Tracing patients from acute psychiatric wards

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Summary
A random sample of those admitted to acute psychiatric wards in Sheffield in 1985 was traced to establish whether or not the patients were homeless 5 years later. Contrary to expectations none were found to be homeless. Although the proportion of mentally ill amongst the homeless may be significantly high, the number discharged from psychiatric hospital, at least in Sheffield, living consistently 'on the streets' or staying regularly in night shelters seems small as a proportion of all discharges.

Introduction
There is surprisingly little information about what happens to psychiatric patients after discharge from hospital. The need for more tracer or follow-up studies has been recognized[1,2]. A widespread popular view is that the closure of psychiatric hospitals should be slowed because of the number of homeless mentally ill persons[3]. This opinion needs to be based on the evidence of the fate of patients discharged from psychiatric hospital. Patients can be difficult to trace[4], but if efforts are made such projects do seem to be viable[5].

We have previously reported that we managed to trace all 438 patients from long-stay psychiatric wards in Sheffield after 8 years[6]. None were found to be homeless, although one was in prison. This finding accords with other similar optimistic results of follow-up of discharged long-stay patients[7-9].

A commonly held impression, however, is that the problem of destitute mentally ill people is getting worse[10]. The Westminster Association of Mental Health has speculated that as the number of long-stay beds is diminished, patients on acute psychiatric wards are more likely to become homeless[11]. The present study was undertaken to trace patients from acute psychiatric wards in Sheffield, as a companion to our study of patients from long-stay wards. Although there may be insufficient research to decide if the resettlement of former longstay patients is working well, there is even less evidence about the outcome of patients from acute psychiatric wards.

Method
Tracing methods
The names of all patients not over the age of 65 years, discharged from acute wards in the psychiatric services in Sheffield during the calendar year of 1985, were obtained from medical records. Records for 1985 were compiled before computerization and had to be obtained from daily manual diary records. A simple random sample of 100 patients was created from this sampling frame of total discharges using a table of random sampling numbers. Patients were traced at follow-up as at 1 January 1991, ie more than 5 years later.

Obviously some patients were easier to trace than others. Some were still in contact with the psychiatric services and their whereabouts could be confirmed from staff contacts. Past medical records often gave telephone contacts which could be followed up. Computerized records of the Family Health Services provided a particularly useful avenue for tracing patients who were no longer in touch with the Sheffield psychiatric services or could not be found from leads in their psychiatric case notes.

Few studies in the literature discuss the definition of homelessness in detail. Operationalized levels of homelessness could be developed. At the end of the spectrum would be those with limited or no shelter (ie sleeping in public places) and those staying in reception centres or night shelters, such as Salvation Army hostels. Publicity about the homeless mentally ill concentrates on this group, as they are the most publically visible, and for this reason it is the definition of homelessness used in this study.

Hearsay evidence of whereabouts was not accepted as valid and all contacts were confirmed.

Sample characteristics
The sample was randomly selected from the population of 899 persons not aged over 65 discharged from psychiatric hospitals in Sheffield during the calendar year of 1985. Some patients had more than one admission and discharge during this time, but they were only counted once. All patients whatever the diagnosis were included. There is little reason to think that patients discharged from Sheffield Health District are unrepresentative of patients discharged from a typical psychiatric service. Differences in consultant practice will have been averaged out by including all discharges from the acute wards.

In the total population of discharges the ratio of male : female patients was 43.4% : 56.6% and the mean age was 39.3 years (range 16-65, standard deviation 13.4). Patients over 65 years at the time of discharge in 1985 were excluded from the sample (they would have biased the results because of admissions for dementia and respite care in this age group).

In the random sample of 100 patients chosen from the total population of 899 discharged patients, the sex ratio was slightly weighted towards men compared with the total population (M : F=45 : 55), but not significantly so (P=0.76, two-tailed). The mean

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age of 41.6 years was higher than might have been expected, but, again, not significantly so ($P=0.085$, two-tailed). The average number of previous admissions was 2.8 (range 0-38, median=1). There were 45 patients who had had no previous admissions before their admission in 1985.

Results

All 100 patients in the sample were traced. The highest proportion (77) were living on their own or with relatives; 14 had died; five were in psychiatric hospital at the time of follow-up; and four were in hostels or nursing homes. None were homeless.

Most of the 77 patients living on their own or with relatives were still living in the Sheffield and Rotherham area, with eight living in other areas of Britain. Of the five patients in psychiatric hospital; three were in long-stay wards (including one in a clinic in Germany); and two were on acute wards (including one who was on leave at the date of follow-up). The two patients on acute wards have subsequently been discharged: one to home; the other to local authority residential care for the elderly. The four patients in hostels or nursing homes were in a local authority home for the mentally ill[2], a half-way house[1] and a private nursing home for the elderly[1].

Discussion

This study has demonstrated, as did our study of patients from long-stay psychiatric wards[6], that with perseverance discharged psychiatric patients can be traced. Geographical instability, lack of family contact and unstable accommodation of psychiatric patients might be anticipated to make them impossible to trace, but this expectation has not generally been found to be the case. A recent large follow-up study of schizophrenic patients also demonstrated that a good follow-up rate can be achieved[12].

The patients from acute wards were in general more difficult to trace than those from long-stay wards in our previous study because a higher proportion were living on their own or with relatives, rather than in institutional or fairly institutional settings. They had also more often moved from the Sheffield area. It is not surprising that acute patients are more mobile, yet none of the sample were found to be homeless at follow-up. This finding accords with the results of a follow-up study in London of patients with schizophrenia 1 year after hospital discharge[13]. Only 2% of this sample reported having slept on the streets at some time during the preceeding 3 months.

According to general public and professional expectations, as we demonstrated for consultant psychiatrists in the case of our study from long-stay wards[14], more homelessness would have been found amongst discharged psychiatric patients than was actually found in this study. These expectations arise from findings of a high level of mental illness in surveys of the homeless[3], a recent example of which was conducted in Sheffield[15]. The concluding paragraph of that study suggested that psychiatric patients are being discharged to live 'on the street'. Our findings do not endorse this impression[16].

Moreover, most surveys of the homeless have concentrated on hostels and day centres rather than those who sleep rough. In the Sheffield survey[15], for example, no attempt was made to contact people on the street. A relatively low prevalence of psychosis has been reported among residents of a shelter made available to people living on the streets of London during a recent severe cold weather period[17]. Possibly, using wider definitions of homelessness in surveys than 'rooflessness' has created a misleading impression about the amount of mental illness amongst the most publically visible group 'on the street'.

Apparent inconsistency seems likely to arise because of the different bases for samples in two kinds of studies. Tracer studies of discharged patients, like our own, suggest a very low proportion of discharged patients become homeless. Surveys of the homeless, on the contrary, suggest a greater proportion of the homeless have been discharged from psychiatric hospital. A much larger number of people are discharged from psychiatric hospital than become homeless, and thus a tiny proportion of discharged patients who become homeless seems significant as a proportion of those who are homeless in general.

The main challenge to the policy of the rundown of the traditional psychiatric hospital is the fear that homelessness is being increased among the mentally ill. Our findings suggest these fears may have been exaggerated. The number of homeless may have been affected more by housing policy than psychiatric deinstitutionalization. Yet there should be no complacency about ensuring good community care for the mentally ill.

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