HOMELESS PEOPLE AND COMMUNITY CARE:

AN ASSESSMENT OF THE NEEDS OF HOMELESS PEOPLE

FOR MENTAL HEALTH SERVICES

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ABSTRACT:

The main aim of this study was to assess the needs of the homeless in temporary hostel accommodation people in Bloomsbury Health District for mental health services. The central question of this assessment was whether the need is for institutional or community care services. Current literature suggests that a high proportion of the homeless are victims of de-institutionalisation and hinted at their need for institutional treatment.

The study aim was achieved by: (a) Comparing the records of homeless and the home-based clients of the CPNs in their problems and care. (b) Comparing a random sample from homeless peoples' hostels with a sample from the chronic psychiatric patients of a community psychiatric service. (c) Undertaking a cross-cultural comparison of the care provided to homeless people in London and New York.

The main results of this study showed that the majority of needs of homeless people for mental health services is related to their poverty and homelessness. Nevertheless homeless people with chronic mental illness have many unmet needs that make them disturbed and visible to the general public. The services needed by homeless people to meet their mental health needs should be community-based with a specialist role to work with them in their residential settings. Their need is for a multi-disiplinary service that can incorporate psychiatric, social and substance abuse services.

DEDICATION

To my father and my mother .....

To my sisters and my brothers.....

to all my friends back home in Iraq.....

Two wars and too much suffering.....

Waiting for good news !!

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CONTENTS OF THE THESIS PAGE NO.

LISTS OF TABLES AND FIGURES:

A.LIST OF TABLES PAGE NO.

B.LIST OF FIGURES PAGE NO.

CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

1 Introduction:

Homelessness is a product of poverty and economic inequality. This is how many sociologists see homelessness; in purely political and economic terms. As early as 1791 William Wordsworth aired the same theme in a poetic image when he wrote (Hutchinson, 1904):

And homeless near a thousand home I stood
And near a thousand tables pined and wanted food.

In spite of the clear socio-economic root of homelessness, society has continued through many ages to label homeless people in different ways many of which show them as undeserving poor. They are labelled as spiritually weak, criminals, alcoholics and lately mentally ill.

This study is not an aetiological one; it is a piece of health service research that has tried to assess the needs of homeless people for mental health services in the vicinity of an inner London Health District. The current argument in this area of aetiological research is that homelessness is caused by community care policies and that the homeless are mainly de-institutionalised chronic mentally ill. This question is crucial to the assessment of the needs of these people for mental health provision and the form of this provision (ie community or institutional provision). That is why it was inevitable to address this question in the context of this study.

George Orwell, who lived as a homeless person himself, described poor homeless people as: "people who have fallen into solitary, half-mad grooves of life and given up trying to be normal or decent. Poverty frees them from ordinary standards of behaviour, just as money frees people from work" (Orwell, 1986).

Recently researchers started questioning the proposition that homeless people are chronic mentally ill. They were using Orwell's argument in that previous investigations had failed to account for the different social, environmental and economic circumstances of the homeless in these investigations. They argued that a lot of what has been assessed as chronic mental illness -using psychiatric diagnoses- could be the process of adaptation to homelessness and extreme poverty.

As mentioned earlier this study has tackled the aetiological question of the relationship of homelessness to community care policies in the context of investigating the form and the content of mental health provision needed for homeless people. This study should not in any way be considered as an evaluation of a community care policy, nor does it contain arguments about the closure of mental hospitals since these are much wider issues than the scope of the aims or the resources of this study.

2 Literature Review:

The main aim of this section is to define the study variables;(i) homelessness and its historical background; (ii) problems and needs in mental health care. The causes of homelessness and its effect on the physical and mental health of the homeless individuals will also be discussed. Finally, the relationship between community care and homelessness will be critically reviewed.

2.1.Definitions and Historical Background.

2.1.1.Homelessness; the problems of the definition:

One of the main problems that faces researchers on the homeless is that homelessness has no universally accepted definition {Bachrach, 1984}&{Susser et al, 1989c}. Two common characteristics have traditionally been identified; a lack of adequate shelter that could be called home, and the absence of affiliative bonds to the social structure {Fischer & Breakey, 1986}&{Bahr & Caplow, 1973}. From these characteristics homeless people could be defined as: "people who lack stable residence and the personal resources, such as work, family and friends to acquire such residence".

Bahr and Caplow (1973) in their study of New York homeless alcoholics (Skid Row), defined homelessness in terms of disaffiliation. They defined six areas of affiliative bonds which include family, school, work, religion, politics, and recreation. The skid row men were unaffiliated in all of the six areas.

The authors identified 3 types of the causes of disaffiliation in the skid row men. The first type relates to factors external to the men, such as loss of family, friends; loss of occupation; and health and biological changes like illness and old age. The second type relates to their upbringing which led to life long isolation and disaffiliation. The third type relates to society which labels and expels them because of imprisonment, alcoholism etc. The authors found that the third factor was the most common cause of disaffiliation among the men they studied (Bahr & Caplow, 1973).

Wiseman described the personality characteristics of the skid row men. They are mainly oriented towards the present with no consideration for the future or the value of time. Other characteristics were the feeling of powerlessness coupled with the necessity to be 'streetwise' in order to survive, and the independence from others with occasional acceptance of dependence from time to time. They also have the sense of adjustment to the transient way of life in money, social relationships and housing needs (Wiseman, 1970).

Rivlin (1986) described many types of homelessness. She distinguishes between the 'visible' and the 'invisible' homeless. The invisible homeless are people who find shelter with friends or family- though clearly these people have affiliative bonds. She also classified homelessness according to the period of being homeless. This included overlapping forms of homelessness; chronic, periodic, temporary, and total homelessness. In the total homelessness there is a complete loss of both the shelter and the affiliative bonds (Rivlin, 1986b).

In Britain under the terms of the 1948 National Assistance Act, the National Assistance Board had a duty to make provision for persons "without a settled way of life". Both the 1966 National Assistance Board survey 'Homeless Single Persons' and the OPCS1972 survey 'Hostels and Lodging Houses for Single People' adopted a similar definition of these people "without a settled way of life". Their definition avoided using "social labels" because "alcoholics, ex-prisoners, and ex-psychiatric patients, some of whom were known to use reception centres, also include people who have accommodation". They decided to "aim the survey at the accommodation and situations where experience suggested that unsettled persons could be found" (Digby, 1972).

This study adopted the operational definition of the National Assistance Board which defined homeless people as the people who use hostels, hotels and other forms of temporary accommodation. This definition provides a more practical sampling frame for study purposes compared with other more theoretical definitions. Applying this definition broadly to the accommodation and situations of homeless people in Bloomsbury Health District, they can be classified into three separate groups (Cumming et al, 1986):

1.Homeless families living in temporary accommodation such as hotels and bed and breakfasts.
2.Single homeless persons who live in hostels and lodging houses.
3.Single homeless people who are living rough sleeping on the streets and using night shelters sporadically.

The first part of this thesis involved comparing homeless clients (from all of these three groups) with home-based clients of the community psychiatric nursing service in Bloomsbury. The second part surveyed the problems and the needs for mental health services of single homeless men living in hostels (which is still the main form of accommodation for homeless people in Britain) in Bloomsbury Health District. This survey sample was then compared with a sample of chronic mentally ill patients. The third part compared the Bloomsbury hostels' sample with a sample from New York shelter.

2.1.2.Historical Background:

Over the ages, homeless people have been viewed as a deviant group and been labelled by society in different ways, often suggesting that they were undeserving social inadequates rather than poor people in need of affordable housing. This section is important in setting the scene for understanding society's reaction to homeless people. The current views about the mechanism and methods of how society views homeless people will be explored in another section.

One of the first written records of homeless people was a German book titled 'Liber Vagatorum: Der Betler Orden' by an unknown author in 1509. It was translated into English in 1860 under the title 'The book of vagabonds and beggars with a vocabulary of their language and a preface by Martin Luther'. The book describes the types of vagabonds and beggars, their 'deviant' behaviour and their language. Luther in his preface suggested that this book could help princes, lords etc. to 'understand how mightily the Devil rules in this world'(Hotten, 1860).

Ribton-Turner (1887) studied the socio-economic roots of homelessness and produced the most comprehensive history of homelessness under the title "A history of vagrants and vagrancy and beggars and begging". His book traces the earliest references to homelessness in Britain to the Roman period where the Scots were reported to be the majority of vagrants (Ribton-Turner, 1887). The socio-economic approach taken in this book has been seen by some contemporary sociologists as a far better approach to studying the problem than today's focus, which tends to give the homeless different labels such as 'criminal', 'alcoholic' or 'mentally ill' (Archard, 1979b).

Thomas Holmes who was the secretary of the Howard Association and a retired police court officer wrote a book under the title 'London's underworld' in which he tried to use the 'psychiatric epidemiology' available at that time from the statistics of the Royal Commission on the care of the feeble- minded (Johnes, 1972) to prove that homeless people were idiots, imbeciles, feeble-minded, insane or demented, and suggested a 'national plan for -their- permanent detention, segregation and control' (Johnes, 1972). The same attitude resulted in the Vagrancy Act of 1824 which was used as a criminalising instrument by which vagrancy could be controlled. Under this Act constables had responsibility for controlling 'vagrants' as potential criminals and as threats to society's structure and stability (Steedman, 1984).

A new development was the work of Edwin Chadwick on the relationship between poverty and ill health (Chadwick, 1842) and the public pressure created by the National Association for the Care of the Feeble-Minded which was established in 1896 (Johnes, 1972).

This changed society's attitude towards poor people in general and the homeless in particular. This led in 1909 to the Royal Commission on the Poor Law which adopted the principle that society's responsibility was to 'treat' the vagrants rather than to punish or detain (Lodge Patch, 1971). This change of the legal definition of the homeless by the state may have reflected the change of society's perception of the homeless from criminals to ill people who needed treatment.

In 1948 the National Assistance Act placed the responsibility on local social services for providing temporary accommodation to "persons without a settled way of living...in reception centres". Later a number of specialised hostels were established to carry out the same responsibilities (Drake et al, 1981). The Act was based on the assumption that homelessness is a need for temporary accommodation. This has led to placing the homeless in unsatisfactory living conditions particularly families who are homeless (Richards, 1981) (Sandford, 1976).

The Housing Act of 1977 gave preference to "Distressed families whose lack of accommodation was not of their own making". This has added to the problems of single homeless people and left a lot of them without proper accommodation. The Act required special vulnerability criteria (which include mental illnesses) to make the homeless person eligible for Local Authority assistance. This has caused single homeless people to be in need of a medically defined and applied label to enable them to be eligible for help (Drake et al, 1981)(Richards, 1981)(Rogers, 1989).

Society has regarded homeless people as undeserving poor and labelled them in different ways; from spiritually weak and criminals to skid row alcoholic (see table I.1). Now homelessness is seen as a mental health service problem that resulted from community care policies (Bassuk et al, 1984)(Weller, 1989). This new focus has shifted the emphasis from the need for decent housing for these people (Goering et al, 1990) to the need for asylums (Elpers, 1987)(The third King'S Fund form, 1987).

As difficult as it is to define "homelessness", it is also difficult to estimate their numbers accurately. In 1844 Engels described the poverty and deprivation of the working class in England. He counted 50,000 homeless persons in London alone (Engels, 1969). OPCS conducted a survey of hostels and lodging houses in 1972. They estimated that the number of people living in these hostels was 2,200 women and 23,300 men (Digby, 1972).

Recently the Salvation Army sponsored a survey to estimate the number of homeless people in London. The survey estimated the number at 130,000 persons who either sleep rough, in squats or badly equipped hotels or hostels (Canter et al, 1989). This constitutes 13 per 1000 of the population in London. Although it is difficult to compare these numbers over time it is likely that the change reflects a real increase in the numbers of homeless people.

The present accommodation for many single homeless people (after the closure of Camberwell and other reception centres) is in hostels and lodging houses provided by local authorities or voluntary organisations. In addition to this there are people who sleep rough in archways and under railway bridges. This latter group has certainly increased in recent years (Malpass, 1986).

2.1.3. Defining chronic mental illness:

The current public image of the homeless is that they are primarily chronic mentally ill people (Weller, 1986),(Weller, 1989)&(Bassuk et al, 1984). One of the difficulties of proving or refuting this assumption is the problem of defining and measuring chronic mental illness. One of the best definitions of the chronic mentally ill is that of the prominent American sociologist Leona Bachrach who defined the chronic mentally ill as "people who, but for the deinstituionalisation movement might be in public hospitals like state hospitals (asylums) (Bachrach, 1983). This definition implies the presence of certain degree of dependency, disability and need.

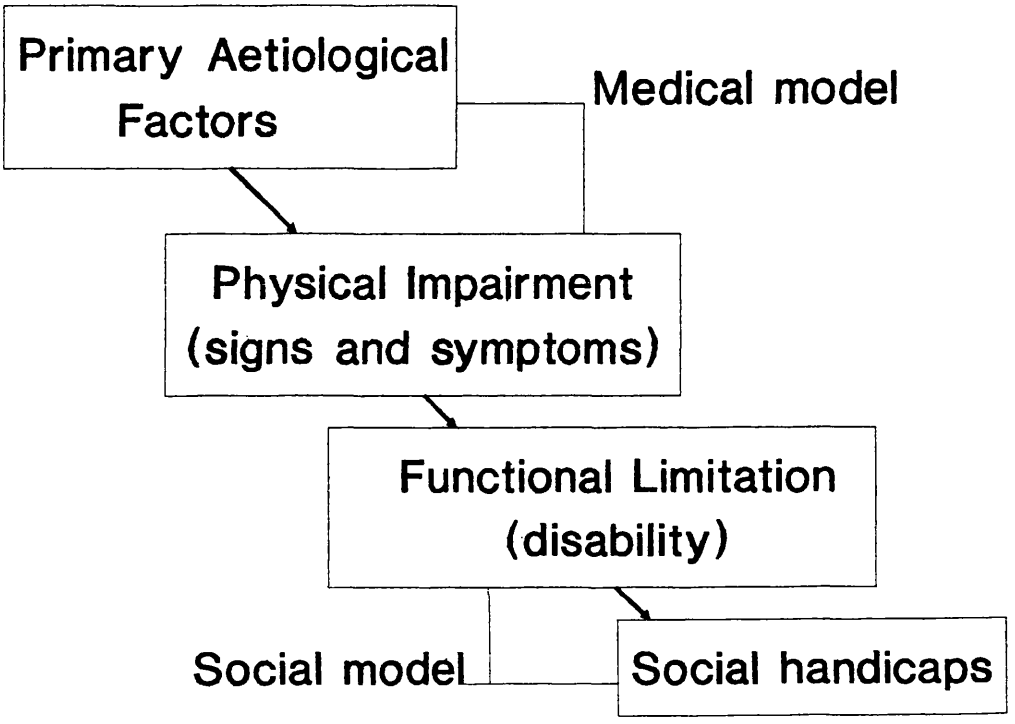
Many of the research projects which investigated the problem of the homeless mentally ill depended only on a diagnosis of functional psychiatric disorders as the sole indicator of the presence of the chronic mental illness among the homeless.Diagnosis is not a good measure of dependency or disability (Wing, 1989) (Sturt & Wykes, 1987) nor of need (Bebbington, 1990). There is also the question of reliability of the psychiatric diagnoses, especially when used with homeless people (Shanks, 1981)(Priest, 1976).

The World Health Organisation in the international classification of impairment and handicaps adopted a disease model which covers both the medical and the social dimensions of illness (see figure-1) (WHO, 1980). In this model impairment includes signs and symptoms that doctors elicit to reach a diagnosis which reflects the presence of an organic dysfunction. In mental health, impairment is described in phenomenological terms and is defined by psychiatric diagnosis (Wing et al, 1974).

Disability -according to the WHO model- is defined as the functional limitation of a person's social role due to primary impairment (Wing, 1972). Handicaps are mainly social in nature, depend on society's expectations of the person and his problems which influence the underlying impairment (Miles, 1981)(Miles, 1984).

Figure-I.1

WHO model of impairment and handicaps



The disease model in psychiatry is far from perfect -particularly in functional psychiatric disorders (Wing et al, 1974). The diagnosis of coronary artery disease from a chest pain can be confirmed by ECG. There is no such technique -nor any demonstrable organic dysfunction- to validate the symptoms of the majority of psychiatric illnesses. The diagnosis rests on the patient's self report of symptoms and experiences which psychiatrists try to fit into syndromes (Wing et al, 1974). This diagnosis based upon symptoms assumes the presence of an underlying psychopathology (Clare, 1979).

There are many schools of thought in understanding, explaining and describing clinical psychopathology that vary from the psychoanalytically oriented schools to the behavioural ones (Eisdorfer, 1981). The difference in the way the clinician explains the psychopathology has been shown to affect the reliability of the diagnosis (Cooper et al, 1972).

The reliability, as measured by the level of agreement of psychiatric diagnosis in clinical practice, remains as low as 30-40% (Mann & Murray, 1979). The most widely used system of classification for psychiatric disorder is the International Classification of Diseases, version 9 (ICD-9). This system has no specific operational guidelines for making diagnoses (Skodol & Spitzer, 1982). The American Psychiatric Association therefore introduced standardised definitions and a multi-axial system to the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Skodol & Spitzer, 1982)&(American Psychiatric Association, 1987). The WHO had introduced a similar DSMIII approach (definitions and multi-axial system) to the 10th version of the ICD (WHO, 1988). There were also attempts to standardise psychiatric diagnosis using a computer programme to enhance its reliability (Wing et al, 1974).

In spite of all these developments in standardising psychiatric diagnosis, the findings of the WHO International Pilot study of Schizophrenia (WHO 1973, 1979) showed striking differences in the outcome of the same disorder between the developing and developed countries. A two-years follow-up showed that a significantly higher proportion of the people with schizophrenia in developing countries exhibited a milder course than those patients in the developed countries. The level of symptoms recorded on the PSE also showed a

different pattern in the two situations (World Health Organization, 1979).

Wing and Brown (1970) showed that some of the symptoms, which used to be considered as part of the syndrome of schizophrenia, can be the result of an institutional environment (Wing & Brown, 1970). Sociological studies showed that the social characteristics (race, gender, social class etc.) of both psychiatrists and patients are strong determinants of psychiatric diagnosis (Killian & Killian, 1990).

These and the findings of other studies have shown that the implication of diagnosis for assessment, rehabilitation and the prognosis of chronic mental illness is debatable (Anthony et al, 1986),(Anonymous, 1988a),(Schinnar et al, 1990)&(Fenton & McGlashan, 1987). This might be due to the fact that psychiatric diagnosis excludes the social element in the definition and classification of psychiatric symptoms (Wing, 1989).

There is a much larger social element in the causation, course and outcome of mental health problems compared with physical problems (Miles, 1981)(Eisenberg, 1988)(Kostrzewski, 1979). The disability in mental illness (social disablement) is mainly related to the social behaviours, roles and functions of the patient (Wykes, 1990)(Wing, 1989). It is defined as "The degree to which the individual falls short of social performance which is generally expected within a given society and by the individual concerned" (Wing, 1972). There is a need for a wider use of the more objective and reliable disability assessment procedures in the evaluation of chronic mental illness (Goldman, 1984).

The definition of the chronic mentally ill implies a certain degree of

disability and dependency for which diagnosis is an insufficient measure. Also the reliability of diagnosis in a group that live in a different social and environmental conditions -such as homeless people- is questionable (Killian & Killian, 1990)(Shanks, 1981). For these reasons, a more reliable way of measuring the prevalence of chronic mental illness would be to measure social disablement. This could be achieved be comparing the disablement of a sample of the homeless with the disablement of those in contact with psychiatric services for the chronic mentally ill.

2.1.4 Social functioning and social disablement:

There is currently an increased awareness of the importance of assessing social functioning as a dimension of health and mental health (Patrick & Bergner, 1990). Social functioning as a dimension of mental illnesses has been found to require assessment and treatment in its own right (Remington & Tyrer, 1979).

Wykes (1990) has identified three different levels of social functioning. The first is social attainments which cover the broad measure of individual function in the community and can be measured by employment history, marital history etc. Social roles are the next layer and are measured as performance in certain roles and usually include the subject's self assessment of their functioning. As the chronic mentally ill at some stages lack the insight into their own level of functioning and tend to have a narrower range of functioning than healthier individuals, a further level of assessment is needed, instrumental behaviours, which are detailed components of social roles (Wykes, 1990).

There are several instruments that have been devised to measure social functioning in its different layers. Some of these instruments are self reported and usually measure the two outer layers of functioning like the Social Performance Schedule (SPS)(Hurry et al, 1983) the Social Functioning Schedule (Remington & Tyrer, 1979) the Social Adjustment Scale (SAS), the Social Maladjustment Schedule (SMS) and the Social Problem Questionnaire (SPQ) (John et al, 1987). There are three reasons why these are unsuitable for assessing the more disabled or institutionalised groups: (i) The underlying normality assumptions; these schedules have been developed and validated on normal people. (ii) self report schedules assume full insight of the respondent. (iii) The range of activities measured by these schedules which extend from home management and child care to employment and finance management and which the chronic mentally ill have not much opportunity to perform them.

Of the many schedules that have been used to measure the instrumental behaviours in the chronic mentally ill, the Social Behaviour Schedule (SBS) (Wykes & Sturt, 1986) and the REHAB Schedules (Hall & Baker, 1983) are the best known and widely used in Britain. They both measure instrumental behaviours which are important in assessing the need for and outcome of rehabilitation. They are both informant driven and the SBS needs an interviewer to score the key-informant's observations.

Falloon and Marshall had followed two groups of people with chronic mental illnesses selected according to their social behaviour. The authors found that social behaviour could predict the significantly different outcome of rehabilitation in the two groups (Falloon & Marshall, 1983).

While diagnosis has been found to be a poor predictor of the outcome of rehabilitation (Anthony et al, 1986)(Anonymous, 1988a), social behaviour has been shown to be highly correlated with the degree of dependency on different psychiatric services and is more predicative than psychiatric symptoms (Sturt & Wykes, 1987) (Fenton & McGlashan, 1987). This made it an ideal instrument to contribute to an assessment of need for community mental health services (Wykes et al, 1985).

Very few studies have tried to investigate the prevalence of social behaviour disabilities in a community sample. Hurry et al (1983) surveyed 800 individuals using the Present State Examination. In the second stage of the survey they interviewed all the individuals identified as cases(n=82) and a sample of the non-cases.

In the second set of interviews Hurry et al used the Social Performance Schedule. This schedule covers eight areas of social role; household management; employment; management of money; child care; intimate relationships; other relationships; social presentation of self and coping with emergencies. They showed that social disability was highly correlated with the presence of psychiatric symptoms. For a given psychiatric disorder, men showed poorer social performance than women (Hurry et al, 1983).

Wykes and Sturt (1986) described the history, development, and reliability assessment of the Social Behaviour Schedule (SBS). The SBS covers 21 behavioural areas that have been shown by previous research to describe the major difficulties exhibited by psychiatric patients with long term impairments (Wykes & Sturt, 1986).

The reliability of the schedule has been assessed by comparing different scores for the same patients from different raters and informants. They tested and re-tested the schedule after a period of time (9 months), and the differences between different settings for patients in the community (the hostel staff and staff of a day hospital). The schedule was shown to be highly reliable in all these circumstances. As the information was gathered from the staff rather than the patients themselves from their observation of patients' behaviour over the previous month, it was difficult in practical terms to assess the validity of one month's observations. However a recent study has shown a high correlation between high SBS scores and SPS (Sturt & Wykes, 1987). The authors suggested that "the behaviour-oriented approach may prove to be the basis for a culture free form of assessment of the kind which cannot be offered by alternative social role approaches" (Wykes & Sturt, 1986).

Leach and Wing in 1979 suggested that the cause of destitution is a combination of disability and social disadvantage and frequently an interaction between the two (Leach & Wing, 1980). The authors suggested that destitute people need rehabilitation (Leach & Wing, 1980). Since then no one has taken this issue further in assessing social functioning or assessing the individual needs of these people for rehabilitation and community care.

Bachrach (1987) described the conceptual difficulties of assessing disability among the homeless. She argued that in addition to the problems of defining homelessness, mental illness and the relationship between them, it is difficult to differentiate between impairment, disablement and handicaps (see figure-1) and their relationship to mental illness in the homeless. In these people many other social and environmental factors could confound its interpretation (Bachrach, 1987).

In the current study, one dimension of disablement was measured in the homeless and compared with that of chronic mentally ill people in contact with psychiatric services. Social roles measure a wider range of functions which most of the homeless have no opportunity to perform. Therefore, the instrumental behaviour was measured in this population. The Social Behaviour schedule was used for that purpose because it is a reliable instrument which has been validated in hospital and community settings (Wykes & Sturt, 1986). It also has normative data for different levels of dependency on services. This makes it possible to compare homeless people's social disablement with that of chronic mentally ill who have different levels of dependency.

The assessment of social functioning and social disablement is ideal to identify and assess the homeless mentally ill. The social behaviour schedule fulfils the need for a reliable assessment procedure within a social, rehabilitative context to contribute to the assessment of the need of homeless people for community mental health services.

2.1.5. The need for health and mental health care:

Health care programmes are built on the assumption that they are meeting some of the health needs of the population. This has made the definition, measurement and assessment of the needs for health care and the degree to which different programmes met these needs one of the basic questions in health care research (Donabedian, 1974). In addition to the professional estimate of problems or situations that require care, the needs for health care also include consumer expectations, opinions and interpretation concerning that care (Holland, 1983).

The need could be 'professionally defined' if it were to be measured according to standards laid down by health professionals. These standards are usually derived from facts about the nature, extent and severity of health problems. The other important aspect of need is the 'perceived need' (Abramson, 1984) or 'want' (Holland, 1983) as stated by patients or the population served by the service. Demand is another dimension of the need for health care. It is also called 'perceived need' and relate to these needs that result in care seeking behaviour and is measured by assessing utilisation of services and waiting lists (Holland, 1983).

There are two main approaches in assessing the professionally defined need. The first is a 'humanitarian' approach in which need is seen as an equivalent to any disturbance in health and well being (Donabedian, 1974). In contrast the 'realistic' approach defines need in terms of the expertise of health professionals and the resources available (Acheson, 1978).

Donabedian argued that as need is a 'service requiring potential' it could be translated into its service 'equivalents'. This means that the statement of need for health care could be made in terms of the services or interventions that may be deployed to meet the need. He also suggested that services could be translated into their capacity to satisfy need or into the resources required to produce services (Donabedian, 1974). He introduced in this concept the 'need for' particular interventions.

The determination of need for health care should be achieved by joint participation of both professionals and clients towards the process of planning health services (Magi & Allander, 1981). The importance of clients' (or potential clients') views and priorities "lay defined need" -though usually different from professionals defined needs (Magi & Allander, 1981)&(MacCarthy et al, 1986)- is very important for the health and mental health services. It has been found that the "lay defined need" of clients with severe mental disorders predict their motivation and utilisation of services reliably (MacCarthy et al, 1986).

Wing defined mental health care as the interventions that are necessary to reduce social disablement or to enable other caring agents to do so within what is possible with the current state of knowledge (Wing, 1990). There are some who argue that the boundaries of mental health services should include only the range of major psychiatric illness that psychiatrists are trained to diagnose and treat (Richman & Barry, 1985).

Psychiatric diagnosis alone is not a good indicator for needs for mental health services for the following reasons:
(i) It does not denote a plane of clinical action nor does it define the person as needing medical care (Kendell, 1975).

(ii) Case definition of psychiatric community surveys tend to over estimate the need for psychiatric services (Bebbington, 1990).
(iii) Social disablement is a more satisfactory measure of the need for psychiatric services (Wing, 1990).
Because of these problems, Bebbington suggested the use of 'needs assessment procedures' rather than diagnostic procedures to assess needs for psychiatric treatment in community surveys (Bebbington, 1990).

Stewart classified need assessment in community mental health care into three components. The first component is whether there is an identified 'problem' within the social context of the patient. The second component is the presence of 'desire' of the person or the community to solve the problem and the third component is the 'solution' which is based on the analysis of the problem and the desire, and addressing the action taken to solve the problem. The author suggests that although the "solution" may flow from the description of the problem, in most cases there is a need for more information about the desire (Stewart, 1979).

There are two approaches in assessing need for community mental health care. The first approach is to define need in terms of the problem or the deficit of functioning without mentioning the need equivalents (Falloon & Marshall, 1983)&(Quarry & Rayner, 1988). The second approach is to define particular forms of intervention needed (need equivalents). Wykes and colleagues made their judgement of need based on information collected from staff members, patients, records and the relatives. This information together with both staff judgement and client perception of needs was used to rate the 13 categories which constituted a professionally defined needs equivalents (Wykes et al, 1982a)&(Wykes et al, 1985). Similar methods have been used to assess the need for a particular intervention (Cutler, 1986)&(Randolph et al, 1986).

The most common criticism of the need assessment procedures used in mental health care is that they include a strong value judgement element (Magi & Allander, 1981)&(Royse & Drude, 1982). This value judgment originates from different services or assessors' ideology and philosophy in the form, priorities, aims and targets of service provision. It has been suggested that using already established needs assessment instruments could lessen the effect of the value judgement element, and make comparison with other studies and other situation possible (Royse & Drude, 1982)&(Wing, 1990).

Brewin et al described a more sophisticated procedure for need assessment developed from the Wykes above mentioned method (Wykes et al, 1982a)&(Wykes et al, 1985). This procedure includes assessment of psychiatric symptoms, social functioning, social networks, attitude of patient and relatives, and information about interventions and their effectiveness (Brewin et al, 1987)(Brugha et al, 1988)(Brewin et al, 1988). The procedure also includes a detailed assessment of the physical health needs and pathological screening (Brugha et al, 1989). For the purpose of this study the sort of information needed by Brewins' procedure was not available from most of the homeless individuals.

It was decided to use Wykes' earlier version which is more suitable for community survey on people not in contact with psychiatric services. There are normative data for Wykes' procedure on the needs of the people in contact with community psychiatric services (Wykes et al, 1982a)(Wykes et al, 1985).

2.2 **Homelessness origins and consequences:**

The causes of homelessness are numerous and remain a controversial subject. Below is a review of the current sociological thinking about the social origins of homelessness and how society defined homeless people and treated them in different ways at different times. The health and mental health consequences of homelessness and homeless peoples' access to health services are reviewed in an attempt to explain the presence of unmet needs for health and mental health services.

2.2.1.Social origins of homelessness:

Homelessness is only one manifestation of the most acute and visible form of class poverty and powerlessness that affects a large section of the lower class in Britain today (Brandon, 1974).

The current Government in Britain has cut back public expenditure on housing from 6.6 billion pounds in 1979 to 2.1 billion pounds in 1985 (Malpass, 1986). The housing share of public expenditure was also cut from 7% in the mid seventies to 2% in 1978-88 (Malpass, 1986). In a report in 1985 the British Association of Social Workers showed the depth of the problem. 53% of all repossession orders were where the owner had had a local authority mortgage. Between 1978 and 1985 there was a shortfall of 750,000 new homes due to inadequate Government spending on housing programmes (Clode, 1985). The Government's policy of reducing spending on housing programmes, high unemployment and cuts in housing and other benefits have been suggested as the major cause of increasing homelessness (Randall et al, 1986).

Archard noted that in spite of the obvious socio-economic origin of homelessness, studies on the homeless had concentrated on the "biographic details of vagrants' moral career" and avoided investigating wider socio-economic factors (Archard, 1979b).

Homelessness of families has usually been seen by society as principally a housing problem while homelessness of single people has been seen as a product of individual inadequacy or abnormality (Beresford, 1974). This has caused the latter group to be exposed to the control by law and correction and later to the diagnosis and treatment by doctors and social workers.

Cooper stated that homeless people are "waste -in the capitalist socio-economic machine- whether they are seen as waste product or as unusable is irrelevant, the point is that they form a human residue" (Cooper, 1979). As the homeless refused to share societal values they were defined as deviant rather than merely eccentric. With the increase in the size of homeless population, society started perceiving them as "an urban guerrilla force" which threatened to disrupt the order of the society (Cook & Braithwaite, 1979).

Sociologists have tried to define the problem of homelessness in term of deviance and social control theory. This theory states that deviance is a behaviour that contravenes the norms of society and social control is the societal reaction to this deviance by labelling, sanction, treatment or control of such behaviour (Clinard & Meier, 1985).

