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Mental Health Services and Quality of Life

SVEINBJÖRG J. SVAVARSDÓTTIR, MSW
University of Iceland and Psychiatric Department of Landspitali –
The National University Hospital of Iceland, Reykjavík, Iceland.

Dr. RAFAEL LINDQVIST, Professor
Department of Sociology Uppsala University, Uppsala, Sweden.
E-mail address: rafael.lindqvist@soc.uu.se

Dr. SIGRÚN JÚLÍUSDÓTTIR, Professor
Department of Social Work, Faculty of Social Sciences, University of Iceland.
E-mail address: sigjul@hi.is

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Correspondence:
E-mail address: svjsv@hotmail.com; sveinbsv@landspitali.is
Mailing address: Silungakvísl 17, 110 Reykjavík, Iceland

Abstract

The article examines the self-reported quality of life among people with mental illness in a psychiatric rehabilitation centre in Iceland. Quantitative and qualitative research methods were used and 47 informants were interviewed and their reports analysed. The interaction between services provided and quality of life was examined. The findings indicate that needs are rarely met and disclosure of treatment information is lacking. Informants describe themselves as socially isolated and non-participants in society. Results confirm that people with mental illness want caring and support in their rehabilitation. Meeting needs reveals accelerated recovery and renewed interaction within society.

Keywords: Iceland; isolation; mentally ill; holistic view; needs; recovery; quality of life.

Introduction

The study is conducted at the psychiatric rehabilitation centre within Mental Health Services at Landspítali, the National University Hospital of Iceland, henceforth referred to as the Rehabilitation Unit (RU). The aim is to gain a deeper understanding of patients recovered from severe mental illness by examining the relation between clinical and social needs and their quality of life after rehabilitation. To what extent do individualized rehabilitation services exist based on the persons' needs and, if so, do such services enhance self-determination, participation in the community and social inclusion? Empirically, this study seeks to identify persons' needs for assistance affecting social, mental and physical health. People who suffer from mental illnesses need services and support in their daily lives and their quality of life depends upon, among other things, how their service needs are met (Rosenberg, Lindqvist & Markström, 2009). As it is difficult to establish reliable trust with people suffering from mental illness the sample is small. In the quantitative research 54 were invited to participate and seven refused leaving 47 informants. In light of such a limited sample, the importance of the qualitative part of the study is of even more importance for deepening the understanding of the quality of life for people with mental illness and strengthens the results. Combined studies of this type have not been conducted previously within the psychiatric ward in Iceland, a nation of 330,000 inhabitants.

The objective of treatment is to strengthen the patient's capacities for independent living according to their abilities. Interest developed in studying the interaction between services received and people with mental illness including their quality of life. It should prove useful to explore whether services provided in a rehabilitation programme are appropriate. An investigation could also help verify which areas of life for people with mental illness using the RU are addressed or overlooked, and what changes to health services provided these patients might improve their situation. The research question is: Which are the dilemmas and opportunities in meeting needs in the recovery process according to self-reported quality of life? Two sub-questions were also considered: Is there a connection between self-reported quality of life and met needs for recovery? What are the implications of this relationship in terms of developing individualized services?

Theoretical Background and Knowledge

Increased emphasis has been on needs and quality of life for people with mental illness both in policy and clinical work. Needs assessment is an essential factor for being able to improve services. Self-reported quality of life is then used to find whether the objectives of the service have been achieved. The concept used is that needs are a subjective assessment and that there is a need for support when mental illness is present. The concept of quality of life, in fact, is seen as one of the preconditions for the broader concept of recovery. Studies have shown that it is very important for people in recovery to feel as if they are cared for. Recovery is, in essence, a personal and unique process and experience, but it often unfolds within a social and interpersonal context. Recovery involves relationships and networks, the social environment and society. It takes material resources and contributions from responsive services and provides support. According to Turton et al., (2011) recovery does not mean that all symptoms of mental health illness are eliminated; recovery is about improving well-being and regaining a role as a citizen. Practitioners and caseworkers need to take on the role of facilitator and support their clients to improve and develop social skills in order to enable social inclusion and to communicate hope (Anthony, 2003; Bury, 2008; Júlíusdóttir, 2013). Studies show that mental health service systems can have potential impact on the quality of the lives of people it serves (Skinner et al. 1999). Furthermore, a study shows (Yip, 2005) the importance of taking into account different cultures. Methods of therapy in one locale may not transfer directly to another, but may rather be used in support of treatment forms in new situations and cultures. Research evidence shows that family-based interventions have positive impacts on the outcome of several mental disorders (Sartorius, Leff, L´opez-Ibor, Maj & Okasha, 2005).

Quality of life

Quality of life is often referred to as a sense of well-being in life (Skinner et al., 1999). The World Health Organization, WHO (1997, p. 1), defines Quality of Life as "an individual's perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns." Quality of life is a broad concept incorporating all aspects of life and is used in various disciplines such as, philosophy, medical sciences, social sciences and health promotion (Oort, Visser & Sprangers, 2005). A general interpretation of the concept is that quality of life is dictated by individual personal characteristics, conditions in life and a subjective view of the current situation and must be defined by the patient's frame of reference (Coppock & Dunn, 2010; McGrath & Holewa, 2004). The quality of life for people with mental illness tends to be worse than for the general population and their life expectancy is shorter (Lindqvist, Markström & Rosenberg, 2010; Laursen, Nordentoft, Gissler, Westman, & Wahlbeck, 2010).

