# Assessment of Quality of Life in Mental Health

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**Abstract:** The paper describes a part of the work on assessment of quality of life that Peter Huxley has been involved in. It first describes the background for the development of Manchester Short Assessment of Quality of Life (MANSA), the content and form of MANSA, some preliminary results and psychometric properties of MANASA that has been found, that it has been recommended for use as an outcome measure for quality of life, and that there has not yet been done a systematic review of MANSA and the use of MANSA. The author then discussed how she became involved in a systematic review of MANSA led by Peter Huxley, parts of the work with the systematic review that is in progress, and her personal and positive experience of Peter as a supervisor and person.

**Keywords:** quality of life; MANSA; mental health, psychometric properties; life satisfaction; systematic review

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## Introduction

The quality of life of people with mental illness has been a common and well-researched construct in the past few decades. Various measures have been developed to access and evaluate the satisfaction with life in general, as well

as with life domains (Orley et al., 1998). One of the measures which has been widely used in Europe is the Lancashire Quality of Life Profile (LQLP) established by Oliver (1991, p.92). Despite its good reliability and sensitivity to change in measuring the subjective quality of life of samples with severe mental illness, research revealed some shortcomings of this instrument (Holloway and Carson, 1998; Kaiser and Priebe, 1998). The most important of all is that many items in the LQLP have not been found to be relevant for discriminating between samples or for demonstrating change (Priebe et al., 1999). Therefore, based on the experiences and empirical evidence gained in studies using the LQLP, the Manchester Short Assessment of Quality of Life (MANSA) was developed by Professor Peter Huxley and his colleagues as a condensed and slightly modified instrument for assessing the quality of life in people with mental illness (Priebe et al., 1999).

In terms of comparing the difference in construct between LQLP and MANSA, objective questions which neither discriminated between settings or groups nor have been sensitive to change were eliminated; while subjective questions were reduced to one item per life domain to rating patients' satisfaction (Priebe et al., 1999). The MANSA consists of three sections: (1) personal details that stay consistent such as date of birth, gender, ethnic origin, and diagnosis; (2) personal details that may potentially vary over time (i.e., education; employment status, monthly income, state benefits and living situation); and (3) only 16 questions are to be asked every time the instrument is applied, with four objective "yes or no." questions and twelve strictly subjective questions (Priebe et al., 1999). The objective items assess the existence of a "a close friend", number of contacts with friends per week, accusation of a crime and victimisation of physical violence. The subjective questions obtain satisfaction with life as a whole, job, financial situation, number and quality of friendships, leisure activities, accommodation, personal safety, people that the patient lives with (or living alone), sex life, relationship with family, physical health, and mental health (Priebe et al., 1999). Same as the LQLP, satisfaction is rated on 7-point rating scales (1 = negative extreme, 7 = positive extreme) (Oliver, 1991, p.92; Priebe et al., 1999). MANSA shows a high correlation with LQLP on the subjective quality of life (0.83 or higher; 0.94 for the satisfaction mean score), a high internal consistency for satisfaction ratings (Cronbach's Alpha= 0.74), and a similar ability to discriminate between well and unwell groups (see Priebe et al., 1999).

MANSA has been widely applied and utilised in various mental health settings (e.g., Priebe et al., 2011; Petrakis and Joubert, 2013). MANSA was given a strong endorsement for its use as an outcome measure in mental health services by The National Institute for Health Research (2011) and the Royal College of Psychiatrists (2010). Despite these positive remarks, there has been no attempt to examine the results of its use in practice and research using systematic review AQ4

or meta-analysis. Thus, a systematic review of the MANSA led to my encounter with Professor Huxley in Wrexham, North Wales.

I first met Professor Huxley, Peter, when I was an undergraduate student at Bangor University studying clinical and health psychology. It was in late February 2020. I started my internship in the Centre for Mental Health and Society (CFMHAS) in collaboration with the Bangor School of Health Sciences as part of the 'undergraduate internship scheme.' That was a project-based internship where I assisted Peter and Dr Sadia Nafees to conduct a systematic review in the use of MANSA in clinical trials and evaluation of mental health service outcomes.

## Aim

The systematic review aims to: (1) determine the extent of available evidence regarding use of the MANSA in clinical trials and evaluation of mental health service outcomes; (2) assess the reliability, validity, responsiveness (or sensitivity to change), interpretability, feasibility, and acceptability of the MANSA data as reported in these studies and apply a quality rating to each of the papers: and (3) examine whether the performance of the MANSA 'overall' rating and its subscale ratings vary across subgroups (e.g., defined by treatment setting, clinical grouping, age group, socioeconomic status).