Archard reviewed the ideologies and the institutions that tried to control homeless alcoholics. He described the way in which social work and medical models of care replaced the moral and legal control methods (see table-1). He noted how religious charities which work with the homeless have recently changed their philosophy of control from spiritual salvation to a more socio-medical approach (Archard, 1979a). It is interesting that some of these ideologies or combination of them are still in action today. Loveland in a study of two cities in California found that homelessness is viewed as a policing rather than a housing issue. He noted that this ideology had temporarily changed after October 1989 earthquake and when homelessness became 'normal'. In that period homelessness was viewed -even by the most right wing politicians- as a housing need (Loveland, 1990).

Table-I.1
Social control matrix of the homeless people After (Archard, 1979a)

Dominant ideological base	Definition of the problem of single homeless	Main strategy of treatment	Treatment institutions
Moral/ religious	Spiritual	Salvation	Missions
Penal	An offender	Correction	Polic cells, courts, prisons
Medico-social	Alcoholic/ social inadequate	Treatment/ rehabilitation	Alcoholism services/ shop fronts
Psychiatric	Mentally ill	Institutional treatment	Big shelters/ Mental hospitals

Miller, in his review of the literature on the homeless alcoholics (Skid Row), suggested that the visible sub-culture of drinking residents had shaped the public image of Skid Row residents as problem drinkers (Miller, 1982). In fact, Bahr and Caplow found that many of the Skid Row men were not drinkers at all and many more were not problem drinkers (Bahr & Caplow, 1973). They compared a sample of skid row men with a sample of poor men in another area and another from a rich area. They found that Skid Row men did not differ much from the poor area men but both differed largely from the men from the rich area (Bahr & Caplow, 1973).

In spite of the obvious socio-economic factors in the causation of homelessness in all its types, researchers tended to study the characteristics of the homeless that are shaped by the public image of this group (Culhane, 1991). These images often influence decision-makers and service providers (Rosenheck & Leda, 1991). Few studies have challenged this trend and used proper survey methods (Bahr & Caplow, 1973).

2.2.2.Urbanisation and poverty:

Urbanisation is "the relative increase of the urban population to the total population". It is due to the rapid rate of the rural population growth which pushes the landless farmers into cities on one hand and on the other the economic force of the cities that pulls rural population toward them (Harpham et al, 1988).

It has been suggested that the largest contribution to urbanisation comes from the natural increase of the urban population itself (65%) (United Nation Centre for Human Settlement, 1982). The lack of available and affordable accommodation in the city pushes the people into slums and squatter settlements and other unsuitable accommodation (Harpham et al, 1988).

In Britain the rapid growth of the urban population started with industrialisation which resulted in the over-crowded and insanitary living conditions in city slums (Hailey, 1974). Edwin Chadwick, through his interest in the living conditions of the poor who lived in the slums of East London in the beginning of the 19th century, studied the effect of poverty on health. His 'Survey into the sanitary condition of the labouring class in Great Britain' was a starting point in the development of public health (Chadwick, 1842).

Oscar Lewis, an American anthropologist, had tried to develop the notion of the 'sub-culture of poverty'. He noticed the remarkable similarities between lower class settlements in London, Paris, Glasgow, Harlem, and Mexico City. He described the social characteristics of this sub-culture as crowded quarters, lack of privacy, gregariousness, a high incidence of alcoholism, frequent resort to violence, early initiation into sex, free union or consensual marriages, high incidence of abandonment of wife and children, male superiority and a martyr complex among women (Lewis, 1965). Sabin tried to define the psychological differences that characterise the subculture of poverty. These characteristics are the different conceptualisation of time, the different linguistic forms and the beliefs about the locus of control which is usually attributed to fate and luck (Sabin, 1970).

Townsend questioned the bias of Lewis's characteristics as they were formulated in terms of his middle-class values (Townsend, 1979). Wikan in a study of a poor district in Cairo, challenged Lewis's views. She stated that poverty was not created by the poor but by political and economic circumstances in the community. She quoted Valentine who suggested that Lewis's 'subculture of poverty' notion leads to the conclusion that the poor 'must become "middle class", perhaps through "psychiatric treatment"' (Wikan, 1980).

Poverty is an important aspect of urbanisation and urban life. As the city grow richer, it creates poor, low paid groups who are marginalised in the slums and the poor districts of these cities. Although some authors tried to blame these people for their poverty and marginalisation, the reality is that these people were pushed into the cycle of disadvantage by factors outside their control and need help from society to break the vicious cycle (Rutter & Madge, 1976).

2.2.3.Poverty, housing and health

Townsend argued that the problem of slums and inappropriate housing cannot be explained without a knowledge of the operation of different institutions of the housing market, ownership of the land, personal incomes, deprivation and unemployment. In his study he found that the most important factor associated with housing deprivation was being in the lower social class (Townsend, 1979).

Austerberry et al in a study of 1,841 homeless households in London found that there were more homeless families in inner London compared with outer London. They also found over-representation of non whites and higher unemployment or work in low paid jobs among the sample compared with the London population. This suggests a strong association between poverty and homelessness. In the same study, a strong association between health and homelessness was found. This was mainly due to the presence of illnesses that were caused by poor housing in the sample (Austerberry et al, 1984).

The urban poor are vulnerable to different health problems because of poor personal and environmental hygiene. Housing is a very important part of their environment and plays an important role in physical and mental health (Lowry, 1989b). Factors like humidity and temperature (Lowry, 1989a), indoor air quality (Lowry, 1989d), sanitation (Lowry, 1990), noise (Lowry, 1989c), lack of space , and domestic lighting are important factors in housing conditions that influence both physical and mental health (Freeman, 1984). Curtis studied the link between individual morbidity and living in deprived area in three London Health Districts. She found that people in deprived areas had more health problems and were more likely to consult their doctors than those living in more affluent areas (Curtis, 1990).

Faris and Dunham, in 1935, in a classic study of mental hospital admissions for schizophrenia and depression, studied the distribution of admissions according to the social geography of Chicago. They found that there was a 10 fold higher admission rate in the inner city area compared with the higher class suburbs (Faris & Dunham, 1939).

Studies which compared urban populations with those of rural areas have found an excess of psychiatric morbidity in the urban areas (Rutter et al, 1975), (Rutter, 1981), (Brown et al, 1977), (Brown & Harris, 1978) & (Blazer et al, 1985).

Hollingshead and Redlich in 1958 studied people in contact with psychiatric services in New Haven, USA and compared them with a sample from the general population. They found that the lower social classes had a much higher proportion of mental disorders especially psychoses. The authors suggested that the difference could be explained by the different diagnostic and therapeutic practices toward the lower class (Hollingshead & Redlich, 1958). More recent sociological investigations have supported Hollingshead's and Redlich's suggestion (Killian & Killian, 1990).

Urbanisation and poverty is associated with high physical and mental morbidity. The inadequate housing conditions of the poor are important factors in ill-health. The high psychiatric morbidity -especially chronic mental illness- among the lower social classes could also be explained by poverty. Another explanation of this high morbidity was suggested to be contributed to different diagnostic and treatment procedures used by psychiatrists in different social classes.

2.2.4.Homeless people as an at-risk group:

Homelessness is one aspect of severe urban poverty. Homeless people are more vulnerable to the multiple health risks associated with urbanisation and poverty. Both physical and mental health problems of the homeless could be explained in part by their poverty and being disadvantaged.

The loss of home is a life event that might precipitate mental or physical illness (Brown & Harris, 1978). 46% of the women and 38% of the men who were displaced from the slums of West End of Boston, USA were found to have a long-term grief reaction to loss of home (Fried, 1970).

Furthermore, both the life-style of homeless people and the environmental conditions associated with homelessness are causes of health problems. The homeless are vulnerable to the effect of extreme climatic conditions and the difficulties of maintaining their body temperature expose them to health problems that range from hypothermia to heat stroke (Sebastian, 1985) as are the poor in general (see previous section).

The higher prevalence of drinking problems among homeless people -compared with general population- (D'souza & Madden, 1984) make them vulnerable to accidents, physical and mental problems associated with alcoholism and this causes them to neglect their health and not to seek help in time (Shanks, 1983).

People who sleep rough on the streets have extreme difficulty in keeping healthy. They are deprived of warmth, privacy, food, cleanliness, and health care (Wootton, 1985)(Young, 1985). The remaining homeless who usually sleep in hostels or bed and breakfast hotels experience similar difficulties in relation to the lack of privacy, crowding and the lack of washing or cooking facilities (Conway, 1988)(Thomas & Niner, 1989). The constant mobility of the homeless and their wandering around in the day time, and inadequate attention to foot care results in foot and leg ulceration (Sebastian, 1985). This, in addition to the lack of proper and healthy diet (Luder et al, 1989), make them vulnerable to all sorts of health problems and infectious diseases (Laidlaw, 1955).

The mortality of homeless people has been found to be four times higher than the mortality of the general population (Alstrom et al, 1975). There is also an excessive mortality rate recorded in the winter months (Shanks, 1984). The commonest cause of death was found to be accidents (Alstrom et al, 1975)(Centre for Disease Control, 1987) of which most cases (70%) were due to drinking problems (Centre for Disease Control, 1987). Other common causes of death were tuberculosis and other respiratory diseases (Shanks, 1984), cirrhosis of the liver (Alstrom et al, 1975), malignant diseases (Shanks, 1984). Although there may be a pre-existing vulnerability, the excess early mortality could be explained by the stresses of poverty and the lack of economic security (Brenner, 1979) which leads the homeless to neglect their health (Whiteley, 1955).

Socio-economic factors have been shown to affect health in other studies of the homeless. For instance Roper and Boyer in a study of perceived health in 201 homeless men and women in Los Angeles, using logistic regression found that the length of unemployment, education, gender, and number of nights spent in the shelter are best predictors of poor health (Ropers & Boyer, 1987). In addition, Shanks noted that the excess in homeless peoples' consultation rate to his general practice from that of the general population disappeared when he adjusted for the difference in social class (Shanks, 1983). These studies indicate that the health problems of the homeless people are closely related to their poverty and being disadvantaged.

2.2.5.The homeless access to health services:

As discussed in the previous section homelessness increases the need for health care. But, homeless people tend to under-utilise the traditional health services (Shanks, 1983)(Hewetson, 1975). They are less likely to be registered with a GP (Bayliss & Logan, 1986)(Shanks, 1983) and use accident and emergency departments as an alternative (Maitra, 1982)(Victor et al, 1989)(Powell, 1987a). They also tend to neglect their health problems until an advanced stage (Shanks, 1988)(Powell, 1987b).

Shanks in 1983 described the establishment of separate primary care services for the homeless and rootless population in Manchester. He reviewed the cases seen in the first quarter of 1981 and found that there was a high incidence of chronic alcoholism and medical morbidity.

Shanks concluded that the problem in caring for these people lay not so much in the availability of care as its delivery. These people failed to use the mainstream medical services because they were suspicious of normal social mechanisms and conventional channels of care. In addition the lack of co-operation between various health and social services diminished the impact of any successful service in the field. He recommended encouraging doctors trained in relevant specialities to work with homeless people, appointing a salaried doctor to deal with this special group, full co-operation between the agencies concerned in order to define a common approach toward dealing with homeless peoples' problems (Shanks, 1983).

Powell in 1987 described a study to evaluate a primary health care scheme which was operated by house doctors working -in hostels- with single homeless hostel dwellers in Edinburgh. The study showed a high health care burden from the chronic handicapping conditions of this population. The scheme was acceptable to hostel dwellers and staff. Female hostel residents requested a female practitioner within the scheme to work with them. The author discussed ways of improving the service through integrating it with the main stream health care provision with more involvement from other services particularly psychiatric and social work (Powell, 1987b).

Shanks in 1988 carried out a prospective study over a period of three years to assess the morbidity of homeless people in Manchester. Compared with the general population -adjusted for social class- homeless people had a similar overall consultation rate, although they showed a very different morbidity pattern. The homeless had a higher number of consultations for psychiatric and dermatological conditions which was balanced by a low consultation rates for cardiovascular and musculoskeletalconditions. He suggested that the information collected by cross- sectional studies tended to overstate the true morbidity of the homeless because of the mixing of current disease problems with previously untreated chronic diseases that were due to homeless people's difficulties in gaining access to health care. Shanks recorded only one diagnosis per consultation although he noted that these patients usually presented with more than one problem (Shanks, 1988).

Maitra in 1982 tried to compare the consultations to the Accident and Emergency Department in Newcastle of 73 single homeless patients of no fixed abode with an age matched control group of 75 home-based patients. He discovered that "the homeless, mostly male, unemployed unmarried or divorced or separated were not registered with any general practitioner. Their medical needs were in the main, caused by alcohol abuse, drug overdoses and psychiatric illness". He concluded that the medical treatment of the single homeless should take a multi-faceted approach which tackles alcoholism; unemployment problems; the need for counselling; social; medical and community support as hospital treatment is not enough and these people as a priority group, need a more coherent form of supportive structure (Maitra, 1982).

In the USA, Robertson and Cousineau (1986) studied the health status and access to care as reported by 238 homeless adults sampled from three "lunch lines" and two shelters. Only one-third reported their health as [redacted] poor and women reported more health problems. Most of them were without health insurance (81%) because they could not afford it and because they had no permanent address. They concluded that homeless people have many health problems; face many barriers to necessary medical care and exhibit more costly utilisation patterns because of greater use of in-patient care. The large numbers of homeless people are a challenge to public health which has not yet been met (Robertson & Cousineau, 1986).

Fischer et al concluded that the homeless exhibit patterns of health service utilisation that differ sharply from those of the home-based people. Homeless people had higher rates of hospitalisation for physical and mental disorders but lower ambulatory care. They had fewer social contacts and a higher rate of imprisonment (Fischer et al, 1986).

The studies on the utilisation of health services by homeless people showed that they are less likely to use the mainstream health services and use A&E department at later stages of their illnesses instead. Specialist services that work with the homeless in their hostels, hotels and day centres increase the utilisation to a great degree. There is a need for multi-disciplinary services that target their resources and expertise towards meeting the needs of homeless people.

2.3 Community Care and Homeless people:

Some researchers have tried to implicate community care policies and the closure of mental hospitals as the main causes of homelessness. As we have seen in the previous section, poverty has been the primary cause of homelessness throughout history but society has defined and treated homelessness in a different ways. This section will try to describe the way mental health services changed from the institutional care to community care. Studies which reviewed the contact of homeless people with both hospital and community mental health services are also reviewed and discussed. Then surveys that have tried to prove that homeless people are mentally ill are reviewed. The limitations of these studies are subsequently discussed highlighting the motivations for the current study.

2.3.1.Community and institutional care:

Mental hospitals were first established in the Middle Ages and were for a long time a place to detain the mentally ill to protect society (Johnes, 1972). It was only in the eighteenth century that the inhuman way in which the mentally ill were treated came under criticism (Parry-Jones, 1988). This was mainly pioneered by the French psychiatrist Pinel whose writing has led to the nineteenth century 'Moral Treatment movement' which called for a more humane treatment of the mentally ill (Pinel, 1962).

In Britain and throughout the nineteenth century mental hospitals (Asylums) remained the main model of care of the mentally ill (Parry-Jones, 1988). When the first mental institutions were set up they were relatively humane in nature (Johnes, 1972). Gradually the common features of these asylums became the inhuman living conditions and the authoritarian, brutal treatment of patients (Scull, 1979). They were usually located several miles away from towns and cities.

The establishment of the out-patient clinics in 1920s and the emergence of the welfare state and its institutions after the Second World War paved the way for the 1959 Mental Health Act.
The Royal Commission which issued that law saw an expanding future for community care and the decline of mental hospitals (Johnes, 1972).

Subsequent research findings suggested that asylums are not only inhuman but also pathogenic. Barton described 'institutional neurosis' which results from prolonged stay in mental hospitals as " disease in it's own right" (Barton, 1959). Goffman in his sociological investigations of the organisation and function of asylums described the 'total institution' and how it worked to control patients' behaviour to the benefit of the staff (Goffman, 1961). Wing and Brown demonstrated that the poverty of mental hospitals' environment is responsible for some of the 'negative symptoms' of schizophrenia (Wing & Brown, 1970).

Over the past few years there has been much innovative work on the development of community care services (Hoenig & Hamilton, 1969)(Shepherd & Clare, 1981)(Shepherd, 1989) together with their evaluation (Wing, 1972)(Wing et al, 1974)(Watts & Bennett, 1983).

Governments attempts to implement community care were less innovative. The DHSS White Paper 'Better services for the mentally ill' (1975) set out the make-up of a comprehensive district service. Per 100,000 population the paper recommended that 50 acute psychiatric beds should be available in District General Hospitals, 65 day hospital places, 6-8 short stay hostels beds, 15-24 long stay residential places and 60 day centres places (Department of Health and Social Security, 1975).

The Audit Commission report in 1986 'Making reality of community care' found that the DHSS white paper recommendations were not implemented in many areas and where it was implemented the services were fragmented (Audit Commission, 1986). In many areas, the mental health provision is heavily dependent on institutional care represented by the old, decayed, understaffed mental hospitals that offer very little privacy or dignity (Pilgrim, 1987).

In 1988 the Griffiths Report 'Community care, agenda for action' was published. The report called for clearer policy and adequate resources for community care. It suggested that the services should be provided in packages tailored to meet individual needs; that the responsibility of long-term care of the mentally ill should be given to local government social services, that minimum standard of care should be defined and that a new Ministry of Community Care should be established (Griffith, 1988).

Government's response to the Griffiths Report 'Caring for people' was published at the end of 1989. It recommended the transfer of primary responsibility for the care and assessment of long term after-care, planning and funding of community care projects to local government social services. It also recommended a more flexible way of funding Local Authorities in the form of central government grants (Secretary of State for Health, 1989).

'Caring for people' had made the distinction between social and health care, many find this distinction practically artificial. Also there is a lot of concern about the ability of local authorities to take the responsibility for the care of the chronic mentally ill (Holloway, 1990). A recent survey by Research and Development for Psychiatry showed that community provision for the chronic mentally ill who are resettled from mental hospitals is reasonably adequate. The area of concern is the provision for the new long-stay ie people who are becoming chronic mentally ill and who have never been in mental hospitals (Dass et al, 1990).

Community care started with the concern over the problems of institutional care, aiming to bring back to people with long term needs their right to live in the community. There is a concern that problems of implementation might cause a decline in the quality of care of both hospital and community mental health services (Wilkinson & Freeman, 1986)(Holloway, 1990).

2.3.2.Homeless people and mental health services.

Homeless peoples' needs for mental health services arise from both stresses of poverty (Cochrane, 1985) and that mentally ill people are more likely to become disadvantaged and drift into poverty and homelessness (Miles, 1981).

Many studies have recorded the contact of homeless people with psychiatric services. Whiteley in 1955 studied 130 patients admitted to an observation ward in South London. Those patients gave a reception centre or a common lodging house as their last address. He described the problems of 100 of them and concluded that the 'down and out community' had a higher incidence of mental illness and relapse rate compared with the "normal population". He suggested that the main problem of these men were personality defects which made them unable to establish a relationship with therapists, particularly in a hospital environment. He suggested that a psychiatrist may be able to help these men by holding counselling groups in their residential settings (Whiteley, 1955).

Berry and Orwin in 1966 examined the trend of patients with No Fixed Abode (NFA) admitted to Hollymoor Mental Hospital in the Birmingham area. They surveyed retrospectively, the records of 105 males and 40 females admitted between 1961-1964. The diagnostic categories were mainly schizophrenia (49%)and personality disorder (28%). There were other categories such as subnormality (11%), alcoholism(10%), drug addiction(8%) and epilepsy(6%). 29% of these people had left the hospital contrary to medical advice. The authors attributed the increase of the proportion of NFAs admitted to this hospital with the implementation of the Mental Health Act 1959 (Berry & Orwin, 1966). The authors played down the significance of the continuing re-development of Birmingham City which resulted in the reduction of lodging houses available for the homeless. This could provide an alternative explanation for the increase in psychiatric patients with NFA.

Herzberg in 1987 studied clinical case notes of all homeless women with no fixed abode (NFA) admitted to an East London psychiatric hospital from 1971-1980. He compared them with the case notes of a group of homeless men admitted during the same period. He found that homeless women appeared to have been more socially stable than the men prior to admission but had less satisfactory admissions in term of compliance and premature self -discharge. The author suggested that this may have been due to the fact that people are prepared to tolerate a greater degree of behavioural disturbance from women although it is not clear why more women are referred to hospital by the police under Section 136 and whether the police perceive the disturbed behaviour of the two sexes differently. The homeless women had a higher rate of schizophrenia than men, while the latter had a higher rate of alcoholism than women (Herzberg, 1987).

Although the above mentioned studies gave an important account of the contacts of homeless people, those who are in contact with the traditional (hospital based) psychiatric services do not necessarily represent the homeless population.

Priest in 1976 compared a sample of 79 residents living in common lodging houses in Edinburgh (representative sample) with 44 patients from the same houses admitted to the Royal Edinburgh hospital psychiatric ward or referred to the Out-Patients Department (clinical series). He used the same method of assessment (psychiatric assessment and three psychological tests) for the two groups.

Priest concluded that homeless people who presented to the service are a highly selected group and quite unrepresentative of homeless single people. The persons presented to the service were more likely to exhibit alcoholism or personality disorders. The representative sample from the lodging houses was older with a much higher prevalence of schizophrenia. The author suggested that the under-representation of people with schizophrenia in the clinical series was due to the fact that they preferred the anonymity of the lodging house while the people with alcoholism and personality disorders were more mobile and consulted more frequently. The difference in the psychiatric diagnoses mentioned above were based on clinical assessment. The standardised instruments Personal illness (PI) scale, the Symptom-Sign inventory SSI produce the opposite difference between the two samples; the clinical series had more 'psychoticism' scores on the SSI. Priest blamed this disparity on the validity of homeless patients' reporting to the SSI but did not questioned the validity of his own psychiatric assessment (Priest, 1976).

There have been very few studies on community psychiatric care for homeless people. Leach and Wing had used an 'action research' approach to evaluate the effectiveness of St. Mungo services to rehabilitate homeless men. They found that this approach had improved the effectiveness of the services provided and that a major determinant of outcome two months after discharge was disability (Leach & Wing, 1980). Roth et al in a survey of 979 homeless people in Ohio, USA showed that the mentally ill among homeless people were -at best- only marginally served by mental health services. They concluded that their data showed a high level of unmet need for mental health services but the meeting of these needs should come together with the other very pressing needs of this population. A co-ordinated service that could include all other health, social and welfare service with an outreach element to bring the services to the people who do not present themselves for it because of their illness (Roth et al, 1986)

Wadsworth reviewed the services that community psychiatric nursing service (CPNs) provide to homeless people in Bloomsbury. She described homeless clients of the services and examined the problems that face the CPNs in working with homeless clients. These clients fall in three broad groups; first those who present with disturbed behaviour and who refuse any help; the second group are those with chronic mental illness whose mobility makes it difficult to assess or help them. The third group constitutes mainly young single or separated adults who come down to London looking for work and present to the CPNs with emotional and relationships problems. Homeless clients are usually referred by hostel staff who refer them on the basis of disturbed behaviour or a history of mental hospital admissions (Wadsworth, 1984).

Dato et al described the problem of the homeless mentally ill in USA. She described the difficulty of establishing a base line for psychiatric disability due to the extreme stresses of homelessness itself. She concluded that nurses must continue their pioneer work in outreach psychiatry in soup kitchens, shelters etc., which helps to break down institutional barriers in working with homeless clients. She also warned that the inability of some of the chronic mentally ill to fit into community settings should not be used as an excuse "towards mass institutionalisation that some would favour" (Dato & Rafferty, 1985).

Myerson and Mayer examined the effectiveness of a community based psychiatric service in treating homeless alcoholics. They followed 101 homeless alcoholic (Skid Row) men attending a rehabilitation halfway-house in a Boston Hospital,USA. They compared these men with another 108 homeless alcoholics who received only hospital care. They showed that these individuals were mostly native-born and had a history of deprived childhoods and adolescence with adulthood failure of adjustment to society. They concluded that this failure of adjustment was often the cause of excessive drinking and subsequent trouble with the law. The treatment group spent more time in hospital and became less dependent on community agencies than the comparison group. There were fewer arrests and fewer hospitalisations for alcoholism. They concluded that although the programme was useful, earlier intervention and the co-operation of several community agencies would have been more beneficial (Myerson & Mayer, 1966).

In non-western societies, it has been shown that community care for the homeless is effective in these different cultures. The warm climate of Africa makes the wandering mentally ill a usual scene in towns and villages. Two studies have examined the effectiveness of community care approach in helping homeless people within their cultural background. In the first study, teams of public health workers and social workers were used to identify 40 of these homeless mentally ill in Abeokuta town in Nigeria. Twenty five were diagnosed as having undifferentiated schizophrenia (one had schizo-affective disorder). Two were found to have positive syphilitic antibodies test suggesting the presence of general paralysis of the insane. All the people identified lacked the presence of the negative symptoms of schizophrenia which often accompany institutionalisation. The author suggested the need for psychiatric social workers to make domiciliary visits to patients. Patients in urban areas whose relatives rejected them should be rehabilitated in a village setting (Asuni, 1971).

Harding carried out a day census of the homeless psychotics in a rural community in West Africa. Fifty one people were identified, 48 of them were found to be already in contact with traditional healers. A follow up study of the treatment of these homeless psychotics by traditional healers was then carried out. 24 patients were followed up for 6 months. Physical restraint, herbal therapy and rehabilitation were used to treat these patients. After discharge 12 of the 24 were completely normal, 8 showed some degree of incapacity and 4 were severely incapacitated.

The author concluded that this rural community had a firm belief in supernatural causes of insanity and were reluctant to utilise psychiatric services, using instead traditional healers. The healers should be encouraged to continue practising with support and advice from psychiatric services (Harding, 1973).

Studies that recorded the contacts of homeless people with psychiatric services revealed the complicated and the multi-dimensional nature of their problems. They also shown that traditional psychiatric services were not addressing these problem which left a lot of their needs unmet. On the other hand community psychiatric services that tried to address and target these problems has been reasonably successful even in the most deprived parts of the world.

2.3.3.The homeless mentally ill in USA:

In the USA homelessness is viewed by many politicians and some psychiatrists as a result of de-institutionalisation (Lamb, 1984) (Hartman, 1984a). In spite of the differences in the welfare and health systems in the UK and USA (Freeman, 1983), many people are trying to prove that the American experience is being repeated here with the implementation of community care (Anonymous, 1988b)(David, 1988), so a brief review of the literature from America will be presented here.

Several surveys within the USA have been carried out trying to elucidate the 'new' and the 'old' homeless populations. For instance, Whitley et al (1985) surveyed 2 samples of 133 vagrants living in a hotel and a shelter. The objective was to investigate differences between the old Skid Row population (in the shelter) and the new homeless mentally ill population who lived in hotels. The shelter sample had more mental illnesses than the hotel sample, but in quantitative terms the two samples were not greatly different. It was suggested that the mentally ill could have learnt 'vagrancy behaviour' or that the vagrants had learnt the mentally ill behaviour to be more 'protected' (Whitley et al, 1985). The authors could more simply have concluded that there were no differences between the 'old' and the 'new' homeless.

Fischer et al (1986) compared a sample of 51 homeless men attending four missions in Eastern Baltimore with 1338 persons living in households from the same area. The differences in mental health status, utilisation patterns, and social dysfunction were significant. The homeless sample showed higher distress score as recorded by the General Health Questionnaire and higher prevalence of psychiatric disorders. The authors stated that although the sample was small and the instruments used were not suited for the detection of chronic mental illnesses, a substantial proportion of mission users were characterised as mentally ill and a third reported previous psychiatric hospitalisation (Fischer et al, 1986).

Bassuk et al(1984) reported the result of a one-day census of three night shelters in Boston and Cambridge (USA) during one winter night. 73 men, women, and children were interviewed. A clinician completed a questionnaire about the demographic and clinical and psychiatric variables. 91% of the interviewees were given a psychiatric diagnosis; 40% psychotic, 29% chronic alcoholics, and 21% personality disorders. They concluded that shelters have become alternative institutions instead of any systematic use of psychiatric services. (Bassuk et al, 1984).

Snow et al (1986) adopted a more extensive methodology to study mental problems of the homeless. One of the researchers spent 12 months "hanging out" with the homeless "to get an appreciation of the nature of life on the street from the standpoint of the homeless themselves". They then tracked a random sample of homeless people in Austin.

To assess the mental health status of these individuals they used three criteria; prior institutionalisation, designation as mentally ill by other homeless individuals and conduct so bizarre and institutionally inappropriate that most observers would be likely to consider it as symptomatic of mental illness. The identification of mental illness was made if the person had two of these three criteria. Only 15% of the 911 homeless in the sample were identified as mentally ill. The authors suggested that previous psychiatric studies tended to inflate the figures because the psychiatrists wanted to medicalize these problems. They also suggested that previous studies had depended on a single brief psychiatric interview which may have recorded an adaptation to the difficult situation rather than a psychiatric illness. Moreover psychiatric inventories have been standardised on more domiciled populations.

They concluded that the "most frequent face on the streets is not that of the psychiatrically-impaired individual, but of one caught in a cycle of low paying, dead-end jobs that fail to provide the means to get off and stay off the streets" (Snow et al, 1986).

Roth et al interviewed the largest sample (979) of homeless people in 19 Ohio counties, USA. The researchers used a psychiatric schedule that they adapted to suit the assessment of homeless people's special circumstances. As with Snow et al's study they found that the prevalence of mental illnesses was relatively low compared with previous studies (Roth et al, 1986).

Susser et al interviewed 223 male first time users of New York City shelters. They used a diagnostic interview for psychosis (adapted from DSMIII), an alcoholism screening test and a depression scale to assess the psychiatric problems of these men. They found that only 8% of the sample had a confident diagnosis of schizophrenia. 58% reported a history of drug abuse and 33% were found to be in extreme distress on the depression scale. The authors suggested that the new users have lower psychiatric morbidity (Susser et al, 1989a). The lower psychiatric morbidity, particularly schizophrenia, might reflect the current more cautious attitude of American researchers in estimating it in the homeless (Susser et al, 1989b). It might also indicate a more reliable estimate of chronic mental illness as a result of the use of multi-dimensional assessment procedures which included parameters similar to the SBS items (Susser & Struening, 1990).

In spite of all speculations on the similarities between homeless people in the USA and Britain, there is only one comparison (Priest, 1970). A sample of 50 people from Chicago's Skid Row was compared with 79 residents of an Edinburgh lodging house. There were striking similarities between the two samples. There were some differences in the degree of these features, such as the presence in the Chicago sample of more married men reporting less unemployment, less stability in accommodation and a greater tendency to seek hospital medical care than in the Edinburgh sample. The psychiatric morbidity was also similar although there was an insignificant trend towards a higher proportion of subjects diagnosed as schizophrenics in Edinburgh sample (Priest, 1970).Although assessment was undertaken by the author in both Edinburgh and USA, the study depended on clinical assessment with no information about sampling procedures.

2.3.4. Psychiatric surveys on homeless people in Britain:

In the nineteen thirties George Orwell lived as a homeless person and wrote his memoirs in 'Down and Out in Paris and London'. He wrote "The Paris slums are a gathering-place for eccentric people- people who have fallen into solitary, half-mad grooves of life and given up trying to be normal or decent. Poverty frees them from ordinary standards of behaviour, just as money frees people from work." (Orwell, 1986). However, researchers who conducted interviews with homeless people have explained Orwell's observation in a different way (see table I.2).

Edwards et al (1966) studied 51 alcoholics from a soup kitchen, who had been sleeping rough. 21 of them had drunk crude (methylated) spirits and most of them experienced visual and auditory hallucinations. He suggested that drinking in this group may be a symptom of a central personality disorder (Edwards et al, 1966).

Crossly and Denmark (1966) studied the psychiatric morbidity of 51 residents of a Salvation Army hostel. They found that 33 residents were suffering from personality disorders. 10 of these 33 had been in a mental hospital: 2 for alcoholism: 2 for drug addiction: 2 for attempted suicide and 4 for psychopathic behaviour. Ten out of the 51 suffered from psychotic disorders and 7 of them had been in a mental hospital. The rest were: three of subnormal intelligence and five had physical disabilities (Crossly & Denmark, 1969). They suggested that these findings indicated that people were being discharged into the community who were still in need of 'Asylum'.

Edwards et al (1968) carried out a census of the Camberwell Reception Centre. They found that the elderly latecomers to the Reception Centre were socially inadequate. The young dwellers were mostly 'immigrants' from outside London. They came to the reception centre either because of drinking problems or because of 'gross and positive psychopathy'. 45 % of residents had been arrested for drunkenness although only 24% of the residents were chemically addicted to alcohol which may suggest that a lot of the men were drinking excessively without being addicted. 24% had been in mental hospitals in addition to a further 10% who had received hospital treatment for alcoholism and 59% had been in prison at one time or another(Edwards et al, 1968). The author recommended further research to be conducted on specific groups of the homeless and that the Reception Centre should be replaced by special needs' hostels.

