DISCHARGED

Homelessness among psychiatric patients

in Scotland

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Preface

In 1993 Shelter (Scotland) published *Housing and Community Care in Scotland.* The intention of that report was to present an early assessment of the progress among social work, health and housing organisations in implementing community care plans. In particular, it focused on how housing decisions were being integrated in the process.

Shelter was conscious that community care embraces an enormous variety of viewpoints and ideas and means very different things to different participants. The earlier report presented the professional perspective. *Discharged* looks at community care from the clients' point of view: that of people who have been discharged from psychiatric care. Shelter was concerned that people in this position were particularly vulnerable to homelessness. The report aims to illustrate the experience of people who have indeed become homeless. It looks at both the nature of this homelessness and the process leading to it.

The fieldwork for the study was undertaken in the summer and autumn of 1993 by Nicole Crockett. Paul Spicker designed the project, acted as consultant and processed the results. Shelter is grateful to the researchers for their hard work, to the many agencies who assisted with their time and arranging access for interviews. Thanks are due most of all to the people who agreed to be interviewed.

The publication of *Discharged* reflects a growing interest within Shelter, and the housing movement more generally, in community care and the response which might be made by housing agencies to different patterns of need. The comments in this report reflect an important failure of policy. The situation of people who are homeless after receiving psychiatric care is disturbing. There is an urgent case for action.

Sheila McKechnie
Director of Shelter

1. Introduction

Community care for psychiatric patients

Although some of the publicity surrounding recent reforms in community care gives a different impression, 'community care' for psychiatric patients is not new. Many Victorian institutions for people who were mentally ill were designed with the aim of isolating them from the community. Institutions were often built outside the main centres of population. Policies for mentally ill people began to change in the 1950s. Part of the reason was the 'drug revolution', which made it possible to consider treating and controlling mental illness outside the institution. Part, too, was a disillusion with the institutions, fuelled by a barrage of critical literature - and subsequently, by a series of scandals in mental institutions. Last, but not least, a major reason for the change in policy was cost; it had become more expensive to maintain people in a residential institution than to discharge them into 'the community'. Enoch Powell, Minister of Health in the early 1960s, looked forward then to a time when all the mental hospitals would be closed.

In the early days of 'community care', people who were discharged were likely to find little practical support in the 'community'. Community care had been presented as a cheap alternative to hospital; but this was true only because services in the community were barely developed. All too often, care in the community meant nothing more than not being in an institution; and the lack of support available outside meant that there was little to prevent further problems. Hospitals were supposed to offer an 'open door'; what they offered became known in the 1970s as a 'revolving door' instead. People would leave hospital only to find that further readmissions were necessary in the future.

The closure of psychiatric hospitals, and the loss of beds in those which remain, have continued. In the health service, the emphasis has shifted from long-stay care in hospitals towards short-stay care with maintenance in the community. In Scotland, this relies particularly on a combination of out-patient clinics and the role of the Community Psychiatric Nurse. If patients are less likely to go back through the 'revolving door', it is because there are fewer places to return to. Lothian, for example, has lost two-thirds of its non-geriatric psychiatric beds since 1966.

On discharge, however, each patient should be the subject of a 'care plan'. The care plan is intended to identify the needs of the patients and to work out the means by which those needs will be met. A circular from the Scottish Office in 1988 outlined procedures for discharge, and commented that

> "The Secretary of State sees no reason to doubt that in the vast majority of cases arrangements for the provision of necessary support to persons leaving hospital operate smoothly."[1]

Ian Taylor has recently reviewed the process of care planning in Scotland, discussing the policies and practice of a number of specific institutions.[2] Many of the procedures have been partially amended following the reform of community care in April 1993, but the importance

of these changes in this field should not be overestimated. Discharges are not a new policy; they have been proceeding over many years. Psychiatric patients in the community still need to receive the kind of medical care which was formerly given in hospitals. And the new arrangements made for community care have much more to do with administration than with the way that people are treated, and they have in any case had little direct impact in this field as yet. The circumstances of the people interviewed for this study have developed in many cases over a long period of time. Community care for mentally ill people is not simply an administrative procedure; it depends on the development over time of an infrastructure of services from which choices can be made for individual patients.

Care plans have been criticised in England on two main grounds. The first is that there is no way of checking the appropriateness of such a plan; where there are no services, plans are unlikely to meet needs. Sone cites the following section from a care plan:

> "This gentleman has been an inpatient at this hospital. He has now been discharged. He is of no fixed abode and needs to be helped to obtain appropriate accommodation. Because of his mental condition he is liable to deteriorate if he has no accommodation."[3]

Second, even where plans are made, it may be difficult to enforce them. Where attempts have been made to follow through people for whom care plans were made, some have 'disappeared' - the services had lost contact (research in Essex suggests it may be about one-quarter of all cases)[4]. It is not always possible to know where people have gone, but in some cases it is all too clear; they are subsequently found in hostels, shelters and services for homeless people.

These problems are likely to be at least as true in Scotland as in England. By comparison, social work services in Scotland have played only a minor role to date in provision for mental health. Scotland is desperately short of the infrastructure of community services necessary for the maintenance and protection of psychiatric patients in the community.

Homelessness among psychiatric patients

Accommodation is an important part of the process of discharge. People who leave an institution after a long stay are unlikely to have somewhere to live; these are the people on whom much attention has focused in the past, and those for whom care plans are most likely to be made. But people who have been in acute psychiatric care, too - that is, short-term care - may well find themselves vulnerable to homelessness on discharge; the mental illness which precedes admission to psychiatric care often leads to a disruption of family relationships, while the circumstances of admission can often make it difficult to keep previous accommodation. Research by Glasgow's Housing Department found that people using the Hamish Allan Centre, which is the Council's homeless persons' section, were more likely to have been in acute psychiatric care.

