ABSTRACT. In the last forty years, there has been a movement (deinstitutionalization) to displace the locus of care of people with severe and persistent mental illness from the psychiatric hospitals to more community-based networks of services. In connection with this movement, the concept of quality of life (objective and subjective) has profoundly altered the perception of the type of care that should be offered to this clientele, as well as the objectives of that care. This paper will first consider the context in which the concept of quality of life first appeared in the mental health field. The work accomplished in this area of interest over the past fifteen years will then be reviewed. Based on descriptive and comparative studies, it will be possible to identify the factors that contribute to the subjective assessment of quality of life-as-a-whole and compare quality of life in clinical and general populations and in different life settings. The paper reports what can be learned from evaluative studies about the contribution of services to quality of life, and concludes with a discussion of ways to improve the quality of life of people with severe mental disorders.

INTRODUCTION

The severely mentally ill are individuals who suffer from severe and persistent mental illness. Severity is generally determined by diagnosis (schizophrenic disorders, major affective disorders and severe personality disorders), disability (difficulties in fulfilling social and vocational roles), and duration of the illness (persistence of symptoms, length and number of hospitalizations). According to epidemiological studies, severely mentally ill individuals represent at least one percent of the total population.

In the last forty years, there has been a movement (deinstitutionalization) to displace the locus of care of these people from the psychiatric hospitals to more community-based networks of services. This movement has profoundly altered the perception of the type of care that should be offered to this clientele, as well as the objectives of that care. This paper will first consider the context in which the concept of quality of life first appeared in the mental health field. The work accomplished in this area of interest over the past fifteen years will then be reviewed. Based on descriptive and comparative studies, it will be possible to identify the factors that contribute to the subjective assessment of quality of life-as-a-whole and compare quality of life in clinical and general populations and in different life settings. The paper reports what can be learned from evaluative studies about the contribution of services to quality of life, and concludes with a discussion of ways to improve the quality of life of people with severe mental disorders.
hospitals to more community-based networks of services. In connection with this movement, the concept of quality of life has profoundly altered the perception of the type of care that should be offered to this clientele, as well as the objectives of that care. The emergence of this issue has caused a double shift: first, from the clinical condition (pathology) to living conditions (material, physical, social and emotional well-being) and, second, from an objective assessment of services and care needs to the consumer’s subjective perceptions of his or her needs. In other words, the concept of quality of life has introduced a new set of concerns about the daily life of psychiatric patients, their life experience in the community, and their perceptions of that experience.

In this paper, we will first consider the context in which the quality of life concept first appeared in the mental health field. The work accomplished in this new area of interest over the past fifteen years will then be reviewed. Based on descriptive and comparative studies, it will be possible to identify the factors that contribute to the subjective assessment of the quality of life-as-a-whole, compare quality of life in clinical and general populations, and study how different life settings can influence objective and subjective quality of life. The second, third and fourth sections of this paper will deal with those topics. The fifth section will report on what can be learned from evaluative studies about the contribution of services to the objective and subjective quality of life. The last section will discuss and suggest ways to improve the quality of life of people with severe mental disorders based on existing data.

THE EMERGENCE OF THE CONCEPT

The emergence of the concept of quality of life in relation to support and rehabilitation services is connected with the deinstitutionalization movement and, more specifically, with its consequences. The original purpose of the movement was to humanize the care given to long-term psychiatric patients by providing them with services based in the community rather than in asylum institutions. As psychiatric hospitals were