Table I.2
Psychiatric surveys of the homeless people

Author (year)	No	Schizophrenia	Affective dis.	Personality dis.	Other diag.	Substace abuse	No problem
1.Hostels and lodging houses:							
Crossly & Denmark London (1966)	51	20%	-	65%	6%	-	10%
Priest (1970) Edinburagh	77	32%	5%	18%	9%	18%	18%
Lodge Patch London (1971)	122	15%	8%	51%	15%	-	11%
Timms & Fry London (1989)							
-New arrivals	65	25%	6%	11%	-	1.5%	38%
-Residents	58	31%	-	2%	-	-	53%
Marshall Oxford (1989)	43	67%	-	-	37%	-	12%

Table I.2 (continued)
Psychiatric surveys of the homeless people

Author (year)	No	Schizophrenia	Affective dis.	Personality dis.	Other diag.	Substace abuse	No problem
2.Camberwell reception centre (London):							
Edwards et al (1968)	279	-	-	-	-	25%	-
Tidmarsh (1970)							
-New users	130	16%					
-Casual	171	29%					
3.People who sleep rough							
Edwards et al London (1966)	51	-	-	-	-	92%	8%
Weller and Weller London (1986)	72	10%	-	-	55%	-	36%
Weller et al London (1987)	100	42%	-	-	13%	-	45%

In a study of a lodging house, Lodge Patch (1970,71) stated that very few men (11% of the residents) could be considered as normal individuals. 15% of them were diagnosed as schizophrenics and they had previously been in a mental hospital. 19% of these men were alcoholics and 50% had personality disorders. Although 23% had been admitted to a mental hospital in the past, only 5% were receiving any psychiatric treatment. The author suggested that this showed both a failure of community care and inappropriate early discharge. He recommended the co-ordination of lodging houses more closely with hospitals, of providing hostels with more and better-trained staff and to organise hostels within a National Hostel Service which could meet the diverse needs of homeless people (Lodge Patch, 1970)(Lodge Patch, 1971).

Weller and Weller interviewed 42 residents from 3 hostels and 30 from Crisis at Christmas during Christmas Eve/ day in 1985. They found that 55% of the people who completed the questionnaire reported mental illnesses leading to psychiatric treatment. 14% of the people who agreed to discuss psychiatric history 'confessed' to hearing voices. The authors suggested that as wandering is common in psychosis, existing legislation may lead to destitution (Weller & Weller, 1986).

Weller et al interviewed 100 men and women at Crisis at Christmas in 1986. They found that 35.8% of the people who gave information had had inpatient treatment in the past. 31 of the subjects were actively psychotic and 12 of those had never received treatment. 30% had a probable or definite diagnosis of schizophrenia. 78% of the people with psychiatric history had been imprisoned. The authors argued that the presence of a high proportion of mentally ill in their sample called into question the ability of the community services to deal with them (Weller et al, 1987).

Both the two Weller studies had problems with the sampling methods which depended on the presence of homeless people at the site of their field work, therefore it was not a representative sample. In addition they excluded people who were drunk on Christmas day (with no indication of the numbers excluded). The assessment procedures depended mainly on short clinical assessments which were based on the subject's own reporting which was shown to be inconsistent (Shanks, 1981) and might have overestimated psychiatric morbidity (Snow et al, 1986).

The exclusion criteria of drunkenness is obviously going to be affected by time of day. After Christmas lunch the prevalence of drunkenness will naturally increase. There is no indication of time of day of interviews in both studies. It is very difficult therefore to draw any comparisons between the 1985 and 1986 samples.

Marshall surveyed two hostels for homeless people in Oxford. He asked the staff to select the residents with mental disability. The staff selected 48 out of 146 residents. 43 of these subjects had had a previous psychiatric admission. The author used staff as informants to assess the social disability of the residents. He found that the mentally disabled were more likely to have stayed longer in the hostel. He then interviewed the staff to ask them about subjects' behaviour and symptoms. 29 had florid psychotic symptoms, 16 had clinically significant neurotic symptoms and only 5 had no clinically significant symptoms. The conclusion of the study was that hostels are having to care for mentally ill people who are discharged into the community (Marshall, 1989).

The main problem of Marshall study lie in the selection of study sample. The exclusion of people with drinking problems might have biased the results in a similar way to that of Weller's studies. Also there might have been a response bias in the disability assessment due to staff awareness of the research hypothesis (Abramson, 1984)(Rumeau-Rouquette, 1978). The author asked the staff to report the degree of disability of the same residents they had originally selected as disabled.

2.3.5.Limitation of previous psychiatric studies of the homeless:

Surveys of homeless people which aimed at assessing their mental health problems have been described above (see table-2). These studies are often quoted and used without taking into consideration the methodological problems and biases that limit the usefulness and the generalisability of these studies. The methodological difficulties of these studies could be summarised as follows:

1.The problem of operational definition: The operational definition (or working definition) defines the characteristic the study actually measures. It should be phrased in terms of objectively observable facts and be sufficiently clear and explicit to avoid ambiguity (Abramson, 1984).

Homeless people are composed of many non homogeneous sub-groups, as we have seen from earlier discussions but researchers have used incompatible operational definitions of the term 'homeless' (Bachrach, 1984). Most studies have defined them in terms of the accommodation in which these people are living. These studies, however, did not give enough details about the characteristics of the accommodation in which the study took place (Lodge Patch, 1970)(Priest, 1976).

Different forms of accommodation differ in the type of people they accept, the people they exclude and the duration of stay. The lack of analogous operational definitions for studies makes it very difficult to compare their results (Bachrach, 1984).

Milburn and Watts noticed that most of the studies they reviewed used 'a theory based definition' of homelessness. That is, it usually related to the hypothesis the researcher is trying to prove (Milburn & Watts, 1986). In Marshall's study, hostel staff were asked to select residents according to his hypothesis (Marshall, 1989).

The other problem with these studies is that they assume the homogeneity of the homeless population, a fact which is far from true (Milburn & Watts, 1986). For example, Weller et al interviewed people who were sleeping rough with those from hostels without questioning the possible differences between the two populations (Weller & Weller, 1986).

2.Sampling problems: The difficulties that face researchers in sampling partly relate to definition problems and partly to the lack of a sampling frame or a denominator as it is difficult to have an accurate estimate of the size of the homeless population (Fischer & Breakey, 1986). In their survey Weller et al selected 42 residents from 3 hostels and 30 people from Crisis at Christmas (Weller & Weller, 1986). The authors did not indicate why they chose their particular sample size and whether it reflected in any way the size or composition of the homeless population.

The sample size is another problem as most of the studies on the homeless had a sample size smaller than 100 subjects (see table-2). The confidence limits will be very wide and this affect the representativeness of study results (Susser et al, 1989c).

The procedure of sampling is also of importance to the generalisability of the study. Very few studies have used random selection as the sampling method. Even studies that claimed to have a representative sample did not report the method of sampling (Timms & Fry, 1989)(Priest, 1976). Out of 75 studies on the homeless reviewed by Milburn and Watts 38 used the presence of study subjects at the data collection site as the sampling method, 27 used this criteria in combination with other criteria like the person's mental status, social support etc. Nine studies used the duration of homelessness as a selection criteria.

Weller's two surveys depended mainly on the presence of the subjects at the research site (Weller & Weller, 1986)(Weller et al, 1987). Such sampling procedures will only select the visible group out of the homeless population which might not represent the homeless in any way. Such studies tend to contribute rather than correct public prejudices about the homeless.

3.The problem of detection of mental illness: Psychiatric interviews had been used as an instrument to detect the presence of mental illnesses in this population. Recent reports (particularly in USA) have begun to throw doubt on the suitability of psychiatric interviews for this purpose as they may measure homeless people's adaptation to their difficult circumstances rather than mental disorders (Susser et al, 1989c)(Snow et al, 1986).

The validity of homeless persons self reporting to professional interviewers whom they meet for the first time have been found to be questionable. Shanks(1981) studied the quality of data obtained by a questionnaire from residents of a common lodging house. He also compared the answers received from these residents on two or three occasions by different interviewers. He concluded that unless the resident knew the interviewer well, the constancy of the data would be poor (Shanks, 1981). This reporting bias may have a powerful effect in altering psychiatric diagnosis rates.

Priest found inconsistencies between his clinical assessment and the standardised psychological tests in assessing the presence of psychotic disorders in his sample. He claimed that sample reporting to the psychological tests were biased and discarded them (Priest, 1976). This bias could equally have affected his own clinical assessment. None of the studies mentioned in the previous section used a standardised method to reach diagnosis apart from Timms and Fry who used the DSMIII (Timms & Fry, 1989). As we have seen in earlier sections, diagnosis is not a reliable measure of disability and does not necessarily indicate a need for psychiatric services (Wing, 1990)(Kendell, 1975) especially in community surveys (Bebbington, 1990). The only study that measured disability was Marshall's survey in Oxford (Marshall, 1989). But unfortunately, this study is limited by the sampling problems mentioned above.

Because of these limitations, a study using a more reliable assessment of the needs of the homeless people for mental health services should be undertaken. The study should also have a defined sampling frame, a consistent operational definition, a precise sampling method and a more reliable and objective assessment procedure.

2.3.6.The need for further research:

In the seventies, the public image of homeless people was of people with drinking problems. At that time many studies tried to confirm and maintain that image. Bahr and Caplow in a systematic study of the Skid-Row homeless people in New York found that the majority of these people are not problem drinkers. They suggested that the visibility of these people had shaped public opinion of Skid Row.

Since the beginning of the eighties and due to changes in the economic and the demographic structure of urban areas (Miller, 1982), public opinion of homeless people has changed again. The homeless started to be considered as 'wandering mad people'. Their problem was seen as a result of community care policies and the closure of mental hospitals. Some researchers -particularly those opposed to community care- have tried to reinforce this publicly-held notion. Though most of these research projects have a lot of methodological problems, they are often quoted and used in service implementation plans without taking into consideration their limitations.

The publicly held notions have great policy and services implications. In the USA where this notion started earlier, most of the services were built on the assumption that the homeless are mentally ill (Hamid, 1989). Homeless people whose only problem is the lack of affordable housing are being institutionalised on the basis of this assumption (Wing & Brown, 1970)(Grunberg & Eagle, 1990).

In Britain, recent studies have tried to prove that homeless people are increasingly being identified as chronic mentally ill (Marshall, 1989)(Weller & Weller, 1986)(Weller et al, 1987)(Timms & Fry, 1989). Dr. Weller and his colleagues in Friern Mental Hospital undertook two surveys on the homeless to prove that they belong to the long-stay population (Weller & Weller, 1986)(Weller et al, 1987). The two surveys, though conducted within a one year period produced two estimates of psychotic illness which varied from 10% in 1986 to 40% in 1987. The author proposed that they showed real increases in the proportion of psychotic patients among the homeless. The difference however, is much more likely to be a manifestation of the unsystematic sampling methods used and the problems of suitability and reliability of the diagnoses.

All the studies done so far on the mental health problems of homeless people do not give a definite estimate of the needs of the homeless people for mental health services. Even if we ignore the methodological limitations of these studies, data about diagnoses do not provide an estimate of either disability nor of need for psychiatric services. Additionally, diagnosis does not indicate the individual needs and wants of the people surveyed.

Bassuk et al suggested the need for a detailed investigation of differences between mentally ill persons with a home and those without a home. The author suggested that service provision needs to adapt to the special characteristics of the homeless population and to the relationship of shelters to the mental health system (Bassuk et al, 1984). The current study started the investigation of the needs of the homeless by comparing the records of homeless and home-based clients of a community psychiatric service (CPN service in Bloomsbury). The clients were compared in their socio-economic features, their presenting problems and the care provided to the two groups. This was undertaken to test Bassuk's suggestion (Bassuk et al, 1984) that the homeless with mental health problems differ in their characteristics and service needs from the home-based.

The new development of community care policies and the recent initiatives to implement these policies makes the assessment of the needs of disadvantaged groups for community care and meeting these needs, essential. Homeless people are one of the most disadvantaged groups of society. Leach and Wing in their study of homeless men, suggested the need for rehabilitation and community care. They tried to show the effectiveness of such work with homeless men. None has tried since to address the needs of homeless people for mental health services. Previous psychiatric surveys had methodological problems that made it impossible to define the needs of homeless people for psychiatric services. This is very important for the design of services. This thesis has tried to fill this gap in the literature.

The other aim of the survey was to test the hypothesis that the homeless people are becoming mainly chronic mentally ill patients. In this study a sample of homeless people was compared in their disability and needs with chronic mentally ill people in contact with psychiatric services. A survey was conducted in the hostels for homeless people in the same area as the first study. The definition of homeless people depended on the presence of person in the hostels which cater for the homeless people in Bloomsbury Health District. This definition is similar to the definitions of the two largest studies on the homeless people in Britain (Digby, 1972). This allowed a comparison of the survey findings with those of these two studies.

The sampling frame for the hostel survey had been defined and quantified by a previous study undertaken by three M.SC. students in London School of Hygiene and Tropical Medicine (Cumming et al, 1986). The sampling procedure depended on random sampling. A set of random numbers were used to pick-up the room numbers from the rooms list of each hostel. The sample size was calculated to provide the most possible accuracy and the least random error with in the available time and personnel.

The American sociologist Leona Bachrach defined the chronic mentally ill as "people who, but for the de-instituionalisation movement might be in public hospitals like state hospitals (asylums) (Bachrach, 1983). Previous survey used diagnosis to estimate the presence of the chronic mentally ill among the homeless people. Diagnosis as discussed previously does not estimate disability or dependency, therefore it does not give accurate estimate of the chronic mentally ill.

The assessment procedure used in this study included the assessment of social disablement associated with mental illness and a schedule for assessing needs for mental health services both of whom have been developed by the Medical Research Council- Social Psychiatry Unit in the Institute of Psychiatry. This schedule score information collected from staff about subjects behaviour. This might have solved the problem of the inconsistency of homeless peoples' self reporting (Shanks, 1981).

The hostels' sample was then compared with a sample of chronic mentally ill in contact with psychiatric services patients interviewed by the researchers of the MRC-Social Psychiatry Unit. The same methods of assessment were used in the two samples. In addition the reliability of the assessments was tested to ensure the consistency of both the disability and need assessment in the two samples.

The American experience in the mental health provision for the homeless people is very important for future development of such services in the UK (David, 1988)(Anonymous, 1988b). The Bloomsbury hostels sample was compared with a sample from a shelter (which is the main model of residential care of the homeless in USA) in New York. Social behaviour disability and needs (met and unmet) for mental health services were compared in the two samples. The restrictiveness of London hostels and New York shelter was also measured and compared.

CHAPTER II

DESIGN AND METHODS

1.Purpose of the study.

1.1 The study aim

The general aim of this study was to investigate the needs of homeless people living in temporary hostel accommodation for mental health care, both expressed and perceived; met and unmet. This was achieved by:

a. Comparing the mental health problems and the care provided to the homeless clients of a community psychiatric service in an inner London district compared with the home-based clients of the same services in the same district. Previous studies suggested the need for detailed investigation of the differences between homeless and home-based people with mental health problems(Bassuk et al, 1984).

b. Assessing social disablement and the needs for mental health services in a random sample from the hostels for homeless men. The data were then compared with previous studies which assessed the same variables in people with chronic mental illness. Previous research suggested that the majority of the homeless are people with chronic mental illnesses who need to be in mental institutions (Weller et al, 1987)(Marshall, 1989)(Weller, 1989).

c. Comparing the needs of the sample of London hostels with a sample of residents from one of the shelters in New York. The shelter is the main model of residential care for the homeless in America. There are recent suggestions that homelessness in Britain is becoming similar to that of USA and that there is a need to use USA services models of care for homeless people in Britain (David, 1988)(Anonymous, 1988b).

More specifically, the objectives of the study were as follows:

1-To describe the mental health problems of the homeless clients of the CPNs in Bloomsbury and compare them with those of the home-based clients from the same area.

2-To examine differences in the referral process and the CPN care provided to the homeless and home-based clients of the CPNs in Bloomsbury.

3-To measure social behaviour disabilities (associated with chronic mental health problems) in a random sample of residents in 4 hostels for homeless men in Bloomsbury, using the Social Behaviour Schedule.

4- To assess the individual needs of hostel homeless for community care services (psychiatric and social) based on three parameters: social behaviour problems, staff judgement of the needs, and the residents' perceived needs.

5-To investigate ways of improving the mental health services provided to homeless people by comparing their needs and service provision in London and New York.

The findings could be used to develop community services for these disadvantaged groups.

1.2 Study design:

The study used two distinct methodological approaches:

a. Retrospective case-record analysis: The computerised clients records 'data coding system' of the Community Psychiatric Nursing services (CPNs) in Bloomsbury was used. The clients seen by CPNs over two years were classified according to their accommodation into 'homeless' and 'home-based'. The study method used here was a comparative approach.

b. Community survey: this was done in two stages:

Stage 1: A random sample was selected from four hostels for homeless people in Bloomsbury. The social disablement and the need for mental health services was assessed in the sample. The Environmental Index -which is a measure of restrictiveness of the settings- was also completed for each of the four hostels. The hostels' sample was then compared with two samples of chronic psychiatric patients interviewed by Dr. T. Wykes and her colleagues in Camberwell in which the same variables were collected.

Stage 2: A random sample was selected from a shelter in New York, USA. The same assessments were made as those conducted on the Bloomsbury hostels were collected. A comparison between New York and Bloomsbury sample was undertaken to assess the differences in restrictiveness of the two models of care and how much of residents' needs were met.

2.**The study areas:**

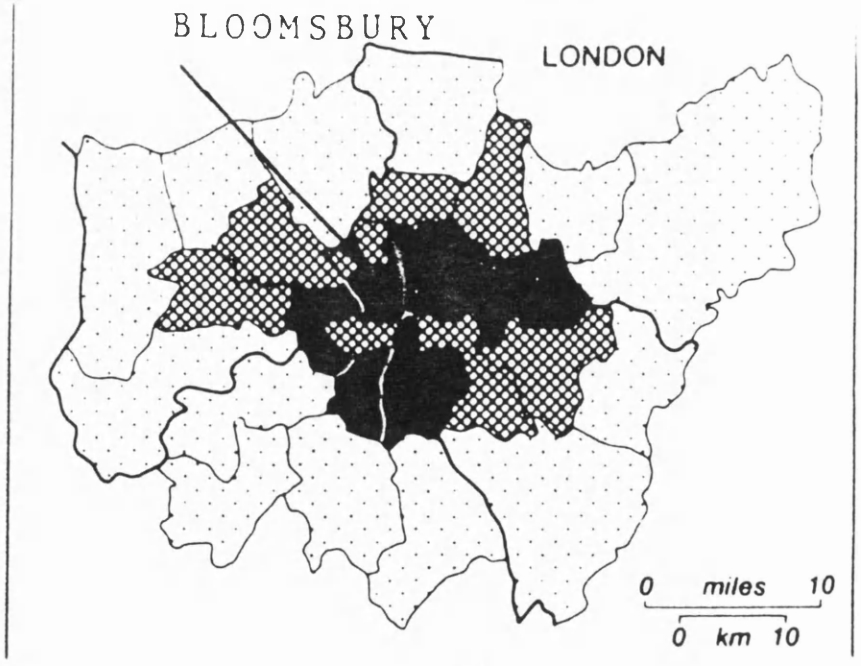
2.1 Geography of Bloomsbury:

Bloomsbury Health Authority (BHA) was created in 1982 during the re-organisation of the NHS. It comprises what was formerly North East Westminster and South Camden Health Authorities in the heart of inner London (see figure II.1). It forms an area of about six and a half square miles (Anonymous, 1986).

There are five major railway stations within this district:Marylebone: Euston: St. Pancras: Kings Cross and Charing Cross.There is also a wide diversity of socio-economic groups within BHA; on one hand Mayfair and St. John's Wood and on the other hand Kings Cross and Soho. The quality of housing is often poor and many live in relatively cheap hostels and bed and breakfast accommodation. Unemployment is high (8% -1981 Census) and long queues can be seen outside job centres (Wadsworth, 1984)&(Tsouros, 1985).

Figure II.1

Bloomsbury Health District



2.2 Population characteristics:

Bloomsbury is a typical example of an inner city area that shows a wide variety of socio-demographic, ethnic and economic characteristics and different groups with special needs for health and social services. The 1981 census also showed many features of social deprivation in Bloomsbury (Anonymous, 1986).

135,200 people live in Bloomsbury (1981 Census). Of these, about 40% are either in a low socio-economic class or are retired, 42.7% of Bloomsbury residents are over 45 years of age. A varied ethnic population also exists (31% of BHA population was born outside the UK) (Tsouros, 1985) (Anonymous, 1986).

As a Central London district, Bloomsbury has been thought to have a high rate of psychiatric morbidity (Wing, 1986). The presence of the main railway terminals and a high number of hostels and other accommodation for single persons makes Bloomsbury attractive to homeless unemployed people from all over the country (Anonymous, 1986).

2.3 Homeless people in Bloomsbury:

In 1981 a large number of homeless people (3,495 homeless) lived in hostels or boarding houses and 120 slept rough (OPCS Small Area Statistics). Although the total number of homeless people in London is believed to be rising, over the last few years the homeless hostel population has been falling due to the closure of some hostels (Randall et al, 1986).

In March 1987 there were 18 hostels in Bloomsbury which catered mainly for homeless people. The hostel population falls into two categories (Cumming et al, 1986):

a. The residents of large hostels who are -in general- more stable and can be easily contacted and monitored by health services. In March 1987 there were 563 men in four big hostels and 289 women in six much smaller hostels.

b. The more mobile population of homeless people who may be living in night shelters or sleeping rough. There are eight small temporary hostels and night shelters that cater for these people.

2.4 Community mental health resources in Bloomsbury:

22 Community Psychiatric Nurses work in Bloomsbury in 3 teams:Northern Team, North-West Team and Central Team. They see between 4-12 hostel residents per month (Cumming et al, 1986). Before the hostel survey (second stage of the study) had started, CPNs withdrew their in-hostel services because the services resources were unable to deal with the increasing referrals (Smith, 1987).

Three day hospitals (DHs) provide services to mentally ill people; Tottenham Mews and Latimer House DH which are linked to Middlesex Hospital and Jules Thorn DH which is linked to St. Pancras Hospital. They provide therapeutic and rehabilitative activities for people discharged from mental hospital.

In addition to these services mental health care is partly provided by the general medical care provision for homeless people. Great Chapel Street Medical centre is a drop-in centre which provides general medical care to homeless individuals. A GP has been appointed by BHA with the aim of improving the uptake of primary care by homeless people and to encourage them to register with GPs (Williams & Allen, 1989).

Drug and alcohol services provide an important resource for homeless people with these problems. For example 30% of the clients of the Alcohol Problem Advisory Service (APAS) in 1986 were homeless clients (personal communication). In addition to APAS there is the Alcoholics Recovery Project which has a drop-in centre for homeless people in King's Cross and offers a residential programme. CASA is another service which provides counselling for alcoholics and their families. Bloomsbury's Drug Dependency Unit, Accept, The Hungerford project and Tranx are also agencies that provide counselling and support for drug addicts and their families in Bloomsbury.

The Compass Project was opened in September 1987 as an information source about different mental health services and as a drop-in centre for assessments and referrals. In addition there are day centres which provide leisure activities for the unemployed and retired people, some of whom are homeless and/ or mentally ill. These day centres are a social services or voluntary services provision.

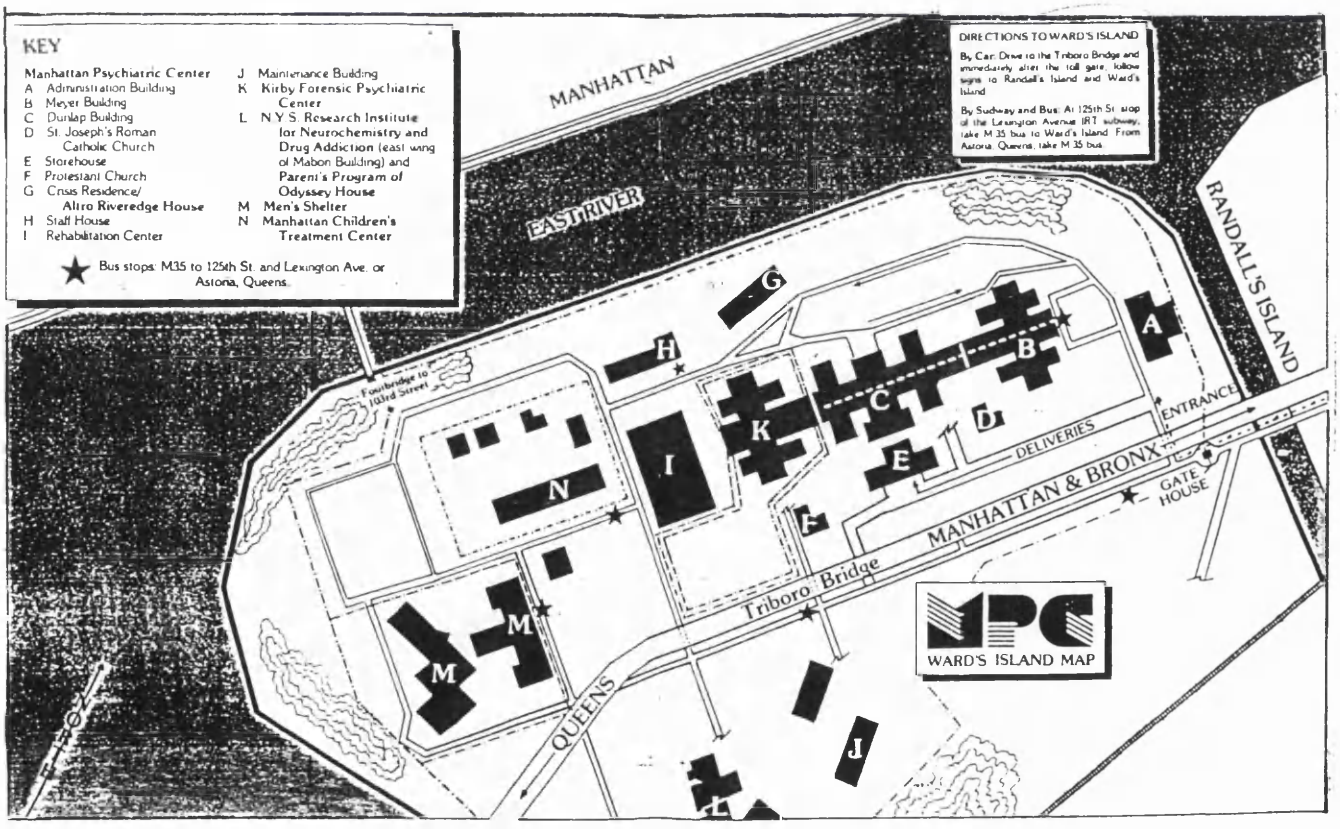
In spite of the presence of these resources, the professionals and carers working with the homeless have the impression that there are a substantial number of unmet needs for mental health services. This study aims to identify (and quantify) these needs in order to help mental health services target their resources towards meeting them.

2.5 Ward's Island shelter for men in New York.

Charles H. Gay shelter for men is one of New York shelters for homeless people. The shelter opened in 1979 and it is run by a charitable organisation called 'Volunteers of America' on contract with the New York City Human Resources Administration (Grinker, 1988). The shelter is situated in one of the islands in the East River between Manhattan and Queens (see figure II.2). Since the Civil War the island was the home of 'New York City Asylum for the Insane'. Now it is the home of the huge Manhattan Psychiatric Centre, a prison, a neuro-psychiatric research centre, and a forensic psychiatric centre in addition to the shelter (Anonymous, 1989).

Figure II.2

New York Wards Island



During the interview period the Human resources demographic report recorded that on 22.4.89, 845 residents were living in the shelter (New York City Human Resources Administration, 22). More than 140 staff were employed and in addition a variable number of volunteers. A medical/ nursing clinic operates in the shelter with staff from St. Vincent's Hospital. A community support system and outreach program -with a visiting psychiatrist- works with residents who are mentally ill. Social services provide social work with residents in the shelter. Each resident who is assigned to the shelter is interviewed by an intake manager who refers him to the case manager who specialises in a particular resident's problem. Security guards are contracted from a private security firm (Heckler, 1984b).

3.Methods:

A The study of CPNS records:

A.1 The CPN service in Bloomsbury:

The Bloomsbury Community Psychiatric Nursing (CPN) Service started in 1968 when a nurse was employed to provide after-care services in Westminster for patients from St. Luke's Hospital, Woodside. Gradually the service grew in size and was re-located in Tottenham Mews Day Hospital in 1976. South Camden CPN service which was established later, had been based in either health clinics or in GPs' surgeries. With the establishment of Bloomsbury Health Authority in 1982 the Westminster service was combined with South Camden CPNs .

At the time of the investigation there were 20 Community Psychiatric Nurses working in Bloomsbury. They work in three teams; the Northern, Central and North-West teams, each with its own leader.

A.2 The recording system:

In 1983 the CPN service in Bloomsbury began to collect standardised information about their clients. Brooker has described this recording system and indicated how it could help to evaluate the service (Brooker, 1984).

Each CPN keeps a case record for each client. Every six months CPNs complete a data coding sheet for all new referrals to their service during the previous six month period.

The data coding sheet contains information about the referral process, client's demographic features and current problem as described by referrer; client; and CPN. It also contains client contacts with psychiatric services, psychiatric medication and diagnosis. The sheet also includes information about CPN intervention and the time spent with the client (see also appendix-1).

Although the CPNs continue to collect data about their clients very little work has been done to analyse these data.

A.3 Data processing and analysis:

The Mental Health Unit in Bloomsbury Health Authority made data available for the three years 1984-86. But only the data of 1985 and 1986 had the same format and codes so that the 1984 data had to be discarded. The data was analysed using 'Statistical Package for the Social Sciences' SPSS-X on the University of London mainframe computer (SPSS Inc., 1986).

(*)-The Present State Examination (PSE) was used in the pilot study. Residents were found to be less cooperative when asked the PSE questions particularly those related to psychosis. In view of this problem and study's limited time and resources it was decided to drop the PSE from study instruments.

The data about clients' accommodation were divided into two categories; Home-Based and Homeless. The home-based category includes people living in owner-occupied and rented accommodation. The Homeless category includes people living in Hostels, Bed and Breakfast, Sleeping rough and Other (including people living in squats and group homes).

B.THE HOSTEL SURVEY

B.1 Survey Instruments:★

The information was obtained from hostel residents and the staff caring for them using the Hostel Interview Schedule (HIS)

B.1.1 The Hostel Interview Schedule (HIS):

This schedule includes the following(see appendix-2):

1 Demographic data about the resident which was collected using a semi-structured questionnaire constructed and piloted to collect data from hostel staff using hostel records of the resident. The same data were collected from the residents using the same questions to complete and validate staff information.

2 Resident's main health problem coded as physical, mental, drug and alcohol or a combination of these problems. A separate category for alcoholism to assess the severity of the problem was derived from the 'Present State Examination' (Wing et al, 1974).

3 Resident's contacts with health services; this included the registration with a GP, the number of services the resident had been in contact with during the previous six months period before the interview and the past psychiatric history.

4 Resident's Life achievement in terms of employment and accommodation.

5 The staff difficulties which were due to resident's health or psychiatric problems.

B.1.2 The Social Behaviour Schedule (SBS):

This schedule covers 21 areas of behavioural difficulties exhibited or experienced by patients with chronic mental illnesses (see appendix-3). These items range from day to day activities like hygiene and social mixing to behavioural signs of psychiatric illness such as depression, overactivity and restlessness. They are rated on a five point scale after discussing the severity and frequency of each of these difficulties with a key informant who was able to observe the client's behaviour in the month prior to the interview. The items were rated (0) if the informant suggested that patient behaviour regarding this item was acceptable and there was no problem in the previous month. A score of (4) was given to any item reported as having a serious problem according to the coding manual definition.

Previous studies have shown that SBS is a highly reliable measure in different settings, across time, and with different informants and different raters (Wykes & Sturt, 1986) (Brewin et al, 1990). Nevertheless because these studies have been conducted only in psychiatric settings, a further reliability check was needed for this study. Twenty one residents out of the 101 study subjects were chosen randomly. Two separate informants were interviewed for each of these residents. The two interviews were compared using Kappa tests to assess the reliability.

