Collected and neglected: Are Oxford hostelers for the homeless filling up with disabled psychiatric patients?

Max Marshall

Abstract

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<0.02). With reference to norms for deviant behaviour, the 46 subjects assessed showed considered 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 (c’=1-3, d=-3, p<0.7); 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 0.30, p<0.03).

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.

Introduction

The presence of mentally disabled “street people” in every major town and city alerted the public in the United States to the unforeseen deficiencies of an ambitious programme of deinstitutionalisation. Surprisingly, although a similar and no better planned policy has been adopted in Britain, equivalent numbers of conspicuously mentally ill people do not seem to be living on the streets. This might reflect a cultural difference, in that homeless mentally ill people in

that the risks of renal failure and hypertension persist for decades. Children with reflux nephropathy should be carefully followed up during their childhood and adolescence. During pregnancy they should be managed as high risk patients, and obstetricians and nephrologists should cooperate closely. Establishment of control of reflux among pregnant women could be useful. The incidence of renal failure in children with reflux nephropathy has been estimated at 5% for boys and 10% for girls. (p=0.017).

References


(Accepted 11 July 1989)
Britain may be more willing to accept help from the state and from charitable institutions and are consequently more likely to congregate in facilities that attempt to resettle the homeless than on the streets. If this is so then the most severely disabled members of this group, for whom resettlement in independent accommodation is not a viable option, will probably collect in such facilities, swamping their resources and perhaps leading to the development of new mini-institutions, which may offer an inferior quality of psychiatric care.

Previous studies of mentally ill people living in hostels for the homeless have tended to be limited to analysis by demographic features and diagnostic categories alone. Their usefulness is limited as they disclose little about the degree of disability and hence the actual burden of care taken on by these hostels. Moreover, the diagnostic categories used are inherently unreliable or entail the use of standardised diagnostic techniques, which are difficult to apply to the most severely disabled people, whose tolerance of lengthy interviews is limited.

The present study is probably unique as it avoids the limitations of a diagnostic approach by instead assessing the level of disability of subjects with chronic and severe mental disability who are living long term in hostels for the homeless in Oxford. It aims at comparing the level of disability in this homeless population with that of more familiar groups such as long stay mentally ill hospital patients.

Subjects and methods

The study was explicitly designed to counteract two key methodological problems: firstly, the tendency of these highly disorganised and often suspicious people to resist assessment actively; and, secondly, the difficulty of obtaining detailed ratings in such an inaccessible setting. Consequently the methods were chosen for their economy, reliability, and robustness.

Subjects were all medium to long term residents of the two main hostels for the homeless in Oxford. They were selected initially by experienced hostel workers on the basis of three written criteria, which were explained in detail beforehand; these were that the subjects had been in continuous residence for at least two months, that throughout the past two months they had shown signs of persistent, severe mental disability, and that the hostel to be closed they would have grave difficulty in looking after themselves and in finding shelter. Five potential subjects were subsequently excluded because they had all been in the care of the mental handicap services. Basic demographic information was collected on the residents who were not eligible for the study so that later comparisons might be made with the study group.

A demographic questionnaire, a psychiatric rating scale (brief psychiatric rating scale) developed by Krawiec et al., and a behavioural rating scale known as REHAB were used to assess the patients and were supported with data from hostel records and psychiatric notes. I completed the questionnaire after interviewing the subject and a care worker who knew him or her well. The brief psychiatric rating scale was specifically designed for rating severity of psychiatric symptoms in long stay inpatient populations and consists of eight items each rated on a five point scale. It is short, easy to use, and its reliability in such populations has been shown. In this study three subscores were derived from the basic eight items, one representing neurotic symptoms, one florid psychotic symptoms, and one symptoms of a deficit state. Interrater agreement on the scale was assessed during the study (coefficients of concordance for the subscales representing neurosis, psychosis, and deficit state 0.81, 0.84, and 0.82, respectively (Kendall's coefficient of concordance)).

The behavioural assessment scale consists of two sections: that on deviant behaviour (seven items) records the frequency of embarrassing or disruptive behaviour, whereas that on general behaviour (16 items) refers to deficits in normal behaviour and is assessed on a visual analogue scale. In addition to recording overall scores in these two categories the scale also analyses general behaviour in terms of five subfactor scores: social activity, speech skills, speech disturbance, self care, and community skills. The behavioural assessment scale may be completed by any rater who has observed the subject in his or her place of residence for a week; in this study all raters were experienced hostel staff. To achieve interrater reliability two one hour group training sessions were given, as recommended. More elaborate studies of reliability could not be achieved given the constraints of the setting. The use of the behavioural assessment scale did not entail any disruption of normal hostel routine, nor did it take much time, having been designed specifically for unskilled users.