Mental illnesses - Rehabilitation services

Psychiatric disorders are the most common cause of disability in Iceland and people with mental illness have higher rates of cardiovascular diseases and natural mortality than the public in general (Matthíasson, 2007; Sveinsson, Thorleifsson, Asperlund & Kolbeinsson, 2012; Velferðarráðuneytið, 2012). Studies show that people with mental problems are more often bullied and classified. Then, stigma generates their feelings of shame, low self-esteem, isolation and hopelessness and they may experience more difficulties after being diagnosed with mental illness (Corrigan, Watson, & Barr, 2006; Sartorius, 2006; Thornicroft, 2006). They are often robbed their rightful opportunities in work, relationships, housing, health care; all arenas in which a full life is achieved. This adversely affects their quality of life, an important factor for the success or failure of health service systems and thereby lowers their chances of recovery (Slade, 2010; Corrigan, Roe & Tsang, 2011).

A number of studies from Australia, the USA and several European countries show that people with diverse mental illnesses such as schizophrenia, bipolar disorder and depressive disorder have mortality rates two to three times higher than the general population (Lawrence, Hancock & Kisely, 2013). About 1% of Icelandic adults suffer from serious mental illnesses which result in a lasting reduction of their quality of life (Stefánsson, Líndal, Björnsson & Guðmundsdóttir, 1991). One in ten people in Iceland use antidepressants and prescription rates across the OECD have dramatically increased (Organisation for Economic Co-operation and Development, 2013). Icelandic studies indicate that people with mental illness and their families are dissatisfied with services for support and rehabilitation after leaving the psychiatric wards (Svavarsdottir, Júlíusdóttir & Lindqvist , 2013). Studies show that patients' evaluation of their service needs and how they are fulfilled are a reliable measure of the quality of service they are provided and predictive of their quality of life (Hanson et al., 2001; Eiríksdóttir, 2009). Results from a study of informant attitudes to the rehabilitation they received at RU (Svavarsdóttir et al., 2013) show that the rehabilitation of people with mental illness does not impact their ability to lead independent lives outside the hospital. Studies indicate that patient evaluations of service needs differ from those done by personnel (Gibbond, Bédard & Mack, 2005; Eiríksdóttir, 2009; Svavarsdóttir et al., 2013). A holistic view of psychiatric rehabilitation is relevant with respect to the treatment, services and support that should be made available (Svavarsdóttir et al., 2013). Employees generally believed rehabilitation had been more beneficial than user opinions indicated. The findings of that study emphasize the validity of giving patients voices that can reveal their unfulfilled service needs and thus improve quality of life (Svavarsdóttir et al., 2013). Accurate measurement of the quality of service and achievement of objectives is necessary so that the voices of people with mental health problems are heard as they comment on their needs and recovery.

Needs - Service Needs

A variety of individuals are involved in assessing needs; professionals, service providers and the clients themselves. It cannot be assumed that "need" holds the same meaning for disparate groups. Assessment of needs, according to Hasenfeld (2009), is based on dominant moral values, and thus reflects the social, economic and cultural power in society. Ideology of dominant professionals has a major impact on how the needs of people with mental illness are defined; the needs must be sorted and categorized in line with relevant professions' cognitive perceptions as well as the mandate of the welfare organization in question. According to Júlíusdóttir (2009) it is important to be able to recognize and understand the problems of individuals in the light of social factors and at the same time to be able to resist the progress of social problems with an understanding of how such problems appear in uneven quality of life for individuals and families. A person's needs tend to be "compartmentalized" according to professional and organizational boundaries, and it is a challenge to develop a holistic perspective on mental health problems. This frequently leads to people's needs being assessed by health and welfare workers, rather than from the patient's perspective. The term service needs, refers to the patient's requirements for assistance in meeting their needs (Stevens & Gabbay, 1991) and may be related to any field of human life. A health and social care assessment is carried out by social services to determine what help and support people need, such as healthcare, equipment or home assistance. According to Wing, Brewin and Thornicroft (1992) a need exists if a method of help is identified.

Studying the relationship between quality of life, need for improved therapy and services and the assessment thereof is essential in order to evaluate which needs must be met for improved recovery from mental illness. Active listening to what people with mental illness have to say about such matters is important.

Methods

Research Design

In this study, the focus is on people with severe mental illnesses. Quantitative and qualitative methods are used to gather information. A quantitative approach using a questionnaire was used to assess participants' quality of life and how they felt their needs were being met. The qualitative method allowed informants to express themselves on how the design and content of services played a role in their health. The focus was on approaches used in rehabilitation and how they could be optimally combined to help the patients. Quantitative and qualitative research methods can be seen as two tools that work in different ways to obtain both a broader depiction and a deeper understanding of the phenomenon under study. Relevant ideas and hypotheses from social sciences, medicine and health care are integrated. The study seeks to identify and estimate a person's needs for assistance in all aspects of life affecting, social, mental and physical health. The impact of these services on self-reported quality of life was examined. A greater understanding and knowledge was sought concerning how recovery is dependent on how well the needs of individuals are met.

The study was approved by the Hospital Ethics Committee.

The criteria for patients' participation in the study were as follows:

1. A diagnosis of severe mental illnesses according to ICD-10, a system developed within psychiatry to categorize and diagnose mental health problems, as in the third edition of the DSM IV (APA, 1994).

2. Rehabilitation at the RU for a minimum of one year and still receiving services.

3. Non-institutional living.

Participants

A total of 54 people fitting the criteria were identified using journals at the RU and a letter, explaining the aim of the study and information about their rights in research, was addressed to all of them. Then, they were approached by a member of the research team and the informants were verbally informed and written consent was obtained for participation in the study. Care was taken that patients were not at the height of an illness episode. Seven people were unwilling to participate, leaving 47 participants and a drop out rate of 13%. Ten participants were randomly selected and interviewed for the qualitative study.

Quantitative Study

The data collected in the quantitative part were analyzed using the "Lancashire Quality of Life Profile" (LQOLP) (Anderson & Lewis, 2000) and the questionnaire Camberwell Assessment of Need (CAN-R) (Phelan et al., 1995). The instruments are specifically designed for both subjective and objective assessment of quality of life of mentally ill people. They are evidence-based and have been used in other studies, which makes it possible to compare the results with research with similar patient groups.