## Method

Five electronic databases (Medline, PsycINFO, ScienceDirect, CINAHL and PubMed) were searched from inception to June 2020. Search strategy was used with variants of the following terms: "Manchester Short Assessment of Quality of Life" or "MANSA." No restrictions were placed on language of publication. The inclusion criteria included studies involving adult population ($18^{+}$ years) reported within mental health services or the community settings; studies with aims to assess adult mental health (MH) services or individual MH outcomes using the MANSA; studies that reported the feasibility and acceptability of MANSA for its use in routine service delivery contexts. Studies with an additional QoL measure or combined measures were included only if the effects of MANSA could be isolated. Included outcome involved any measurement characteristic revealed by this review and any measure of feasibility and acceptability of MANSA. Studies of young adults (below 18 years) were excluded as well as reports where limited

data were reported or not published in full in a peer-reviewed journal (e.g., study protocols and conference abstracts, letters, and other short communications).

## Results

This systematic review of the MANSA is still in progress and the result write-up will be published soon with the collaboration of the colleagues in the UK and Norway. The searches retrieved 165 papers from the electronic databases. After the removal of duplicates, and screening for titles, abstracts, and full texts, the preliminary results suggested that 38 papers met the inclusion criteria and were included for data extraction and synthesis. For the characteristic of the included studies, fourteen were conducted in the UK; seven were conducted in the Netherlands; and four were conducted in Sweden. Two papers were conducted in Poland, Norway, Croatia, and Serbia respectively. Israel, Australia, Italy, Bosnia and Herzegovina, USA also contributed to one paper of the included studies. In terms of the settings, fourteen of the included papers adopted MANSA in a community setting, in which six of them examined MANSA in the healthcare service, five were in general community, two in residential home and one in mental health support home. On the other hand, thirteen included studies examined MANSA as a QOL scale in a hospital setting, in which seven were in general hospital, three in outpatient units, two in inpatient wards and one in secure unit. Also, seven studies used MANSA in clinics, in which three papers were psychiatric clinics, two were mental health outpatient clinics and one were in university clinic and psychiatric institution respectively. Lastly, four papers were considered as other settings, which included two papers examining MANSA in both hospital and clinic, one on hospital and residential care, as well as one in ACT team. The mean sample size in these 38 papers was 415 to 416 participants, with a range of 27 to 4167 participants. In terms of the categorization of groups of papers, fifteen papers were quantitative studies which included mainly questionnaires; six papers were cross-sectional studies; three papers were clinical trial studies; three papers were longitudinal studies; two papers were validation studies; and two papers were randomised controlled trial studies. The rest of the papers design included: mixed-method study, observational study, multi-centre epidemiological study, case study analysis, focus group study, multi-centre cluster randomized controlled pragmatic trial, and pilot study. In terms of diagnoses of the target sample, nine studies included participants with schizophrenia; eight studies focused on severe and non-severe mental illnesses (SMI and non-SMI); eight studies focused on psychiatric

disorders and/or lifetime psychotic symptoms (including first-episode psychosis; FEP); and four studies focused on participants with post-traumatic stress disorder (PTSD). The rest of the studies included: ICD-10 (F00-F49; F60-69), stress-disorder, drug addition, scleroderma, opiate addition, suicidality and self-harm, chronic fatigue syndrome (CFS), primary mental health diagnosis, and auditory vocal hallucinations (AVH). Lastly, the type of psychiatric disorders among participants in the studies reported in the papers included the primary diagnosis of SMI such as the diagnosis of schizophrenia, schizoaffective disorder, or bipolar affective disorder; as well as schizophrenia-spectrum disorders or related disorder such as schizophrenia, delusional disorder and bipolar disorder, paranoid schizophrenia, and personality disorder.

## Concluding remarks

Peter is not only well-known in his research on mental health and psychology but also his great personality. Although my internship experience in CFMHAS was brief with lockdowns in place due to the COVID-19 pandemic, I was lucky enough to have Peter and his colleagues who guided and supported me through the whole review process. As a final year undergraduate student at that time, that was my first experience in conducting a systematic review with limited or no knowledge in databases and reviewing techniques. Peter was always welcoming and friendly who makes people around him feel at ease, and he was very patient in guiding me through the internship and providing me with sufficient support. In addition, he always has interesting stories about his passion, hobbies, work and basically life in general, which I have always found fascinating. One of the precious qualities in Peter is that not only he excels at his research, but he is also a kind and likable person. He once offered to host me for my short stay in Wrexham if I ever needed any help (that was when he only knew me for a short while)! To date, I have graduated from my professional doctorate in health psychology and have been working as a qualified psychologist in London. Yet, I am still very much full of passions in research and lecturing. There is no doubt to say that my encounter with Peter and his colleagues at CFMHAS has a huge impact of my career as they have all been an inspiration, and that it was something I have been and am still very grateful for.

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