On the basis of statistical and clinical similarities, the 21 items of the SBS have been grouped into five areas. These areas were Social withdrawal (items 1, 18, 19); Socially embarrassing behaviour (items 2, 3, 4, 9, 11, 16, 20); Depression and anxiety (items 6, 7, 8, 15); Hostility and violence (items 5, 14); and Socially unacceptable behaviour (items 12, 13, 17, 21) (Wykes et al, 1982b).

The scores of the SBS have been shown to correlate with the level of supervision and dependence on the services. It has been suggested that the SBS is a better measure of the need for care and dependency on services than psychiatric symptoms (Sturt & Wykes, 1987).

B.1.3 The Needs Schedule (NS):

This schedule is a semi-structured questionnaire that has been developed from previous work on the identification and definition of needs of the people with chronic mental illnesses for community psychiatric services (Wykes et al, 1982a)(Wykes et al, 1985)(Brewin et al, 1987).

This schedule is constituted from 13 items that cover particular kinds of interventions that describe community mental health care and support (see appendix-4). They cover day care, residential care, support for the clients and their carers and psychiatric, social and alcohol and drug services assessments and interventions.

The schedule was used to collect data from the staff about the resident's needs for these interventions and the meeting of these needs. The data collected about each intervention were coded by the researcher as follows; (0) no need; (1) met need; (2) unmet need; (3) overmet need; (4) unclear need.

B.1.4 The Environmental Index (EI):

The Environmental Index (TAPS 1985) assesses the degree of residents' autonomy and evaluates the quality and available amenities in the locality of the residential setting (see appendix-5). It was developed from the Hospital and Hostel Practice Profile (Wing & Brown, 1970)(Wykes et al, 1982b). The Index Items are:

1.Activities: These cover restrictions on residents' going in or out of the hostel; being visited; TV viewing times; going to bed and getting up in the morning.

2.Possessions:This item evaluates the freedom of the resident to keep personal possessions such as razors; matches; medication; money and furniture, if they can be locked away and whether the staff check or catalogue these possessions.

3.Meals: This item covers residents' participation in the planning and preparation of food, whether they can make their own snacks and drinks and whether they are allowed to drink alcohol in the hostel.

4.Health and hygiene: This item covers supervision of self care (i.e. bathing, getting dressed, and weighing them) and whether residents can chose their own bathing time and do their own laundry.

5.Residents' Rooms: This item covers residents' privacy and access to their rooms, the presence of set visiting times and the ability of the staff to have access to residents' rooms without their permission.

6.Services: This section relates to the freedom of the residents to make their own appointments with health services, whether the hostel is visited regularly by different caring agents, the availability of a hairdresser, shop, library, routine meetings between staff and residents

and if the staff wear uniform.

7.Environment: This item concerns the availability of different amenities in the hostel locality such as shopping facilities, pubs, cafes, day centres, parks, cinemas.

B.2 Survey sample:

B.2.1 Selection of study sample:

In March 1987 there were 563 men in four big hostels and 289 women in six much smaller hostels. Some of the hostels which cater for female homeless people refused to participate in this study. These hostels refused access to a male researcher. No resources were available to appoint a female interviewer so the study was undertaken in male hostels only. The mental health problems and needs of homeless women are different from those of the men (Ryback & Bassuk, 1986). So the results of this survey cannot be generalised to homeless women.

The decline of available bed-spaces in Bloomsbury hostels and the rehousing of younger and more able persons have left a more stable population which is older and more disabled. These hostels therefore contained 563 relatively more permanent residents than in the smaller hostels and shelters. These small hostels and shelters usually cater for younger more mobile population of homeless people who traditionally come to London to look for work. These people have different problems and needs (Brandon, 1980) and were not included in the study.

The sample was drawn from the room-lists of the four long-stay male hostels in Bloomsbury. A random sample of 110 residents was selected for the study (see below for sample size estimate). The warden and the staff were asked to appoint, for each resident selected, the staff member who knew him best to be the informant for this particular resident.

B.2.2 Exclusion criteria:

1.Residents who had been in the hostel less than one month before the interview were excluded from the study sample. The resident of the next random number was chosen from the room-list instead of the excluded residents. Only two residents were excluded for this reason.

2.Residents who refused to be interviewed (nine out of 110 residents) were excluded from this study. The number of residents who refused to be interviewed was much less than was expected thanks to the co-operation of the hostel staff.

B.2.3 Sample size:

Previous studies estimated that between 15-50% of the hostels' residents had mental problems of some description. If 30% is taken as average, it can be estimated that 90 residents are needed for the survey to allow the detection of 10 % difference in the social behaviour disabilities and the possibility of random error of 10 % (Schlesselman, 1982). As 10-20% of the residents were anticipated to refuse to participate (from the pilot study) an additional 20 residents were added to the estimated sample size.

B.3 Survey Procedures:

B.3.1 Staff interviews:

Shanks suggested that homeless people are usually suspicious of any strange interviewer and consequently might tend to give unreliable information (Shanks, 1981). So, each resident in the sample was approached through a member of the hostel staff who knew them best. After selecting the residents to be interviewed, the staff were asked to select those other members of staff who knew these residents best. The staff were then asked to approach each resident to explain the exercise and to determine his willingness to participate. The hostel warden, meanwhile was interviewed using the Environmental Index to assess the degree of residents' autonomy.

If the resident agreed to participate the designated staff member was interviewed first using the HIS, SBS, and the needs schedule (see above).

B.3.2 Resident's interviews:

The resident was asked to choose the place of the interview. Some were conducted in resident's rooms; some in the staff-room or in the GP's surgery. The residents were asked about the same aspects of demographic characteristics and contacts with health services (as in the staff interviews). More emphasis was given to the psychiatric history and current psychiatric problems if any.

The residents were also asked whether they thought they needed any mental health intervention such as those listed on the Needs Schedule. Their perceptions of these needs and what had been done about them were recorded on the schedule.

B.3.3 The need assessment (final assessment):

Having finished interviewing a group of 10 residents and the staff who knew them, the researcher and Dr. Mark McCarthy who supervised the first part of the study met to record the final assessment of the needs of these residents. A team assessment was used to decrease the subjective value judgement in the assessment.

The team then reviewed all the information collected about each resident. The socio-demographic, health and mental health problems, psychiatric history and present mental status and behaviour, staff burden, staff judgement of the presence of needs and resident's perception of these needs were all reviewed to reach the final assessment.

The need for each item (intervention) of community mental health care was recorded into five categories; no need; met need; unmet need; overmet need and unclear need. The item was recorded as no need if there was no deficit of resident functioning or health problem that required this intervention. Met need was recorded as any item in which intervention had been provided effectively to alleviate or treat a resident's problem. Unmet need was recorded when there was a problem that required this intervention which had not been provided at all or had not been provided effectively. Overmet need was recorded when an intervention was provided when no problem was identified that might require that intervention.

The unclear need category was recorded when there was a problem that required specific intervention but something hindered the utilisation of this intervention e.g. resident's refusal or if the intervention was secondary to another intervention e.g. the need for day care or counselling when the resident had not received any psychiatric assessment which would have revealed more clearly the need for the previous two items.

A further independent assessment was undertaken by Dr. Til Wykes who made a final assessment on ten randomly selected subjects out from the sample. This assessment used the same information used for team assessment. Dr. Wykes's assessments were then compared with team assessments to check the reliability.

B.4 Survey data analysis:

The data were entered into the computer in two different forms.Case-notes of the subjects in the sample were entered into a word processing file -after the subjects had been interviewed- and they were used in the final assessment of needs. Numeric codes was entered into a data-base file after final assessment, using 'dbase 3 plus' programme in the PC-form.

The data for the comparison samples from Netherne hospital (Wykes & Sturt, 1986) (for the SBS comparison) and from the Camberwell community psychiatric service (Wykes et al, 1982a) (for the needs comparison) were kindly provided by Dr. Til Wykes who conducted these studies with colleagues in the MRC- Social Psychiatry Unit in the Institute of Psychiatry.

The statistical analysis included the following statistical methods:

1- Producing simple frequencies of study variables in the sample.

2- Hypothesis testing using bivariate analysis of crude rates (using Chi-square test*) and age adjusted rates '(using Mantel-Haenszel Chi-square) (Schlesselman, 1982).

4. Multivariate analyses to test for the significance and interaction of the Grouped item SBS scores with the needs for mental health services.

5- Measuring the reliability of the SBS and the Need assessment using Kappa and Weighted Kappa tests (Hunt, 1986)(Fleiss & Cohen, 1973).

(*)= Please note that (chi-square) was abbreviated as (CHI) throughout the results.

CHAPTER III

RESULTS

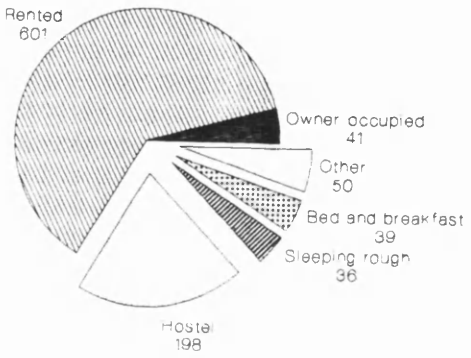
A.Results of CPNs records analysis:

In order to test whether homeless CPN clients are treated for more chronic mental health problems than home-based clients, the presenting problems and the care provided for the two groups was compared. But, first we need to establish how similar the two groups are in basic characteristics such as age, sex, marital status etc.

The data consisted of 974 referrals of which 642 were home-based clients and 322 were homeless (see figure A1). Of the home-based clients, 41 were living in owner occupied accommodation and 601 were in rented accommodation. The homeless clients included 198 clients living in hostels, 36 sleeping rough and 89 clients living in bed and breakfast hotels, squats and group homes. The homeless clients were compared with the home-based clients on their presenting problems and the care provided to them.

Figure A1

CPN's clients
according to their accommodation



A.1.Socio-demographic features:

a.Sex (see table-A1): The majority of both 'home-based' and 'homeless' clients were women but there was a significantly higher proportion of women in the home-based client group compared with the homeless clients (Chi=18.2, P=0.0001).

b.Age (see table-A1): Home-based clients were older(mean 50.75 years, SD 21.5) than homeless clients (mean 35.7, SD 16.02). The age distribution of the homeless clients showed a skewed distribution towards younger age groups compared with the age of the home-based distribution which showed an approximately 'normal distribution'. Only 5.5% of the homeless clients were over 65 years of age compared with 31% of the home-based clients (Chi=79.7, P=0.00001).

c.Marital status and living arrangements (see table-A1): 81.3% of homeless clients were single compared with 53.4% of the home-based clients (Chi=69.03, P=0.00001). 81.4% of the homeless were living alone compared with only 46.4% of the home-based clients (Chi=107.6, 0.00001).

d.Employment (see table-A1): There were marked differences in the employment status of the two groups. The majority of the homeless clients were unemployed compared with home-based clients (78.5% vs 29.8%, Chi=199.7, P=0.00001). This difference remain significant if the clients who were under 65 years were compared (83.7% of homeless clients compared to 43.1% of home-based clients, Chi=118.1; P=0.000001)In contrast, the largest group of the home-based clients were the retired who constituted 36.6% of those clients compared with 8.7% of the homeless clients (Chi=82.4, P=0.00001).

(TABLE-A1)
Demographic characteristics of homeless and home-based clients

Characteristic	Home-based clients (n) (642) (%)		Homeless/clients (n) (323) (%)	
Sex:Female	436	68.1	174	53.9
Male	204	31.9	149	46.1
Age: -35	198	30.8	174	53.8
36-65	228	35.5	123	38.0
66-	204	31.9	18	5.5
Marital status				
Single	341	53.4	261	81.3
Married	195	30.6	25	7.8
Widowed	58	9.1	9	2.8
Divorced	43	6.7	26	8.1
Living arrang.				
Alone	297	46.4	263	81.4
Employment				
Regular	120	18.8	16	4.1
Casual	36	5.6	14	4.4
Unemployed	191	29.8	252	78.5
Retired	234	36.6	28	8.7
Student	9	1.4	4	1.2
House pers	50	7.8	7	2.2
Ethnic origin				
Chinese	3	0.5	2	0.6
Greek/Cyp	24	4.0	0	0.0
Caribbean	26	4.3	32	10.1
Asian	14	2.3	11	3.5
African	11	1.8	7	2.2
Scottish	18	3.0	18	5.7
Irish	79	13.0	36	11.4
Mid.East	5	0.8	1	0.3
Other(Eng)	427	70.3	210	66.2

e.Ethnic origin (see table-A1): There was no significant differences in the proportions of ethnic minorities between the homeless group (33.8%) and the home-based clients (29.7%). But the Caribbean clients were significantly higher in the homeless group (10% vs 4%, Chi=12.03, P=0.005). When people from black ethnic origin (Caribbean, African and Asian) were grouped together, their proportion in homeless clients (15.8%) was significantly higher than that in home-based clients (8.2%) (chi=12.2, P=0.0005).

A.2.Psychiatric history and current mental problem:

More than half of CPNs' clients had been seen by a psychiatrist in the past; 64.7% of the home-based clients and 62.8% of the homeless (Chi=0.21; P=0.6 NS).

More of the homeless clients who had been to a psychiatrist saw them more than six months prior to seeing the CPN (27.1%) compared with home-based clients (18.7%) (Chi=8.3; P=0.004).

More homeless clients (55.2%) had a history of admission to mental hospital than the home-based clients (45.4%) (Chi=6.8; P=0.009). 26.9% of the homeless clients had been discharged more than six months prior to referral to CPN compared with 20.4% in the home-based group (Chi=4.9; P=0.03).

As to the psychiatric diagnosis given to clients who had been seen by a psychiatrist, (see table-A2) a significantly higher proportion of the homeless clients were diagnosed as schizophrenics (26.3% compared with 17.8% of the home-based) (Chi=7.67; P=.005). In the home-based clients there was a higher proportion of affective disorders (14.8% compared with 4.3% in the homeless, Chi=22.45; P=00001) and dementia (5% compared with nil in the homeless, Chi=15.1; P=.00001). Although there were significant differences in the type of diagnosis given to homeless and home-based clients, when overall rates for psychiatric diagnosis were considered there were no significant differences.

Table-A2
Psychiatric Diagnosis given to clients

Psychiatric Diagnosis		Home-Based	Homeless	Chi-Squ (P)	Odds Ratio (Conf. Lmt.)
Not applicable		265 41.3%	141 43.7%	0.4 (.5 NS)	1.1 (.8-1.45)
Affective disorders	1	95 14.8%	14 4.3%	22.5 (.00001)	0.26 (.13-.47)
Schizophrenic disorders	2	114 17.8%	85 26.3%	7.7 (.005)	1.58 (1.1-2.2)
Personality disorders	3	34 5.3%	22 6.8%	0.65 (.42 NS)	1.30 (.72-2.3)
Dementing Process	4	32 5.0%	-	15.1 (.00001)	0
Anxiety state	5	27 4.2%	1 .3%	10.2 (.001)	0.07 (.01-.48)
Alcoholism/ drug abuse	6	13 2.0%	11 3.4%	1.2 (.27 NS)	1.7 (.7-4.1)
Other	7	24 3.7%	5 1.5%	2.8 (.09 NS)	0.4 (.13-1.13)
Not known	8	38 5.9%	44 13.6%	15.4 (.00008)	2.5 (1.5-4.0)
Total		642 66.5%	323 33.5%		

The presenting mental problem was described in the CPN data in three ways (see table-A3);1. as expressed by the referring agent; 2. as expressed by the client; and 3. as assessed by the CPNs themselves. The commonest problems among both homeless and home-based clients, in the view of the referrers and the CPNs, were 'mood-related problems' and 'abnormal experiences' and inter-personal relationships. Referring agents also identified behavioural problems.

(TABLE-A3)

The three assessments of main current mental problem

as expressed by>	Referring agent		The client		CPN assessment	
The presenting mental problem	Home-based	Homeless	Home-based	Homeless	Home-based	Homeless
Mood related 1	172 26.8%	92 29.1%	138 21.7%	68 21.1%	130 20.3%	62 19.2%
Abnormal experiences 2	111 17.3%	75 23.7%	58 9.1%	39 12.1%	105 16.4%	70 21.7%
Drug/Alcohol dependence 3	39 6.1%	19 6.0%	28 4.4%	16 5.0%	39 6.1%	18 5.6%
Interpersonal relations 4	78 12.2%	26 8.2%	85 13.3%	30 9.3%	110 17.2%	43 13.3%
Organic 5	24 3.7%	5 1.6%	26 4.1%	9 2.8%	30 4.7%	5 1.5%
Financial/Housing /Employment 6	11 1.7%	6 1.9%	42 6.6%	53 16.4%	14 2.2%	20 6.2%
Behavioural disturbance 7	70 10.9%	49 15.5%	20 3.1%	10 3.1%	39 6.1%	31 9.6%
Recent loss or separation 8	24 3.7%	3 0.9%	30 4.7%	7 2.2%	29 4.5%	7 2.2%
Anxiety 9	60 9.4%	24 7.6%	62 9.7%	25 7.7%	57 8.9%	27 8.4%
Other 10	41 6.4%	13 4.1%	55 8.6%	20 6.2%	69 10.8%	34 10.5%
None 11	9 1.4%	4 1.3%	91 14.3%	45 13.9%	16 2.5%	6 1.9%
COLUMN TOTAL	641 67.0%	316 33.0%	637 66.4%	323 33.6%	639 66.4%	323 33.6%

The clients, however expressed their main problem in a different order. The second most frequent problem according to the homeless clients was 'financial and housing problems'. 16.4% of the homeless clients expressed it as the main problem while it was the main problem for 6.6% of the home-based clients (Chi=22.1, P=0.00003). In contrast clients rarely described their main problem as a behavioural disorder.

Comparing each of the presenting problems as assessed by the CPN between the homeless and the home-based clients similarities rather than differences were shown (see table-A4). The only two items which showed a significant difference were organic problems and financial, housing and employment problems. The financial, housing and employment were -as expected- much higher in the homeless clients (6.2% compared with 2.2% of the home-based) (Chi=8.9, P=0.002). The organic problems were more prevalent in the home-based (4.7% compared with 1.5% of the homeless clients) (Chi=5.2, P=0.02).

Using the odds ratio to determine the magnitude of the difference most of the problems were of an odds ratio near to one, apart from the financial, housing and employment problems in which the homeless clients were three times more likely to present with these problems compared with the home-based clients.

When controlling for age, the clients who were under 65 showed a significant difference between the two groups. 21.9% of the homeless clients under 65 presented with abnormal experiences compared with 15% of home-based clients from the same age group (Chi=5.2, P=0.02). In the same age group, there was no difference in the proportion of clients given the diagnosis of schizophrenia (25.9% vs 20.3%, Chi=2.8, P=0.08).

TABLE A4
CPN assessment of the main current problem

The presenting mental problem	Home-based	Homeless	Chisquar (P)	Odds Ratio (Confidence Lmt)
Mood related	130 20.3%	62 19.2%	0.73 (0.7)	0.93 (0.65-1.32)
Abnormal experiences	105 16.4%	70 21.7%	3.6 (0.06)	1.4 (0.98-1.9)
Drug/Alcohol dependence	39 6.1%	18 5.6%	0.03 (0.85)	0.9 (0.49-1.66)
Interpersonal relations	110 17.2%	43 13.3%	2.2 (0.14)	0.73 (0.49-1.1)
Organic	30 4.7%	5 1.5%	5.2 (0.02)	0.32 (0.1-0.8)
Financial/Housing /Employment	14 2.2%	20 6.2%	8.9 (0.002)	2.9 (1.4-6.24)
Behavioural disturbance	39 6.1%	31 9.6%	3.4 (0.06)	1.63 (0.97-2.7)
Recent loss or separation	29 4.5%	7 2.2%	2.7 (0.1)	0.46 (0.18-1.12)
Anxiety	57 8.9%	27 8.4%	0.03 (0.8)	0.93 (0.56-1.54)
Other	69 10.8%	34 10.5%	0.0003 (0.98)	0.97 (0.61-1.53)
None	16 2.5%	6 1.9%	0.2 (0.73)	0.73 (0.26-2.02)
Total	639 66.4%	323 33.6%		

The main current mental health problems with smaller cells have been recoded for further analysis. Interpersonal relationships; financial and housing problems; and recent loss or separation have been coded under one category 'life events'; drug/alcohol, organic, behavioural disturbance, anxiety, other and no problem have been coded under 'other' category.

To study the agreement of CPNs' assessments with both referring agent and the clients, percentage agreement and kappa statistics were used. The highest agreement was with referring agents in their assessment of home-based clients (percentage agreement (PA)=69%, Kappa=0.64 as compared to PA=59%, Kappa=0.52 in homeless clients' referring agents). The lowest agreement was with the homeless clients' expressed main problem (PA=51%, Kappa=0.46 compared with PA=53%, Kappa=0.50 with home-based clients' expressed main problem). The agreement between the CPNs and clients was used to represent the degree of empathy with the two groups. Clearly there are other factors like the degree of client insight and whether they were self or "other" referred also affects the agreement.

A3.Referral process and main intervention:

The majority of CPN clients were new referrals, more frequent for the homeless clients (79.3%) than for the home-based (71.2%) Chi=6.75, P=0.009.

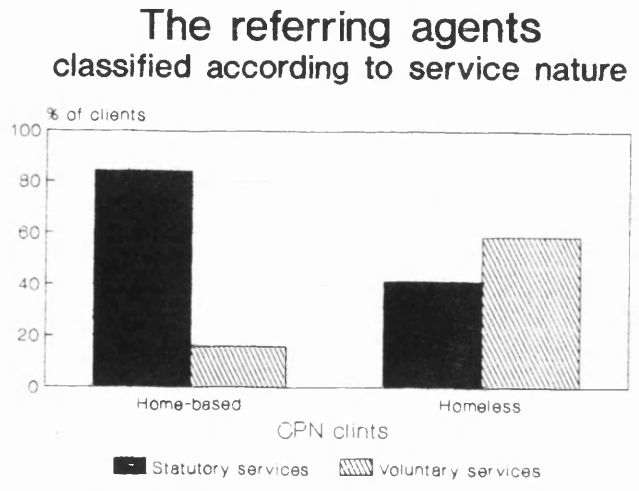
There were significant differences between the two groups in the referring agents (see table-A5). The main referring agents for the homeless clients were hostels, West End Co-ordinated Voluntary Services, GPs. In the home-based clients the main referring agents were GPs, psychiatrists and CPNs.

TABLE-A5

The agents which referred the clients to CPNS

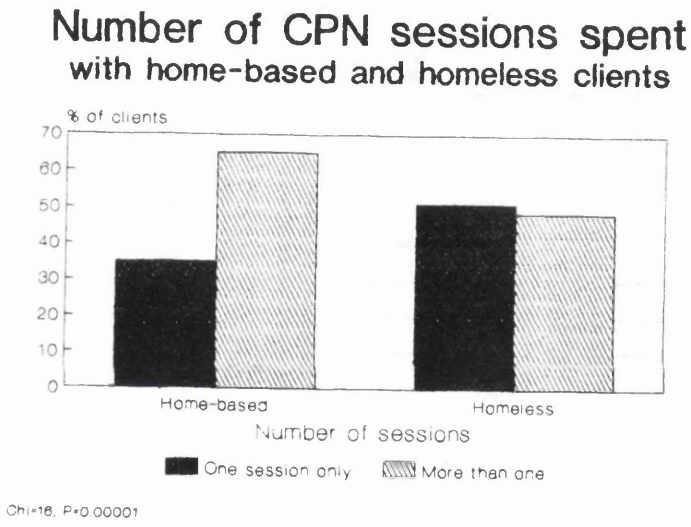
	HOME-BASED		HOMELESS	
	NO	%	NO	%
GP	233	36.3%	55	17.0%
SOCIAL SERVICES	41	6.4%	12	3.7%
HEALTH VISITOR	54	8.4%	8	2.5%
PSYCHIATRIST	102	15.9%	23	7.1%
DISTRICT NURSE	13	2.0%	2	.6%
HOSTEL	1	.2%	83	25.7%
AGE CONCERN	10	1.6%		
PROBATION SERVIC			1	.3%
DAY CENTRE	8	1.2%	3	.9%
DAY HOSPITAL	13	2.0%	2	.6%
WARD STAFF	28	4.4%	3	.9%
W.E.C.V.S.	9	1.4%	61	18.9%
OTHER VOLUNTARY	6	.9%	7	2.2%
SELF	50	7.8%	28	8.7%
OTHER	17	2.7%	8	2.5%
CPN	56	8.7%	27	8.4%

Figure A2



When the referring agents were sorted broadly into statutory and voluntary services, the differences became even more striking (see figure A2). The majority of the home-based clients (84.2%) were referred by statutory services while only 41.2% of the homeless clients had been referred by a statutory service (Chi=16, P=0.00001). After referral homeless clients' referring agents continued caring for 82.6% of referred clients compared with those referring the home-based clients who provide continued care for 74.3% (Chi=8.4, P=0.004).

Figure A3



The number of sessions spent with clients differ significantly between home-based clients and homeless clients (see figure A3). More than half the homeless clients (51.2%) had one session only compared with only 35% of home-based clients who had one session. The homeless are twice more likely to have one session only (Odds Ratio=1.94).

Table-A6
Main CPN intervention in homeless and home-based clients

INTERVENTION	HOME BASED	HOMELESS	Chisquar (P)	O.R. (C.L.)
1 DRUG SUPERVISION	60 11.1%	41 13.8%	1.03 (0.31)	1.27 (.8-1.9)
2 SUPPORTIVE PRACT	129 23.9%	25 8.4%	29.7 (.00001)	0.29 (.2-.46)
3 COUNSELLING/ PSY	105 19.4%	44 14.8%	2.6 (0.1)	0.72 (.5-1.1)
4 FAMILY THERAPY	21 3.9%	3 1.0%	4.7 (0.03)	0.25 (.07-.9)
5 BEHAVIOUR THERAP	10 1.9%	1 .3%	2.3 (0.12)	0.18 (.02-1.3)
6 REFERRED ON	74 13.7%	82 27.5%	23.3 (.00001)	2.4 (1.7-3.5)
7 OTHER	23 4.3%	16 5.4%	0.3 (0.57)	1.3 (.6-2.6)
8 NONE	87 16.1%	48 16.1%	0.009 (0.92)	.999 (.7-1.5)
9 LOST CONTACT	31 5.7%	38 12.8%	11.6 (.0006)	2.4 (1.4-4)
COLUMN TOTAL	540 64.4	298 35.6		

Twice as many clients in the homeless group were referred to other caring agents (27.5%) compared with the home-based (13.7%) (Chi=23.2, P=0.00001) (see table A6). Medication supervision and administration was not significantly different as the main intervention in the two groups (13.8% of the homeless clients compared with 11.1% of the home-based clients)(Chi=1.03, P=0.3 NS).

Support, practical help and education were used much more with the home-based clients (23.9%) than with the homeless (8.9%) (Chi=29.7, P=0.00001). A higher proportion of homeless clients (12.8%) lost contact with the CPN service compared with the home-based clients (5.7%) (Chi=11.58, P=0.0006).

When the interventions drug supervision, supportive & practical help, counselling/ psychotherapy, family therapy and behavioural therapy were grouped under one category "CPN intervention", the differences between the home-based and the homeless become more striking. These differences remained significant when the differences in presenting problems were controlled for. Table-A7shows the proportion of homeless and home-based who got Community Psychiatric Nursing care for different presenting mental health problems. 78.5% of the home-based clients who presented with mood related problems were getting CPN care compared with 58.8% of the homeless clients presenting with the same problem (Chi=5.3, P=0.02).

A higher proportion of the home-based clients who presented with abnormal experiences (87.8%) had CPN care compared with 63% of the homeless clients with the same problem (Chi=9.4, P=0.002). The differences were more striking in the client presenting with a life event which needed the preventive and crisis intervention skills of CPNs. Only 38.5% of the homeless clients presenting with life events had received CPN care compared with 78.6% of the home-based clients presenting with the same problem (Chi=23.7, P=0.0000).

TABLE-A7

The proportion of homeless and home-based clients who are getting CPN intervention controlled by the presenting problem.

Presenting Problem	Intervention	Home -based	Homeless	Chisquar (P)	O.R. (C.L.)
Mood related	CPN	73 78.5%	30 58.8%	5.3 (.02)	.39 (.2-.87)
	Other	20 21.5%	26 41.2%		
Abnormal experinces	CPN	72 87.8%	29 63%	9.4 (0.002)	.24 (.08-.6)
	Other	10 12.2%	17 37%		
Life events	CPN	88 78.6%	20% 38.5%	23.7 (0.0000)	.17 (.07-.37)
	Other	24 21.4%	32 61.5%		
Other	CPN	92 64.3%	35 41.2%	10.6 (0.001)	.39 (.2-.7)
	Other	51 35.7%	50 58.8%		

A4.The differences between male and female homeless clients:

The demographic features of the two groups (see table A8) showed that they had similar age distributions. The marital status showed that a significantly higher proportion of male homeless clients were single (87.9%) compared with female homeless clients (75.6%) (Chi=8.16, P=0.004).

Employment status showed that the male homeless had a higher unemployment rate (85.9%) compared with the female homeless (72.1%) (Chi=9.13, P=0.003). Similar proportions of people from ethnic minorities were found among both the two groups.

(TABLE-A8)

Characteristics of male and female homeless clients

Characteristic	Male homeless clients (n)(146)(%)		Female homeless clients (n)(169)(%)	
Age: -35	83	56.8	91	53.8
36-65	56	38.4	67	39.6
66-	7	4.8	11	6.5
Marital status				
Single	131	87.9	130	75.6
Married	8	5.4	17	9.9
Widowed	3	2.0	6	3.5
Divorced	7	4.7	19	11.0
Living arrang.				
Alone	123	82.6	140	80.5
Employment				
Regular	3	2.0	13	7.6
Casual	8	5.4	6	3.5
Unemployed	128	85.9	124	72.1
Retired	8	5.4	20	11.6
Student	2	1.3	2	1.2
House pers			7	4.1
Ethnic origin				
Chinese	1	0.7	1	0.6
Greek/Cyp				
Caribbean	12	8.2	20	11.8
Asian	6	4.1	5	2.9
African	3	2.0	4	2.4
Scottish	10	6.8	8	4.7
Irish	16	10.9	20	11.8
Mid.East			1	0.6
Other(Eng)	99	67.3	111	65.3

The CPN assessment of the main current problem at the time of the referral (see table A9) showed that a higher proportion of the male homeless had abnormal experiences (28.2%) compared with the female group (16.1%) (Chi=6.22, P=0.01). According to the odds ratio the male homeless clients are more likely to have abnormal (psychotic experiences) compared with the female homeless clients. The male homeless were more likely to have alcohol and drug problems (8.7% vs. 2.9%) (Chi=4.17, P=0.04). Similarly the male homeless were three times more likely to have anxiety disorders compared with the female (Chi=5.94, P=0.01).

TABLE A9

CPN assessment of the main current problem in male and female homeless

The presenting mental problem	Male homeless	Female homeless	Chi-square (P)	Odds Ratio (Confidence Lmt)
Mood related	21 14.1%	41 23.6%	4.05 (0.04)	0.53 (0.29-0.99)
Abnormal experiences	42 28.2%	28 16.1%	6.22 (0.01)	2.05 (1.15-3.64)
Drug/Alcohol dependence	13 8.7%	5 2.9%	4.17 (0.04)	3.23 (1.04-10.7)
Interpersonal relations	19 12.8%	24 13.8%	0.01 (0.91 NS)	0.91 (0.45-1.8)
Organic	2 1.3%	3 1.7%	Fisher (0.57 NS)	0.77 (0.04-5.7)
Financial/Housing /Employment	11 7.4%	9 5.2%	0.3 (0.55 NS)	1.5 (0.5-3.96)
Behavioural disturbance	10 6.7%	21 12.1%	2.07 (0.14 NS)	0.52 (0.22-1.2)
Recent loss or separation	1 0.7%	6 3.4%	1.76 (0.19 NS)	0.19 (0.01-1.6)
Anxiety	19 12.8%	8 4.6%	5.94 (0.014)	3.03 (1.2-7.8)
Other	6 4.0%	28 16.1%	11.15 (0.0008)	0.22 (0.07-0.57)
None	5 3.4%	1 0.6%	2.05 (0.15 NS)	6.01 (0.67-69.9)
Total	149 46.1%	174 53.9%		

On the other hand female homeless clients were significantly higher in the mood-related problems (23.6%) compared with the male homeless (14.1%) (Chi=4.05, P=0.04).

When the current CPN assessed problems were compared with previous psychiatric diagnosis (see table A10) there were striking differences. There were no significant differences in the types of diagnosis given to the two groups.