The LQOLP, a standardized questionnaire, (Anderson & Lewis, 2000) was applied to assess the quality of life of the participants. The psychometric properties of the LQOLP have been extensively measured on populations of persons with severe mental illness (e.g. Hansson, Svensson & Björkman, 1998; Lehman, Ward & Linn 1982; Lehman, Possidente & Hawker 1986; Oliver, Huxley, Priebe & Kaiser, 1997; Van, Schene, Boewink, & Wolf, 1998).

Objective aspects of quality of life and subjective sense of wellness is evaluated in nine areas of life. For discussion purposes, the abbreviation LQLP is used here, while the results are referred to as QoL (i.e. Quality of Life).
The second questionnaire used is the Camberwell Assessment of Need (CAN-R) which is a structured interview that assesses clinical and social needs and is reliable to evaluate the needs of persons with mental health problems both in research and practice (Phelan et al., 1995). The CAN questionnaire allows assessment by the patient and the caregiver, but in this study only patients were interviewed.

Qualitative Study

The qualitative interviews discussed and evaluated social relations and health in order to gain a deeper understanding of the subject matter at hand. Ten informants took part. Locations for the typically 45-minute long interviews were selected by the informants. The interviews were concerned with seven topics intended to gauge the opinions of informants toward their current situation and their needs. The topics covered physical and mental health, residence, finance, communications, economic and psychological support, employment, education, leisure and recreational activities. The informants related their opinions and descriptions concerning health issues and the level of support that they received. Information obtained was coded, analyzed and divided into meaningful units resulting in blocks comprising short descriptions of the text. Units with similar meaning were grouped in subcategories and finally the analysis led to the core category of support illustrating more general and abstract aspects of recovery. While it is not possible to make broad generalizations from qualitative results, it is possible to make analytic conclusions that illuminate the perspective of the participants, in this case recovery from mental illness (Esterberg, 2002). This qualitative research method complements the quantitative one.

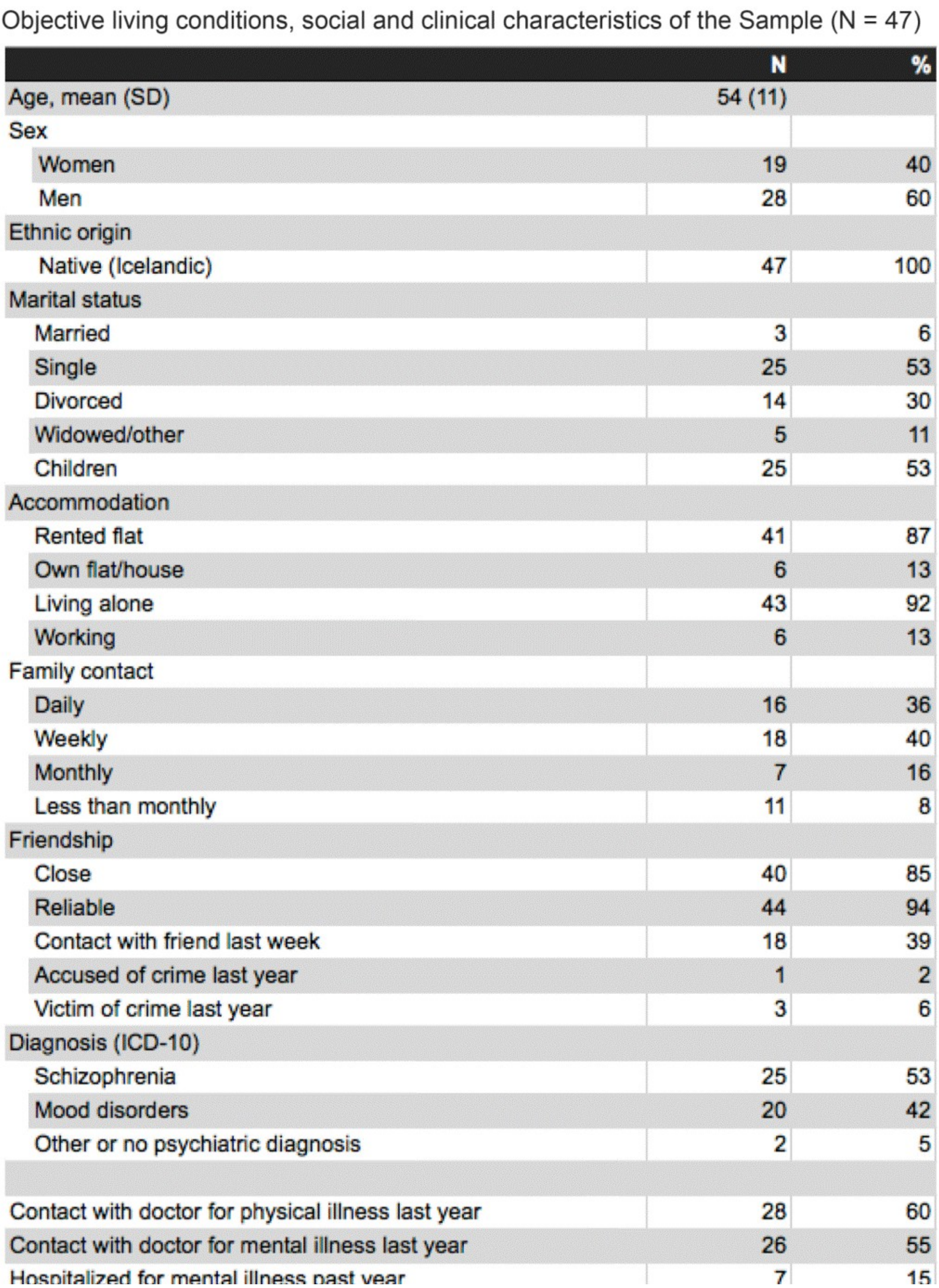
Results from the Quantitative Part of the Study

All participants suffered from long-term mental illnesses. They had been diagnosed with schizophrenia, schizoaffective disorder, depression, bipolar disorder, personality and mood disorders. Most of them had been diagnosed with multiple disorders and all had been diagnosed with physical illnesses. The 47 patients responding to the quantitative assessment revealed characteristics and living conditions.

