses belonging to South Yorkshire Housing Association, some of which are

new properties. It is about six years since it was a night shelter.

There is a problem about the definition of homelessness. For example, the census in Sheffield by George *et al* (1991) did not include homeless people on the street, but I think did include Sheffield hostels. Nor am I saying that none of our sample have stayed at the Salvation Army or reception centres at some time, although we do not have the evidence.

Drs Newton and Geddes repeat an argument put forward by the Westminster Association of Mental Health (Hatch & Nissel, 1989), which conceded that there was evidence that the resettlement of long-stay patients was working reasonably well, but suggested that the lack of long-stay provision was making the homelessness situation worse for acute psychiatric patients. It seems to me that there is a vested interest in proving that deinstitutionalisation has been a mistake, however good the local facilities are, and the argument will change to fit the evidence. I am not sure if publication of a study that we have recently completed in Sheffield, following up a random sample of 100 out of 899 patients discharged from acute psychiatric wards during 1985, will change attitudes. We managed to trace all the sample and none were homeless.

A difficulty in interpreting the census in Sheffield by George *et al* (1991) is that detailed records of psychiatric admissions were not collected, although there is information on the year of discharge from hospital (George & Westlake, 1991). Only 22 of 98 with a history of psychiatric admission had been discharged in the previous year.

Despite Drs Newton and Geddes, I do think it is important to correct the myths about deinstitutionalisation. I believe more resources will be provided to meet mental health needs if the real situation is described.

D. B. Double

Middlewood Hospital
Sheffield S6 1TP

References

George, S. L., Shanks, N. J. & Westlake, L. (1991) Census of single homeless people in Sheffield. *British Medical Journal*, **302**, 1387–1389.

—— & Westlake, L. (1991) Homeless people and psychiatric care. *British Medical Journal*, **303**, 785.

Hatch, S. & Nissel, C. (1989) *Is Community Care Working? Report on a survey of psychiatric patients discharged into Westminster*. London: Westminster Association of Mental Health.

Johnstone, E. C. (1991) (ed.) Disabilities and circumstances of schizophrenic patients – A follow-up study. *British Journal of Psychiatry*, **159**, Supplement 13.

Consumer opinion of resettlement

Dear Sirs

We read the paper by Hughes *et al* (*Psychiatric Bulletin*, 1991, **15**, 662–663) with interest and would like to present our findings regarding patients' quality of life before and after resettlement from a psychiatric hospital.

To assist in the identification of appropriate placements, the rehabilitation team in East Dyfed introduced a formalised assessment system in October 1989, the Hampshire Assessment for Living with Others. The consumer opinion of resettlement was seen as important so a questionnaire was devised to assess this. The Halo Assessment Project Patients' Interview (HAPPI) consists of 58 items covering accommodation, health, social life, leisure and occupation and a final question, "On the whole would you say you are satisfied with your life at the moment?" The HAPPI was completed as part of each overall assessment. At the time of the study, of the first 50 patients to be assessed, 27 had moved out of hospital into the community. All were available to fill in the HAPPI questionnaire after resettlement.

The mean length of stay in hospital was nine years (range = 0.25 to 33 years, SD = 12). Patients had been discharged from the hospital on average three months before they were surveyed (range = 2 to 24 weeks, SD = 30). The mean scores before and after resettlement showed that scores improved significantly ($P = 0.01$) in relation to: accommodation, health, and social life. The percentage increase in mean scores on the other sections was striking but not significant.

The clinical impression that patients are generally happier out of hospital is confirmed and, despite worries about the effects of institutionalisation, all of these people adapted very readily to their new situations. The results clearly show that there is an improvement in many aspects of life when people are transferred from an institution to the community.

Assessment of patients before and after a major life event, such as resettlement from a psychiatric institution, should be routine. A simple questionnaire such as the HAPPI is a useful tool to this end.

Emma Soane
Jane Harris
Peter Donnelly

St David's Hospital
Carmarthen
Dyfed SA31 3HB

Further details are available on request to the authors.