Table-A10
Psychiatric Diagnosis of the male and female homeless clients

Psychiatric Diagnosis		Male Homeless	Female Homeless	Chi-Sq. (P)	Odds Ratio (Conf. Lmt.)
Not applicable		66 44.3%	75 43.1%	0.01 (.9 NS)	1.04 (.7-1.6)
Affective disorders	1	4 2.7%	10 5.7%	1.15 (.3 NS)	0.45 (.12-1.6)
Schizophrenic disorders	2	47 31.5%	38 21.8%	3.41 (.06)	1.64 (.97-2.8)
Personality disorders	3	7 4.7%	15 8.6%	1.37 (.52 NS)	0.52 (.18-1.4)
Dementing Process	4	- -	- -	- -	- -
Anxiety state	5	- -	1 .6%	Fisher (.52 NS)	-
Alcoholism/ drug abuse	6	6 4.0%	5 2.9%	0.07 (.79 NS)	1.4 (.4-5.5)
Other	7	2 1.3%	3 1.7%	Fisher (.57 NS)	- (.04-5.8)
Not known	8	17 11.4%	27 15.5%	0.8 (.36 NS)	0.7 (.34-1.4)
Total		149 46.1%	174 53.9%		

5.Summary:

This is a comparison of the homeless clients of the CPN service in Bloomsbury with the home-based clients of the same service. The demographic characteristics showed that the homeless clients live very impoverished, lonely and stressful lives. The homeless clients were more likely to be unemployed, single, living alone and from black ethnic origins compared with home-based clients.

The comparison between the presenting mental health problems of the two groups showed that the homeless clients were only significantly higher in problems related to their housing, employment, and financial problems. On the other hand homeless clients who had been in contact with a psychiatrist were more likely to have been given a diagnosis of schizophrenia compared with the home-based. In the clients under the age of 65 similar proportions of the two groups were given the diagnosis of schizophrenia, however more homeless clients of this age group presented to the service with psychotic problems.

A significantly higher proportion of the male homeless clients presented to service with psychotic experiences compared with the female homeless. In the homeless clients who had been to a psychiatrist, there was no significant difference in the diagnoses given to the two sexes.
The response of the CPN service to the problems of the homeless was different from their response to similar problems of the home-based clients. The CPN service is less involved in their care compared with the home-based.

Results of Bloomsbury hostels survey:

The CPN data analysis illuminated the way to the hostel survey. According to both the CPN data and to the 1981 Census most of the homeless people in Bloomsbury live in hostels. The major question that this survey tried to answer is whether it is true that hostels for homeless people are becoming long-stay wards and that the homeless are mostly chronic mentally ill patients as some people have hypothesized (Marshall, 1989). This was achieved by measuring the social functioning and the individual needs for psychiatric services of a random sample from four big hostels for homeless people in the Bloomsbury Health District.

These data were then compared with two samples of patients with chronic mental illnesses in contact with psychiatric services. The results of the hostels survey consist of the socio-demographic characteristics, health and contacts with health services, social behaviour disability, and the assessment of needs for mental health services.

B1 Socio-demographic characteristics, health and contact with health services:

B1.1.Socio-demographic characteristics of the study sample:

a. Age: The age of the men in the sample ranged from 29 to 84 years with a mean of 59.3 (SD= 13). The majority of the sample were over the age of 50. 36.6% of the sample were over the age of 65. The age of the men in the sample was compared with the men in OPCS survey of hostels and lodging houses for single people (Digby, 1972) (see table B1.1).

TABLE B1.1

Age of men in Bloomsbury hostels compared with men in OPCS hostels study, Bloomsbury & U.K. population (1981 census)

Characteristic (%)	OPCS 72 STUDY	BHA Hostels	BHA CENSUS 81	UK -CENSUS 81
Sample size (n)	100.0 (1821)	100.0 (101)	100.0 (54677)	100.0 (26053190)
Age:15-29	11.0	2.0	29.3	29.9
30-49	32.0	18.8	30.6	33.1
50-64	37.0	42.6	22.9	21.5
65-	20.0	36.6	17.2	15.5

The age of the hostel sample show more old people compared to OPCS sample. Both samples were older than the general population.

b. Marital status: The majority of the hostel residents were single (74% of the sample). The marital status of the sample was similar to that of the OPCS sample (see table-B1.3).

c.Employment: The majority of the men in the sample were unemployed (47.5%) or retired (34.7%). Only 5% were in regular employment (table B1.2). When these figures were compared with the OPCS sample, less proportion of the hostel sample (10.9%) were working compared with (43%) of the OPCS sample (see table B1.3). This may be due to the increase in unemployment figures in UK from 1972 (OPCS study) to 1988.

TABLE B1.2
Demographic characteristics
of the men in the survey hostels in Bloomsbury

Characteristic (%)	Frequencies	Percent
Age:		
-50	23	22.8
51-70	58	57.4
71-	20	19.8
Marital status		
Single	74	74.0
Widowed	5	5.0
Divorced	21	21.0
Stay in hostel		
1mth-1yr	18	17.8
1yr-5yrs	29	28.7
5yrs-10yrs	26	25.7
10yrs-	28	27.7
Employment		
Regular	5	5.0
Casual	6	5.9
Unemployed	48	47.5
OAP	35	34.7
Other	7	6.9
Ethnic origin		
UK	54	53.5
Eire	36	35.6
West Ind.	2	2.0
Asian	2	2.0
Europe	2	2.0
Other	5	5.0
Life achivemnt		
Nil	37	36.6
Job	39	38.6
+House	24	23.8

e.Ethnic origin: The country of birth of the residents showed that only 53.5% of the residents were of UK origin. 35.6% were from Eire (see table B1.2). Compared with OPCS sample and Bloomsbury population, people from Eire are over represented in the hostel sample (see table B1.3).

Table-B1.3
Demographic characteristics of the men in the survey hotels in Bloomsbury

Characteristic (%)	OPCS 72 STUDY	BHA Hostels	BHA Census 81
Sample size(n)	(1821)	(101)	(54677)
Age:15-29	11.0	2.0	29.3
30-49	32.0	18.8	30.6
50-64	37.0	42.6	22.9
65-	20.0	36.6	17.2
Marital status			
Single	63.0	74.0	*
Widowed	9.0	5.0	*
Divorced	28.0	21.0	*
Employment			
Working	43.0	10.9	69
Unemployed	40.0	47.5	7.9
OAP	17.0	34.7	14.8
Other	0.0	6.9	8.3
Ethnic origin			
UK	81.0	53.5	62.9
Eire	15.8	35.6	5.3
Other	4.0	11.0	31.8
Stay in hostel			
1mth-5yrs	32.0	46.5	
5yrs-10yrs	19.0	25.7	
10yrs-	47.0	27.7	
Life achievmnt			
Nil	19.0	36.6	
Job	57.1	38.6	
+House	23.8	23.8	

*-Data not available.

f.Length of stay in hostel: These hostels are -in general- long stay hostels. The length of stay was from 2 months to 45 years. A majority of the residents (53.4%) have been there for more than 5 years (see table B1.2). This is very similar to the finding of the OPCS study on hostels in general (see table B1.3).

g.Life achievement:This measure was devised to assess residents' past life achievements in housing and employment (see table B1.2). 36.6% of the residents had never lived in private accommodation and had never had any stable job in their lives. Only 23.8% of them had ever lived in private accommodation.

B1.2.Health and contacts with health services:

TABLE B1.4
Health and contact with health services of the men in the survey hostels in Bloomsbury

Characteristic (%)	Frequencies	Percent
Health problem		
None	22	21.8
Physical	34	33.7
Psych.	26	25.7
Alcohol	10	9.9
Phy+Psy	9	8.9
Alcoholism		
No problem	64	64.4
Moderate	14	13.9
Severe	22	21.8
Gp registrat.		
Registered	79	78.2
Services util.		
GP	47	46.5
CPN	2	2.0
Psychiatr.	3	3.0
Hospital	23	22.8
SW	14	13.9
Other	18	17.8
History of men -tal hospital.	19	18.8
Staff burden		
No burden	67	66.3
Physical	1	1.0
Psycholog.	27	26.7
Both	6	5.9

a.Main health problem:This category records only the main health problem (see table B1.4). Only 21.8% of the residents had no health problems. 33.7% had a physical illness, 25.7% had psychiatric problems and 8.9% had a combination of both physical and psychiatric problems. Of the 35 who had psychiatric problems 17 (48.6%) had depressive illness, 7 (20%) had psychotic illness, 4 (11.4%) dementing illness, 3 (8.6%) anxiety disorders, 3 (8.6%) personality disorders, 1 (2.8%) epilepsy (from hostel records and researcher assessment). Only 9.9% were recorded as having drinking as the main problem.

b.Alcoholism: This Item was derived from the Present State Examination (PSE) (Wing et al, 1974). 35.6% of the residents had a drinking problem. 21.8% of them were rated on the PSE as having a severe drinking problem (see table B1.4).

e.Utilisation of health services in the previous six months prior to the interview (see table B1.4):

i-GP service: 78% of the residents were registered with a GP, though this varied from hostel to hostel. The registration with GPs was higher in hostels visited by a GP (97%) compared with hostels with no visiting GP (42%) (Chi=11.4, P=0.007). The proportion of residents who were in contact with this service in the hostels with a visiting GPs (52.7%) was not significantly higher than the hostels without one (42.9%). The residents of the hostels with no in-house surgery tended to consult the GP visiting nearby hostels with such a surgery. Interestingly a health centre which deals specifically with the homeless had little contact with residents from the nearby hostel.

ii-CPN: In spite of the presence of a relatively high prevalence of mental health problems very few residents has been in contact with the CPN service (2%). All these residents were in one hostel which had a visiting CPN. Before the survey started, the CPN withdrew their services from the hostels.

iii-Psychiatrist: Only 3% of the residents had been in contact with a psychiatrist.

iv.Hospital: Although few people were admitted to hospital most went to the A&E department. 22.8% of the sample used hospitals.

v. Social worker: 13.9% of the sample had been in contact with social worker. 40% of the residents of one of the hostels with an attached SW utilised the service .

vi.Other services: 17.8% of the residents have been in contact of other services such as dentists, opticians, chiropodists etc. Most of these have been to the chiropodist who visited one of the hostels weekly.

f.History of mental hospital admission: 19 out of the 101 residents have been admitted to a mental hospital at one point in their life. The majority of these residents (11) were admitted for less than six months and none of them for more than one year.

g.Staff burden:33.7% of the residents cause the staff some sort of burden due to their health problems. The main burden was psychological one due to the worry about the resident's condition and the lack of health and social services support. 5.6% of the residents caused both physical and psychological burdens to staff due mainly to the residents physical disability.

B2 The social disablement of the sample:

Social functioning and social disablement are better measures of the level of dependency on psychiatric services than diagnosis (Sturt & Wykes, 1987). In this Bloomsbury survey a measurement of the social behaviour of the random sample has been undertaken and compared with a sample of patients with chronic mental illness. The results of this are as follows:

B2.1.The reliability of the SBS in the community survey:

As this study was the first in which the SBS has been used in a community survey, it was necessary to assess its reliability in such a survey. 21 residents out of the sample were selected at random from the original sample for this purpose. Two different members of staff were interviewed separately as informants about each one of these residents.

The percentage agreement between the two informants was calculated and from that a kappa was computed (Fleiss & Cohen, 1973). The overall BSM score revealed 90% agreement with a kappa of 0.70 (SE=0.03). The reliability of the individual SBS items was also calculated and showed a high agreement (see table-1). The percentage agreement ranged from 81% to 100% (with an average of 92%). In six out of the 21 items the kappa did not reach a significant level because of the small numbers and the lack of variability (Anker, 1983) in these items (ie both informants agreed that there was no problem in each these items).

Table B2.1
The reliability of the SBS in the hostel survey

SBS Items	Percentage Agreement	Kappa
1. Little spontaneous communication	90%	0.26
2. Incoherence of speech	95%	0.55
3. Odd or inappropriate conversation	95%	0.83
4. Inappropriate social mixing	90%	0.51
5. Hostility	95%	0.65
6. Demanding attention	92%	0.57
7. Suicide idea or behaviour	100%	N.S.
8. Panic attacks and phobias	95%	N.S.
9. Overactivity and restlessness	81%	N.S.
10. Laughing and talking to self	94%	0.77
11. Acting out bizarre ideas	95%	N.S.
12. Posturing and mannerisms	100%	N.S.
13. Socially unacceptable habits or manners	89%	0.42
14. Violence or threats	90%	0.49
15. Depression	86%	0.60
16. Inappropriate sexual behaviour	98%	0.85
17. Poor self care	95%	0.82
18. Slowness	100%	N.S.
19. Underactivity	83%	0.45
20. Poor attention span	86%	0.35
21. Other Behaviour	83%	0.58

These items were; suicidal ideas or behaviour, panic attacks and phobias, overactivity and restlessness, acting out bizarre ideas, posturing and mannerisms, and slowness.

B2.2.Social behaviour profile of the survey sample:

The BSM scoring method was used to assess the presence and the absence of social behaviour problems. This method score the problem as present (1) when the item score is 2, 3 or 4 and absent (0) when the score is 0 or 1. The total number of items scoring 1 then give an overall BSM for each subject in the sample.

Out of 21 behavioural problems the most prevalent were hostility (score of 18), inappropriate social mixing (15), underactivity (14), poor self care (12), depression (10), overactivity and restlessness (10), demanding attention (9) and laughing and talking to self (9). The "other behaviour" category (a measure of idiosyncratic problems) scored 36 because it included alcoholism.

Table B2.2
Comparison of the number of SBS problems between the homeless hostels and long stay ward

Number of SBS problems	Long-stay wards	BHA hostels	Chisquar (P)	O.R. (C.L.)
No problem (0)**	6 (9.1%)	43 (42.6%)	20.0 (0.00007)	0.13 (.04-.36)
1-2 problems	14 (21.2%)	30 (29.7%)	1.07 (0.29 NS)	0.63 (.28-1.4)
3-5 problems*	26 (39.4%)	18 (17.8%)	8.5 (0.003)	2.99 (1.4-6.5)
> 5 problems*	20 (30.3%)	10 (9.9%)	9.9 (0.001)	3.95 (1.6-9.9)

* P<0.01
** p<0.001

On the basis of statistical and clinical similarities, Wykes et al (Wykes et al, 1982b) grouped the 21 items of the SBS into five areas. These areas were social withdrawal (items 1, 18, 19); socially embarrassing behaviour (items 2, 3, 4, 9, 11, 16, 20); depression and anxiety (items 6, 7, 8, 15); hostility and violence (items 5, 14); and socially unacceptable behaviour (items 12, 13, 17, 21). When the same coding was used with the Bloomsbury sample (see table-2) the commonest area was the socially unacceptable behaviour on which 40.6% of the sample had at least one problem on its items. Socially embarrassing behaviour was recorded for 25.8% of the sample, depression and anxiety for 21.8%, social withdrawal for 19.8% and hostility and violence for 18.8%.

B2.3.Sample's social behaviour compared with long-stay ward in a mental hospital :

Social behaviour problems were significantly less frequent in the hostels sample than in patients with chronic mental illness (Wykes & Sturt, 1986)(see table-B2.2).

A significantly higher proportion of the hostels sample had no problem (42.6% compared with only 9.1% of the long-stay ward) (chi=20, P=0.0000007) and there was a significantly lower proportion who had more than five problems (9.9% compared with 30.3% in the long-stay ward) (Chi=9.9, P=0.001). There was no significant difference in the proportion of people who had 1 or 2 problems in the two samples. The odds ratios showed that the long stay patients were approximately four times more likely to have more than five problems compared with the hostel sample.

There was a statistically significant difference between the two samples in 13 out of the 21 items of the SBS (see table B2.3). The overall scoring of the SBS items which rate 2 and more (BSM) showed a mean of 1.8 (SD=0.14) in the hostels sample compared with 4.3 (SD=0.09) in the long -stay wards sample. The difference was statistically significant using T test $P<0.0001$.

An Odds Ratio (OR) was calculated comparing the relative risk of the long stay ward patients (cases) with that of the residents of the homeless people hostel (controls) in having the social behaviour problems. The OR assesses the magnitude of the difference in these two samples. The odds ratios on different SBS problems ranged from around one (similar risk in both groups) to an odds ratio of 7.8 (in 'odd or inappropriate conversations'). A mean of the odds ratios for the 21 SBS items was calculated as 3.5 which means that the hostels sample was 3.5 times less likely to have SBS problems compared with the long stay ward sample.

The Mantel-Hanenszel Chi-square was used to re-assess the difference between the two groups adjusting for the age of both groups (Schlesselman, 1982). The results of these analyses were similar for most items, apart from the 'suicidal ideas or behaviour' where the differences were not significant. This might be due to the small number of people who had this problem in both groups which became even smaller with the adjustment for age. The mean OR showed that the magnitude of difference was greater (4.2) when an adjustment for the age was made.

Table-B2.3
Comparison of SBS items in homeless hostels and long-stay ward

SBS Items (n)	BHA hostels (101)	Long-stay ward (66)	CRUDE OR (C.L.)	ADJ. OR (C.L.)
1. Little spontaneous communication	5%	26%	6.66*** (2.1-22)	9.79*** (2.8-34)
2. Incoherence of speech	2%	14%	7.81** (1.5-36)	10.2* (1.4-71)
3. Odd or inappropriate conversation	6.9%	26%	4.65** (1.7-13)	4.23** (1.4-12)
4. Inappropriate social mixing	14.9%	38%	3.49** (1.6-8)	3.1** (1.3-7)
5. Hostility	17.8%	21%	1.24 NS (.5-2.9)	1.13 NS (.03-36)
6. Demanding attention	8.9%	27%	3.8** (1.5-10)	2.7* (1-7.4)
7. Suicide idea or behaviour	2%	9%	4.95* (.9-30)	4.05 NS (.7-24)
8. Panic attacks and phobias	6.9%	30%	5.83*** (2.1-17)	6.29*** (2.2-18)
9. Overactivity and restlessness	9.9%	14%	1.43 NS (.5-4.1)	1.23 NS (.1-15)
10. Laughing and talking to self	7.9%	23%	3.4* (1.2-10)	3.4* (1.2-10)
11. Acting out bizarre ideas	4%	6%	1.56 NS (.31-8)	2.4 NS (.2-39)
12. Posturing and mannerisms	3%	15%	5.83** (1.4-22)	7.4*** (2.5-22)
13. Socially unacceptable habits or manners	5%	15%	3.42* (1-12.2)	6.2** (1.6-24)
14. Violence or threats	5%	6%	1.23 NS (.3-5.5)	1.1 NS (.3-4)
15. Depression	9.9	12%	1.25 NS (.4-3.7)	1.1 NS (.0003-)
16. Inappropriate sexual behaviour	2%	2%	0.76 NS (.2-3.2)	0.3 NS (42-.001)
17. Poor self care	11.9%	39%	4.82*** (2.1-11)	6.4*** (2.6-16)
18. Slowness	5%	23%	5.64** (1.8-19)	12.2*** (3.7-40)

Table-B2.3 (continued)

SBS Items (n)	BHA hostels (101)	Long-stay ward (66)	CRUDE OR (C.L.)	ADJ. OR (C.L.)
19.Underactivity	13.9%	17%	1.24 NS (.2-3.2)	1.3 NS (.3-5)
20.Poor attention span	5%	17%	3.84* (1.2-13)	3.3* (1-11)
21.Other Behaviour	35.6%	36%	1.03 NS (.5-2.1)	0.9 NS ()
MEAN ODDS RATIO (OR)			3.5	4 .2

NS: P>0.05,
*: P<0.05,
**: P< 0.01,
***: P< 0.001.

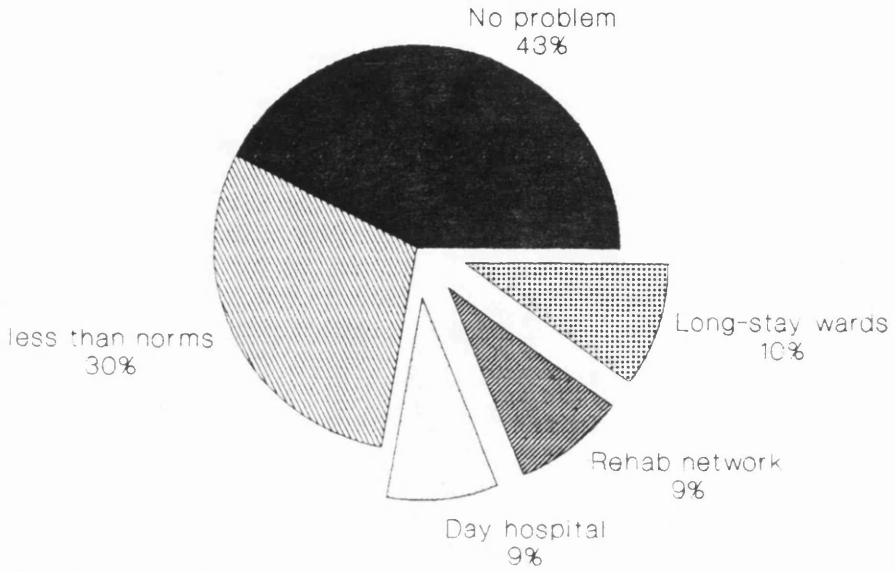
B2.4.Norms for different psychiatric services:

The BSM scores of the hostels sample were compared with the different 'norms' for psychiatric services which provide for different levels of dependency (see figure B2.1). This was done to see how much of the hostel sample have a disability that conforms to that of patients in long stay wards or other psychiatric services. These norms were calculated from the average BSM percentage scored for patients in different service settings (Wykes & Sturt, 1986).

The different services norms were used as cut-off points on or above which people are considered to 'need' such services. Only 9.9% of the hostels sample had a BSM equal or higher than that of the norm of the long stay wards' populations (see figure B2.1). 8.9% were equal or higher than the norm for patients in a rehabilitation network and another 8.9% were equal or higher than the norm for those attending day hospitals. 30% of the hostels sample had a BSM less than that of the norm for any long term service provision and 42.6% had no problem.

Figure-B1

Proportion of study subjects with BSM equal or above 'norms of services*'



* from Wykes and Sturt (1986).

B2.5 The hostel residents with psychotic problems:

Because strict diagnostic measures were avoided in this study, subjects with psychosis were identified using the social behaviour problems which are associated with psychotic illnesses. These problems are incoherence of speech, odd or inappropriate conversation, laughing and talking to self, and acting out bizarre ideas. Any subject of the hostels sample who had one or more of these problems was selected.

The demographic variables of the 13 residents with psychotic SBS problems (PSBSP) were compared to the characteristics of the rest of residents without these problems. Both groups had a similar mean age (57.1 years -SD=12.8- for the PSBSP group compared with 59.8 for the rest, T=0.69; P=0.49 NS). The distribution on age groups show a similar pattern also (see table B2.4). The employment status show similar proportions of working men, unemployed and pensioners in the two groups.

TABLE B2.4

Demographic characteristics and health status of survey residents with psychotic problems (PSBSP)

Characteristic (%)	With psychosis	No psychosis
Age:		
-50	3 (23.1)	20 (22.7)
51-70	7 (53.8)	51 (58.0)
71-	3 (23.1)	17 (19.3)
Employment		
Regular	1 (7.7)	4 (4.5)
Casual	0	6 (6.8)
Unemployed	7 (53.8)	41 (46.6)
OAP	5 (38.5)	30 (34.1)
Other	0	7 (8)
Stay :		
-5 yrs	8 (61.5)	39 (44.3)
5 yrs-	5 (38.5)	49 (55.7)
Ethnic origin		
UK	5 (38.5)	49 (55.7)
Eire	4 (30.8)	32 (36.4)
Black	3 (23.1)	1 (1.1)
Other	1 (7.7)	6 (6.8)
Health problem		
None	0	22 (25.0)
Physical	0	34 (38.6)
Psych.	8 (61.5)	18 (20.5)
Alcohol	1 (7.7)	9 (10.2)
Phy+Psy	4 (30.8)	5 (5.7)
Alcoholism		
No problem	9 (69.2)	56 (63.6)
Moderate	0	14 (15.9)
Severe	4 (30.8)	18 (20.5)
GP registrat.		
Registered	12 (92.3)	67 (76.1)
Services util.		
GP	7 (53.8)	40 (45.5)
CPN	2 (15.4)	0
Psychiatr.	2 (15.4)	1 (1.1)
Hospital	3 (23.1)	20 (22.7)
SW	4 (30.8)	10 (11.4)
Other	1 (7.7)	17 (19.4)
History of men -tal hospital.	6 (46.2)	13 (14.8)

The length of stay in the hostel showed also a similar pattern in the two groups. The residents with PSBSP mean length of stay was 8.6 years (SD=7.7) compared with length of stay of 6.4 years (SD=9.6) for the rest of the residents (T=0.76, P=0.45 NS).61.5% of the residents with PSBSP stayed less than 5 years compared with 44.3% of the rest of the residents (Chi=0.7, P=0.4 NS).

The only significant difference in the ethnic origin of the two groups was the presence of significantly higher proportion of people from black ethnic origin in the PSBSP group (23.1%) compared with rest of the residents (1.1%) (Fishers; P=0.006).

The main health problems showed the specificity of the SBS in identifying psychotic problems. All the residents identified as having psychotic problems, were assessed as having psychiatric problems (61.5%), alcoholism (7.7%) or combinations of psychiatric and physical problem (30.8%) as the main health problems. On the PSE measure of drinking problems, 30.8% of the residents with PSBSP had drinking problems all of severe degree.

The registration with GPs showed that a satisfactorily high proportion of the residents with PSBSP were registered with a GP (92.3%). This was reflected in the utilisation of health services as there were more contacts with physical and general medical care (53.8% with GPs and 23.1% with a hospital) compared with their contact with mental health care (15.4% with CPNs and 15.4% with psychiatrists). Less than half of the residents with PSBSP have been in a mental hospital (46.2%).

Table B2.5

The Social behaviour problems of the hostel residents with pschotic problems

SBS Items (n)	Homeless psychotic SB (13)	WYKES & STURT (66)	FISHERS P	OR (C.L.)
1. Little spontaneous communication	15.4%	26%	0.34NS	0.61 (.01-3.4)
2. Incoherence of speech	15.4%	14%	0.57NS	1.15 (.4-7.1)
3. Odd or inappropriate conversation	53.8%	26%	0.049	3.36 (.8-13.2)
4. Inappropriate social mixing	61.5%	38%	0.1NS	2.6 (.7-10.5)
5. Hostility	30.8%	21%	0.33NS	1.65 (.4-7.2)
6. Demanding attention	23.1%	27%	0.5NS	0.8 (.000-3.7)
7. Suicide idea or behaviour	0%	9%	0.3NS	---
8. Panic attacks and phobias	23.1%	30%	0.4NS	0.69 (.01-3.1)
9. Overactivity and restlessness	38.5%	14%	0.047	3.9 (.9-17.9)
10. Laughing and talking to self	61.5%	23%	0.008	5.44 (1.3-23.1)
11. Acting out bizarre ideas	30.8%	6%	0.02	6.88 (1.2-42.1)
12. Posturing and mannerisms	23.1%	15%	0.36NS	1.68 (.05-8.5)
13. Socially unacceptable habits or manners	15.4%	15%	0.58NS	1.01 (.93-6.1)
14. Violence or threats	23.1%	6%	0.08NS	4.65 (.68-31)
15. Depression	23.1%	12%	0.25NS	2.2 (.17-11.5)
16. Inappropriate sexual behaviour	7.7%	2%	0.3NS	5.4 (------)
17. Poor self care	53.8%	39%	0.25NS	1.79 (.47-6.9)
18. Slowness	0%	23%	0.049	-----
19. Underactivity	15.4%	17%	0.63NS	0.90 (.48-5.4)
20. Poor attention span	23.1%	17%	0.41NS	1.5 (.009-7.4)
21. Other Behaviour	53.8%	36%	0.19NS	2.04 (.53-7.9)

The BSM scores for these subjects were then compared with that of patients in long-stay wards (see table B2.5). The comparison showed that 13 hostel residents (who exhibited social behaviour problems associated with psychosis had similar mean BSM scores (5.9,SD=3.3 compared with 4.3, SD=0.09) and on most individual SBS items compared with long-stay ward sample (T=0.86, P=0.38NS)

B2.6 The hostel residents compared by the length of stay:

The residents were classified into two groups according to the length of stay in the hostels; those who stayed less or equal to five years (n=47) and those who stayed for more than five years (n=54). As expected the residents with length of stay less than 5 years are younger than those who had stayed for more than 5 years (see table B4.2). 40.4% of the first group were less than 50 years of age compared with only 7.4% of the second group (Chi=13.7 P=0.0002).

The employment status of the two groups reflected their age structure (see table B2.6). Higher proportion of the first group were unemployed (59.6% compared with 37% of the second groups , Chi=4.25, P=0.04) while more of the second group were old age pensioners (44.4% compared with 23.4% of the first group, Chi=4.02, P=0.045). There were no significant differences between the two groups in the marital status or the ethnic origin.

TABLE B2.6

Demographic characteristics of the survey sample according to length of stay

Characteristic	Stay < 5 years	Stay > 5 years
Age: **		
-50	19 (40.4)	4 (7.4)
51-	28 (59.6)	50 (92.6)
Marital status		
Single	37 (78.7)	37 (69.8)
Widowed	2 (4.3)	3 (5.7)
Divorced	8 (17.0)	13 (24.5)
Employment		
Regular	2 (4.3)	3 (5.6)
Casual	4 (8.5)	2 (3.7)
Unemployed	28 (59.6)	20 (37.0)
OAP	11 (23.4)	24 (44.4)
Other	2 (4.3)	5 (9.3)
Ethnic origin		
UK	27 (57.4)	27 (50)
Eire	15 (31.9)	21 (38.9)
Other	5 (10.6)	6 (11.2)
Health problem		
None	10 (21.3)	12 (22.2)
Physical	11 (23.4)	23 (42.6)
Psych.	11 (23.4)	15 (27.8)
Alcohol	7 (14.7)	3 (5.6)
Phy+Psy	8 (17.0)	1 (1.9)
Alcoholism		
No problem	27 (57.4)	38 (70.4)
Moderate	8 (17.0)	6 (11.1)
Severe	12 (25.5)	10 (18.5)
Gp registrat.		
Registered	31 (66.0)	48 (88.9)
Services util.		
GP	26 (55.3)	21 (38.9)
CPN	2 (4.3)	0
Psychiatr.	2 (4.2)	1 (1.9)
Hospital	15 (31.9)	8 (14.9)
SW	9 (19.2)	5 (9.3)
Other	12 (25.5)	6 (11.2)
History of men-tal hospital.	9 (19.9)	10 (18.5)
Staff burden		
No burden	26 (55.3)	41 (75.9)
Burden	21 (44.7)	13 (24.1)

The main health problem showed no significant differences between the two groups (see table B4.2). Only the few people who had both physical and psychiatric problems were higher in the shorter stay residents (17% compared with 1.9% of the people who had stayed more than 5 years, Fishers P=0.009). Drinking problems measured by the PSE scale did not show a significant difference between the two groups.

Registration with GP showed a significant association with the length of stay. 88.9% of the residents who had stayed more than 5 years had registered with a GP compared with 66% of the residents who stayed less than 5 years (Chi=6.46, P=0.01). The utilisation of services did not show significant differences between the two groups. The burden to the staff caused by the two groups was not significantly different.

The social behaviour problems were compared in the two groups (see table B2.7). Residents who stayed less than 5 years (2.4, SD=3.04) had significantly higher BSM scores than residents who stayed for more than 5 years (1.3 SD=1.7) (T=2.25, P=0.03). The individual items of the SBS did not show no significant difference apart from 'acting out bizarre ideas' (Fishers P=0.04), although 17 of the 21 items were all greater in the shorter stay group.