Table 1. Results from the LQOL list

Objective living conditions, social and clinical characteristics of the Sample (N = 47)

	N	%
Age, mean (SD)	54 (11)	
Sex		
Women	19	40
Men	28	60
Ethnic origin		
Native (Icelandic)	47	100
Marital status		
Married	3	6
Single	25	53
Divorced	14	30
Widowed/other	5	11
Children	25	53
Accommodation		
Rented flat	41	87
Own flat/house	6	13
Living alone	43	92
Working	6	13
Family contact		
Daily	16	36
Weekly	18	40
Monthly	7	16
Less than monthly	11	8
Friendship		
Close	40	85
Reliable	44	94
Contact with friend last week	18	39
Accused of crime last year	1	2
Victim of crime last year	3	6
Diagnosis (ICD-10)		
Schizophrenia	25	53
Mood disorders	20	42
Other or no psychiatric diagnosis	2	5
Contact with doctor for physical illness last year	28	60
Contact with doctor for mental illness last year	26	55
Hospitalized for mental illness past year	7	15



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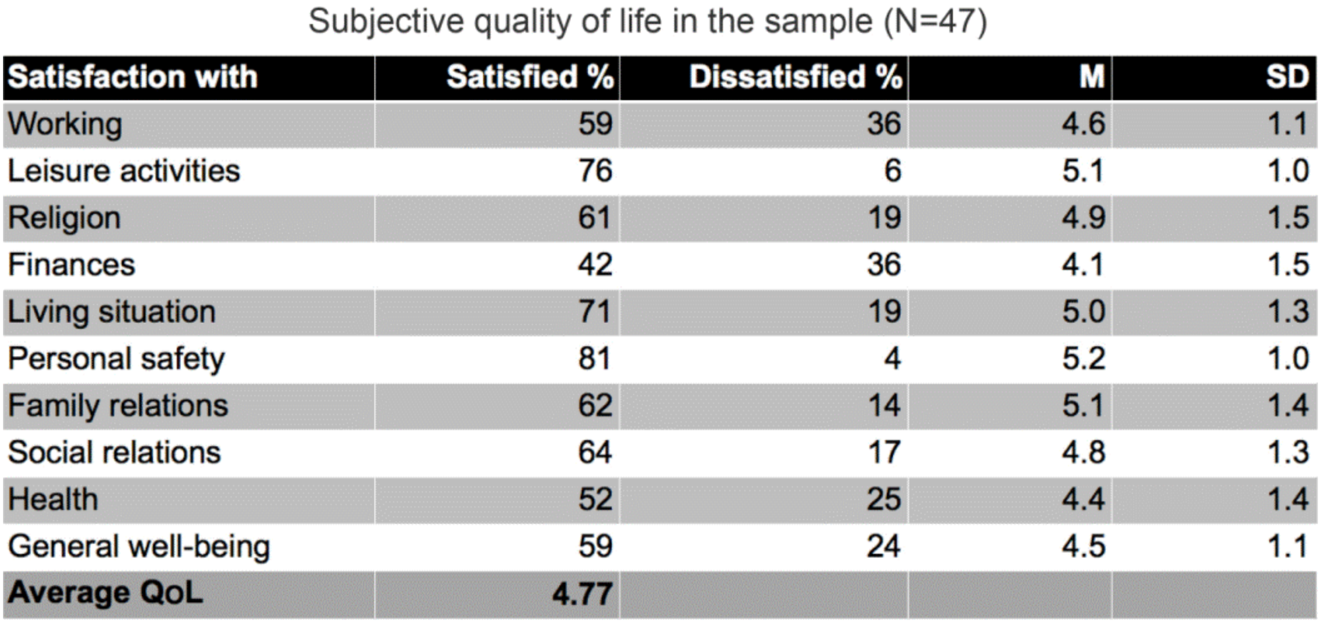
The mean age was 54 years and 60% were males. Just over half (53%) of the participants had children. Most patients (92%) reported living alone in rented apartments and only 13% were employed. Most of the patients (85%) stated that they had a close friend and around two thirds were in contact with their primary family at least once a week. With regards to personal safety, 6% stated that they had been a victim of some sort of violence during the past year.

