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Collected and Neglected: Are Oxford Hostels for the Homeless Filling up with Disabled Psychiatric Patients?

P. GARETY and R. M. TOMS

"*Objective* – To assess the severity of psychiatric symptoms among residents of hostels for homeless people. *Design* – Survey of residents in two hostels in Oxford, comprising three weeks of background fieldwork, a demographic questionnaire, and rating behaviour over two weeks with a behavioural rating scale (REHAB) and mental state with the brief psychiatric rating scale. *Setting* – Two hostels for homeless people in Oxford. *Subjects* – 146 Medium to long term residents, of whom 48 were selected by hostel workers by the following criteria: continuous residence for at least two months, signs of persistent severe mental disability, and difficulty in coping independently in the community. Two subjects died during the study; three (previously long term psychiatric inpatients) declined to be assessed on the psychiatric scale. *Main outcome measure* – Behavioural disturbance and mental state. *Results* – Only a third of the total sample had been born in Oxfordshire. Subjects had been accepted into the hostel either by arrangement with the local psychiatric service (22) or straight off the streets (26); 43 had had a previous (non-drug related) psychiatric admission. Subjects were significantly more likely than other residents to have spent longer (>80 weeks) in a hostel in the past three years ($p<0\cdot02$). With reference to norms for deviant behaviour, the 46 subjects assessed showed considerable deviant behaviour (average weekly scores: 0 (11 subjects), 1 (14), 2–3 (16), and ⩾4 (5)) not significantly different from that expected in moderately to severely handicapped psychiatric inpatients ($\chi^2=1\cdot3$, df = 3, $p>0\cdot7$); 22 had scores equivalent to those in most severely handicapped inpatients. Of the 43 subjects assessed with the psychiatric rating scale, 16 had symptoms of neurosis, 29 of florid psychosis, and 32 of a deficit state. Symptoms of deficit state were positively correlated with ratings of low social activity on the behavioural scale (Spearman's rank correlation coefficient $0\cdot30$, $p=0\cdot03$). *Conclusions* – Hostels are having to care for long term severely affected psychiatric patients discharged into the community. The suitability of the services offered to such subjects should be assessed."

The summary quoted above is from an article by Marshall (1989). The present authors were invited to comment upon the study.

P. Garety

Concern that the policy of deinstitutionalisation is making a significant contribution to the numbers of homeless people is now widespread. On 31 October 1989, the London *Evening Standard* published an emotive and potentially inflammatory article in which psychiatric patients were depicted as uniformly dangerous, deranged, and deprived, even of a place to sleep. Vignettes of current in-patients (who by venturing onto the local streets were assumed to be homeless) were intermingled with true and distressing accounts of deprivation, and frank fiction. Such articles are not uncommon, and reflect awareness of a real problem. However, it is of the utmost importance to gather accurate data about the homeless mentally ill, and in the pursuit of this, Dr Marshall's paper is an important and timely contribution to the literature.

In this study, hostel staff identified approximately one-third of a total population of two shelters for the homeless as suffering from a persistent and severe mental disability. Using a brief symptom rating scale (the BPRS), Marshall found approximately 90% to be currently floridly psychotic, or showing symptoms of a defect state. In addition, and more unusually, he assessed the functioning of the subjects: the level of disability and behavioural disturbance, as assessed by the REHAB scale, was high – at a similar level to that found in long-stay psychiatric wards for the moderately to severely disturbed.

Nearly all the subjects had been in contact with psychiatric services, either locally or elsewhere. About half had been referred *directly* to the shelters from the local psychiatric service. Of those who were technically 'off the streets', 85% had previously been in psychiatric hospitals, many of them for long admissions.

It is instructive to consider whether these data reflect a significant social change, as bed numbers reduce nationally. The homeless have always included some mentally ill in their ranks (Herzberg,

1985). An early anecdotal study of a common lodging house (London Council of Social Services, 1960) gives a graphic description of mentally ill 'inmates':

> "one man walked backwards and forwards, carrying a fish basket and talking aggressively and ceaselessly to himself.... Another man at a table nearby was speaking into an imaginary microphone, and jotting notes in an imaginary notebook.... Another packed and unpacked a little cardboard box with a great show of ritual. Anybody who had worked in a mental hospital could not fail to recognise some of the symptoms. The problem was why these men were in a lodging house at all."

Nonetheless, the writer estimated that only about 4% of the total were seriously mentally ill.