> "The research findings do not substantiate the view, often expressed in the media, that significant numbers of people are being discharged directly from long stay wards into the homeless/hostel network. ... These findings suggest that, while appropriate accommodation and support services are sought for long stay patients being discharged to the community, this is at the expense of the needs of people being discharged from acute wards." [5]

People are not homeless simply because the services have lost contact. Recent research in Edinburgh interviewed people who were on the street. The researchers identified 12 people who were schizophrenic; 8 of them were receiving psychiatric care. When similar work was undertaken in the 1960s, researchers found 20 people suffering from schizophrenia, and none of them was receiving care.[6] The popular image of homelessness among mental patients is that of people who have been dumped and forgotten about. This is not true, for the most part. But what appears to be happening is, in its way, almost as disturbing; it is that people discharged from psychiatric care are receiving only medical services, not social support.

Homeless people are particularly vulnerable. Their benefits, given only on special terms, are less favourable than those of others on benefit. Their diets are inadequate. They are less likely to receive basic health care. They are vulnerable to attack. People recovering from mental illness are more vulnerable than most, but they are exposed to circumstances and conditions which few could be expected to cope with.

This report is a description of the circumstances and conditions of people who are homeless after being in psychiatric care; it also attempts to explain something of the process through which people have become homeless. Much of it is in their own words, because part of our concern has been to give people a voice when they are in particularly adverse and difficult situations.

2. Method

The aim of the research was to learn something of the processes by which people discharged from psychiatric hospitals become homeless. To do this, we wanted to try to understand the process from the point of view of the people who were affected by it. The study we undertook was qualitative, rather than quantitative, in its approach. Quantitative social research can identify how big a problem is, but by comparison it gives very little idea of the sources of a problem. We were trying to find out not how many people are homeless, but what their experience had been.

The method we chose was to interview people in depth, for two reasons. The first was that it was the method best suited for the issues we wanted to examine: the topic is complex, sensitive, and concerned with process rather than a single observable experience. [7] The second was that we wanted not only to find out what the experience of homelessness had been like for people discharged from psychiatric care, but to give them the opportunity to speak for themselves. The interviews had a clear agenda; they were 'semi-structured'. The kinds of questions that were asked are included in an appendix at the end of the report.

The sample. We wanted to conduct a sufficient number of interviews to gain an insight into the range of problems which people experience, from several different perspectives. It is virtually impossible to follow through the process by which people actually become homeless on discharge. But it is possible to try to describe the problems as they are found in night shelters or other services for homeless people. In total, thirty four interviews with discharged psychiatric patients were conducted, although for reasons explained later we have only used twenty-seven of these. All of these people had experienced homelessness at some point following their discharge from hospital. Nearly all were homeless at the time that the interviews were carried out; one person had recently moved into his own flat.

People were initially identified via the agencies which we had approached. An appointment was usually made to see a particular person at a particular time. However, the lifestyles of people living in hostels and visiting day centres precluded strict timetables. We sometimes spoke to people who were present, rather than those with whom interviews had previously been arranged, if they fitted the criteria for the sample and agreed to be interviewed. There were two basic characteristics which were required of all our interviewees. These were firstly, that they had spent a period of time receiving psychiatric care in hospital. Our respondents had been patients for differing lengths of time: some had been in hospital for years, some only for a matter of weeks. Others had been periodically re-admitted, suffering from what has been described as the 'revolving door' syndrome. Secondly, people had to have some experience of homelessness. We identified respondents by contacting services for homeless people, including night shelters and hostels.

The other main criterion for selecting people to interview was geographical location. We wanted to cover some of the areas which had been left out of other studies on mental health

and homelessness, particularly the less urbanised regions. Interviews were carried out in Edinburgh (12), Glasgow (12), Dumfries (5) and Inverness (5).

Access. In order to identify individuals to interview about their experience of discharge from hospital and homelessness, we approached organisations which provide services for homeless people. These included hostels run by the DSS, by local councils, and by voluntary organisations, as well as day centres offering advice, support and leisure activities. We also contacted those involved in organising special projects connected to mental health and homelessness. These included projects run by the National Schizophrenia Foundation, by community psychiatric services, and Social Work Departments. We are grateful for their help.

The respondents. Of the 34 interviews, 7 were with women, and 27 with men. The age of men in the study ranged from 25 to 72 years, with the majority aged 25-60. The women were aged from 25 to 45, a much smaller age range than was found among the men. This probably reflects the experience of psychiatric care, where people aged 25 to 45 represent the highest proportion of admissions.

The conduct of the interviews. The experience of conducting the interviews varied according both to the setting where they were carried out, and to the individual who was being interviewed. They took place in the hostels where the interviewees were living, in day centres, and a couple were conducted in social work centres. The agencies made every effort to provide us with a quiet and private place to talk to people, but this was not always possible. In busy hostels with limited space there was not always a vacant room to spare for interviewing. Even when a room was available there were often interruptions, and the large numbers of people coming and going created noise levels which intruded into conversations.

The people who we were interviewing were not necessarily people who were mentally ill. Some people who are mentally ill do not receive appropriate psychiatric treatment; on the other hand, people who have received psychiatric treatment in the past cannot be assumed to be mentally ill currently. It is important not to assume that what people who have been mentally ill say is especially defective or irrational. There is a risk in any kind of consumer evaluation that people will embellish their stories or be inconsistent, but there is no evidence that mentally ill people are any less reliable than anyone else[8]; and if we are concerned to respect the rights of people who are disadvantaged, it is important to take what they say seriously. There are difficulties which affect interviews with people who are mentally ill, and some of these affected this study, but they are not problems of irrationality or wild allegations. Mental illness often leads to disruptions in communication; the effects of medication can also mean that people can find it difficult to hold a conversation, through tiredness, slurring of speech or impaired ability to concentrate. In many of these interviews, it was difficult to find out exactly what people meant to say; the report of what people said is slightly unusual in that it often contains fragments of a conversation with the interviewer, rather than the words of the person answering alone. In total, seven of the interviews were unusable because of the extent of the damage and distress which people were experiencing.

