

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.

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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.

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