Crossley & Denmark (1969) surveyed male residents of a 60-bed Salvation Army hostel: 33% of these had previously been in a psychiatric hospital. Priest (1971) interviewed 79 residents in common lodging houses in Edinburgh; psychiatric morbidity was diagnosed in 75% of the residents, with 32% of the total diagnosed as schizophrenic. A study of the Camberwell Reception Centre by Tidmarsh & Wood (1972) found that, of new cases attending the centre, 22% suffered from mental illness, 14% had predominantly alcohol-related problems, and 16% were considered to have a personality disorder. Ten per cent of the sample had been admitted to a mental hospital in the previous year, and a further 19% more than a year previously. In a later paper, Wood (1976) reported that nearly two-thirds of those currently mentally ill at the centre were not receiving medical treatment, and that the centre was inappropriately acting as a home for the chronically mentally ill in the absence of suitable after-care facilities. These studies, unlike Marshall's, provided no information about the level of disability of those diagnosed as mentally ill.

In the United States, recent figures on the homeless mentally ill are alarming. Bassuk (1984) reports that 90% of residents of a Boston night shelter had a diagnosable mental disorder, while Baxter & Hopper (1984) report a number of studies that found psychiatric disorders present in 25–85% of homeless people.

The problem of psychiatric problems among the homeless is thus not new. However, it is quite possibly growing. In 1985 the House of Commons Social Services Committee accepted that there is an association between the rundown of mental hospital beds and the growth of the homeless population. Furthermore, it is likely that the *severity* of disability of psychiatric patients in the community is on the increase, although more studies will be needed which, like Marshall's, specifically gather these data.

The question is raised of how to provide a suitable psychiatric service. Should psychiatric hospitals be prevented from discharging their patients directly to such inadequate accommodation as shelters for the homeless? Or indeed, should those identified in these settings as severely disabled be returned to the hospital? Yet, at present, the health service is not recognised as the statutory agency for providing housing. Those admitted to psychiatric units often have accommodation problems. Ebringer & Christie Brown (1980) found that 28% of short-stay admissions to a London mental hospital had no or only temporary accommodation, and that during the course of the admission, 40% lost their accommodation. Thus, mentally-ill patients in hospital often require rehousing.

Apart from the problem of a shortage of suitable (often staffed) housing, the views of the service users are relevant. Given a lack of suitable permanent accommodation, do they prefer to remain in hospital wards, supervised by nurses, or in shelters, largely left to their own devices? Are they exercising a legitimate choice not to be treated, or being denied access to psychiatric care? Assuming that some will prefer not to remain on hospital wards, or that hospitals will continue to discharge them anyway, some responsibility for providing them with psychiatric services should be accepted. In a time of scarcity of resources, a high priority should be accorded to the provision by community psychiatric teams of services to shelters for the homeless, as an urgent social, psychiatric, and political need.

R. M. Toms

My children have become adept at spotting which television programmes Mum, as a rehabilitation psychiatrist, 'ought' to watch. More and more frequently, these deal with the closure of large psychiatric hospitals, and – with varying degrees of emotion and accuracy – the fate of their residents. Typically, the camera focuses on an imposing Gothic building surrounded by flower beds and rolling lawns, followed by a shot of 'Cardboard City' in one of our large towns, a crowded hostel, a lodging house in a dingy street, or a mouse-infested broken-down car abandoned by the roadside – all of which serve as 'home' for discharged patients. Rare indeed must be the old lady whose ward was demolished around her and who exchanged the echoing corridors of a large institution for an elegant Kensington mansion.

These scenes may be exaggerated, but Dr Marshall's work is firmly based on reality. He has carried out a painstaking and revealing study in two of these 'homes' – hostels for homeless people in Oxford.

His conclusions replicate the findings of other studies that homeless mentally-ill people tend to congregate in hostels originally intended as temporary shelters for travelling workers or vagrants. A survey carried out in Westminster to examine the whereabouts of patients discharged from short-stay psychiatric units over six months in 1988 found that one in four was homeless, and that in the capital's hostels, half of those seeking a bed for the night were mentally ill (Westminster Association for Mental Health, 1989). However, Dr Marshall's study goes further: he points out that previous studies, when considering residents of hostels for the homeless, have concentrated on demographic factors and diagnosis. His work is probably unique in that it aimed to assess the level of disability of these people by focusing on the intensity of their psychiatric symptoms and the degree of disturbance of their behaviour. Taken together, these aspects give a very accurate picture of the practical difficulties which hostel staff have to deal with day by day.