Ethical issues. There are two important ethical issues which we have to mention. The first is that research with people who are undergoing medical treatment should not adversely affect the way that they are being treated. The material has to be sufficiently confidential, not simply so that a neighbour or casual acquaintance cannot recognise it, but so that a doctor, social worker or nurse working with the patient cannot recognise it. The names we have used are fictitious; we have also had to edit material so that it is completely anonymous. Secondly, we had to consider that a number of the people we were talking to were often very vulnerable, and sometimes clearly damaged by their experiences and their illnesses. Some answered the questions put to them in monosyllables, which made it impossible to strike up a conversation and thus get to the details which we needed. We had little positive to offer people, except for the opportunity to make a contribution to people's understanding of policy. We paid contributors £5 for their time.

3. The people: some personal histories

Everyone we spoke to had their own unique story to tell, and they differed substantially from one another. However, there were patterns of experience which were common to several of the people that we interviewed. The following are the stories of six of the people that we spoke to in the course of the study. They have been chosen because they are good representatives of the group as a whole. The names have been changed, and some details have had to be omitted because they would make it possible to identify individuals, but nothing has been added; though the words in this chapter are ours, they are based on our conversations with the people themselves.

Neil

Some of our respondents have spent a lifetime moving between hospitals and hostels for homeless people. Many of this group spend in between times sleeping rough and have very nomadic lifestyles.

Neil is in his early thirties. To all intents and purposes he has been either homeless or in a psychiatric hospital for the past eight years. Neil is currently living in one of the hostels for homeless people run by Edinburgh District Council. He likes the privacy of the hostel. He has his own room with his own key. He says that it is properly heated and there is plenty of hot water, there are also cooking facilities available. He feels safe there; the security is much better than in other hostels that he has lived in.

Neil was first admitted to a hospital eight years ago after his sixth suicide attempt. At this time he was a voluntary patient for six weeks. He has suffered from acute paranoia. A girl he knew died, and he hears her voice asking him to join her in heaven. After this first stay in hospital he went back to the bed and breakfast which he had been living in beforehand. He was still under the care of a psychiatric nurse and had to attend a clinic every day, which he says was terrible.

Neil has slept rough for two periods. He slept in a basement near to his old home. He had no money at all for food and would go through dustbins looking for empty bottles to get money for chips. He looked for dog ends to roll up and smoke. One time he slept out with a piece of cardboard covering him, it was near to winter time and it was very cold. He saw accommodation advertised in the local paper, found enough bottles to get money for a couple of phone calls and somehow managed to find a place in a hostel.

When Neil next found himself in hospital, he was admitted as a voluntary patient. However, he was subsequently held compulsorily after he tried to run away. He was put into a locked ward. Neil was in hospital for eight or nine months, after which he persuaded the staff to discharge him. The senior psychiatrist at the hospital was against this, but a relative offered to put him up.

Neil was discharged and went to live with his relative. The arrangement only lasted a month, and then he moved to Glasgow. He had been referred to a social worker, but he left before any contact was made. He found accommodation in one of the hostels run by the district council.

But Neil got harassed by people in the hostel and was, he says, "ready to snap", when one of the other residents gave him an address of a hostel in Edinburgh. He went to see a social worker who phoned on his behalf and managed to get him a place in a hostel. He has been there for several months.

Neil has thought about getting a tenancy of his own. He thinks that he could get extra points with the council due to his housing situation and the condition of his health. But he keeps thinking back to a time that he was burgled, before he became ill, so he has put the idea on hold for the time being. He feels that he would like to live with someone in a relationship. He doesn't think that he could cope living alone, he would feel isolated. In the hostel he doesn't have great friends but there is always someone who says hello. Neither does he fancy the idea of supported accommodation, again because he believes that it would be isolating. He feels that the warden would get sick of seeing him. He thinks that he will stay in his present hostel for as long as possible, perhaps even for years.

Alex

A number of our interviewees spent years and years in hospitals and have been discharged under 'Care in the Community' into 'appropriate accommodation' such as Bed and Breakfasts where they are left to fend for themselves with little support.

Alex lived with his father and step mother until his father died. He was not feeling very confident and asked the psychiatrist to take him into hospital. That was twenty years ago; he remained there for twelve years. Alex was told that he was suffering from an anxiety disorder following a serious mental breakdown. He was discharged from hospital eight years ago.

Alex says that he had come to accept that he would be in hospital for the rest of his life but government policies meant that he had to leave. He went through a rehabilitation scheme which lasted for about a year during which time he did a labouring job for the manpower services. He had been doing the job for about five months when a doctor came and told him that he was being discharged from hospital altogether and that he would be found good digs. This turned out to be Bed and Breakfast accommodation.

Alex was dissatisfied with some aspects of his discharge. Some of the doctors did not seem to know why he had been in hospital and no one got in touch with his GP for him. He takes his own medication which he gets from his GP. He has relied on his GP for support and says that he would turn to him if he felt in need of help.

Alex was anxious about leaving the hospital, but says that he has "managed ... with a lot of effort." When asked about the support he received, he told me that after he was discharged he did not see anybody from the hospital. Eventually, he got a visit from a Home Care Officer connected to the hospital after he moved into a second Bed and Breakfast, but he did not see her again for a few years. A Community Psychiatric Nurse helped Alex to find this accommodation and said that Alex should visit him at the clinic; which he did on occasion.