TABLE 2. Subjective assessments



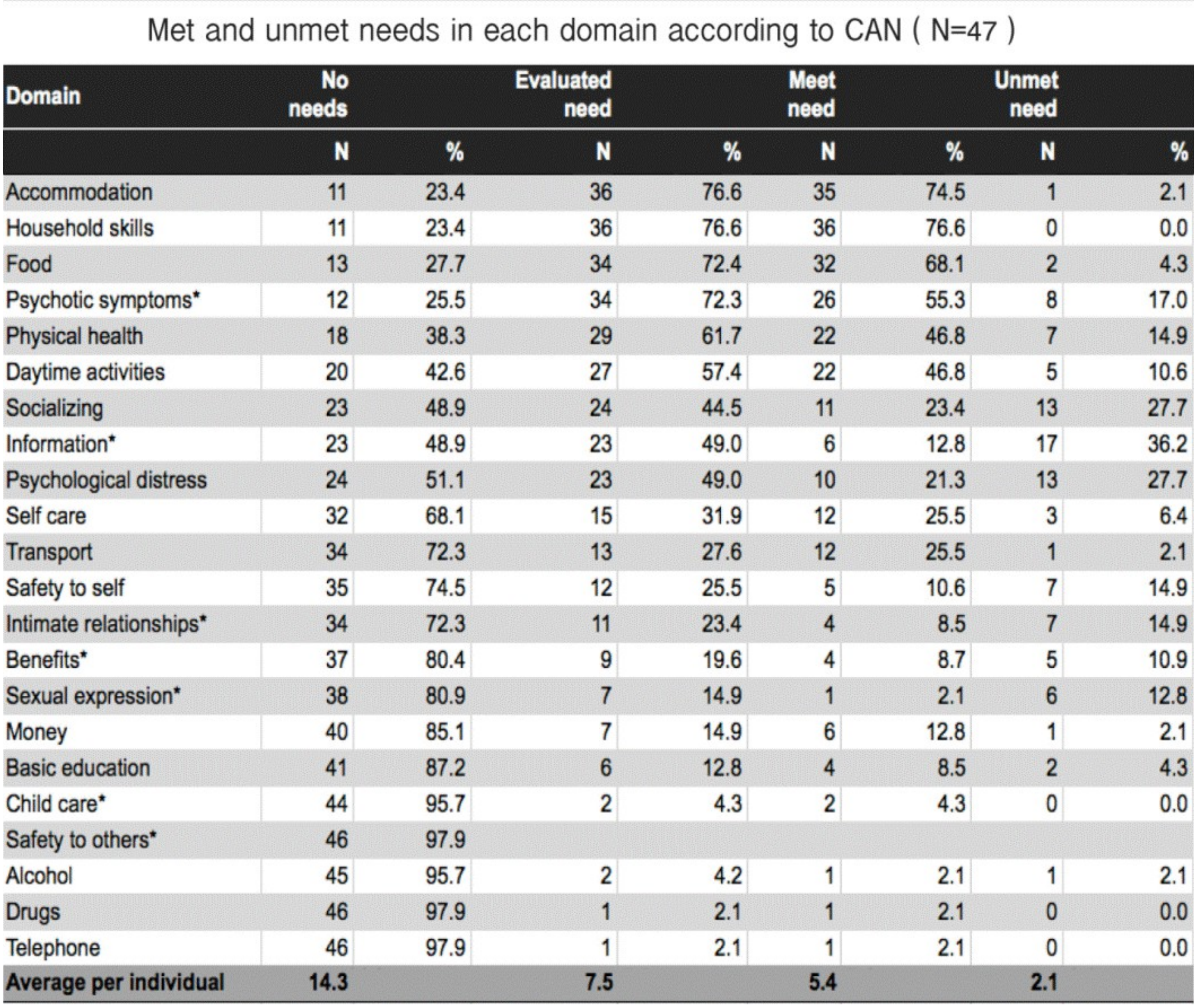
Subjective quality of life in the sample (N=47)

Satisfaction with	Satisfied %	Dissatisfied %	M	SD
Working	59	36	4.6	1.1
Leisure activities	76	6	5.1	1.0
Religion	61	19	4.9	1.5
Finances	42	36	4.1	1.5
Living situation	71	19	5.0	1.3
Personal safety	81	4	5.2	1.0
Family relations	62	14	5.1	1.4
Social relations	64	17	4.8	1.3
Health	52	25	4.4	1.4
General well-being	59	24	4.5	1.1
Average QoL	**4.77**			

The life satisfaction scale ranges from 1 (could not be worse) to 7 (could not be better). The mean score for all the domains was used as an indicator of subjective wellbeing for a QoL score of 4.77. Results are presented for the entire sample in Table 2. The greatest levels of reported satisfaction were found in the areas of leisure activities and personal safety, whereas the highest rates of dissatisfaction were found in the areas of work and finances. Mean scores for each of the subjective factors in the LQLOP were computed for each participant and they were then used as an indicator of QoL. The life satisfaction scale ranged from one to seven. Scores of 1 - 3 were coded as reflecting "dissatisfaction" and scores from 5 - 7 were coded as "satisfaction", whereas a rating of 4 reflected a noncommittal stance. The correlation (Pearson's r) between QoL and reported needs was also calculated.

The participants were asked which type of psychiatric services they use and which one they felt had been of most benefit. Forty per cent of the participants thought that consultation with professionals was of most benefit, 12% thought that a consultation with a psychiatrist and walking were of most benefit, whereas approximately a quarter (24%) felt that drugs were most beneficial. Another factor mentioned by participants was support from other patients, as it made them feel good to discuss their concerns with people in a similar situation.

TABLE 3. Fulfilled and unfulfilled needs according to CAN-R



Met and unmet needs in each domain according to CAN (N=47)

Domain	No needs		Evaluated need		Meet need		Unmet need	
	N	%	N	%	N	%	N	%
Accommodation	11	23.4	36	76.6	35	74.5	1	2.1
Household skills	11	23.4	36	76.6	36	76.6	0	0.0
Food	13	27.7	34	72.4	32	68.1	2	4.3
Psychotic symptoms*	12	25.5	34	72.3	26	55.3	8	17.0
Physical health	18	38.3	29	61.7	22	46.8	7	14.9
Daytime activities	20	42.6	27	57.4	22	46.8	5	10.6
Socializing	23	48.9	24	44.5	11	23.4	13	27.7
Information*	23	48.9	23	49.0	6	12.8	17	36.2
Psychological distress	24	51.1	23	49.0	10	21.3	13	27.7
Self care	32	68.1	15	31.9	12	25.5	3	6.4
Transport	34	72.3	13	27.6	12	25.5	1	2.1
Safety to self	35	74.5	12	25.5	5	10.6	7	14.9
Intimate relationships*	34	72.3	11	23.4	4	8.5	7	14.9
Benefits*	37	80.4	9	19.6	4	8.7	5	10.9
Sexual expression*	38	80.9	7	14.9	1	2.1	6	12.8
Money	40	85.1	7	14.9	6	12.8	1	2.1
Basic education	41	87.2	6	12.8	4	8.5	2	4.3
Child care*	44	95.7	2	4.3	2	4.3	0	0.0
Safety to others*	46	97.9						
Alcohol	45	95.7	2	4.2	1	2.1	1	2.1
Drugs	46	97.9	1	2.1	1	2.1	0	0.0
Telephone	46	97.9	1	2.1	1	2.1	0	0.0
Average per individual	**14.3**		**7.5**		**5.4**		**2.1**	