Table B2.7
SBS problems of resident according to length of stay

SBS Items	Stay < 5year	Stay > 5years
1. Little spontaneous communication	3 (6.4)	2 (3.7)
2. Incoherence of speech	2 (4.3)	0
3. Odd or inappropriate conversation	5 (10.6)	2 (3.7)
4. Inappropriate social mixing	9 (19.1)	6 (11.1)
5. Hostility	11 (23.4)	7 (13.0)
6. Demanding attention	6 (12.8)	3 (5.6)
7. Suicide idea or behaviour	1 (2.1)	1 (1.9)
8. Panic attacks and phobias	5 (10.6)	2 (3.7)
9. Overactivity and restlessness	7 (14.9)	3 (5.6)
10. Laughing and talking to self	7 (14.9)	3 (5.6)
11. Acting out bizarre ideas	4 (8.5)	0
12. Posturing and mannerisms	3 (6.4)	0
13. Socially unacceptable habits or manners	4 (8.5)	1 (1.9)
14. Violence or threats	3 (6.4)	2 (3.7)
15. Depression	4 (8.5)	6 (11.1)
16. Inappropriate sexual behaviour	2 (4.3)	0
17. Poor self care	6 (12.8)	6 (11.1)
18. Slowness	2 (4.3)	3 (5.6)
19. Underactivity	8 (17.0)	6 (11.1)
20. Poor attention span	3 (6.4)	2 (3.7)
21. Other Behaviour	21 (44.7)	15 (27.8)

B3.Needs for mental health services:

In spite of the fact that much has been written on the needs of the homeless people for mental health services, there is no attempt to assess the needs of homeless individuals empirically. This section discusses the results of an individual needs assessment on the Bloomsbury hostels sample. It also contains a comparison between the needs of this sample and the needs of chronic psychiatric patients in contact with Camberwell community service (Wykes et al, 1982a). The comparison aims to test further the widely publicised hypothesis in the current psychiatric literature which claims that homeless peoples' hostels are becoming long-stay wards (Weller, 1985) (Marshall, 1989).

B3.1.The reliability and validity of the assessment:

B3.1.1 The reliability of the needs assessment:

Needs assessment procedures in general are usually criticised for being highly value loaded (Wing, 1990). That may make the assessment of the reliability of these procedures difficult because different services have different resources, philosophies, values and politics.
In spite of these problems it was essential for the purpose of this study to assess reliability because it involved a comparison with a needs assessment study undertaken on Camberwell community psychiatric services (Wykes et al, 1982a).

The reliability of the study sample was assessed by the main author of the Camberwell study. Dr. Wykes completed an independent final assessment of the needs of 10 randomly selected subjects from Bloomsbury survey sample (see table B3.1).

Table B3.1
The needs for mental health services ; researcher assessment compared with Dr. T. Wykes assessment

THE NEEDS	UNMET NEEDS PERCENTAG AGREEMENT	UNMET NEEDS WEIGHTED KAPPA	TOTAL NEEDS PERCENTAGE AGREEMENT	TOTAL NEEDS WEIGHTED KAPPA
1 Security:	100%	++++	90%	++++
2 Medication and medical assessment:	90%	0.78	90%	0.78
3 Training in domestic skills:	90%	0.615	90%	0.615
4 Self care:	100%	++++	90%	++++
5 Behavioural therapy:	100%	++++	100%	++++
6 Social activity:	90%	0.615	90%	0.615
7 Counselling	80%	0.524	80%	0.60
8 Residential care:	80%	++++	80%	0.58
9 Day care:	90%	0.65	50%	++++
10 Domicilary psychiatric service:	100%	++++	100%	++++
11 Staff support:	90%	0.78	90%	0.78
12 Alcohol and drug services:	80%	0.58	80%	0.58
13 Other needs:	80%	0.412	80%	0.412
14 Social assessment:	90%	0.80	90%	0.80
Total of 14 needs:	90%	0.67	86%	0.619

++++: Kappa was not significant

The comparison of Dr. Wykes' assessment with the assessment research team using Kappa statistics revealed good reliability. As the comparison was undertaken on the unmet needs and the total met and unmet needs, the reliability was assessed on these two measures. The overall unmet needs showed a percent agreement of 90% and Kappa=0.67. The percent agreement of the overall total needs was 86% and Kappa=0.62.

For the individual items it was possible to calculate the percent agreement which ranged from 80% to 100%. The kappa statistics were not significant on some of the items because of the lack of variability (Anker, 1983). The calculated kappa ranged from 0.412 on other needs to 0.80 on social assessment. This constitutes fair to good agreement (Hunt, 1986).

B3.1.2.The validity of the assessment:

The assessment of needs was carried out at three levels. Information was collected from both the resident and a member of staff about a resident's characteristics and problems. Furthermore both the resident and the staff member were asked to make independent assessments of the need for different mental health interventions. In the last stage the researcher made the final assessment based on all the above mentioned information.

The method used in assessing need was identical to that adopted in Camberwell study (Wykes et al, 1982a) in order to make possible a comparison between the two samples. This method gives greater weight to staff assessments of unmet needs because 'they were made when the need was particularly serious or long lasting'.

TABLE B3.2
The needs for mental health services researcher assessment compared with residents and staff assessments

The Needs	vs. residents % agreemnt	vs. residents Wtd Kappa	vs. staff % agreemnt	vs. staff Wtd Kappa
1 Security:	97%	-.20 NS	98%	0.432
2 Medication and medical assessment:	84%	0.427	85%	0.502
3 Training in domestic skills:	93%	0.506	94%	0.500
4 Self care:	91%	-.018 NS	94%	0.489
5 Behavioural therapy:	see table B3.3		95%	0.295
6 Social activity:	90%	0.498	83%	0.233
7 Counselling	75%	0.234	89%	0.455
8 Residential care:	37%	0.090 NS	88%	0.490
9 Day care:	83%	0.397	79%	0.387
10 Domicilary psychiatric service:	89%	0.178	94%	0.500
11 Staff support:	see table B3.3		98%	0.950
12 Alcohol and drug services:	69%	0.193	75%	0.393
13 Other needs:	82%	0.281	79%	0.101 NS

This was reflected in the agreement between the researcher's assessment and both the residents and staff assessment. That is, the agreement of the research team and staff was higher than that between the team and residents (see table B3.2).

In the need for psychiatric assessment the observed percentage agreement (OPA) between researcher and the residents was 84%with weighted kappa 0.42 compared with OPA between researcher and staff of 85% with a kappa 0.50.

TABLE B3.3
The needs for mental health services reliability of staff assessment versus residents perception

THE NEEDS	PERCENTAGE AGREEMENT	WEIGHTED KAPPA
1 Security:	92%	-.020 NS
2 Medication and medical assessment:	80%	0.108
3 Training in domestic skills:	86%	0.369
4 Self care:	82%	-.010 NS
5 Behavioural therapy:	Was not calculated because information were gathered only from staff regarding this item	
6 Social activity:	81%	0.169
7 Counselling	74%	0.205
8 Residential care:	36%	0.077 NS
9 Day care:	77%	0.157
10 Domicilary psychiatric service:	89%	-.022 NS
11 Staff support:	See item 5	
12 Alcohol and drug services:	87%	0.255
13 Other needs:	78%	-.054 NS

In residential care there was low agreement with the residents (OPA=37% kappa=0.09) because many residents were asking for more independent accommodation although they were not ready for it because of physical, mental or drinking problems. This is why there was a higher agreement with the staff in their assessment of the need for residential care (OPA=88%, kappa=0.490). In assessing staff support the rating depended mainly on staff assessment (OPA=98%, kappa=0.95).

In assessing the need for alcohol and drug services, there was lower agreement with residents 69% with a kappa of 0.19. A relatively higher agreement was recorded with staff assessment of the need for alcohol services (OPA=75%, kappa=0.39). The research team agreement with residents was higher than that between the team and staff on few items. These items were; the need for social activity(OPA=90%, kappa=0.498 compared with OPA=83%, kappa=0.233); the need for day care (OPA=83 kappa=0.397 compared with OPA=79% kappa=0.387) and other needs (OPA=82%, kappa=0.281 compared with OPA=79%, kappa=0.101). Kappa did not reach significant level in some of the items like security, self care, residential care and other needs (in the agreement with staff) because of lack of variability.

The agreement of the research team with both the residents and the staff was higher than the agreements between the staff and residents (see table B3.3). Each of these three were looking at the problem from different angles. The different assessment of needs between staff and residents is the common incongruence between professionally-defined need and the lay-defined need (Magi & Allander, 1981).

The research team assessment took into consideration both staff and residents' assessments of need for services with more weight to staffs' assessment of the unmet need. Tables B3.2 and B3.3 show that the team agreements with both the residents and staff were higher than the agreement between residents and staff. This might have given the researcher's assessment more validity as it took into consideration not only the professionally defined need (staff assessment) but also residents' motivation which is particularly important in predicting the utilisation of mental health services (MacCarthy et al, 1986)(Brewin et al, 1987).

B3.2. The needs:

This covers 14 items of community mental health interventions (see table B3.4). Need is recorded as unmet if the intervention has not been provided at all or had not been provided effectively.

a. Security: This covers the need for special supervision or protection because there is a danger that residents may harm themselves or be a nuisance or danger to others. Only 2 residents needed such supervision; one because he was lighting fires in the hostel and the other because staff were worried about his repeated expressed desire to commit suicide.

b. Psychiatric assessment: This item covers the need for assessment of mental state and advice on medication. 26.7% of the sample were judged to need assessment for a mental health problem, all of whom had an unmet need. Another 3% of the sample were thought to need such assessment but had refused and so were classified as unclear need.

TABLE B3.4

The needs for mental health services of the men in the survey hostels in Bloomsbury

The needs (%)	NO NEED	MET NEED	UNMET NEED	OVER MET NEED	UNCLEAR NEED
1 Security:	98.0	0.0	2.0	0.0	0.0
2 Medication and medical assessment:	65.3	0.0	26.7	0.0	3.0
3 Training in domestic skills:	93.1	0.0	4.0	0.0	3.0
4 Self care:	92.1	0.0	7.9	0.0	0.0
5 Behavioural therapy:	98.0	0.0	0.0	0.0	2.0
6 Social activity:	87.1	1.0	7.9	0.0	4.0
7 Counselling	79.2	2.0	10.9	0.0	7.9
8 Residential care:	0.0	65.4	13.9	13.9	6.9
9 Day care:	64.4	8.9	14.9	0.0	11.9
10 Domicilary psychiatric service:	86.1	0.0	1.0	0.0	12.9
11 Staff support:	72.3	1.0	26.7	0.0	0.0
12 Alcohol and drug services:	68.3	1.0	19.8	0.0	10.9
13 Other needs:	79.2	2.0	18.8	0.0	0.0
14 Social assessment:	69.3	1.0	28.7	0.0	1.0

c. Training in domestic skills:This includes training in skills such as laundry, shopping, cooking and budgeting. If the resident is able, motivated and has the time to benefit from such training, he was judged as having a need in this area. Only 4% of the sample had an unmet need for these skills in addition to 3% in whom the need was unclear.

d. Self care:The need for supervision included help with eating, drinking, bed-wetting, personal hygiene, physical health etc.). 7.9% of the sample needed such care.

e. Behavioural therapy:The need for therapeutic intervention to change or modify certain harmful, difficult or embarrassing behaviours. There was only unclear need for this item (2% of the sample). It was difficult to assess the need for this form of therapy as many of the residents needed a general psychiatric assessment before an assessment for the suitability for specific form of therapy.

f. Social activity:This includes provision to increase social activity (e.g. befriender, social club etc.). 7.9% of the residents had an unmet need for social activity in addition to one person who was already getting social activity of some sort and 4% in whom the need was unclear because they refused such intervention.

g. Counselling: This includes the need for personal counselling (ie advice and reassurance) about matters such as housing, welfare benefit and worries about the future. 10.9% of the sample had an unmet need for counselling, 2% in whom the need is met and 7.9% in whom the need was not clear.

h. Residential care:This includes the need for a different sort of accommodation that will suit each resident's condition. 65.4% of the sample had a met need for residential care ie their current placement was suitable for their condition. Only 13.9% of the sample were judged to need a place with more supervision because of physical or mental problems and another 13.9% in whom the need is overmet (ie they could be placed in less dependent accommodation) and 6.9% where the need was unclear.

i. Day care: This includes the need for facilities such as day centres, day hospitals, occupational day centres, sheltered workshops etc. 14.9% of the sample had an unmet need for day care in addition to 11.9% with unclear need. 8.9% of the sample were already attending day care (met need).

j. Domiciliary psychiatric service: The need for this item was judged as unclear in 12.9% of the residents. The fundamental need of these residents was for psychiatric assessment, therefore it was difficult to assess the need for domiciliary services before a proper psychiatric assessment had been carried out. Only one person (1%) had a clear unmet need for such service.

k. Staff support: This includes the need for support or advice to staff on practical matters or on how to cope with a resident's behaviour. This item correlated with the need for assessment for mental problems. In 26.7% of the sample there was an unmet need for staff support.

l. Alcohol and drug services: This includes a need for detoxification services, alcoholism treatment units or residential projects. 19.8% of the sample had unmet need for these services. In addition 10.9% of the

sample had an unclear need -these are mainly people who refuse to utilise the service-.

m. Other needs: These needs mainly concern financial matters, provision of health services (other than mental health services) and needs regarding domestic hostel matters regarding the services and amenities available to the residents. 18.8% of the sample had other needs.

n. Social assessment:This item deals with the need for more information regarding issues in which there was no agreement between informant, resident and the research team. 28.7% of the sample had an unmet need for such assessment one person (1%) a met need and another one (1%) had an unclear need. The highest level of unmet need was in this category.

B3.3. Comparison with patients in psychiatric services:

The needs of the study sample (BHA hostels sample) were compared with those of long-term mentally ill in contact with community services in Camberwell (Wykes et al 1982) (Wykes et al, 1982a). The same definitions and methods of assessment were used in 10 of the needs categories.

When the total needs (the met plus the unmet) were compared, eight out of 10 need categories were significantly lower in the study sample compared with the Camberwell sample (see table B3.5). The items which did not differ significantly were the need for training in domestic skills and the need for social activity.

TABLE B3.5

Total needs for mental health services; surveys hostels residents and long-term mental health services users

The needs (%)	BHA TOT NDS	WYKES TOT NDS	O.R. (C.L.)	ADJ O.R. (C.L.)
1 Security:	2.0	12.0	6.76 ** (1.5-27.7)	7.00 ** (1.6-31)
2 Medication and medical assessment:	31.7	87.3	14.87 *** (7.6-29.4)	14.7 ** (8.2-27)
3 Training in domestic skills:	4.0	7.6	1.29 NS (0.5-3.19)	1.71 NS (.29-10)
4 Self care:	7.9	25.9	4.07 *** (1.7-9.9)	4.9 *** (2.1-11)
5 Behavioural therapy:	0.0	7.6	—	—
6 Social activity:	8.9	13.9	1.65 NS (0.7-4.07)	1.65 NS (.6-4.3)
7 Counselling	12.9	27.2	2.48 * (1.2-5.3)	2.19 * (1.1-4.6)
8 Residential care:	74.3	56.9	0.48 * (0.3-0.9)	0.51 * (.89-.3)
9 Day care:	23.8	89.9	28.47 *** (13.6-61)	25.6 *** (13.8-47)
10 Social assessment:	29.7	52.5	2.61 *** (1.5-4.6)	2.45 ** (1.4-4.3)
Mean Odds Ratio:			6.96	6.74
Standard Error of the Mean (SEM):			3.06	2.76

NS Not Significant, * P<.05, ** P<.01, *** P<.001

The calculation of the Odds Ratio (O.R.) showed the magnitude of the difference between the two samples. The O.R. ranged from 0.48 in the need for residential care (which meant that the Camberwell sample had half the risk of needing this care compared with Bloomsbury sample) to 28.47 in the need for day care (which meant that Camberwell sample had 28 times more need for day care compared with Bloomsbury sample).

The mean Odds Ratio was 6.9 (standard error of the mean=3) which meant that the Camberwell sample was seven times more in need of community psychiatric services compared with the Bloomsbury sample. The differences remain significant and of a similar magnitude when adjustment for age using Mantel-Haenszel Chi-Square test (Schlesselman, 1982) were made (see adjusted odds ratios).

When a separate analysis of the unmet needs of the two samples was made, it was surprising that the opposite trend was observed (see table B3.6). The previous significant differences disappeared and even reversed in some of the items. In only two out of the 10 items of unmet needs was the difference significant. These two unmet needs were the need for medical assessment of mental state and the need for help in self care. These unmet needs were higher in the study sample compared with the Camberwell sample. The Odds Ratio showed that these two unmet needs were twice as high in the study sample compared with that of the Camberwell sample. The overall Odds ratio was 0.91 (SEM=0.1) which indicates that the unmet needs were similar in the two samples (the O.R. is approximately equal to one). A similar pattern was found after controlling for the difference in age of the two samples.

TABLE B3.6

Unmet needs for mental health services; survey hostels residents and long-term mental health services users (Wykes 82)

The needs (%)	BHA UNMET ND	WYKES UNMET ND	O.R. (C.L.)	ADJ O.R. (C.L.)
1 Security:	2.0	0.6	0.31 NS (.001-99)	0.39 NS (3939-.000)
2 Medication and medical assessment:	26.7	14.0	0.44 * (.23-.87)	0.45 * (.88-.23)
3 Training in domestic skills:	4.0	4.4	1.12 NS (.29-4.7)	1.01 NS (.89-1.15)
4 Self care:	7.9	1.9	0.22 * (.05-.96)	0.21 NS (1.09-0.04)
5 Behavioural therapy:	0.0	2.5	____	_____
6 Social activity:	7.9	7.6	0.95 NS (.34-2.7)	0.97 NS (1.3-0.7)
7 Counselling	10.9	10.0	0.92 NS (.38-2.2)	0.86 NS (5.7-0.1)
8 Residential care:	13.9	14.5	1.05 NS (.48-2.3)	1.08 NS (.01-90)
9 Day care:	14.9	22.0	1.63 NS (.80-3.3)	1.58 NS (.74-3.4)
10 Social assessment:	28.7	38.6	1.56 NS (.88-2.8)	1.50 NS (.83-2.7)
Mean Odds Ratio:			0.91	0.89
Standard Error of the Mean (SEM):			0.16	0.15

NS Not Significant, * P<.05

B3.4 The needs of the hostel residents with psychotic problems:

13 residents were identified as having psychotic SBS problems (see section B2.5). This section will describe their need for mental health services. These needs will be compared with that of Camberwell chronic psychiatric patients.

The total needs of the sample showed that the highest recorded need of these residents is the need for psychiatric assessment (in 84.6%) and the need for residential care (84.6%) (see table B3.7). 46.2% of the residents needed day care and 23.1% needed social activities.

TABLE B3.7
Total needs for mental health services; residents with PSBSP and long-term mental health services users (Wykes 82)

The needs (%)	BHA PSYCH TOT NDS	WYKES TOT NDS	Chi-sqr (P)	O.R. (C.L.)
1 Security:	7.7	12.0	Fishers (0.53)	1.64 (.2-1.4)
2 Medication and medical assessment:	84.6	87.3	Fishers (0.52)	1.25 (.06-6.7)
3 Training in domestic skills:	7.7	7.6	Fishers (0.66)	0.99 (.1-1.03)
4 Self care:	15.4	25.9	Fishers (0.32)	1.92 (.3-23.8)
5 Behavioural therapy:	0.0	7.6	Fishers (0.37)	___
6 Social activity:	23.1	13.9	Fishers (0.29)	0.53 (.1-6.3)
7 Counselling	7.7	27.2	Fishers (0.11)	4.4 (.5-50)
8 Residential care:	84.6	56.9	Chi=2.7 (0.09)	0.24 (.04-1)
9 Day care:	46.2	89.9	Chi=16.2 (.00005)	10.35 (3-41)
10 Social assessment:	46.2	52.5	Chi=0.02 (0.87)	1.29 (.4-4.5)

The comparison of residents total needs with that of Camberwell patients showed no significant difference between the two sample on the ten needs. Only the total need for day care was significantly lower in the hostel residents (46.2% compared with 89.9% of Camberwell sample) Chi=16.14, P=0.000005.

The unmet needs of the hostel sample showed that need for psychiatric assessment is the highest unmet need in the sample (69.2%) (see table B3.8). 46.2% of the hostels sample had unmet need for social assessment. 23.1 % of the sample had an unmet need for day care and 15.4% had unmet need for social activity.

These results show that none of the hostel sample needs for social assessment were met. Only in 15.4% out of 84.6% of the sample needs for psychiatric assessment were met. In contrast the majority of the needs for residential care were met (53.8% out of 84.6%) also half of the needs for day care (23.1% out of 46.2%). Both the needs for residential and day care needs were met completely or partly by hostels' activities.

The unmet needs of the hostels sample were compared with that of Camberwell sample. 69.2% of the hostel sample needed psychiatric assessment compared with 14% of Camberwell sample (Fishers P=0.00003). The hostels sample showed significantly higher unmet needs in self care (15.4% compared with 1.9% of Camberwell sample) Fishers P=0.046.

TABLE B3.8
Unmet needs for mental health services; residents with PSBSP and long-term mental health services users (Wykes 82)

The needs (%)	BHA UNMET ND	WYKES UNMET ND	Chisqr (P)	O.R. (C.L.)
1 Security:	7.7	0.6	Fishers (.15)	0.07 (.0003-17)
2 Medication and medical assessment:	69.2	14.0	Fishers (.00003)	0.07 (.02-0.2)
3 Training in domestic skills:	7.7	4.4	Fishers (0.47)	0.55 (.05-1325)
4 Self care:	15.4	1.9	Fishers (0.046)	0.12 (.01-1.1)
5 Behavioural therapy:	0.0	2.5	Fishers (0.73)	____
6 Social activity:	15.4	7.6	Fishers (0.29)	0.45 (.07-14)
7 Counselling	7.7	10.0	Fishers (0.62)	1.35 (.16-26)
8 Residential care:	30.8	14.5	Fishers (0.13)	0.38 (.1-1.6)
9 Day care:	23.1	22.0	Fishers (0.58)	0.94 (.2-1.4)
10 Social assessment:	46.2	38.6	Chi=.06 (0.81)	0.73 (.21-2.6)

B3.5 The needs of hostel residents according to length of stay:

The needs of the residents who stayed less or equal to 5 years were compared with the needs of those who stayed longer (see section B2.6)

The mean number of total needs (met and unmet) were significantly higher in the less than 5 years stay group (3.06 need SD=1.9) compared with residents who stayed more than 5 years (Mean=2.3 needs SD=1.7) (T=2.1, P=0.03) (see table B3.9). The Mean number of unmet needs did not show significant difference between the two groups (T=1.9, P=0.06).

TABLE B3.9
Unmet needs for mental health services; according to length of stay

THE NEEDS	Stay < 5 years	Stay > 5 years
1 Security:	1 (2.1)	1 (1.9)
2 Medication and medical assessment:	16 (34.0)	11 (20.4)
3 Training in domestic skills:	2 (4.3)	2 (3.7)
4 Self care:	4 (8.5)	4 (7.4)
5 Behavioural therapy:	0	0
6 Social activity:	4 (8.5)	4 (7.4)
7 Counselling	7 (14.9)	4 (7.4)
8 Residential care:	10 (21.3)	4 (7.4)
0 Day care:	7 (14.9)	8 (14.8)
10 Domicilary psychiatric service:	1 (2.1)	0
11 Staff support:	17 (36.8)	10 (18.5)
12 Alcohol and drug services:	13 (27.7)	7 (13.0)
13 Other needs:	8 (17.0)	11 (20.4)
12 Social assessment:	14 (29.8)	15 (27.8)

The individual items of the needs for mental health services (both for unmet and total needs) showed that a significantly higher proportion of the people who stayed less than 5 years needed psychiatric assessment (42.6% compared with 22.2% of the residents who stayed more than 5 years) (Chi=3.9, P=0.048). Non of the other needs (unmet or total) showed any significant difference between the two groups (see table B4.4).

B4 Further comparisons:

In this section further questions will be tackled comparing study data and groups to construct a more comprehensive profile of study population. The first is what are the differences and the similarities between the CPN hostel male clients (see section A) and the men in the survey sample. The second is how much of the social behaviour problems in the survey hostel sample explain the needs for psychiatric services.

B4.1. Comparison between the survey sample and the hostel clients of CPNs:

The CPNs male clients who lived in Bloomsbury hostels (N=79) were compared to the survey random sample (N=101) which was taken from the long-stay hostels for homeless men in Bloomsbury (see table-8). The CPNs clients were much younger than the residents in the sample. 84.8% of the CPNs hostel clients were under the age of 50 compared with only 2.8% of the sample (Chi=9.7, P=0.00001).

The age distribution of the two groups is reflected in marital status. A higher proportion of the CPNs hostel clients were single (92.4% compared with 74% of the hostels sample; Chi=8.9, P=0.003) and less of the CPNs hostel clients were divorced(3.4% compared with 21.8% of the hostel sample; Chi=9.7, P=0.002) or widowed (2.5% compared with 5% of the hostel sample).

TABLE B4.1
Characteristics of the men in the survey hostels compared with the CPNs men clients in Bloomsbury hostels

Characteristic (%)	Bloomsbury hostels No.	Bloomsbury hostels %	CPN hostel clients No.	CPN hostel clients %
Age:Mean (SD)				
-50	23	22.8	67	84.8
51-70	58	57.4	10	12.7
71-	20	19.8	2	2.5
Marital status				
Single	74	74.0	73	92.4
Married	0	0.0	1	1.3
Widowed	5	5.0	2	2.5
Divorced	21	21.0	3	3.8
Employment				
Regular	5	5.0	2	2.5
Casual	6	5.9	3	3.8
Unemployed	48	47.5	69	87.3
OAP	35	34.7	4	5.1
Other	7	6.9	1	1.3
Ethnic origin				
UK+other	61	60.5	59	74.4
Eire	36	35.6	5	6.3
West Ind.	2	2.0	8	10.1
Asian	2	2.0	5	6.3
African	0	0.0	2	2.5
Hostels sample unmet needs and CPN intervention				
Med & ass	27	26.7	22	28.9
Counselling	11	10.9	7	9.2
Supportive (Domestic, self care)	12	11.9	7	9.2
Other	51	50.5	40	52.6

A higher proportion of unemployment was observed in the CPNs hostel clients (87.3%compared with 47.5% of the hostel sample; Chi=29.2, P=0.000001). A lower proportion of the CPNs hostel clients were retired or working.

The ethnic origin of the CPNs hostel clients showed under-representation of the people from Eire (6.3% of the CPNs hostel clients compared with 35.6% of the hostel sample;Chi=20, P=0.0000000). The difference was still significant even after controlling for age (P=0.006). CPNs hostel clients had more people of black ethnic origin (West Indian, Asian and African) (18.9% compared with 4% of the hostel sample; Chi=9.1, P=0.003).

When the CPN intervention was compared with the unmet needs of the hostel sample needs in the comparable items a similar picture emerged. A similar proportion of both samples needed or had psychiatric assessment or medication (26.7% compared with 28.9%; chi=0.0004, P=0.99 NS). Similar proportions of both samples needed or received counselling (Chi=0.04, P=0.8 NS), supportive and practical help (corresponding to domestic training and self-help in the survey sample) (Chi=0.17, P=0.68 NS).

B4.2 Social disablement and the need for the services:

In this section multi-variate analyses were used to try to explore the question of how much the SBS items explain the different needs for psychiatric services.

A logistic regression model was used to assess the contribution of the social disablement of the sample (independent variables) to the unmet need for psychiatric assessment and medication and to the unmet need for alcohol services (dependent variables). The grouped five items SBS were used as the independent variable. The age was also used as an independent variable to control for the effect of age (see table B4.2&3).

The results showed that the unmet need for psychiatric assessment and medication (see table B4.5) was significantly associated with a the disablement on items like social withdrawal (SW), socially embarrassing behaviour (SE), and depression and anxiety (DA). But on the other hand the unmet need for alcohol and drug services (see table B4.6) associated significantly with hostility and violence (HV) and socially unacceptable behaviour (SU). The SBS problems that associate with the unmet need for psychiatric assessment is depression and anxiety (DA) on which the highest relative risk (RR) was recorded (11.7). The socially embarrassing behaviour (SE) -which includes psychotic problems- associated with half this relative risk only (5.5).

The social behaviour schedule items are good predictors for the needs for psychiatric services. But the need for psychiatric assessment does not explain all the social disablement of the sample. The major disablement that associates with the unmet need for psychiatric assessment are problems related to a more neurotic rather than psychotic spectrum of mental health problems.

Table B4.2

Logistic regression of the five grouped SBS items with the unmet need for psychiatric assessment.

Dependent variable= Psychiatric assessment.

	estimate	s.e.	%PE	RR	parameter
1	-3.254	0.7981	-3.25439	0.03860	1
2	0.5259	0.9047	0.52594	1.69204	Alcohol ser.
3	0.03808	0.7306	0.03808	1.03881	AGE
4	1.087	0.7938	1.08722	2.96602	SW
5	1.713	0.8189	1.71312	5.54623	SE
6	2.459	0.7650	2.45861	11.68851	DA
7	0.5987	1.003	0.59870	1.81976	HV
8	0.8150	0.9229	0.81502	2.25922	SU

Table B4.3

Logistic regression of the five grouped SBS items with the unmet need for drugs and alcohol services.

Dependent variable= Alcohol service

	estimate	s.e.	%PE	RR	parameter
1	-1.703	0.5950	-1.7034	0.1821	1
2	0.3325	0.9368	0.3325	1.3944	PSYCH. ASS.
3	-1.399	0.7513	-1.3986	0.2470	AGE
4	0.3201	0.8365	0.3201	1.3772	SW
5	-1.802	0.8959	-1.8020	0.1650	SE
6	-1.991	1.037	-1.9910	0.1366	DA
7	1.088	0.9803	1.0878	2.9677	HV
8	3.201	0.8922	3.2006	24.5483	SU

B5. Summary:

The survey in Bloomsbury hostels for homeless men tried to measure and address their needs for mental health services in a community survey. A large proportion of these men were elderly; most of the younger and more able residents had been resettled in private accommodation. The majority of these men were either unemployed or on pensions and they feared moving to a flat because they would be worse off after having to pay rent and bills.

The age structure of these men and the presence of many elderly among them reflected on their high physical and general psychiatric morbidity. However, homeless clients presenting to CPNs with psychotic problems were younger. In addition a third of these residents had moderate to severe drinking problems. The sample contacts with health services showed low access and utilisation of these services in spite of their high morbidity.

The social disablement -measured by the SBS- of the sample differed significantly from that of a sample of chronic psychiatric patients. The proportion of people with psychotic illnesses was much lower than that estimated by previous studies. The disability of the subjects with psychotic behaviours did not show a significance difference compared with that of chronic psychiatric patients.

The total needs of the survey sample for psychiatric services was also significantly lower than that of chronic psychiatric patients. Nevertheless the unmet needs of both sample for psychiatric services were surprisingly similar. The major unmet needs of the hostels sample were the need for; social assessment; psychiatric assessment and medication; staff support; alcohol services; and day care -in order of the proportions of people in need-. In comparison with the CPN service data, it was found that services were targeted towards younger, more black, and fewer Irish clients compared with those in the hostels sample. The intervention provided to the CPN hostel clients matched the unmet needs of the hostels sample.

The analysis of the association between the social behaviour problems and the needs for psychiatric services showed that SBS is a good predictive tool for the need for psychiatric services. Social disablement was highly associated with the need for psychiatric assessment. Nevertheless the need for alcohol services was also strongly associated with some aspect of the sample social disablement. Furthermore the need for psychiatric assessment was strongly related to problems that lay in the neurotic -rather than psychotic- spectrum of SBS problems.

C.London hostels and New York shelter comparison:

This small survey in one of New York shelters was undertaken to describe how this model -a more institutional model- of care is meeting the needs of the homeless people for mental health services compared with London hostels which are still -till now- the main model of care for the homeless in UK.

randomly selected
Out of the 58 residents invited to the interviews 42 turned up. Out of these 42 residents three refused to participate in the project and one Hispanic resident who did not speak English was excluded from the study. For the 38 residents remaining, interviews were completed with the residents and their case managers.

The sample interviewed was compared with the 101 men interviewed in Bloomsbury Health Districts hostels for homeless men. The results were as follows:

C1.Demographic characteristics (see table C1):

The mean age of New York sample was 37.6 years (SE=1.7) compared with the London sample at 59.4 years (SE=1.3). The difference was statistically significant (T=9.36,P<0.000). Most of the NY sample were under the age of 40 (57.9%) (Chi=35.5, P< 0.0000), while most of London sample were over the age of 60 (51.5%) (Chi=25.9, P<0.0000).

The marital status of the two samples showed a slightly higher proportion of the NY sample were separated or divorced (36.8% compared with 21%) (Chi=2.86, P=0.09 NS).

The two samples did not differ in the proportion of people with unemployed status (47.5% vs 50%). Yet there was a higher proportion of the New York sample in full or part time employment (47.4% compared with 10.9% of London sample;Chi=20.1, P=0.000007). But a higher proportion of the London sample were pensioners (34.7% compared with none of the New York sample; Chi=15.8, P=0.00007).

A separate analysis of the people under 65 in the two samples was therefore undertaken. It showed significantly higher unemployment in London sample (72.7% compared with 50% of New York sample; Chi=4.48, P=0.03). The New York sample still had significantly higher full or part time employment (47.4% compared with 12.2% of London sample; Chi=14.1, P=0.0002).