Alex stayed in his first accommodation for a few months; he then moved into new Bed and Breakfast accommodation, where he stayed for a long time. Conditions were poor; he was sharing a room, and he was not allowed to use the bathroom. He used to wash and shave in public toilets. Alex found this period very difficult. He lost a lot of weight; he says that, as time went on, he was not getting very much to eat. When Alex had to leave the Bed and

Breakfast, due to his landlady's ill health, again it was the Community Psychiatric Nurse who helped him to get his present room in a Salvation Army run hostel.

Alex says that he feels quite happy there at the moment. He is fed, and can come and go as he pleases. Though he does feel that he is becoming a bit institutionalised. He says that he doesn't know how long he will stay for and that he just takes it as it comes. Although Alex was offered a couple of houses three or four years ago by the council, he turned them down because he did not feel confident enough to live in a house by himself. He still doubts whether he would be able to achieve this goal.

John

Many people encounter mental illnesses and homelessness at the same time as major life events, such as the break-up of a marriage.

John lives in a church run hostel. He is in his forties, and used to be in a secure middle-class occupation. He has been in psychiatric hospitals on a number of occasions as a voluntary patient. He was first admitted after a breakdown, which coincided with his separation from his wife several years ago.

In total he has been in hospital on about four separate occasions. Each time they wanted to know where he was going to stay after he was discharged. On one occasion the hospital was not going to discharge him until they had found him a place. After his first spell in hospital he moved back into the house which he had shared with his wife. He kept that for a year after she left but then gave it up and moved into a Bed and Breakfast. He left there and began to move around a lot living in Youth Hostels and hostels for homeless people.

The second time John was discharged from hospital he again found himself in Bed and Breakfast accommodation. He was given a list of hostels by social workers who were connected to the hospital unit and was told to phone around and find somewhere to live.

John discovered the hostel in which he is currently living because he used to visit their soup kitchen. One night he asked whether they had any spare rooms; it happened that they did. He had come to find some company because he felt lonely. Prior to his present stay John had previously lived there for a period a few years ago.

The last time that he was discharged from hospital John was asked whether or not he had anywhere to live. He replied that there were a number of places he could go to. John did not know that he could return to the hostel; the hospital assumed that he knew this already. He stayed at various locations for a few days before he found out that there was a room free in the hostel and that he could return there if he wished. He liked the idea of moving back. He said that it was quite hard coping in the other circumstances, moving from hostel to hostel, it was beginning to wear him down. John felt that the hospital should have a responsibility to find out where he was going on discharge.

John has never slept rough; he has always had somewhere to go. Though he did say that he has made errors of judgement and had to spend time in the station waiting for Bed and Breakfasts to open at 6.00 in the morning.

John registered as homeless with the Housing Department and was offered a house but he felt it was in a horrible part of town and he preferred to remain in the hostel. He has thought

of buying his own flat with some money that he got from an occupational pension but he says that he just has not got round to this yet.

It is important to John that he is not alone. He likes to be with other people.

Jake

We also came across several single men who have coped with illnesses at home until the support given by one or both of their parents has been removed, either as a result of death, remarriage or some other form of life change.

Jake had only been homeless for about three months. He was out on the streets for about two months before he found the hostel in which he is currently living.

Before that he lived in his mother's house. After she became ill she went into hospital and Jake was left to fend for himself. He lost the house three months ago when the council refused to renew the tenancy. He told us that he had let the house get into a bit of a mess. He says that he wasn't cleaning it. He was depressed and things were lying about; the dishes were piling up. Jake said that when he was evicted from the flat the council changed the locks to the doors and got him out. It was freezing cold he had nowhere to go: "... they didn't care where I was going to go, they just put me out on the street."

For the two months that Jake spent roofless he slept outside the old house. Eventually Jake saw a social worker, who gave him the address of the hostel in which he is living at the moment. He said that he had to make his own way to the hostel, though he cannot remember how he got there. He thinks that he will stay here until he moves on to another hostel.

Jake has been in hospital on several occasions. The last time was two weeks ago. He was in hospital for two or three weeks having been sectioned because he was not taking his medication. He feels that this was not a good reason for admitting him to hospital, arguing that "You need to be mentally ill for that." Jake does not believe that he is mentally ill, but he gets a compulsory injection once a week.

The psychiatrist who has responsibility for his hostel arranged for Jake to go into hospital. He was admitted from there and discharged back into the hostel afterwards. He told us that the hospital made sure that he was going somewhere other than the streets. But he feels that they are helping to destroy his life, and his family.

He does not dislike the hostel, but he does not think that it is a good place, it is just a place to stay; it is better, he says, than being on the streets.

He sees his social worker when he wants to, though the social worker does not visit Jake in his accommodation. Jake has to go and see him. The social worker knows about Jake's housing situation, he helped him to get his current place in the hostel. But Jake is not aware of any attempts to help him move on from there. He is not happy with the situation, he would like a house of his own back in the town where he lived before, where all his friends are. He visits his friends once a week, the rest of the time he just sits and watches television.

Stuart

Some long-term patients begin their experience of mental illness at a fairly young age. This undermines family relationships and means that they have to rely mainly on the system for support.

Stuart lived at home with his mother, step father and sister before he went into hospital the first time about seven years ago when he was in his early twenties. He was a patient at the hospital for about two months and was then discharged back home again. That was when things started to go wrong. Stuart says that his self confidence had taken a battering as a consequence of his illness and he spent three years doing nothing and became very depressed: "almost suicidal at times."

Eventually Stuart's Community Psychiatric Nurse got him referred to a rehabilitation ward but he stayed for only a week because it was such a horrible place. "There were a lot of very disturbed people there." He then went back home and continued seeing the Community Psychiatric Nurse every two weeks.