Is there a correlation between quality of life and needs for recovery being met?
No statistically significant correlation was found between QoL and needs being met. However, the correlation (Pearson's r) between quality of life and fulfilled needs was 0.41 (> 0.05). According to measurements obtained using the CAN-R, participants had, on average, a need for services in 7.5 areas, with the greatest needs occurring in the areas of accommodation, household skills, food, psychotic symptoms, physical health, daytime activities, companionship, information and psychological distress. The number of unmet needs ranged from zero to 17, with the average being 2.1. The highest proportions of unmet needs were in the areas of information about treatment and condition, companionship, and support during psychological distress and psychotic symptoms.

The correlation of overall quality of life and unmet needs showed that a higher quality of life is assessed when there are fewer unmet needs. The correlation between the primary variables unfulfilled needs and self confidence was found to be significant at Alfa 00:05 (bilateral test) and was .319. The stepwise regression of the data, where the quality of life was the dependent variable and unfilled needs and self-esteem were the independent variables, showed that the better the self-esteem of an individual, the better the quality of life the respondent considered themselves to be enjoying ($\beta = 0{,}121$ ** ($p < 0{,}001$). $R2 = 0.33$ ($p < 0.001$)). Unfilled needs were not significant (β), but there was a correlation between the two variables with regards to met needs and quality of life ($\beta = 0.39$). β was not significant when unmet needs were the primary variable and QoL a secondary variable, but there was correlation between QoL and unmet needs.

Significantly different findings are revealed in this study, with respect to the influence of intimate friendship. The mean score for all nine subjective domains used in the LQOLP was 4.88, which is higher than the mean score of 4.55 revealed in a British study (Slade et al., 2004). That study (N=265) found unmet needs to be, on average, 1.22 while unmet needs in the present study were 2.1. Another study in Iceland by Eiríksdóttir (2009), evaluating the impact of severe mental illness on service needs and quality of life of 90 outpatient adults at the RU indicated that the average level of unmet needs was 2.4.

Results from the Qualitative Part of the Study

Ten informants were randomly selected from the group, five women and five men, with an average age of 52. They were all single and three had children not living with them. All had been diagnosed with a mental illness around the age of twenty. In analyzing the qualitative data, every effort was made to consider the informants apart from their illness and avoid using a medical lens. Several themes emerged and were divided into main and sub-themes. Common traits were identified within each theme as well as differences between the participants. The main theme identified was current situation which in turn had four sub-themes; social isolation, escaping the role and associated stigma of being a patient, hopes being met and follow-up with regard to ideal quality of life.

Current situation

This main theme reveals that all informants were on full disability benefits and did not work. They were single and not involved in activities of any kind. They were unhappy with their lives and their status in society. Loneliness and being harassed was of great concern. One said: "*The current situation could be better. I wish I was more functional, but I am mentally ill and not capable of doing anything. Why should I try to get a job or new housing?*"

All the informants said that they were often mistreated and pigeonholed and generally experienced more difficulties after being diagnosed with mental illness.

Social Isolation

Under this sub-theme all informants described themselves as socially isolated and repeatedly talked about loneliness. They were not involved in relationships with others and they felt a lack of communication with their families, relatives and friends, as they had before they were stricken. One said:
My medications help me relax and relieves depression. My friends are a few patients who live near me. My family never comes here and I never go to visit them. I often feel very isolated. It's like my family has prejudices against people with mental illness like me.

Families and friends of informants appear to have had little desire to be with them after they became ill and most of the informants felt rejection, sadness and loneliness. Prejudices against mentally ill people in the community result in isolation and reduce their possibilities (Bury, 2008).

Four of ten informants did not want to be in contact with their families because of some earlier difficulties, which they felt reluctant to describe. One said:
Well you see I do not feel well near my relatives. All the old and evil comes back up and then I start feeling badly. There was so much that went on in my family. I've met a few here who do not know how I was before. It's all different somehow. I cannot explain it properly. I just hope that one fine day I can be with my family without feeling bad.

Most informants describe themselves as not being involved in relationships with others. During acute phases of their illness friendships might be broken off, either by themselves or by the other person. But when the acute phase had passed, all informants said that they had poor relationships with families or friends and they did not try to renew old relationships.

Hopes being met

The aspects of this sub-theme were that the informants tried to form new relationships with other patients, who were often their main supporters and provided mutual assistance which gave them hope. One said:

I sometimes go to the club Geysir with friends I have met after I became ill, use computers there, have a coffee and chat. I feel comfortable there. People there seem to understand me much better and my illnesses. Sometimes I go home to see my parents and there I use the computer. I miss my friends that I had before I got sick. Life's all upside down, everything is different now.

Being together and interacting with others with a similar experience was an important factor in the lives of most of the participants, which, in their opinion promoted confidence and a sense of wellness. Their illnesses appear to prevent their hopes being met with regard to their ideal quality of life. Studies show that individuals come together ignorant of each other's past and therefore have no preconceived notions or prejudice, which allows them to be themselves without pressure (Bury, 2008)

Escaping the role and associated stigma of being a patient

The findings support the supposition that participant sense of identity is often tied to their role as a patient and a consequence of the stigmatization process, rather than reflecting some trait within themselves. One said:

Once diagnosed as a patient, always a patient. It is as if the word "patient" is stamped on the outside of a person. One somehow does not get rid of it and is therefore always in the "patient's" role. I want to be seen as a human being, not as a medical case.

