What happens to homeless mentally ill people? Follow up of residents of Oxford hostels for the homeless

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Abstract

Objectives—To follow up severely mentally ill residents of hostels for the homeless to determine their social and psychiatric outcome.

Design—Follow up at 18 months of hostel residents previously assessed with psychiatric and behavioural measures.

Setting—Two Oxford hostels for the homeless.

Subjects—48 hostel residents previously identified as disabled by mental illness.

Main outcome measures—Current housing, admissions to psychiatric hospital, violent or anti-social behaviour, and score on standardised behavioural rating.

Results—45 of the 48 residents were traced. 27 had remained in the hostels; only 10 had been rehoused, mainly in bedsits or with their families. 16 had a poor outcome as judged by death (four subjects), lengthy hospital readmission (two), marked deterioration in behaviour (six), sleeping rough (one), or disappearance (three).

Conclusion—More effort is needed to provide suitable housing for homeless mentally ill people.

two kinds of behaviour, general and deviant. General behaviour covers the performance of everyday social skills and is rated on four subscales (social activity, self care, speech disturbance, and community skills). Deviant behaviour is socially unacceptable behaviour, such as violence or sexual offensiveness. The behavioural ratings were based on observations made by hostel staff after training. An important finding was that almost half of the residents ($n=22$) were as severely disabled as the most disabled long stay patients in hospitals according to the national averages.⁵

In the follow up at 18 months the assessment procedure depended on whether or not subjects had left the hostel. For subjects who remained in hostels the behavioural rating scale was used again, available psychiatric notes were examined, and the hostel staff were interviewed about the subject's progress. For subjects who had left the hostels MM attempted to determine the nature and quality of their accommodation. In each case information was obtained from someone who was in touch with the subject, usually a member of the hostel staff or a mental health worker.

Introduction

Although there is nationwide concern about the numbers of mentally ill people who are homeless,¹ surprisingly little is known about the social outcome for such people.² This lack of knowledge may result from the belief that the homeless mentally ill are highly mobile and difficult to trace. But one important group of homeless mentally ill people—those who reside in hostels for the homeless—are not highly mobile and may therefore be suitable for follow up study.^{3,4}

Numerous mentally ill people live in hostels; such people are considerably disabled and therefore impose a heavy burden of care and they have high levels of unmet need.^{5,6} We report an 18 month follow up of 48 mentally ill residents in two Oxford hostels for the homeless. The group was previously studied in 1988.⁵ The aim of the follow up was to determine how these residents had fared in terms of rehousing, effect on the general public, deterioration in behaviour, readmission to psychiatric hospital, and death.

Subjects and methods

In the 1988 study 48 residents (one third of the population of the two hostels) were found to be disabled by mental illness, as determined by persistent signs of mental illness over the previous two months and inability to care for themselves without assistance. Their mean age was 48.1 (SD 12.4) years. Forty were classified as having schizophrenia, either on the basis of a previous diagnosis or because they met ICD (ninth revision) criteria for schizophrenia at interview. Four of the remaining eight subjects had paranoid delusions, though there was insufficient evidence to make a formal diagnosis. Forty three had had at least one previous psychiatric admission. Only six had ever married.

In 1988 the residents were rated on a standardised behavioural rating scale (REHAB),⁷ which measures

Results

Of the 48 subjects, 27 had remained in the hostels throughout the 18 months, and 21 had left. In the 27 subjects who had remained in the hostels the overall general behaviour scores were not significantly worse than in 1988 (matched t test: $t=0.47$; $df=26$; $p=0.64$). Two subjects had substantially better disability scores (one reduced from 122 to 25, and the other from 80 to 36; both had received psychiatric treatment in hospital); six subjects had substantially worse scores (mean (SD) increase 32 (12.5); range 25-57).

Deviant behaviour scores remained high (mean (SD) 1.9 (1.9)) but not significantly different from those obtained 18 months before (Wilcoxon signed rank test; $p=0.615$). Several residents had shown antisocial behaviour: two had committed acts of arson and seven had committed physical assaults, though none had caused serious injuries. One assault was against a member of the public and the remainder were against the police or the staff of hostels or hospitals. Two subjects had been arrested, including one of the arsonists, but neither had served prison sentences.

Several of the residents were ill treated by members of the general public. Three reported physical assault and two reported sexual assault (verified as a rape and an indecent assault).

Behavioural rating scores could not be obtained for the 21 subjects who had left the hostels. Five had left Oxford and most of the others were not living in accommodation where their behaviour could be rated. Information on antisocial behaviour was limited, although one subject had set fire to a hostel.