Gradually things started to improve and Stuart was offered a place in another rehabilitation unit. This one was connected to the hospital and while there he learned household skills. During this time Stuart felt that his confidence and self esteem improved.

He lived there for six months, after which his family decided that he should move on. He says that his family were supportive but that they felt pretty isolated in dealing with his illness. They had no prior knowledge of schizophrenia and no one gave them any help.

Stuart was offered a place with a housing trust which had several hostels for young people. That which he moved into had places for sixteen people. He cannot remember who arranged for the place but thinks that it was probably his hospital social worker. He thinks that he stayed there for about a year and a half, though he is not sure as his memory is not too good. When he first moved in it was fun, there were a lot of young people but things went sour and Stuart started to go home every week-end which caused further problems with his sister.

After a period of time living with his brother Stuart moved into the hostel in which he is still living. But he has discovered that it is not as good as he hoped it would be. One of the other residents is very distressed, the warden's brother moved in causing a lot of trouble, and the warden himself was having problems with his wife. He describes things as pretty intolerable at the moment and Stuart is very unsettled by what is going on.

Stuart has been living there for over a year. He looked at a flat that was going for private rent but there were problems with it. Now one of the workers at a day centre which he attends has got together with his Community Psychiatric Nurse and nominated him for a flat with a housing association. He is hopeful that this will work out.

Stuart considers himself to be technically homeless. He doesn't feel as though he has a secure roof over his head and says he would not recommend the housing trust which runs his hostel to anyone coming out of hospital. His "dream accommodation" would be a one person flat, though he worries about where he is going to get furniture from. He says that he will be eligible for a grant but this will only be for £500 and he does not think that this would be enough. Stuart is not too nervous about living alone. If he got a flat in the centre of town he would have places to go and people to see.

Stuart feels frustrated about his situation: "There just isn't the housing.... Housing has been the main problem with me". He feels that his difficulty in getting housing has compounded his illness. Stuart thinks that there is a ghetto of mental illness in his home town. He is trying to get away from it. He views a job as the way out, but getting one has proved to be extremely difficult.

Jane

In the case of women, domestic violence can be intertwined with a decline into a vicious circle of illness and homelessness.

Jane lives in a Salvation Army run residential care hostel. She has been living there for eighteen months. She has a room of her own and her meals are provided. She says that it is the best place she has ever lived. Jane was stuck in her home town with no place to go because her husband had abused her yet again. She remembered the hostel from a previous stay seven years earlier when she lived there for six months.

Jane spent three days in her home town sleeping rough. She spent her nights at the railway station. At this time she was pregnant but she subsequently lost the baby.

Jane is the youngest child of a big family. Her story is one of constant abuse. Her ex-husband abused her physically and mentally for years. She has a child in her teens who she hasn't seen for many years. At the 'end' of their relationship Jane's husband was hitting her and spitting at her; she says he was also starving her. He made her prostitute herself for money and she was fined countless times for soliciting.

Jane spent seven or eight months in a psychiatric hospital when she was nineteen. She had just had the baby when she began to hear noises and to see things, she became less and less able to cope with the baby. She was diagnosed as having schizophrenia and post natal depression. When she was discharged from hospital she went back to live with her husband. Jane has been on fortnightly injections since that time.

Jane says that she is supposed to be getting one of the bedsits that are presently being built round the corner from the hostel. She says that she is fed up waiting and that no one seems willing to talk to her about it. After the interview one of the hostel workers told me that though Jane thinks that she is getting one of the bedsits, she probably will not.

Jane feels that no one has helped her with her housing, the hostel workers do not want to speak about it. She thinks that a bedsit or a flat with a warden would be better, given her illness, than living on her own.

Jane wishes that she had a social worker to help her, for example, get a flat. The waiting gets her down. She does not think that she will get a house. Normally while she is waiting she just goes home to her husband. But this time she's determined to stick it out.

The chapters which follow try to explain something about homeless people from their own perspective. The things people said and felt have been brought together as a way of pointing to some general patterns in their experience. The chapters focus on the kinds of problems which our respondents were likely to have, how they live from day to day, and the responses that services make. People's housing problems have to be seen as part of their personal histories; the kinds of options and choices they have are shaped by their past and present experience.

4. Daily life

The impact of homelessness

Homeless people are vulnerable to a gamut of problems, including the insecurity of homelessness:

John: unless you are fairly resilient it begins to get to you. You don't know from time to time where you are going to sleep, People's Palace, Salvation Hostels ...

physical illness:

Heather: With walking the Streets, and that.....its gone into my lungs again. I've got asthma now, I've got an inhaler. It's thingumied my rib cage, it's bruised, with all the coughing and it's cold at night.

drugs:

Elaine: I developed asthma and angina and I was in the Royal for a week, desperately ill, but they cured me for a week. The first time I was taken in an ambulance to Casualty in the Royal with an asthma attach, they told me it was a sterile attack, I'd been sterilising tubs and dishes you know, that caused the asthma attack. The second time they said I was addicted to solvents, it was solvent abuse.

and the risk of physical violence and attack:

Heather: On Saturday I went out to Parkhead, and Saturday night a man. I used to go to the park everyday. ... I met this man and he said, " Oh, I've not seen you before, blah, blah, blah." And what did he do? At eleven o'clock at night, he pulled this big sword out and put it against my throat. Look at my neck.

People were not in general on the street when we talked to them, because we found them in hostels. More than half of the people interviewed, however, said that they had been roofless at one time or another because they did not have anywhere else to go. For some this lasted only for one night or for a few days but others spent weeks and even months skippering out. No one had gone straight from hospital to the streets. Rough sleeping seemed to be the outcome of a collapse of living arrangements such as the loss of a tenancy, being asked to leave the home of a friend or relative, or being evicted from a hostel. They were fairly matter-of-fact about their experience:

Jake: I've only been homeless about three month. I was out on the streets for two month before I found this place ... I was living in my mother's house. But my mother went into hospital due to a stroke a year and a half ago. I lost the house, they wouldn't

give me the tenancy. ... I was out on the streets a couple of month then I found this hostel.