Studies (Sartorius; 2006; Thornicroft, 2006; Corrigan, et al., 2011) show that many people who suffer from mental illness believe that the stigma they face is in many ways more disabling than the illness itself and can trap people in a cycle of illness. This may exacerbate mental health problems, and delay or impede people from getting help, treatment, and recovering.

Follow-up

All informants suggested that there is a significant lack of follow-up from services or support schemes outside the RU once they are discharged from rehabilitation. Other aspects of this sub-theme were experiences of segregated support measures and long waiting times until needs for support were met. Also, difficulties in obtaining adequate support were mentioned. One said:

It is such a long wait for an appointment with a social worker, up to six weeks. I don't feel like waiting so long and refrain from asking. I wish I could get better housing. I do not make contact with psychiatric staff very often. They just upload my medication regularly in pharmacies. I contact my doctor only if necessary.

Topor et al., (2006) conclude that professionals meet many such people every working day and are seldom in a position to follow up their patient's development for a long period of time.

In summary, informants felt that their identity was strongly linked to their diagnoses and the patient role, and that this in turn makes it difficult to escape being labeled as mentally ill. How much contact they have with their families differs as does the level of support they receive. They also assert that when their health deteriorates and a so-called attack occurs, support decreases. The informants talked about people in their lives knowing them as "ordinary" people and having patience with them and also having confidence in them to make good choices and give them hope through interactive support. But, after being diagnosed with mental illness most of them linked social isolation, poor housing, unemployment and poverty to their poor health.

Discussion

The aim of the study was to provide increased insight into the impact of mental health services on patients' reported quality of life. Studies indicate that the evaluation of service needs and how they are met by the individuals themselves are reliable measures of the quality of service received and predicts quality of life (Hanson et al., 2001). Results were also an indication of the individual's self-perceived recovery from mental illness. The study was conducted using quantitative and qualitative methods to explore the interaction between service needs and recovery of people with severe mental illnesses.

The findings indicate that needs are rarely met and disclosure of information about treatment is lacking. It is particularly striking that participants evaluate their treatment as being their primary unmet need. The more unmet needs, the poorer the assessment of quality of life. The highest proportions of unmet needs were in the areas of information about treatment and condition, companionship, networking and support during psychological distress and psychotic symptoms (see Table 3). The informants were not at all pleased with their lives and they felt that they were not participating in society. Loneliness and being harassed were of great concern. Stigmas against individuals who have a mental illness lead to injustices, including discriminatory decisions. Overcoming the stigma associated with mental illness is yet one more challenge that mental health patients must face. The findings suggest that individuals with mental illness require complex services and support in their daily lives and their recovery depends, among other things, on how service needs are met by the organizations they mainly interact with.

The results indicate that psychiatric care is still overly administered from a medical model perspective, i.e. psychiatric expertise dominates hospital and community care settings. The consequences are that doctors do not invite patients to design care, treatment and rehabilitation measures. Lack of information also makes it difficult to design personalized care and services, as professionals and patients do not always have the same views of what works for the person in rehabilitation and in society (Svavarsdóttir et al., 2013). All informants suggested that there was a significant lack of follow-up from services or support schemes outside the RU once patients are discharged from rehabilitation. In a study (Svavarsdóttir et al., 2013) where both personnel and patients considered the perceived lack of follow-up as a major concern, it was shown that patients easily fall between cracks in the system. They describe themselves as socially isolated, experiencing a lack of communication with their families, relatives and friends. Bury's (2008) explanation of these conditions is that the individual's life is divided into a "before" and "after" phase. When a problem situation has persisted for a longer time, the individual's social environment begins to adapt itself to new circumstances. Memories of the individual's earlier life begin to fade. Concurrently, the person's social network gets smaller and fewer people are present who knew the person "before". This might be a tenable explanation for why participants in this study become isolated from others and do not experience themselves as participants in the community.

The study shows that friends in the same situation are their contacts and they provide mutual support. These new friends know the individual only as he is today and feel compassion where conditions are similar. Topor et al., (2006) indicated throughout their narrative study that the informants talked about the importance of having support while they learned to cope with their illnesses. Similar results can be interpreted in this study, e.g. solidarity and trust between friends seems to be very important when it comes to recovery. They are the main recourse for support. The more this is possible, because of personal efforts or support of others, the greater cause for hope. Studies indicate that it is seldom services alone that enable recovery for people with mental illness. Earlier recovery research emphasizes strongly that other people can play an important role for persons with mental illness and give them hope to overcome their symptoms and cope with everyday life (Deegan, 1996; Topor et al., 2006; Bury, 2008; Slade, 2010; Turton et al., 2011). An Icelandic study showed that communications and social interaction had the strongest influence in a patient's recovery and reflected the degree of social competence which enabled them to meet their social and emotional needs (Svavarsdóttir et al., 2013). Why do friends play such an important role and why do people with mental illness feel that there are so many unmet needs and marginal success for the "real" treatment and rehabilitation? This might possibly be explained by the dominant use of the medical model and the organizational structures, which lead to little communication between personnel within the RU and others that the mentally ill depend on (Svavarsdóttir et al., 2013).

People who have a history of mental problems experience difficulties in registering as patients with general practitioners and they lack access to general health care (Lindqvist, Markström, & Rosenberg, 2010). From a social work point of view it is important to observe the social as well as medical health of people with mental illness. Greater individual and system level attention to physical disorders may improve psychiatric stability, treatment adherence, and life expectancy as well as quality of life for these generally disadvantaged populations. Unavailability of support, results in the application of traditional medicine and in many cases, the social circumstances of people with mental illness are not considered.