The study began with three weeks of fieldwork in each hostel, during which I acted essentially as a new hostel worker in the hope that I would become a familiar face and so increase compliance in the subsequent interviews. I also had the opportunity to observe the behaviour of the subjects and ensure that the selection criteria had been properly applied. After completion of the fieldwork and psychiatric ratings all members of the study group had their behaviour rated over two weeks. These ratings were later averaged to give a more representative sample of behaviour than for one week alone. The data were analysed with an Apricot XEN personal computer, and non-parametric statistical tests were used for all tests of significance except for comparisons of age and length of stay, for which a two tailed t test was used. The study was approved by the local research ethical committee.

Results

In all, 48 long term psychiatrically disabled residents (four women) were identified from a total population of 146 in the two hostels. Roughly a third (15) of the sample had been born in Oxfordshire, another third (16) came from the south of England, mainly London, and most of the remainder (13) came from Scotland, Wales, and Ireland. Their mean age was 48.1 (SD 12.4) years, and they were not significantly older than the other hostel residents (mean age 49.2 (13.4) years; p>0.2).

They seemed to have arrived in the hostels in two main ways: by arrangement with the local psychiatric service (22 subjects), and by being taken literally off the streets (26). Most of those taken off the streets (16 subjects) had arrived in Oxford shortly before admission, but seven were local long term psychiatric patients who had lost contact with the local services and become homeless. The remaining three had lived in Oxford for several years before admission; two had had occasional contact with local psychiatric services. Of the 16 subjects who had arrived in Oxford shortly before admission to the hostels, 10 had been long term psychiatric patients in other parts of the country, three had had intermittent psychiatric admissions or consultations, and only three had never seen a psychiatrist. Considering the group as a whole, 34 (70%) had had previous psychiatric admissions in Oxford and 16 (33%) the basic words elsewhere (excluding admissions for treatment of drug or alcohol dependence). Only five did not have a history of a previous (non-drug related) psychiatric admission, one of whom had spent almost a year in a head injury rehabilitation unit.

There was a clear difference in length of stay in the
TABLE 1—Summary of scores on general behaviour rating scale in 46 long term psychiatrically disabled residents in two hostels in Oxford

<table>
<thead>
<tr>
<th>Score</th>
<th>0-40</th>
<th>40-64</th>
<th>64-144</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (% of subjects)</td>
<td>12 (26)</td>
<td>12 (26)</td>
<td>22 (48)</td>
</tr>
<tr>
<td>Category according to norms on scale</td>
<td>Potential for discharge</td>
<td>Moderate handicap</td>
<td>Severe handicap</td>
</tr>
</tbody>
</table>

TABLE II—Correlations between behavioural ratings and ratings of psychiatric symptoms (Spearman's rank correlation coefficients) in long term psychiatrically disabled residents

<table>
<thead>
<tr>
<th>Behavioural ratings</th>
<th>Deviant behaviour</th>
<th>General behaviour</th>
<th>Social activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florid symptoms</td>
<td>0-229</td>
<td>0-07</td>
<td>-0-15</td>
</tr>
<tr>
<td>Symptoms of deficit</td>
<td>0-15</td>
<td>0-30*</td>
<td></td>
</tr>
<tr>
<td>* p=0.03 (one tailed)</td>
<td></td>
<td></td>
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correlations between the scores for deviant and general behaviour scores by the behavioural scale and the brief psychiatric rating scale subfactor scores. Symptoms of a deficit state on examination of mental state positively correlated with ratings of low levels of social activity on the behavioural scale (p=0.03).

Discussion

The two hostels for the homeless had a substantial population of chronically and severely disabled persons, who had a high level of psychiatric symptomatology and a pattern of deviant behaviour similar to that expected in a ward of long stay psychiatric patients. In terms of skills and abilities half of the sample were functioning so poorly as to fall into the category of the most severely disabled class of long term psychiatric patients.

The two hostels, staffed by psychiatrically untrained workers and volunteers, were effectively attempting to do the work equivalent to that in two long stay psychiatric wards while also caring for another 98 homeless residents, many of whom have considerable problems with substance abuse. This seems to have arisen as a result of efforts to transfer the care of long term psychiatric patients to the community—almost half of those studied (22) had been referred to the hostels directly by the Oxford psychiatric service. Most of them were very ill indeed. We are witnessing in the inadvertent creation of mini-institutions in hostels whose original function was the rehabilitation of homeless alcoholic subjects. The different strategies adopted by the two hostels to meet this unsolicited challenge was impressive. An analysis of the met and unmet needs of the psychiatric residents might help to disclose the extent to which the services offered by the hostels suit the many problems of this very disabled population and is an obvious direction for further research.