Gary: I had to leave that and I went to stay with my sister, she threw me out so I lived in a railway cabin (laughter) for two weeks.

Were you sleeping rough?

Ewan: Yes.

Where did you sleep?

Behind Addison bus station. Train station.

Were you by yourself or with other people?

Other people and that is where we are still staying. If you don't go into that you go into the Wayside, that is where you got your food. It was either that or you were stealing it.

Craig: Well I was falling behind with the rent. And you know, the electricity ... and I was living this wild life-style. Lots of people coming and going to my flat and that; staying over, playing loud music, that sort of thing. People were coming to the door and complaining and that. That was one of the reasons that I lost the tenancy. ... I left voluntarily just prior to the court appearance. I didn't want to waste anybody's time. ... I wandered the streets for a while, then I went to [a hostel] in Glasgow. Ended up back in hospital for two weeks - just to recover, short stay recovery - then I went back to the hostel again.

From the point of view of the people we interviewed, one of the most important things to say about the hostels where they were living now was that they were usually better than being on the street:

What do you like about the place?

Elaine: Well, there's the fire. You never may be cold, just close your window and put the fire on, the room is warm in 20 minutes ... you go back and your room is warm.

Stuart: I suppose technically I am homeless because I'm staying in a hostel. I don't know, am I? I certainly feel as if I've got a secure roof over my head.

Do you feel that you are homeless?

Alan: Oh no, I am quite happy with, I think it is a good crowd and they keep everybody happy. But you see what I learned in hospital was that there is somebody worse off than yourself.

Life in hostels

The hostels were run and managed by a variety of different agencies, including District Councils, the DSS, social work departments, The Salvation Army and other church

organisations, and private bodies. The hostels varied greatly both in terms of the living conditions offered and in terms of the levels of support which they provided. Some were high dependency, like that run by the Jericho Brothers in Edinburgh; this hostel accommodated some very damaged and distressed people. A significant proportion of its residents spent periods of time in psychiatric hospitals, usually either on respite stays - to give hostel staff a break, or in order to stabilise medication. In this type of hostel, though residents were able to come and go as they pleased, few lived very independent lives. In many cases meals were provided three times a day and medication, for those suffering from psychiatric illnesses was held and administered by staff. These hostels tended to be small and to have a high ratio of staff to residents which enabled them to work individually with residents. Some of these hostels operated semi-rehabilitation elements, while others were concerned merely to care for their residents on a daily basis.

The hostels run by district councils that we visited were generally all of a type. Though they varied in size, the smaller providing accommodation for twenty people the larger with beds for more than two hundred people, they were all fairly institutional. They were functional but clean. Residents in these hostels usually had their own rooms and had keys to the main entrance door so that they could come and go as they pleased. They lived largely independent lives. While some of the hostels provided cooked meals which had to be paid for, others provided facilities to allow people to cook for themselves. Group activities were rarely organised in these hostels but residents could socialise with each other in communal areas and television rooms.

Some of the people in the hostels seem reasonably content with them.

John: Of all the places the hostels are dreadful some of them, this is the best one.
What is good about this one?
Well you have a separate room. ... it is very clean they keep it clean all day. ... This isn't a "wet" house, people aren't drinking and there is always some men that go and have a drink ... This is the only one where drinks are out.

Philip: I like the fact that you can do your washing when you feel like it, more or less or when it's needed. You have a room to yourself. The staff are here all the time.

However, many of our respondents had experienced worse hostels elsewhere. Physical conditions can be poor:

Neil: (In the hostel) There was hardly any heating on and I've never known any hot water, only warm water. Almost all the residents were walking around with coats on, gloves, it was that cold (laughter). ... I did miss the cooking facilities, not being able to cook, I couldn't even make a cup of tea; the price of tea is 70p or 80p, I had to pay that but when I was thirsty I made do with a bottle of water.

Often there is a lack of privacy:

Neil: Everybody's key fitted everybody's lock so anyone could walk into your room and help themselves to what they wanted. ... I shared this room with four other people. ... I kept awake, never being able to sleep in case someone tried to come in.

Heather: they call it a basic bed, a basic room. And what that entails is, it's next to the duty room, right. So I'm in the basic room, and the basic room includes the old women coming in pissed during the night. ... there are three in the room. And when they come in pissed at night, they put on the light, give them tea and a sandwich, and let them smoke.

Cleanliness is also a problem: one of the interviewees had caught infectious hepatitis, which he thought was from the common washing facilities. Others complained about the toilets:

Ewan: I was in there for about three weeks. I had to get out it wasn't up to much anyway. The smell in the toilets, terrible, stinking.

The worst physical conditions in a hostel visited during the course of the study were in the Glasgow Resettlement Unit which is run by the Department of Social Security. The unit is housed in a prefabricated army barracks and is situated in an isolated location six miles from the centre of the city. It is thus difficult to get to and men arrive by taxi, by bus or on foot. The Unit has seventy-seven beds for homeless men; the men residing there are among the most damaged and distressed that we encountered. The manager of the Unit told us that a third of residents are ex-psychiatric patients, another third alcoholics and the remainder young men aged seventeen to twenty-five. As well as a roof over their heads the men get three meals a day. They stay from one night to six years, the average length of stay being thirty weeks.