The length of stay in the NY shelter was much shorter than that in London hostels. The mean length of stay in NY shelter was 0.75 year (SE=0.12) compared with 8.0 years length of stay in London hostels (T=5.79, P=0.000). 78.9% of NY sample had spent less than 1 year in the shelter compared with 17.8% of London sample (Chi=15.8, P=0.00006). 53.3% of London sample had been in the hostels for more than five years compared with none of the New York sample (Chi=31, P< 0.0000).

Table C1
Demographic characteristics of London and New York samples

	City			
	LONDON		NY	
	Count	COLUMN PERCENT	Count	COLUMN PERCENT
AGE				
-40	9	8.9%	22	57.9%
41-60	40	39.6%	15	39.5%
61-	52	51.5%	1	2.6%
MARIT				
SINGLE	74	74.0%	23	60.5%
WIDOWED	5	5.0%	1	2.6%
SEPARATED/DIVORCED	21	21.0%	14	36.8%
EMPL				
WORKING	5	5.0%	12	31.6%
CASUAL	6	5.9%	6	15.8%
UNEMPLOYED	48	47.5%	19	50.0%
OLD AGE PENSIONER	35	34.7%		
OTHER	7	6.9%	1	2.6%
STAY				
<1 YEARS	18	17.8%	30	78.9%
1-5 YEARS	29	28.7%	8	21.1%
>5 YEARS	54	53.5%		
ETHNIC				
UK	54	53.5%	29	76.3%
EIRE	36	35.6%		
OTHER	11	10.9%	9	23.7%
LIFE				
NO PRIVATE ACCOMMODATION OR STABLE JOB	37	37.0%	8	21.6%
STABLE JOB BUT NO PRIVATE ACCOMMODATION	39	39.0%	10	27.0%
STABLE JOB AND PRIVATE ACCOMODATION	24	24.0%	19	51.4%
BURD				
NO BURDEN	67	66.3%	31	81.6%
BURDEN	34	33.7%	7	18.4%

The ethnic origin of the two samples also showed some differences. More of the NY sample had been born in US (76.3%) compared with only 53.5% of London sample who were born in the UK (Chi=5.08, P=0.02).

Life achievement of the two samples showed a significant difference in the proportion of the residents who had had a stable job and had lived in private accommodation. Twice as many people in the NY sample had had a stable job and private accommodation (51.4%) compared with the London sample (24.0%)(Chi=8.4, P=0.004).

The degree to which the residents caused additional difficulties for the staff was only slightly higher in the London sample (33.7% vs 18.4% NS).

C2.Health and Contacts with Health Services (see table C2):

The main health problem was recorded for each resident. The striking difference between the main health problem in the two samples was the high prevalence of substance abuse in the NY sample (44.7%) compared with the London sample (9.9%) (Chi=19.2, P< 0.0000). The London sample had a higher proportion of physical problems (33.7% compared with 10.5) (Chi=6.3, P=0.02) which is likely to be related to the age difference between the two samples. There was no significant difference in the psychiatric problems between the two groups(25.7% vs 13.2%; Chi=1.8, P=0.2 NS).

table C2
Health and contact with health services in London and NY samples

	City			
	LONDON		NY	
	Count	COLUMN PERCENT	Count	COLUMN PERCENT
Main hlth problm				
NONE	22	21.8%	9	23.7%
PHYSICAL HEALTH	34	33.7%	4	10.5%
PSYCHIATRIC/NERVOUS PROBLEMS	26	25.7%	5	13.2%
ALCOHOL AND DRUG DEPENDENCY	10	9.9%	17	44.7%
PHYSICAL AND PSYCHIATRIC	9	8.9%	3	7.9%
Drinking problm				
NO PROBLEM	79	78.2%	35	92.1%
PROBLEM	22	21.8%	3	7.9%
Drug problm				
NO PROBLEM	99	98.0%	24	63.2%
PROBLEM	2	2.0%	14	36.8%
Regist/hlth prgm				
YES	79	78.2%	12	31.6%
NO	22	21.8%	26	68.4%
Contact/GP				
NO CONTACT	54	53.5%	16	42.1%
CONTACT	47	46.5%	22	57.9%
Contact/CPN				
NO CONTACT	99	98.0%	38	100.0%
CONTACT	2	2.0%		
Contact/psychiarst				
NO CONTACT	98	97.0%	29	76.3%
CONTACT	3	3.0%	9	23.7%
Contact/hospital				
NO CONTACT	78	77.2%	21	55.3%
CONTACT	23	22.8%	17	44.7%
Contact/SW				
NO CONTACT	87	86.1%	1	2.6%
CONTACT	14	13.9%	37	97.4%
Hist. ment. hosp.				
NO	81	81.0%	27	71.1%
YES	19	19.0%	11	28.9%

Looking at the substance abuse problems in more detail, it was found that drug abuse was the main feature in the NY sample. 36.8% of the NY sample had severe drug abuse problems compared with 2% of the London sample (Chi=29.6, P< 0.0000). The main substance abuse problem in the London sample was alcohol, 21.8% had severe drinking problems compared with 7.9% of the NY sample (Chi=2.7 P=0.09 NS).

Registration of residents with GPs (in London) or health programmes (in NY) was also compared. A higher proportion of the NY sample had not registered with any health programme (68.4%) compared with the residents who were not registered with any
GP in the London sample (21.8%) (Chi=24.5, P< 0.0000).

Contacts with health services in the six month period prior to research interviews were also compared. Similar proportions of New York and London samples had been in contact with a physician (57.9% of New York sample compared with 46.5% of London sample; Chi=1, P=0.3 NS).

Contacts with mental health services showed a different pattern.23.7% of the New York sample had been in contact with a psychiatrist in the six months period prior to interview compared with 3% of the London sample (Chi=12.5, P< 0.0000).

Contacts with hospital departments (other than psychiatric) showed that a higher proportion of the New York sample had contact with these departments (44.7%) compared with the London sample (22.8%) (Chi=5.5, P=0.02).

The contacts with social workers showed a striking difference as 97.4% of the New York sample had been in contact with them compared with 13.9% of the London sample (Chi=79.3, P< 0.0000).

The proportion of the New York sample who had been in mental hospitals (28.9%) did not differ significantly from the London sample (19%) (Chi=1.07, P=0.3 NS).

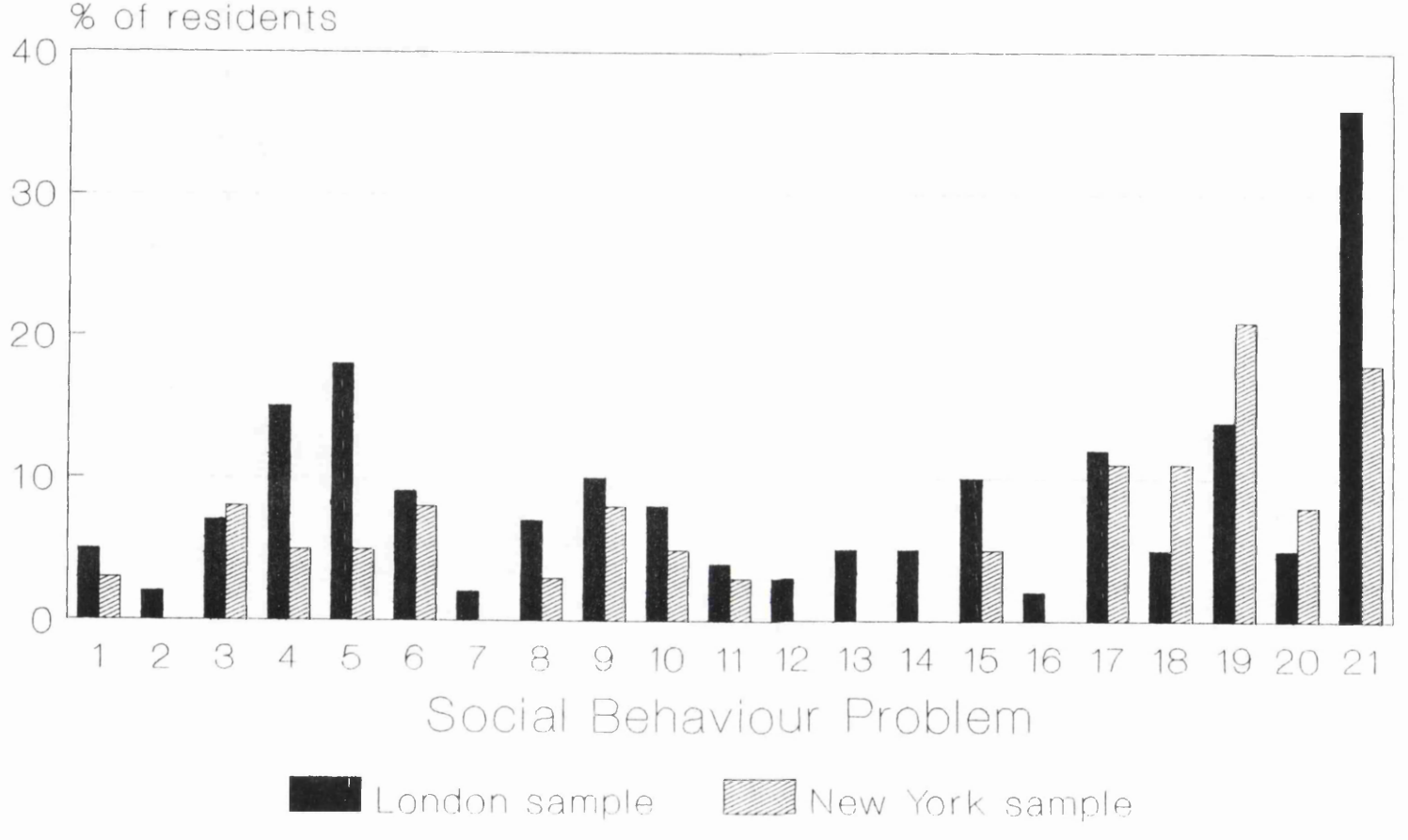
C3. Social Behaviour Problems (see table-3a,b):

The SBS was used to assess the social disablement that results from chronic mental health problems. The overall score of SBS (BSM) did not show a significant difference between the two samples. The London sample mean BSM score was 1.8 (SE= 0.2) while the New York sample mean score was 1.2 (SE= 0.2) (T=1.32, P= 0.17).

But, on examining the individual items of the SBS there were partially different -but not significant- profiles (see figure C1). The most frequent problem in the London sample was hostility (in 17.8%) while underactivity was the most frequent problem in the New York sample (in 21.1%) (Chi=2.6, P=0.1 NS).Slowness was also higher in the New York sample (10.5%) compared with the London sample (5%) (Chi=0.64,P=0.4 NS).

Figure C1

Social Behaviour Problems
in London and New York Homeless



In all the other items of SBS, there were no significant differences between the London and New York samples. Only 4 persons out of the New York sample had one or more of the psychotic SBS problems, and the numbers were too small to make any comparison. The London and New York samples were more similar than different in their social disablement.

C4. The need for mental health services (see table-4):

The total need was significantly higher in the New york sample on many items of needs. The need for training in domestic skills was higher in the New York sample (36.8%) compared with 4.0% in the London sample (Chi=23.6, P=0.0001).

There were higher proportions of judged total need for counselling in the New York sample counselling (52.6% compared with 12.9) (Chi=21.9, P=0.000003), alcohol and drug services (42.1% compared with 20.8%) (Chi=5.3, P=0.02) and social assessment (65.8% compared with 29.7%) (Chi=13.5, P=0.0002) compared with the London sample.

The need for psychiatric assessment showed that the overall needs were similar in the two samples (34.7% in the London sample and 34.2% in the New York sample) and there was no significant difference in the met or unmet needs for this service.

Table C3
Total Needs of London and NY samples.

(%)	BHA TOT NDS	NY TOT NDS	Chisquar
1 Security:	2.0	0	0.76 (0.38 NS)
2 Medication and medical assessment:	31.7	34.2	0.08
3 Training in domestic skills:	4.0	36.8	23.6 ***
4 Self care:	7.9	2.6	0.55
5 Behavioural therapy:	0.0	0.0	____
6 Social activity:	8.9	18.4	1.6
7 Counselling	12.9	52.6	21.9 ***
8 Residential care:	74.3	60.5	0.16
9 Day care:	23.8	34.2	0.30
10 Domicilary care:	1.0	1.5	0.000
11 Staff support	27.7	18.4	0.8
12 Alcohol service	20.8	42.1	5.37 *
13 Other need	20.8	31.6	1.2
14 Social assessment:	29.7	52.5	13.5 ***

NS Not Significant, * P<.05, ** P<.01, *** P<.001

Table C4
Unmet needs of London and NY samples

The needs (%)	BHA UNMET ND	NY UNMET ND	Chisquare
1 Security:	2.0	0.0	0.005
2 Medication and medical assessment:	26.7	23.7	0.02
3 Training in domestic skills:	4.0	28.9	15.4 ***
4 Self care:	7.9	2.6	0.55
5 Behavioural therapy:	0.0	0.0	____
6 Social activity:	7.9	15.8	1.1
7 Counselling	10.9	34.2	8.9 **
8 Residential care:	13.9	13.2	0.0000
9 Day care:	14.9	10.5	0.14
10 Domiciliary care:	1.0	0.0	0.0000
11 Staff support:	26.7	5.3	6.5 *
12 Alcohol/drug services:	19.8	26.3	0.3
13 Other needs:	18.8	31.6	1.9
14 Social assessment:	28.7	52.6	5.9 *

Significance: * P<.05, ** P<.01, *** P<.001

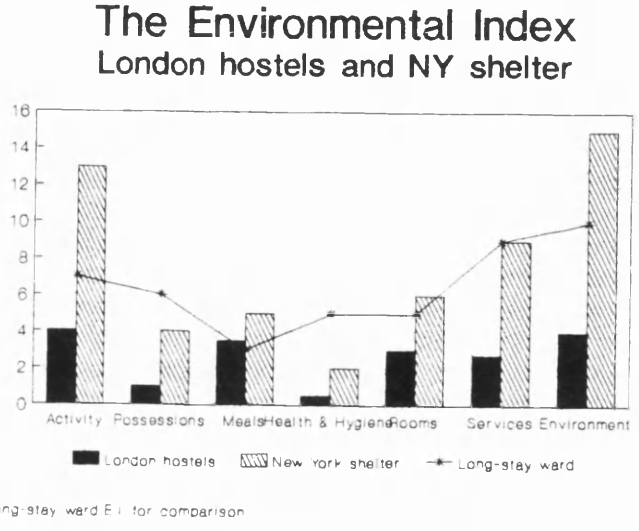
The number of needs recorded for the New York sample was significantly higher than those recorded for the London sample.

The mean number of needs for the New York sample was 4 (SE= 0.2) compared with 2.7 (SE= 0.2) (T=3.98, P=0.004). The number of unmet needs was still higher in the New York sample (2.4 compared with 1.8 in the London sample) but the difference was not significant (T=1.75, P=0.08).

C5. The Environmental Index of London hostels and New York shelter:

The Environmental Index (E.I.) is an index which measures the restrictiveness and institutional practices adopted by different services. In this study measurement of the E.I. was undertaken in the four London hostels and in the New York shelter. The mean scores of the index items for London hostels were compared with those for the New York shelter. A further measurement was undertaken in two long-stay wards in Cane Hill hospital (a Victorian mental hospital) to be compared with the above mentioned scores.

Figure C2



* Long-stay ward E.I. for comparison

Figure-C2 show that the New York shelter had a higher restrictiveness on all the E.I. items compared with London hostels. The shelter restrictiveness was also higher than that of mental hospital long-stay ward in activities, meals, rooms, services and environment. The overall score of the E.I. showed similar pattern, the New York shelter (overall score=54) had a higher score than London hostels (overall score=18.7) and more than the long-stay wards in mental hospitals (overall score=45).

C6.Summary:

The residents of the New York shelter were young people, a large proportion of whom were in full-time employment. They had less physical and psychiatric problems compared with the London sample. Their major problem was substance abuse and in particular drug problems.

There was no significant difference in the social disablement of the two samples although the New York sample had fewer physical or psychiatric problems. This could be due to the presence of higher substance abuse problems that increased the level of disablement to the London sample level. Another explanation may lie in the institutional nature of the New York shelter (Grunberg & Eagle, 1990)&(Wing & Brown, 1970).

The need for psychiatric services was also significantly higher than that of the London sample. In spite of the presence of a much higher service provision and utilisation as seen on the contacts of the shelter residents with health services, both the needs (significantly) and the unmet needs (not significant) were higher than that of the London sample.

Chapter IV

DISCUSSION

Introduction:

Homeless people as a disadvantaged group have been seen by society and through history as a deviant group that need spiritual salvation, punishment or treatment. The current view of the homeless is that they are mostly chronic mentally ill in need of institutional care.

Many authors have tried to link homelessness to the implementation of de-institutionalisation and community care. This was based mainly on psychiatric surveys that used short interviews that revealed high prevalence of the diagnosis of schizophrenia and other psychotic illness.

In the seventies Bahr found that the stereotype of the homeless at that time as problem drinkers was not true and that this view had been formed by a small, more visible group of homeless alcoholics who do not represent the homeless in general (Bahr & Caplow, 1973). It has also been suggested that psychiatric diagnosis over-estimates chronic mental illness in homeless people by not considering the social and the environmental circumstances in which these people live (Snow et al, 1986).

This study investigated the needs of homeless people for mental health services in three stages. The first stage was to investigate their expressed needs through the utilisation of community psychiatric services (CPN services) in Bloomsbury and to compare homeless with home-based contacts within the same service. The second stage was to

assess their perceived needs through a more detailed survey in four hostels in Bloomsbury. The survey sample was compared with a sample of people in contact with high dependency psychiatric services in Camberwell to test for the similarities and differences in problems and needs between the two samples. The third stage was to examine how different models of care were meeting the needs of homeless people by comparing New York shelter-based provision with the hostel-based provision in London.

Study design and generalizability:

In investigating the needs of the homeless people for mental health services, this study used a multi-dimensional approach. Data sources included health services records and two community surveys in London and New York. The types of investigations used included both descriptive and analytical surveys (Abramson, 1984). The study described the characteristics, problems and needs of the study populations. It also included hypothesis testing comparisons between study groups and with other samples.

The CPN records analysis served to investigate homeless people who were in touch with the psychiatric services and to compare them with home-based people in touch with the same service. In general, any service data is biased because not every body who suffers morbidity is in contact with that service (Abramson, 1984) but because the CPNs work in the community, their data is more representative of morbidity than data from hospital-based services (Barker & Rose, 1976) (Shepherd & Clare, 1981).

The CPNs' data coding system is a very valuable tool to monitor and evaluate the provision of community care. Research into the mental health problems of homeless people has been carried out mainly by psychiatrists. Many of these studies used only case notes of homeless patients admitted to psychiatric hospitals (Whiteley, 1955) (Berry & Orwin, 1966) (Herzberg, 1987). Priest has shown that people who have been to psychiatric hospital are different in many ways from those who were not in contact with psychiatric services. He has also shown that people who receive a hospital-based service are quite unrepresentative of homeless people and their problems and have less serious problems than people in a representative sample from Edinburgh hostels (Priest, 1976).

The extent to which the survey results could be applied to the homeless people or a certain group of them (generalizability) depends on the definition of the denominator, the precision of sampling, and the validity and reliability of measurement.
The denominator of the survey has been defined and quantified by previous study (Cumming et al, 1986) which was carried out for that specific purpose. The data from this study has been used in the sampling procedure of the hostels survey. A random sample was taken from the room-lists of study hostels. The sample size was calculated using statistical procedures to ensure that the sample characteristics represent those of the denominator.

The measurement procedures included two instruments to describe social disablement and needs for psychiatric services. These two variables were used because they are more suitable measures of the presence of chronic mental illness among the homeless people according to Bachrach's

definition of these illnesses (Bachrach, 1983). Recent developments in community care and the transfer of care of people with chronic mental illness from health services to social services and the voluntary sector (Secretary of State for Health, 1989) have additionally created a need for methods of broader social rehabilitative assessment (Kostrzewski, 1979). Traditional psychiatric clinical measures depend mainly on symptoms and exclude the social elements of mental health problems (Wing, 1989). Assessing social disablement fulfils the need for a socially oriented assessment.

The Social Behaviour Schedule (SBS) was developed to measure social behaviour problems in people suffering from chronic mental disorder. In this study such disability was assessed in a community survey of non-psychiatric hostels. The SBS has been developed both in hospital and community settings and it provides a basis for an assessment of chronic mental health problems which is more culture-bias free than conventional psychiatric assessment (Wykes & Sturt, 1986). It is also easy to use by care staff from different disciplines and at different levels of training e.g. by care staff with little professional training.

The reliability assessment of the SBS in this study showed reasonable inter-observer agreement for individual items of the schedule and there was very good reliability of the BSM overall score. The need assessment procedure used in this study took into consideration both staff and residents' perception of the need for services with more weight to the staffs' assessment of the unmet need. This might have given the procedure more validity as it took into consideration not only the professionally defined need (staff assessment) but also residents' motivation which is particularly important in the utilisation of services (MacCarthy et al, 1986)(Brewin et al, 1987).

The New York sample was too small to be considered representative of its shelter homeless. It has been used in this study to describe the shelter as a model of institutional care and to show how shelters try to meet the needs of homeless people for psychiatric services compared with London hostels.

Who are the homeless?:

Both the CPN clients and the hostels' sample showed the importance of socio-economic factors in homelessness. The CPNs' homeless clients were more likely to be unemployed, single, living alone and from black ethnic origins. These variables by themselves have been targeted as risk factors for mental ill-health (Cochrane, 1985) (Newton, 1988). The age distribution of the Bloomsbury hostels sample reflects the decline in bed spaces available in these hostels. They were an older population, due to 'rehousing' a lot of the younger residents who are more willing to move to private accommodation.

The Bloomsbury sample was similar to that of the OPCS sample in marital status but a large difference was observed in the employment status of the two samples. This is partly due to the increase in unemployment between 1972 to 1988. A comparison shows that the effect of unemployment on homeless people (as a marginalised group) is far more than on the general population.

The ethnic origin in the sample -measured by country of birth- showed significant differences from both the OPCS sample and the Bloomsbury population. A higher proportion of residents of Irish origin in Bloomsbury hostels reflects the fact that most of these hostels are in areas where there is a large Irish community, particularly in the case

of Arlington House.

The under-representation of black ethnic minorities may reflect stronger social networks (Fuller & Toon, 1988) within these groups that make their homelessness invisible. It could also be due to the difficulties that these people have in getting access to and living in these hostels. Anecdotal evidence collected during the study suggested that racial harassment and attacks were a major problem for the few black people who were interviewed.

The separate analysis of the ethnic origin of the residents with psychotic problems and the ethnic origin of the homeless CPN clients showed a different pattern showed over-representation of the people from black ethnic origin. Although black homeless people were under-represented in the hostels sample compared with Bloomsbury population (Tsouros, 1985), they were over-represented in the residents with psychotic problems. Although black people have social networks that make them less likely to become visibly homeless, this mechanism does not operate with black psychotics, a fact that might be explained by the effects of stigma on weakening these networks (Fuller & Toon, 1988). Additionally, people with psychotic problems tend to isolate themselves and have much smaller social networks in western societies (social isolation) (Warner, 1985).

More than half the sample had been in the hostel for more than five years. The OPCS sample indicated a similar length of stay. This shows that these hostels -though they were meant as temporary accommodation- are homes for a large proportion of homeless people. The decline in bed spaces and the closure of some of these hostels might be an important reason for the increasing number of people who sleep rough.

Approximately one third of the sample had never been in a stable job and only one fifth had lived in private accommodation. A higher proportion of the New York sample had had stable jobs and private accommodation but they became homeless because of the lack of affordable accommodation and the absence of a comprehensive welfare system (Hartman, 1984a).

Unemployment was strikingly high in both the CPNs' homeless clients and the survey samples compared to the general population. The survey sample showed how hard hit the homeless now are compared with the 1972 OPCS sample from hostels in England and Wales (Digby, 1972). There are more people in the New York sample who were working in full or part-time jobs compared with the London sample. These differences remain significant even after controlling for age. Many working people are unable to afford the expensive accommodation available to them in New York even in the limited city housing programmes on offer.

The chronic mentally ill are not by any means the dominant group in the homeless. The majority of these people are simply those with a housing problem due to poverty. This was demonstrated by the presenting problems of the homeless clients of the CPNs which showed that the significantly higher problems in these clients are those related to housing, unemployment and financial problems. Also this was shown by the relatively low prevalence of psychotic problems in the hostels sample compared with previous estimates (Weller et al, 1987)(Weller & Weller, 1986)(Marshall, 1989).

Psychiatric problems of homeless people:

The psychiatric problems of homeless people could be classified broadly into two types. The first are those caused by homelessness and by the social, financial and environmental problems that the homeless experience. The second type relates to chronic mental illness which causes drifting and homelessness. Some psychiatrists hypothesised that the second type is the predominant problem of homeless people and blamed this on community care and the closure of mental hospitals for the rise of homelessness(Weller, 1986)(Marshall, 1989)(Weller, 1985).

In CPNs' homeless clients, it was not clear whether the significantly higher proportion of the homeless clients who were given the diagnosis 'schizophrenia' reflected a real difference of prevalence of this psychiatric disorder in the two groups or a tendency to give different psychiatric responses to mental problems in different social groups (Hollingshead & Redlich, 1958). Although a similar proportion of both groups had been in contact with a psychiatrist, more homeless clients had been diagnosed as schizophrenic and had been admitted to mental hospitals. The differences might also suggest a selection bias in the referral process so that more homeless people with schizophrenia were referred to CPNs. But against such suggestion is the fact that both groups presented to the service with a similar proportion of psychotic experiences as assessed by CPNs (see table A4).

If the proportion of clients who were diagnosed as having schizophrenia is added to those diagnosed as having affective disorders the difference becomes non-significant. This might suggest different labelling of the two groups (Scheff, 1966)(Hollingshead & Redlich, 1958). The most significant presenting problems in the homeless clients were those related to finance, housing and unemployment.

Male and female homeless clients have different characteristics and problems. The male homeless clients presented with significantly higher unemployment; were more likely to be single and presenting to the service with abnormal (psychotic) experiences. These differences, together with a lack of resources, shaped the decision to survey only the hostels for men. CPNs described significantly different presenting problems in the male and female homeless. But, the psychiatric diagnosis given in the past to the two groups did not show any differences. This might indicate that homelessness -being in the bottom of the social strata- might influence psychiatric diagnosis more than presenting problems or gender. The other possible explanation is that the difference in presenting problems between the two sexes is due to the better outcome of schizophrenia in women (Shepherd et al, 1989).

In the hostel sample, psychiatric problems had been recorded as the main health problem in more than a quarter of the sample. The majority of psychiatric problems were neurotic problems. Only 7 subjects in the sample had psychosis as their main problem.
One fifth of the sample had severe drinking problems according to the PSE questionnaire although it was considered a main problem by hostel staff in only 9.9% of the sample.

Drinking in these hostels is still part of their culture such that it is probably less likely to be considered a problem until it is very severe (Archard, 1979a) (Clinard & Meier, 1985). The main health problem in the New York sample was drug abuse. Crack is becoming a nightmare for the services, specifically among young people. This relatively cheap and highly addictive drug is becoming more available and used by poor, young and vulnerable people.

Only 18 subjects had a history of mental hospital admission. None of these 18 residents had been in a mental hospital for more than two years; only 7 had been for six months to two years and 11 were there for less than six months. This suggests that very few of these men could be defined as a long-stay psychiatric patients according to the length of hospitalisation (Hailey, 1974).

The social behaviour has been assessed in order to survey the disabilities associated with chronic mental disorders (social disablement). The most frequent problem was in the category of 'Other problems' (35.6%). The majority of people who scored on this item had problems relating to alcoholism. The next most prevalent problem was hostility which means a frequent expression of hostility, more than the situation demanded. Hostility and aggression might be a direct result of the high prevalence of alcoholism (Myers, 1984).

The comparison of social behaviour problems of the study sample with that of the long-stay ward in a mental hospital showed a different level and pattern of problems. Overall scores of the SBS (BSM) and the scores of individual items of the schedule were significantly lower in the study sample compared with those of a long-stay ward. The items that were not significantly different related to hostility and violence (items 5, 14), socially embarrassing behaviour (items 11, 16) and other behaviour which, as shown in the logistic regression (see table B4.3), relates more to alcoholism rather than to chronic mental disorders.

Levels of depression and retardation (items 15,19) in the hostels sample were similar to those of the long-stay sample. The high scores on these items in the hostels sample might be due to the life-events they were experiencing (Brown & Harris, 1978) and the grieving of earlier losses particularly the loss of home (Fried, 1970).

Depression and retardation could also have resulted from the poverty of these men's environment, unemployment and social isolation, and marginalisation (Newton, 1988). Similar findings have been reported by investigators who used a psycho-analytical approach to assess homeless people in New York (Jones et al, 1984). A more detailed investigation of depression and hostility in hostel homeless is needed to tease out whether this is an environmental response.

The Hostel homeless sample were 3.5 times less likely to have social behaviour disabilities compared with those in long-stay wards. This difference became even larger after an adjustment for age and length of stay. This makes it unlikely that the hostel sample fulfil Leona Bachrach's definition of the chronic mentally ill i.e. that this sample has similar disabilities and needs as those of people in long-stay wards (Bachrach, 1983).

Only ten percent of hostels sample had a disability which was similar to or greater than that of people in long stay hospital wards. This was evident in people who had very few contacts with psychiatric services and under no medication in most cases. These findings challenge the publicly held stereotype of homeless people as florid psychotic patients who are unable to relate to others or care for themselves and confirms the view that homeless people are a non-homogeneous groups of disadvantaged people. It might be argued that more psychotic patients would be found in short-stay homeless hostels but two previous studies have shown that a higher proportion of chronic mental illness was found in the longer stay residents compared with new arrivals (Timms & Fry, 1989). In addition, the shorter stay residents did not have more admissions to mental hospitals compared to longer stay residents.

The findings of the study also suggest that though there is a need for long-term psychiatric care for a few of these people, this need may have been over-estimated in previous studies. The greater proportion of these people with disabilities require rehabilitative community services as shown by the 'norms' of services.

The small proportion of the subjects with psychotic problems (compared with previous studies) showed similar levels of social behaviour problems as those of the patients in long stay wards. These subjects were more likely to be black (than the rest of the residents), a high proportion of them had severe drinking problems and very few were in contact with any psychiatric services although they had high unmet needs for these services.

These more visible disturbed homeless people may have formed the public image of homeless people as psychotic patients. These subjects might have been over represented in studies which used less precise sampling methods which resulted in non-representative samples. These studies have therefore, overestimated the presence of chronic mental illness among homeless people.

The residents who stayed for 5 years or less had higher SBS problem and total needs for psychiatric services than those who stayed more than 5 years. This might be mainly due to the fact that residents with a shorter length of stay may still be experiencing the loss and life events that preceded their homelessness (Fried, 1970). It might be suggested that the higher SBS problems indicate the presence of a higher proportion of chronic mental illness in this group, nevertheless the length of stay of the residents with psychotic problems and the results of the logistic regression make the first explanation more likely. The logistic regression analysis showed that the need for psychiatric assessment and medication was more significantly associated with neurotic social behaviour problems than with the psychotic problems.

In summary, CPN data showed that diagnosis is not a good predictor of the presenting mental health problems in homeless people, and that their problems are multi-dimensional and related strongly to their social disadvantage. On the other hand the assessment of social behaviour problems in the hostel homeless showed that it is not true that the majority of these people are florid psychotics nor are they chronic mentally ill people.

The needs of homeless people for psychiatric services:

Given the low prevalence of florid psychotic behaviour and the level of disability as measured by SBS, and the fact that a lot of these problems can be reduced if assessed and treated, there is still a debate about whether these needs should be met within an institutional setting.
A consumer survey of homeless people in Fresno County showed they preferred community to hospital settings and counsellors to psychiatric service professionals (Sacks et al, 1987). Research in the Bloomsbury area suggested that many homeless people are reluctant to utilise traditional psychiatric services and prefer using the services of a visiting community psychiatric nurse (Satchell, 1988). This had also been confirmed by the high utilisation of the CPN service in Bloomsbury by homeless people when it was widely available (Hamid & McCarthy, 1989).
There is obviously a need for community based psychiatric services to meet the needs of homeless people. In-depth assessment of the individual needs of these people would give a more accurate profile for such services. With the new advances in policies towards community care, represented by the Griffiths Report (Griffith, 1988) and the Government response to it (Secretary of State for Health, 1989); the assessment of needs for health care in the community is becoming a priority.