Only 10 of these subjects had been rehoused, of whom five were in bedsits, three in supported accommodation managed by the hostels, and two with their families. In each case the accommodation was of a reasonable standard. Among the 11 subjects who had not been rehoused the outcomes were varied. One subject was sleeping rough. Three were patients in

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psychiatric hospitals (two of whom had been admitted for more than a year). Four had died, the causes of death being ruptured aortic aneurysm, heart attack, suffocation during an epileptic fit, and road traffic accident. In three of these deaths mental illness seemed to be contributory—in two cases because the subject had not sought treatment and in the third (the accident) because the subject was wandering the streets after absconding from the hostel. Finally, three subjects could not be traced; all had suddenly departed leaving their belongings behind but without leaving contact addresses.

Nine of the 48 subjects had been admitted to psychiatric hospitals during the 18 months. At the time of admission all had been hostel residents. Four of these patients had had two or more hospital admissions in the 12 months before the 18 month follow up had begun and five patients had had no admissions in that period. Among the four with two or more admissions, three were still in hospital at follow up and one had returned to his hostel but showed no improvement on the behavioural rating scale. Hospital case notes showed that the mental state of four of the other five patients had improved considerably after treatment. Three of these four subjects also showed improvement on the behavioural rating scale: two had improved general behaviour scores, as reported above, and one had an improved deviant behaviour score, falling from 5 to zero. None of the nine subjects admitted to hospital had been rehoused.

Discussion

Our data show that the general outcome of the 48 subjects was not good. Only 10 patients had been resettled in bedsits, supported accommodation, or family homes, nine had been admitted to psychiatric hospitals, and 16 had had a poor outcome as shown by death (four subjects), disappearance (three), inpatient care exceeding one year (two), sleeping rough (one), or marked deterioration in behaviour (six).

Not only was the rate of rehousing low but accommodation was limited to bedsits owned by private landlords, supported accommodation managed by the

hostels, and the family home. Of these three kinds of placement, only supported accommodation seems likely to be of long term benefit. Neither private landlords nor family homes are likely to meet the needs of our subjects. Such mentally disabled people would probably fare best in small group homes or cluster flats supported by local social or psychiatric services. None of our subjects had achieved a placement of this kind. Perhaps the explanation is that once people become homeless they become isolated from mainstream community care. This theory is further supported by the fact that a third of the subjects had a poor general outcome.

The high rate of admission to psychiatric hospitals is consistent with the high level of psychiatric morbidity found in this group of subjects. This high admission rate does not necessarily mean a failure of community care; on the contrary it may indicate success in identifying treatable mental illness. On the other hand, there is cause for concern that none of the subjects admitted to psychiatric hospitals was rehoused.

Overall our findings suggest that the homeless mentally ill should be given increased access to supported accommodation, where their needs could be better met. If conventional agents cannot provide such access the hostel staff should be given adequate funds to do so.

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Alcohol consumption and its relation to cardiovascular risk factors in British women

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Abstract

Objective—To examine the relation between alcohol consumption and risk factors for coronary heart disease in women.

Design—Cross sectional study of a stratified random sample of the population grouped into five categories of habitual alcohol consumption.

Setting—People registered with general practitioners at two large health centres in east Bristol, England.

Subjects—1048 women aged 25-69 years.

Main outcome measures—Fasting plasma concentrations of insulin, total cholesterol, total triglycerides, and high density lipoprotein cholesterol, including its subfractions HDL₂ and HDL₃, and body mass index.

Results—Compared with non-drinkers women consuming a moderate amount of alcohol (1-20 g/day) had lower plasma concentrations of triglycerides, by 0.19 mmol/l (95% confidence

interval 0.07 to 0.35); cholesterol, by 0.4 mmol/l (0.19 to 0.61); and insulin, by 1.4 mU/l (0.43 to 1.97) and a lower body mass index, by 1.2 kg/m² (0.43 to 1.97). They also had higher concentrations of high density lipoprotein cholesterol, by 0.09 mmol/l (0.03 to 0.15); HDL₂ cholesterol by 0.05 mmol/l (-0.02 to 0.10) and HDL₃ cholesterol, by 0.06 mmol/l (0.06 to 0.11). All these were independent of body mass index, smoking habits, and taking oral contraceptives.

Conclusions—Moderate alcohol consumption is associated with lower levels of cardiovascular risk factors in women. Insulin may have a central role.

Introduction

In most epidemiological studies moderate alcohol consumption has been associated with a decreased risk of coronary heart disease.¹⁻⁴ Because of the well known inverse relation between high density lipoprotein

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