The three dormitories, in which the men sleep, are in a state of disrepair. They are old, damp and dirty. To increase their privacy the men have tacked old curtains and blankets across the opening of their bed areas. They hang awkwardly and create a dark and dingy atmosphere in the main corridor. The rest and recreation rooms are as dirty as the dormitories. In each a number of chairs in regimented rows face television sets which are boxed into the walls and programmed to a single channel.

Social contact with other homeless people

One of the positive features of a hostel environment is that it provides some kind of social contact for people who might otherwise be isolated.

Neil: I try to avoid friends in the hostel. ... It's a single room I have but this company here, we may not be the best of friends but somebody always says good morning and I don't feel completely isolated.

Robert: I'd rather be in a hostel where I can sit and have a bit of a blather and I've got company ...

Wendy: You get your breakfast in the morning at half past seven. ... It's easy to meet people, even if they are the worst people to know sometimes.

However, relationships are often strained. The main concern is to keep some distance from other residents rather than spending more time with them.

Alex: There's too much hassle.
What sort of hassle?
One night, I went to bed early and I was lying sleeping. I was wakened at 9.30 at night. My roommate was downstairs and I heard an awful commotion, I said to myself that there was a fight down there, I'll just stay put where I am. It turned out my roommate got a fractured skull that night.

Stuart: A hostel, there's about 20 other people all at each other's throats.

John: Some of the men go off their heads with drink and medication.

Staff

The best thing about the hostels is probably the staff:

Carol: You get a lot of help and understanding, the staff's very good to you.

Elaine: I think the staff in the hostels are the dedicated, caring people to look after the homeless. ... It's all so correct, the staff are correct and they do anything for you. They couldn't be nicer.

The role of staff in council run hostels was usually to act as a custodian. They spent the majority of their time administering the arrival and departure of residents, making sure that the latter obeyed the rules, and either precluding or attempting to resolve conflicts of various sorts. Social work services and community psychiatric nurses could be found visiting clients who were resident in these hostels but some of our interviewees had slipped through the net and were not in touch with these services despite their obvious needs. Though hostel staff made attempts to make referrals, very often the lack of a worker with clear responsibility for an individual made it difficult to follow these through. Another factor affecting referrals was the high level of respect which hostel workers maintained towards the personal privacy of residents.

The problems of former psychiatric patients

Much of the experience which we have described is common to that of many homeless people. However, this is to ignore one of the central aspects of the life of our respondents; they had

been mentally ill, and the continuing problems associated with this made them especially vulnerable.

Alan: When I had my nervous breakdown, everything just went. Everything went to pieces.

Neil: I was really cracking up, I couldn't take much more of it. ... It really was a struggle to live. With all this and then the voices, no wonder I was feeling suicidal. I thought there was nothing to live for anyway and then I got this idea, this voice, I had made up my mind to do it after a few weeks of putting up with it, I thought I'd better do it, keep her happy.

Craig: I was suffering from depression, schizophrenia, I had lots of problems - more of a manic depression. I was going off my head sometimes, to tell you the truth.

These problems often stay with them:

Gary: the whole thing about being in hospital and coming out of hospital leaves you very weak, very drained, you feel like you have got no soul.

Alex: I am capable, but I realise - I know - when I don't feel exactly right. I'm not dangerous, it's just a lack of confidence comes over me and I just withdraw a wee bit and gather myself together again. I reckon I'm intelligent enough.

Social networks

Mental illness often has a devastating effect on people's social lives. If they do not lose contact with family and friends as they become ill, the experience of hospitalisation, and later of becoming a long-term patient, can often break contact with others. If anything, this seemed to be more true of our respondents than other former psychiatric patients; it is quite common for people to maintain contact with their immediate family, but the people we spoke to here had lost all real contact.

Are you still in contact with your parents?

Neil: My mother by phone and my father by phone. ... (My mother) phones up once a week.

But she doesn't want you to know where she lives?

No, just in case I try to move back.

Carol: My children are happy now ... I never see them.

Robert: I still keep in touch with my brothers and sisters, but they've all got their families and their kiddies, they are all married and got their children, got their lives to lead. ... Say you're my sister and you're married with a couple of kids, you wouldn't want me to

come to your door every Friday night. Your man would do his nut. He would be saying this is not on, you know what I mean? Well my sister done it for me, but her man put up with it, but I had to break away for her sake ... if I was wanting to pick up the phone and say to my sister I'm coming back down, can I stop for a couple of weeks till I get a place, she'd put me up no bother. But people, when people settle down and get married they've got their life to lead, you can't keep knocking at their door, can you?

Richard: Well I never really got on with my family, and they've all gone their own separate ways and that, so I've come up here. Actually, they don't know about this at all. They don't know where I am.

Albert: My brother and sister ... they rejected me after my dad died. When my mum died they actually disowned us altogether.

Are you still in touch with your family

Jane: No

Not any of them?

No

How do you feel about that?

Rotten, not to get in touch with them.

Have you tried to get in touch with them?

No, hell, that is all I need.

Friendships are difficult to maintain. The problem is that communication is difficult:

Neil: My longest conversation would be 'Good morning, how are you today, anything on TV?' That way they don't get to know my background (laughter). ... I couldn't hold a conversation with anyone, nobody was interested in wanting to know what I knew or passing on knowledge to people because they had so many problems psychologically themselves, they just couldn't be bothered to listen to people. ... When I moved to all these city lives, living in these high-rise flats wherever I've been, I've met lots of people but they don't make time for me. I have seriously thought about it, if I did move, how would I get on with the neighbours? Are they going to run away from me?

Robert: I am on tranquillisers now. They just keep you calm, see when it wears off you get into an agitated state and that's why I can't settle because people look at me and sometimes when I'm looking at a person I'm in a trance. You understand what I mean? It's not that I'm trying to read you, it's just one of those things. And people think, "I'm not having that", 'cos they can tell.