This research was supported by a grant from the Wellcome Trust. I thank Dr John Hall and Ms Lorna Hogg for their help with this research; Ms C Cherrera for her help in preparing the manuscript; and all staff at the two hostels, in particular, Mike Hall, Clive Bishop, and Mark Thompson for their enthusiastic support of the research.

Use of medical record linkage to study readmission rates

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Abstract

Readmission rates after inpatient care were studied by using routinely collected data from the Oxford record linkage study for 1968-85. Discharges from hospital and subsequent admissions were identified for people who were both resident and treated in the area covered by the linkage study. Rates were calculated for readmissions within 28 days after discharge from the first, index event. Readmission rates for elective readmissions after elective index admissions rose from 3-5% in 1968 to 7-1% in 1985. Those for elective readmissions after immediate (emergency or accident) index admissions rose from 2-4% to 3-5% during the same period. Emergency readmissions after an immediate index admission rose from 4-0% to 7-0%, and emergency readmissions after an elective index admission rose from 1-3% to 2-5%. All these increases were significant. The rise in elective readmissions may in part reflect a trend towards planned discharge with the expectation of readmission. The rise in emergency readmissions, which has been fairly gradual over many years, may, in some cases, be due to pressure on resources and inappropriately short lengths of stay. Further evidence is required to confirm or refute this.

Readmission rates are one of the few potential measures available from routine statistics for assessing outcome, but due consideration must be given to issues of method and interpretation.

Introduction

Current interest in studying readmissions to hospital after discharge from inpatient care is due to several reasons. Firstly, hospital admission rates in England have increased for many years, but as routine hospital statistics are based on unlinked counts of admissions the extent to which these statistics are inflated by an increase in readmissions rather than primary admissions is generally unknown. Information about readmissions is therefore required to distinguish between changes in admission rates due to a change in numbers of patients treated and those due to a change in multiple admissions per person. Secondly, readmission is one measure of prognosis: routinely available data on readmission rates for patients in particular diagnostic groups may be useful to clinicians in predicting the course of patients' illnesses. Thirdly, if patients who are at high risk of unintended readmission can be identified approaches to their care may be implemented that reduce the likelihood of readmission. There has also been interest in the use of readmission rates as possible indicators of quality of care. Two admissions for an individual patient may or may not be related. When they are related the readmission may be planned as part of a programme of phased care or it may be unforeseen. Unforeseen readmissions may be a consequence of the natural course of the patient's disease or may result from suboptimal care during the first admission. Because of the second possibility variation in quality of care, either over time or between different hospitals, might result in variation in readmission rates. The package of performance indicators currently used in the NHS has been criticised for its lack of outcome indicators, and in the search for outcome indicators that could be obtained from routinely collected statistics the use of readmission rates is under consideration.

The National Steering Group on Health Services Information (the Körner committee) recommended the use of a unified district medical record system so that each patient treated within a district would have the same medical record number for each admission. The use of this number in the computerised abstract of the hospital admission is intended to facilitate the linkage of episodes in hospital for individual patients within a district. Now that health authorities are implementing the recommendations of the Körner committee the means will exist to calculate readmission rates for the various purposes described above.

We analysed readmission rates by using data from the Oxford record linkage study for 1968-85. We report some broad trends in these rates and discuss some of the methodological issues that need consideration in analysing readmission rates.

Population and methods

The Oxford record linkage study includes brief abstracts of hospital inpatient records. These are similar to the abstracts that have been collected elsewhere in England as Hospital Activity Analysis in the past and that are collected currently as the Hospital Episode System. For many years these data have been collected in the Oxford region in ways such that records relating to the same patient can be linked together. These data have been collected in two of the eight health districts in the Oxford region since 1968 (population about 850 000) and in six of the districts since 1975 (population about 1·9 million). The data presented here cover hospital discharges for 1968-85 in all specialties except psychiatry and obstetrics.

We used the following definitions and criteria for selection of records. An index event in each year was defined as the first recorded admission and subsequent discharge for each patient in the year. First discharges for a patient within a calendar year were excluded if the patient's admission occurred within 28 days after a discharge in the previous year (identified by linking records for each patient back to the previous year). Index events longer than 28 days in duration were excluded. Patients who died during the index event or the following 28 days were excluded. The time period for readmission was taken as being within 28 days after the date of discharge from the index event. When a patient had several readmissions only the first was tabulated. The analysis was confined to patients who...