This study clearly indicated that social interaction is of importance to the recovery process, whether with family and friends or clinicians and other professionals. Recognition by family and friends for a person diagnosed with a mental illness seems to be of great importance in the recovery process and has a significant impact on their well-being. Emphasis must be placed on the individual, his family and social environment, along with the consideration of disease symptoms. An assessment must be made of a person's ability to adjust and to provide help by working with him and his family towards the resolution of the problems that arise. The fact that a significant number of people experience a lack of information about treatment and their health conditions indicate the need for shared decision making, i.e., a process that encourages full participation by the patient for the purpose of improving knowledge about the person’s own health, medication and treatment. An Icelandic study indicated that the more satisfaction people have with their level of support, the better they view their quality of life (Svavarsdóttir et al., 2013). Studies suggest that continuity in medication, secure residence and access to appropriate social support in everyday life are the factors that contribute to the improvement and maintenance of quality of life in people with mental illness (Matthíasson, 2007). Topor et al., (2006) conclude that for professionals to remain with a person through the course of his or her illness, or to do more than expected, may entail changing how professionals work in institutions, their personal view of work, and how they are viewed by society.

This study indicates that there are some crucial elements missing in the rehabilitation process that could facilitate the achievement of the expected results, especially with regard to patients’ quality of life. It is stated in research by Topor et al. (2006) that to remain by someone’s side and to become involved over and above familial or professional duty appears to make the difference between help and hindrance. The illness is not, according to Lindqvist et al. (2010), necessarily the problem, but rather how quality of life is dependent on how well the needs of individuals are met. People with mental illness want the same opportunities, and the same control over their opportunities, as all adults. Therefore we need to look at the community and the environment the person lives in, not just the person and their problem. The findings of this study suggest that service providers should aim to better listen to patients’ opinions about their own health and the social support they receive. Research shows according to Rosenberg, Markström, and Lindqvist (2012) that to recognize the voices of users may help to overcome an individual’s obstacles to functionality.

The results of the study indicate that the RU is not meeting needs for recovery and also that there is a correlation between self-reported quality of life and met needs for recovery. Also, the study shows how important it is to meet individuals on their own terms in the recovery process. It seems sensible to break down real and perceived barriers to care and recovery in mental health and that understanding the needs of mental health patients offers them real hope. It requires much understanding and sensitivity for professionals to perceive the elements that need to work together for people in mental distress. Complex factors including genetic, biological, social and environmental issues can cause mental illness. Understanding how inseparable mental and physical health really is, and how they influence each other is complex and profound. According to Wing, Brewin and Thornicroft (1992) quality of personal life, the extent to which a disabled individual can maintain self-respect and autonomy, maintain interests, make a recognised contribution to society and increase his or her self-knowledge all play a role. The flow of information among those involved is very important and it is important to focus on communication within and between systems, creating links between society, service agencies, and clients. The client's welfare depends on quality interaction between professionals internally, as well as between organizations. Integrated services are important for reaching better recovery and well being.

The results suggest, therefore, a need to emphasize working systematically with unfulfilled needs of people who need psychiatric services. When these needs are not met their recovery and quality of life often diminishes and other health problems gain a foothold (Corrigan et al., 2006). This leads to decreased potential for improving quality of life for people with mental illness and for providing enriching activities within society to meet their needs (Rosenberg et al., 2012). The more needs that are met, the better the recovery and quality of life, which can help the individual to regain previous capacities for independence and dignity in coping including the social, economic and cultural aspects of daily life, which are necessary to all. Participation in society, freedom of choice and ways to improve circumstances for people with mental illness are important factors in psychiatric rehabilitation (Lindqvist, 2010; Matthíasson, 2010; Velferðarráðuneytið, 2012). The focus must be on the need for human and social services that reinforce capability and empowerment. Studies (Júlíusdóttir, 2013; Sartorius et al., 2005) show that people's needs are socially oriented and are linked to their situations. People provided with comprehensive support have a better quality of life, develop better social contacts and have fewer relapses. Recovery was more likely when roles were functioning well meaning effective involvement, care and concern within families and maintaining discipline and good behavior. This underlines the importance of gathering holistic information about the individual's situation and social relations in order to find root problems and make recommendations for improvements.

Studies show (McGrath & Holewa, 2004; Skinner et al., 1999; Svavarsdóttir et al., 2013) that the focus should not be restricted to the mental illness, but rather concerned with the individuals and how to best rehabilitate them from both a psychological and social perspective through a broad array of social and domestic activities. This is for best for them, their families and friends. Opportunities missed in childhood and youth can cause irreversible damage that accompanies individuals into adulthood, often with unpredictable consequences for them, their families and society (Júlíusdóttir, 2013). Results of research (Yip, 2004) pointed to the importance of professionals, for example social workers who utilize intervention models such as changing the social environment. Furthermore, Yip (2004) pointed out that empowerment should be employed in parallel with psychotherapy in treating and rehabilitating people with mental illness. In light of this, it is vital to develop rehabilitation models in the psychiatric rehabilitation centre in Iceland and strengthen the ability to function in the community and overcome social and institutional barriers. Recovery should be about developing a new identity beyond that of being mentally ill. Informants emphasize the importance of making their own initial decisions to get well and maintain their mental health. It is important to develop a sense of self-control in their lives by managing their symptoms, determining how they spend their time and how they may develop ways to defend themselves and restore their quality of life as human being.

Future Remarks

It would be highly beneficial to further investigate the interaction between mental and physical health, to analyze levels of cooperation and to ascertain whether work is performed in the best interests of patients. The study revealed that participants feel they are not informed about their treatment. This raises the question, of how is the patient's experience of receiving information and services different from the experience of those who provide it? It was noted that some of the informants did not feel comfortable with their family, but were not willing to discuss it further. It is well known that some families experience various forms of violence and abuse and people who encountered violence in childhood can develop a mental illness later in life. It would be interesting to examine this issue more closely with respect to the quality of life of the individual and why mentally ill people are so often forgotten? Finally, as the community in Iceland is becoming more multicultural, it would be interesting to study how professionals cope with people with different backgrounds.

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