The majority of the needs of the hostels sample for mental health services were unmet. The highest unmet needs were recorded for social assessment, medical assessment of mental health and assessment of drinking problems. This finding shows the multi- dimensional nature of homeless peoples' problems and supports the demand for a multi-disciplinary team that works with the homeless and incorporates mental, social and alcohol services.

The items that showed relatively high met needs were residential care in which the greater part of needs were met by hostels which in addition helped to meet a reasonable proportion of the need for day care by providing or liaising with day care facilities. In spite of the services provided by these hostels, the bed space has continuously declined since 1983 without any adequate alternative being provided (Randall et al, 1986).

The total needs (met and unmet) of the hostels sample were significantly lower than that of the Camberwell sample in most of needs items recorded in the Camberwell study. Only the need for social activity and the need for training in domestic skills were not significantly different in the two samples. This may have happened because of the similarity between homeless people and chronic mentally ill people in being both stigmatised and marginalised groups which caused higher needs for social activity in both samples. The fact that both the mentally ill and the hostel homeless had experienced institutional environments may explain the similarity in their need for training in domestic skills. This environment does not give them the opportunity to practice any of these skills (Wing & Brown, 1970).

The comparison of unmet needs in the two samples revealed a completely different picture. Not only did the significant difference in the total needs disappear but the differences were reversed in two items. The unmet needs of the Bloomsbury sample for medical assessment of mental condition and for help in self care were significantly higher than that found in the Camberwell study (Wykes et al, 1982a).

So in spite of the fact that the total needs of the homeless people sample were significantly different from that of the chronic mentally ill sample, the unmet needs were more similar than different in the two samples. This may be due to what Shanks (1986) has pointed to as the "cumulative unmet needs" that were due to chronicity and that homeless residents get help in very late stages of their illness (Shanks, 1988). This is mainly due to the difficulties experienced by homeless people in utilising the main stream mental health services. Very few such services try to address the mental health problems of these people.

The needs of the 13 residents with psychotic problems (see section B2.5) were compared to the remaining residents. The majority of the needs for psychiatric assessment were unmet while a high proportion of the residential and day care were met by the hostels.

The residents with a shorter length of stay had a significantly higher need for psychiatric assessment. As revealed in the logistic regression this need is more related to neurotic rather than psychotic problems. These problems may be higher in the shorter stay residents because of the recency of homelessness and accompanied losses and life events (Fried, 1970) (Jones et al, 1984).

In comparison with Camberwell sample, the total needs of the residents with psychotic problems were similar. The unmet needs of these psychotic residents were significantly higher than that of Camberwell sample especially the unmet needs for psychiatric assessment as a result of the very inadequate contact of homeless people with such services.

Previous psychiatric surveys of the homeless have used diagnosis based on a brief interview to conclude the presence of a high proportion of chronic mental disorders among these people. These surveys had over-estimated chronic mental illnesses by not adjusting for unmet social and other needs which contribute to their psychiatric picture. The few people who do have chronic mental illnesses are so disturbed because of their high unmet needs that they become more visible to the public. They are more easily over-represented in studies that used less rigorous sampling methods and less objective methods of assessment. This, in my opinion, is one of the main reasons behind the publicly held notion in that all homeless people are chronic mentally ill. Similarly, in the seventies Bahr and Caplow in their work with the homeless in New York had challenged this wrong impression held by the public and some scientists that all homeless people are chronic alcoholics (Bahr & Caplow, 1973).

Service responses to the homeless psychiatric needs:

Fischer et al (1986) concluded that the homeless exhibit patterns of health service utilisation that differ sharply from those of the home-based people (Fischer et al, 1986). The CPN data suggested that it is not only homeless people's behaviour that determines that difference, but also the way services respond to homeless people and their problems.

The standard of care provided to homeless clients is worse than for home-based clients. This is despite the fact that both groups presented with similar problems. The lack of agreement between the CPN and homeless people will probably affect the engagement of these clients with the services.

Homeless clients tended to be referred by voluntary and informal services and not by statutory professional services. This may have happened because of the liaison pattern of CPNs or because of the difficulties homeless people have in gaining access to statutory services {Bayliss & Logan, 1986}{Shanks, 1983}. There may be a need for better liaison with voluntary services by all those who provide care to homeless people.

Although Community Psychiatric Nurses provide the key community service in Bloomsbury, the data show that a common CPN outcome for homeless clients is referral on, no intervention, or loss of contact. CPNs are more involved with the home-based clients providing them with more support, practical help, counselling and psychotherapy. The proportion of the homeless clients who had a one-off session was much higher than home-based clients.

CPNs tend to refer homeless clients (more than the home-based clients with same problems) on to other caring agents. They explained that this was a result of the multi-dimensional nature of homeless people's problems and therefore their need for a multi- disciplinary intervention. The referral of homeless clients may make the delivery of the service even more difficult because the new caring agents need to re-approach and establish the delivery of care again. In targeting services a team approach with good communication between different professionals is essential.

The problems of establishing and maintaining rapport with homeless people, make this group more difficult and unrewarding for services and cause a drift towards caring for more amenable and probably less needy groups (Zusman & Lamb, 1977). There may be a need for a service with a specialist role to work with homeless people and other disadvantaged groups. Shanks (1983) suggested that for general medical care there is also a need for more co-ordination between various statutory services to allow the best use of existing resources (Shanks, 1983). This is also a problem for targeting psychiatric care.

The comparison of CPN clients with the survey sample showed that the CPNs may have been targeting their limited resources towards an unrepresentative section of the homeless, mainly of young people who come to London looking for work. Nevertheless, the examination of the intervention provided by CPNs to their hostel clients matched to a certain degree the needs of the representative sample.

The explanation of the presence of high unmet needs for mental health services among the representative hostel sample, in spite of the CPN's potential for meeting them, may lie in the limited resources of CPN services. Even this limited service had been withdrawn from the hostels before the survey started (Smith, 1987).

Services which are local and work flexibly with these men are utilised much more than other services. This was demonstrated by the higher registration when a GP visited the hostel and the higher utilisation of in-house based services. The impression from the interviews with these men suggested that they were marginalised to the extent that they felt they did not have the right to use health services. One of these men said 'I don't believe in bothering doctors with my problems'. Their previous experiences -which were mentioned in the interviews- of rejection and bad treatment from some health professionals has built up and maintained this belief. 'I have been called a dosser and kicked out of the surgery, I will never try again' said another of these men.

The hostel staff felt unsupported by mental health services (by this time even the CPN service had been withdrawn). One third felt unable to deal with the resident's problems. The residents in the New York shelters caused less burden to the staff. This is due mainly to the presence of more services available and to the strict regulations imposed by the shelters which 'refer out' any resident who causes problems or difficulties. This fact might have been one cause of the short mean length of stay of the residents in the New York sample.

Registration of the shelter residents with health schemes was low in New York in spite of the presence of the Medicaid programme. The main reason is probably the bureaucracy involved in obtaining Medicaid cover(Brown & Dallek, 1990). The resident has to wait up to two months and probably more to receive the Medicaid card by which time he may have moved from the shelter.

In spite of the difficulty of getting Medicaid there are many other services that work within the shelter (Grinker, 1988). There are community support programmes for the mentally ill, a health clinic that is attached to a general hospital and a large social services department that offers different specialised services.

In spite of the fewer social behaviour problems in the New York sample and the presence and utilisation of many services the needs and the unmet needs were higher than those of the London sample. The institutional model of care is prominent in the large shelters for homeless people in New York. The Environmental Index showed that the New York shelter was much more restrictive in its practice compared with London hostels and even more restrictive than the long-stay wards in mental hospitals (Wykes et al, 1982b).

These restrictions might create more dependency on the system (Wing & Brown, 1970) since shelters are creating a new institutionalised population (Rivlin, 1986b)(Rivlin, 1986a). Services to homeless people should be community-oriented and aim to encourage their independence towards a life which is perceived as valuable to them.

The huge amounts of money spent on putting people in shelters could be used to build better houses and more community-oriented services for these people. City shelters spend approximately 6,485 pounds per month per resident (Grinker, 1988) compared with only 390 pounds per month per resident in London hostels (Anonymous, 1988b).

Summary:

Unemployment and poverty are the most important demographic characteristics of the homeless people studied. These characteristics were the single most important factors in the presenting problems of the homeless people to CPN services.

Psychiatric problems are one of the main problems of the hostel homeless. These problems are closely associated with the difficulties of homeless life. Drinking problems are still a major problem in homeless hostels and still part of their culture. In spite of the presence of these problems the hostel sample had very little contact with psychiatric services.

Chronic mental illness constitutes a smaller proportion of the hostel sample than previously suggested. These people are so disturbed and have a lot of unmet needs that they are more visible to the public and researchers than the rest of the homeless. That might be one reason why chronic mental illness was over estimated in this population.
The need of the hostel sample for psychiatric services showed the multi-dimensional nature of these needs. The main needs are for psychiatric, social and alcohol services. The CPN data illustrated the need for continuing care of the homeless clients.

The utilisation of services of the hostel sample confirmed that the services that work locally and are accessible to the homeless are utilised more easily by these people. These conclusions suggest the need for a multi-disciplinary team with a specialist role to work with the homeless in their hostels and other residential settings.

There is a fear that increasing numbers homeless people may tempt decision makers to use big institutions to care for them. This form of service provision is neither acceptable nor beneficial to homeless people. Small hostels are less institutional and are a more acceptable base for service provision for the homeless.

Study limitations:

1. The CPN clients did not represent the Bloomsbury Population nor their problems represent the psychiatric morbidity in Bloomsbury. They represented only these people who came into contact with this service. The characteristics of these people might have been influenced by many factors (Abramson, 1984). Nevertheless data from community based services like GPs and the CPNs give a more accurate estimate of the morbidity compared with data from hospital based services (Shepherd & Clare, 1981).

2.The CPN recording system assumes face validity as the CPNs themselves agreed on the recording criteria. No formal assessment of the reliability of the system and the assessment criteria has been undertaken.

3.The CPN recording system did not measure an outcome of the care. The comparison made in the care provided to the homeless and home-based clients regarded the process of care rather than its outcome.

4.The Bloomsbury hostels sample included hostels which have more than 30 beds because the smaller hostels are night shelters which cater for a mainly transient population that only stay for three nights. These people -though they might have their special needs for mental health services- were not in the scope of this study. Previous studies suggested that these people are mainly young people who come to London looking for work (Brandon, 1980).

5. The survey part of the study excluded hostels for women. This made the survey only representative of the male hostel homeless. Previous studies suggested that women homeless have problems and needs of a different nature compared with male homeless (Ryback & Bassuk, 1986).

6.The Social Behaviour Schedule required that people assessed should have been in the setting more than one month. This has excluded a small number of residents. Previous studies suggested that these people do not have higher prevalence of mental illnesses so the direction of the bias might not be significant to the study hypotheses (Timms & Fry, 1989).

7.The cultural differences between New York and London might have influenced the comparison between the two populations and services by using schedules which had been developed for the British services. The same researcher had completed the interviews in both London and New York and that might have enhanced the reliability of the interviews.

The selection of the survey sample is biased toward the homeless men who live in hostels. This is the biggest group of homeless people in Bloomsbury and that there is evidence that they interchange with street homeless according to the season (Cumming et al, 1986). Nevertheless one should be careful in generalising the results to homeless women and young newcomers homeless. In addition, the age distribution of the sample may suggest the presence an underlying cohort effect. The results of this study could be considered as one layer of cumulative data collection process that could provide researchers and services providers with a reliable profile of the needs of these disadvantaged groups.

8. While it appears clear that most of the needs for psychiatric services in homeless people living in hostels are unmet, the method verification in the current study may have not been sufficiently sophisticated. However, this will require enormous resources to complete, and involve careful inspection of psychiatric records.

9. The lack of Diagnostic information could be considered as one of the limitations of this study. However diagnosis is not a good measure of dependency (Sturt & Wykes, 1987) or of needs for psychiatric services (Bebbington, 1990).

10. It is possible that the level of severe psychiatric disorders might be greater in people sleeping rough than in those sleeping in hostels for the homeless. The appropriate use of diagnostic instruments might reveal this.

Conclusions:

1.A third of Bloomsbury CPN services clients are homeless. Homeless clients presented to the service with similar mental health problems to those of home-based services. Nevertheless those who had contacted a psychiatrist had been given a different psychiatric diagnosis from home-based clients.

2.The socio-economic factors were more prominent in both the CPN homeless clients and the hostels sample. Unemployment, and coming from black ethnic origins were significantly higher variables in the homeless people under study compared with the general population even after controlling for age.

3.The pattern of care provided to homeless clients by CPNs was significantly different from that provided to home-based clients. This reflects the multi-dimensional nature of homeless people's problems which might have caused CPNs to refer them to another service though they know that the client will not take the referral and might lose contact with any services.

4.The homeless people living in Bloomsbury hostels have substantial psychiatric problems but they differed significantly in their social disablement and in their needs from chronic psychiatric patients. This with the fact that very few of them have been in mental hospital and none for more than two years challenges the hypothesis that homeless people's hostels are becoming long-stay wards. The logistic regression showed that the need of these people for psychiatric assessment was related to the neurotic rather than psychotic problems. Their problems are more likely due to a result of homelessness than its cause.

5.The unmet needs of the Bloomsbury hostels sample for mental health services were high and multi-dimensional. This was mainly due to lack of service provision that left them with cumulative unmet needs for services, and left the few homeless with psychotic problems visible to the public more than the rest of the homeless. Previous studies had overestimated the proportion of these visible homeless by using unrepresentative samples.

6.Hostels provide a less institutional residential setting for the homeless in London than the shelters in New York. There is a need to provide more support from mental health and other services to these hostels and there is also a need to ensure better access for ethnic minorities to these hostels.

7.The more acceptable form of service to homeless people is the community based services that work within a residential setting which will gain the trust of the resident through working with them and the other staff caring for them. Both the CPN and the survey data showed that there was a larger uptake of services that work in this way.

Recommendations:

The recommendations of this study fall into two categories; the first concerns service provision for homeless people and the second suggests further research needed to compliment and develop the main findings of this study in the field of mental health needs of homeless people.

1.Service recommendations:

1.The CPN recording system should be maintained and developed by testing and improving its reliability. This would provide an audit function that gives CPNs feed-back about their service particularly that provided to disadvantaged groups.

2.The expertise that the CPN has developed through working with the homeless people should be used to train and advise other professionals who could work with the homeless.

3. A co-ordinated multi-disciplinary service input to the services that already work with the homeless should be provided. It should pay particular attention to the need for social, psychiatric and alcohol services.

4. A multi-disciplinary team should be set up to work specifically with homeless people in their hostels and other settings to provide co-ordinated care to these groups and to provide a link with main-stream services. The aims of this team should include the meeting the needs of the homeless people with psychotic problems.

5.The social behaviour schedule and the need assessment schedule used in this study have proved to be useful, reliable and easy to use instruments in the assessment of homeless people. It is highly recommended to be used by services working with the homeless for assessment purposes.

6. The staff of hostels provide a key role in the care of the homeless. Any service that aims at helping the homeless should also provide support to these staff and work through them to help residents.

7. Hostels are a valuable resource for homeless people. There is a need for more non-institutional, small, well-supported and equipped hostels to cater for the homeless who wish to live there. Care should be taken that the provision does not create more institutionalisation as has happened in USA.

2.Recommendation for further research:

1.There is a need to assess the social disablement and the needs of the homeless people who sleep rough to complete the profile drawn by this study for single homeless men.

2.There is an increasing number of homeless women and homeless families that the survey did not address. A detailed investigation of the social disablement and needs for mental health services of homeless women and homeless families needs to be undertaken.

3.The study has screened the hostels' sample for the social disablement associated with chronic mental illnesses. There is a need for a study that could assess the prevalence of neurotic illnesses and the role of environmental factors and life events in these disorders.

5. Drinking problems have only been assessed in a limited way in this study as it was outside the study objective. Alcoholism is a problem for these people and needs more detailed assessment.

6.The relationship between chronic mental health problems and homelessness could be assessed through a follow-up study of people with chronic mental illnesses using a psychiatric register to assess how many of them become homeless (Lesage & Tansella, 1989).

7.A follow up of people who are at risk of homelessness to assess and explore the association between homelessness and mental health problems.

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APPENDIX-1

DATA CODING SHEET

		1 COLUMN NUMBERS
1	CPN NO	(2,3)
2	CASE NO	(4,5,6)
3	MONTH OF REFERRAL	
	01 JANUARY 02 FEBRUARY 03 MARCH 04 APRIL 05 MAY 06 JUNE 07 JULY 08 AUGUST 09 SEPTEMBER 10 OCTOBER 11 NOVEMBER 12 DECEMBER	(7,8)
4	YEAR OF REFERRAL	(9,10)
5	REFERRAL STATUS	
	1 NEW REFERRAL	
	2 TRANSFERRED FOR ANOTHER CPN	
	3 RE-REFERRAL	(11)
	6 SEX	
	1 MALE	
	2 FEMALE	(12)
	7 AGE (IN YEARS)	(13,14)
	8 MARITAL STATUS	
	1 SINGLE 3 WIDOWED 2 MARRIED/COHABITING 4 SEPARATED/DIVORCED	(15)
	9 ETHNIC BACKGROUND/IDENTIFICATION	
	1 CHINESE	
	2 GREEK/GREEK CYPRIOT	
	3 CARIBBEAN	

4 INDIAN SUBCONTINENT

5 AFRICAN

6 SCOTTISH

7 IRISH

8 MIDDLE EASTERN

9 OTHER (16)

10 REFERRER'S VIEW OF MAIN CURRENT PROBLEM

01 MOOD RELATED
02 ABNORMAL EXPERIENCES
03 DRUGS/ALCOHOL
04 INTERPERSONAL RELATIONS
05 ORGANIC
06 FINANCIAL/HOUSING/EMPLOYMENT
07 BEHAVIOURAL DISTURBANCE
08 RECENT LOSS OR SEPARATION
09 ANXIETY
10 OTHER
11 NONE (17,18)

11 CLIENT'S VIEW OF MAIN CURRENT PROBLEM AT FIRST INTERVIEW

01 MOOD RELATED
02 ABNORMAL EXPERIENCES
03 DRUGS/ALCOHOL
04 INTERPERSONAL RELATIONS
05 ORGANIC
06 FINANCIAL/HOUSING/EMPLOYMENT
07 BEHAVIOURAL DISTURBANCE
08 RECENT LOSS OR SEPARATION
09 ANXIETY
10 OTHER
11 NONE (19,20)

12 CPN'S ASSESSMENT OF MAIN CURRENT PROBLEM

01 MOOD RELATED
02 ABNORMAL EXPERIENCES
03 DRUGS/ALCOHOL
04 INTERPERSONAL RELATIONS
05 ORGANIC
06 FINANCIAL/HOUSING/EMPLOYMENT
07 BEHAVIOURAL DISTURBANCE
08 RECENT LOSS OR SEPARATION
09 ANXIETY
10 OTHER
11 NONE (21,22)

13 PROBLEM DURATION

1 LESS THAN ONE MONTH
2 ONE MONTH TO SIX MONTHS
3 SIX MONTHS TO TWO YEARS
4 MORE THAN TWO YEARS (23)

14 EMPLOYMENT STATUS

1 REGULAR
2 CASUAL
3 UNEMPLOYED
4 RETIRED
5 SCHOOL/STUDENT
6 HOUSEPERSON (24)

15 IF UNEMPLOYED - HOW LONG (IN MONTHS)

0 NOT APPLICABLE
1 LESS THAN ONE MONTH
2 ONE MONTH TO SIX MONTHS
3 SIX MONTHS TO TWO YEARS
4 MORE THAN TWO YEARS (25)

16 MAIN SOURCE OF INCOME

1 PRIVATE
2 EARNINGS
3 STAFF BENEFIT/PENSION
4 DEPENDENT
5 NO INCOME (26)

17 ACCOMMODATION

1 OWNER OCCUPIED
2 RENTED
3 HOSTEL
4 B & B
5 SLEEPING ROUGH
6 OTHER (27)

18 REFERRING AGENT

01 GP
02 SOCIAL SERVICES
03 HEALTH VISITOR/GERIATRIC VISITOR
04 PSYCHIATRIST
05 DISTRICT NURSE
06 HOSTEL
07 AGE CONCERN
08 PROBATION SERVICE
09 DAY CENTRE
10 DAY HOSPITAL
11 WARD STAFF
12 W.E.C.V.S.
13 VOLUNTARY ORGANISATION (OTHER)

14 SELF
15 OTHER
16 CPN (28,29)

19 IS REFERRING AGENT STILL INVOLVED

1 YES
2 NO (30)

20 LIVING ARRANGEMENTS

1 LIVES ALONE (INCLUDING HOSTEL)
2 LIVES WITH FRIEND(S)
3 LIVES WITH SPOUSE & CHILDREN
5 LIVES ALONE WITH CHILDREN
6 LIVES WITH PARENTS
7 OTHER (31)

21 PRESCRIBED PSYCHOTROPIC MEDICATION - ON REFERRAL

1 MINOR TRANQUILLIZERS
2 MAJOR TRANQUILLIZERS
3 ANTI-DEPRESSANTS
4 NONE
5 OTHER (32)

22 PRESCRIBED PSYCHOTROPIC MEDICATION ON DISCHARGE

1 MINOR TRANQUILLIZERS
2 MAJOR TRANQUILLIZERS
3 ANTI-DEPRESSANTS
4 NONE
5 OTHER (33)

23 MAIN INTERVENTION FOLLOWING ASSESSMENT

1 DRUG SUPERVISION/ADMINISTRATION
2 SUPPORTIVE PRACTICAL HELP/HEALTH EDUCATION
3 COUNSELLING PSYCHOTHERAPY
4 FAMILY THERAPY
5 BEHAVIOUR THERAPY
6 REFERRED ON
7 OTHER
8 NONE
9 LOST CONTACT (34)

24 HAS CLIENT EVER BEEN SEEN BY A PSYCHIATRIST

1 YES
2 NO (35)

25 IF YES, HOW LONG AGO WAS THE LAST CONTACT THE CLIENT HAD WITH A PSYCHIATRIST (IN MONTHS)

0 NOT APPLICABLE
1 LESS THAN SIX MONTHS
2 SIX MONTHS TO TWO YEARS

3 MORE THAN TWO YEARS (36)

26 WHICH OF THE FOLLOWING DIAGNOSTIC CATEGORIES MOST APPLY DESCRIBE THE FORMAL PSYCHIATRIST DIAGNOSIS GIVEN

0 NOT APPLICABLE
1 AFFECTIVE DISORDER
2 SCHIZOPHRENIC DISORDER
3 PERSONALITY DISORDER
4 DEMENTING PROCESS
5 ANXIETY STATE
6 ALCOHOLISM/DRUG ABUSE
7 OTHER
8 NOT KNOWN (37)

27 HAS THE CLIENT EVER BEEN IN A PSYCHIATRIC HOSPITAL AS A PATIENT

1 YES
2 NO (38)

28 IF YES, HOW MUCH TIME ELAPSED BETWEEN LAST DISCHARGE AND CPN REFERRAL

0 NOT APPLICABLE
1 WHILE IN HOSPITAL
2 WITHIN SIX MONTHS
3 SIX MONTHS TO TWO YEARS
4 MORE THAN TWO YEARS (39)

29 DID THE CLIENT REQUIRE PSYCHIATRIC HOSPITAL ADMISSION WHILST ON YOUR CASELOAD

1 YES
2 NO (40)

30 TOTAL NO OF SESSION WITH CLIENT (41,42)

31 HOW MANY HOURS DID YOU INVEST WITH THIS CLIENT IN TOTAL (INCLUDING NOTES) (43,44)

APPENDIX-2

(HOSTELS INTERVIEW SCHEDULE)

(Informant.....Date.....)

Cols

ID 1 Schedule No: [ ][ ][ ] 1-3

HOS 2 Hostel: [ ] 4

ROOM 3 Resident's Room No: [ ][ ][ ] 5-7

AGE 4 Age: [ ][ ] 8,9

SEX 5 Sex: [ ] 10

MARIT 6 Marital Status: (1) Single (3) Widow/er [ ] 11
(2) Married (4) Separated/Divorced
(5) D K

EMPL 7 Employment Status: (1) Working (2) Casual [ ] 12
(3) Unemployed (4) Old age pensioner
(5) School/student (6) Other.....
(7) D K

STAY 8 How long has the resident been in this hostel (in months)? [ ][ ][ ] 13-15

ETHNIC 9 Country of origin: (1) UK (2) Eire [ ] 16
(3) W. Indies (4) Cyprus
(5) Indian Subcontinent (6) Far East
(7) African (8)Europe
(9) Other.....

HLTH 10 Health Problems:
(0) none
(1) physical ill-health..... [ ] 17
(2) psychiatric/nervous problems.....
(3) alcohol and drug dependency
(4) physical and Psychiatric
(5) other.....

ALC 11 Is alcohol in any way a problem for the resident
(0) No problem. [ ] 18
(1) A problem but not as severe as (2).
(2) A severe problem that caused him:
a.social and legal problems.
b.missed work or therapy.
c.morning shakes or other withdrawal symptoms.
d.blackout for several hours.
e.hearing voices or seeing visions.

REG 12 Is the resident registered with a GP?
(1) Yes [ ] 19
(2) No GP will accept him.
(3) The resident is not interested.
(4) D K

Which of the following caring agencies has been helping the resident in the past six months:

Cols

GP 13 General Practitioner
(0) no contact. ☐ 20
(1) there were irregular contacts
(2) there were regular contacts

CPN 14 Community psychiatric nurse
(0) no contact ☐ 21
(1) there were irregular contacts
(2) there were regular contacts

PSY 15 Psychiatric outpatients' Department
(0) no contact ☐ 22
(1) there were irregular contacts
(2) there were regular contacts

HOSP 16 Other Hospital department
(0) no contact ☐ 23
(1) there were irregular contacts
(2) there were regular contacts

SW 17 Social worker
(0) no contact ☐ 24
(1) there were irregular contacts
(2) there were regular contacts

OTHER 18 Other service, please specify..... ☐ 25

MHOSP 19 Has the resident been in a mental hospital? ☐ 26
(1) Yes
(2) No
(3) D K
Details:.....
.....

MSTAY 20 length of stay in mental hospital? (0) not applicable ☐ 27
(1) less than six months
(2) six months to two years
(3) two years to five years
(4) more than five years

LIFE 21 life achievement
(0) never lived in a private accommodation or had a stable job. ☐ 28
(1) had a stable job but not lived in private accommodation.
(2) had lived in private accommodation and had a stable job

BURD 22 Does the resident's health or psychiatric problem(s) cause staff difficulties?Please specify: ☐ 29
(0) No significant additional problems.
(1) physical burden (to cater for his physical disability)
(2) psychological burden (anxiety/embarrassment etc) caused by the resident
(3) Both types of burden

APPENDIX-3

SOCIAL BEHAVIOUR CODING SHEET

Cols

see schedule for coding schemes

Communication

INIT	1.	Taking the initiative	30
COHER	2.	Coherence of conversation	31
ODD	3.	Oddity/Inappropriateness of conversation	32
SOC	4.	Ability to make appropriate social contacts	33
HOST	5.	Hostility/Friendliness	34
ATTEN	6.	Attention seeking behaviour	35

Other Behaviours

SUICID	7.	Suicidal ideals and self harm	36

Cols

PANIC	8. Panic attacks and phobias	☐	37
OVERAC	9. Overactivity and restlessness	☐	38
LAUGH	10. Laughing and Talking to self	☐	39
BIZAR	11. Acting out bizarre ideas	☐	40
POSTUR	12. Posturing and Mannerisms	☐	41
DISGST	13. Socially unacceptable manners or habits	☐	42
VIOLNT	14. Violent, threatening or destructive behaviour (Do not code behaviours already coded under 6)	☐	43
DEPR	15. Depression	☐	44

Cols

SEXL 16. Inappropriate sexual behaviour ☐ 45

HGN 17. Personal appearance and hygiene ☐ 46

SLOW 18. Slowness ☐ 47

UNDACT 19. Underactivity ☐ 48

CONC 20. Concentration ☐ 49

OTHBH 21. Other behaviours that impede progress ☐ 50

prompts: not eating, over-eating
alcoholism
obsessional
stealing
suspicious of everyone
low self-esteem
poor memory
excessive smoking

Cols

Occupation

OCCUP 22. Type of weekday occupation
If coded 1,2,3 or 4 write the address here
and name of person who might supply information
about S's behaviour at work

LEIS 23. Leisure activities

24. Restrictions on activity

AIMS 25. Unrealistic aims

26. Reason for being in setting

WORST 27. The most difficult problem to deal with
(problem number)

PHYSHD 28. Physical handicaps (include obesity)

THHD 29. Other extrinsic handicaps

Attempts to modify behaviour

APPENDIX-4

The needs schedule:

Key: (0)-no need (1)-met need (2)-unmet (3)-overmet (4)-unclear need Cols

SECU 1 Does the resident need special supervision or protection because there is a danger that he may harm him self or be a nuisance or danger to others ☐ 51
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

MASS 2 Do you think that the resident needs assessment of mental condition, advice or medication? ☐ 52
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

DOMSK 3 Would the resident benefit from training in domestic skills (laundry, shopping, cooking, budgeting etc.) if you think that the resident is able, motivated and has the time to benefit from such training? ☐ 53
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

SELFCR 4 Does the resident need supervision and help in self care (ie with eating, drinking, bedwetting, personal hygiene, physical health etc.)? ☐ 54
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

BEHMOD 5 Does the resident need therapeutic intervention to change or modify certain harmful, difficult or embarrassing behaviours? Cols
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....
55

SOCACT 6 Would the resident benefit from a provision to increase social activity (eg befriender, social club etc.) ?
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....
56

COUNS 7 Does the resident need personal counselling (ie advice and reassurance) about matters such as housing, welfare benefit and worries about future?
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....
57

RESCR 8 What sort of accommodation will suit resident's condition?
(a) Present accommodation
(b) Different, details.....
.....
.....
what is being done about it:.....
.....
58

DAYCR 9 Does the resident need day care facilities(eg day centre, day hospital, occupational day centre, sheltered workshop etc.)?
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....
59

Cols

DOMPSY 10 Is there a need for a domicilary psychiatric service (eg CPN) to help the resident. [ ] 60
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

STAFF 11 Do the staff need support or advice on practical matters or on how to cope with resident's behaviour? [ ] 61
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

ALCSER 12 does the resident need alcohol service (e g detoxification service, alcoholism treatment unit or residential projets) ? [ ] 62
(a) NO
(b) Yes, details.....
.....
.....
what is being done about it:.....
.....

OTHND 13 Other needs:..... [ ] 63
.....
.....

Date .....
Location .....
Rater .....

Questions 1-40 Circle Y for Yes
Circle N for No

Activity

Score	0	1
1 a)	N	Y
b)	N	Y
2	N	Y
3	N	Y
4 a)	N	Y
b)	N	Y
5	N	Y
6	N	Y
7	N	Y
8 a)	N	Y
b)	N	Y
9	N	Y
10	N	Y
11	N	Y
12	Y	N

Total ____

Possessions

	0	1
13 a)	Y	N
b)	Y	N
c)	Y	N
d)	Y	N
14	Y	N
15 a)	N	Y
b)	N	Y
16	N	Y
17	Y	N

Total ____

Meals

	0	1
18	Y	N
19 a)	Y	N
b)	Y	N
20 a)	Y	N
b)	Y	N

Total ____

Health and Hygiene

21 a)	N	Y
b)	N	Y
22	N	Y
23 a)	Y	N
b)	Y	N
24	Y	N
25	N	Y
26	Y	N

Total ____

Residents Rooms

27	N	Y
28	N	Y
29	N	Y
30	Y	N
31	Y	N
32	Y	N
33	Y	N

Total ____

Services

34	Y	N
35 a)	N	Y
b)	N	Y
c)	N	Y
d)	N	Y
e)	N	Y
36	N	Y
37	N	Y
38	N	Y
39	Y	N
40	N	Y

Total ____

Questions 41 - 47

Circle a , b i , b ii , c or d

Environment

Score	0	1	2	3	4
41	a	b i	b ii	c	d
42	a	b i	b ii	c	d
43	a	b i	b ii	c	d
44	a	b i	b ii	c	d
45	a	b i	b ii	c	d
46	a	b i	b ii	c	d
47	a	b i	b ii	c	d

Total ____

Questions 48 - 49

Circle a or b

Score	0	1
48	a	b
49	a	b

Total ___

TOTALS : ACTIVITY ___ POSSESSIONS ___ MEALS___ HEALTH AND HYGIENE ___

RESIDENTS' ROOMS ___ SERVICES ___ ENVIRONMENT___