Trainees in psychiatry who come to a rehabilitation unit after a period in general acute psychiatry are often disconcerted to find that actual diagnosis frequently seems less important than behavioural abnormalities, social disabilities, and the ways in which a person's psychiatric symptoms affect behaviour. These three factors are crucial in determining potential for resettlement in the community: a former psychiatric patient should not be marked out as 'different'. An old man with well encapsulated delusions who will talk about them when encouraged but whose day-to-day behaviour seems unaffected will integrate more easily than his friend whose paranoid delusions make him suspicious of everyone he meets and who is occasionally abusive or violent as a result of these beliefs.

The industry and persistence shown in collecting data on such a difficult group of patients in this study is very impressive. Almost 50% of the residents had been referred by the Oxford psychiatric services, and only 10% of the total had had no psychiatric admissions. Mental state assessment showed that 70% of the sample had florid psychotic symptoms, and 79% symptoms of a deficit state. The behavioural rating scale revealed a high level of deviant behaviour (aggression, violence, sexual offensiveness, self-injury). General behaviour scores indicated that only 26% had abilities which, had the survey been used in a psychiatric hospital, would have indicated 'potential for discharge'. No fewer than 48% fell into the 'high-dependency' range, indicating very little ability to cope with daily living. In my own hospital, where REHAB rating scales were used some years ago to place all long-stay patients according to their level of functioning rather than diagnosis, people with high scores are either chronic psychotic patients who have been in hospital for many years and whose chances of resettlement in the community are slight, or else those who have a significant degree of physical illness in addition to their psychiatric problem and who require much nursing care. Many have behavioural disturbances which, although tolerated to a certain extent in the corridors of a large psychiatric hospital, would certainly shock, alarm, or annoy people in the average street or road.

Similar individuals to these, as Dr Marshall clearly shows, are being cared for in the two Oxford hostels – people who remain chronically and severely mentally ill and whose behaviour reflects this. His study raises several important questions, the answers to which must be found in further research.

Forty-eight per cent of the group studied had been referred to the hostels by Oxford psychiatric services. It is not clear how many were discharged there direct from hospital, possibly because of closure of beds, and how many had been living in other residential accommodation but were asked to leave there because of disturbed behaviour or florid symptoms. It seems that all but the 26% who had a 'potential for discharge' deserved a hospital bed. Were the psychiatric services satisfied that they were doing the best for their patients, or were they under pressure to discharge because of financial and policy reasons? Was alternative community accommodation available? How many of the 48% should have been admitted to hospital but refused treatment, and how many would have been admitted had a bed been available?

It would be interesting to know what level of follow-up was provided for patients referred by psychiatric services. The hostel staff and volunteers were not psychiatrically trained, and one wonders whether support and guidance was available to them from professional mental health workers. Were the staff prepared in any way for the problems they might have to face in dealing with this group of people? Untrained staff can often become demoralised and despairing if they feel unsupported and unappreciated, especially when faced with unfamiliar and sometimes frightening aspects of behaviour.

"We are witnessing the inadvertent creation of mini institutions in hostels" says Dr Marshall. The idea of "mini institutions" is currently unpopular, as they imply little effort to promote rehabilitation techniques, but I believe that they are not necessarily bad for a certain group of people who would feel confined and disorientated in a small house but who could take advantage of some move towards

domesticity and 'normalisation'. Dr Marshall hints that the hostels are able to manage their very difficult task because of the devotion and ingenuity of the staff who had adopted 'impressive strategies' to deal with the challenge. Support, continuing training, and follow-up of residents by professionals could make their work even more effective and less of a burden. In north-east Essex, a large number of former psychiatric patients live in former seaside boarding houses in Clacton, and a specialised community rehabilitation team has been recently established to care for people with long-term psychiatric problems living in the town. Members of this team are frequent visitors to individual boarding houses to offer advice on management of specific clinical problems, and a proprietors' support group has recently been formed.

The need for a whole range of community accommodation for all levels of disability will become increasingly necessary as long-stay hospitals close. We must be sure that the best possible care continues to be given to a much neglected group of people. It is up to mental health professionals, particularly those in the rehabilitation field, to ensure that their skills are used not only to treat patients with long-term needs directly, but to support, teach, and encourage others to work effectively alongside them.

Properly organised and supervised, community care can be very successful, but we must ensure that all aspects of a community service receive maximum help and encouragement to meet the clients' needs.

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