The strains of living in a hostel are aggravated, then, by the lack of support outside. There is little social contact, and the people we talked to saw little prospect of it in the future.

Daily activities

In the absence of social activities, what people do during the day is very limited:

Mark: I don't like it here at all. You get nothing....nothing. There's nothing to do at all - there's nothing - it's no use. ... Gamble, that's all you can do.

Elaine: I find plenty to fill my days. I'm not well enough to do much but I can always disappear, lie on top of my bed and disappear, I can always do that. I've got a great big colour television ... I might turn the radio on ...

What do you do with yourself?

Jake: Just watch the television.

Any particular programmes you like to watch?

None in particular, just watch the television. Whatever's on, I enjoy watching.

Our interviewees told us that they spent their days walking around outside, if the weather permitted. Some people had special haunts; one liked to visit second hand shops to see what he could pick up, others had certain cafes in which they would spend periods of time. Staff in hostels told us that some residents would be out all day returning in the evening to eat and sleep. Others barely left the hostel from one week to the next.

5. Community care

Discharge from hospital

When people are discharged from hospital, there should be a care plan in place for them. In general, we know from Ian Taylor's work[9] that the policies are there, and so in principle are the mechanisms to make the care plans work. But the experience which these people had had often seemed very different from what is supposed to happen. Some felt they were not ready for discharge:

Gary: The thing was I wasn't better, as they put me back into the community, as I was becoming part of the community again, part of the society, I was still ill and then they said to me, you know we think that you are fine, you don't need to come and see us any more. That's the only criticism I have, I wasn't well enough to come out.

Who decided that it was time for you to leave?

Philip: Dr X or one of the other doctors.

How did you feel about that?

I wasn't very happy but I did leave.

Why were you not happy to leave?

Because I had been there for so long.

Some had been discharged without any effective support:

John I discharged myself I got so cheesed off I don't like being in hospital. ... I think that the Social Work and the hospital should have done a lot. ... it was always the assumption that I was going to go somewhere else. Just a breakdown in communication.

Alex: I'd been in the hospital for twelve years and I seemed to be in a frame of mind that that was the place I would have to live for the rest of my life. But with Government policies after twelve years I began to realise that they were wanting to discharge people. I just went through the rehabilitation scheme.

I was told I was being discharged on a Friday and on the Monday I moved from the ward, I also got a letter at that time from the charge nurse in the ward which I took to my GP. That was my medication cut down ...

When did that happen?

At the time I was being discharged, that's between the time they told me on the Friday I was being discharged and the Monday. I went to the doctor the following Tuesday. I wasn't happy about this.

So that happened at the same time they discharged you? ...

Yes and I feel that should be done under supervision which is right enough. I could have become very unwell because of that situation.

What happened when you were discharged from the hospital?

Albert: I had to rely on my common sense. I just had to go to the social security.

Some people had discharged themselves. This should not mean that no support is maintained, but some people can be difficult to find:

Harry: I escaped out of it. ... I got discharged, I jumped out of the top window.
Were you found and taken back?
No.

When you discharged yourself did anyone ask you where you were going?

Mark: I told them that I was going to my sister's. ... she took me in, it was alright. But I didn't stay long.

Others were discharged directly to hostels for homeless people:

How come you ended up (in this hostel)?

Jim: More or less because they arranged it for me.
Did they give you any choices about where you could go?
It wasn't like that, not really, no. Didn't have very much option.

Neil: The social worker ... took me to this place ... sharing with men. It was just like catering facilities, there was cooking facilities there. I felt claustrophobia, not enough space and there were all these men so I thought not for me. I think the room I had to share and I wasn't keen on that idea especially with another man. That was the only choice he offered me. He took me up to look around the place. I was at this interview, there were about six or seven people around me. He asked me what I thought and I told him that it would do as temporary accommodation but I'm not really wanting to live here, too many men. I don't like the idea of sharing a room with another man. Then they said that if I wanted to move in, I can because you passed the interview. But I didn't.

What happened when you were discharged from hospital?

Nick: They sent me back here again.
Did they give you any choice?
No.
How did you feel about that?
I just felt all right.

Only two people interviewed, Joe and Carol, seemed to have had adequate and lasting arrangements made on discharge - but this, of course, reflects the circumstances of the people we had chosen to speak to. Carol had previously been homeless and on the street, but after going into hospital she was discharged to a supported hostel. "I'd like a nice house", she said, but she also said that "I like living here ... I couldn't live out." Joe had moved from pillar to

post, including guest houses, bed and breakfast and hostels, before his last discharge, when he was allocated a supported flat.

Joe: I'd got a flat when I left.
That was set up for you?
Yes, well while I was in hospital I put in for an application form for a house and a couple of months later I got a reply back saying that they were offering us a house, and I went up to see the house and that and I said 'right, fine'.
So who arranged for you to....?
I think it must have been the hospital, you know.

Agencies in the community

Homelessness often means that it is difficult for people to receive the kind of support which others in the community might expect. It would not be true to say that the people we interviewed were not receiving services; on the contrary, it is striking how far psychiatric services in particular have been able to maintain contact. However, they are limited in what they are able to achieve; the problems of the people they are dealing with, and the difficulty of providing adequate support when there is no home base to work from, mean that the coverage and level of care which are provided are patchy.

Psychiatric services

When people are discharged in the community, it may mean that their course of psychiatric treatment is at an end; the research for the Hamish Allan centre found that much homelessness is among people who have been receiving acute psychiatric care, rather than long-term care. But it is also common for long-term patients to be treated while they are in the community. Psychiatric nurses administer medication on a regular basis:

Jim: I get my injection once a fortnight

Richard: Yes, well I went every two weeks for my injection and that, but nobody was concerned about what I was doing.

Robert: if I don't stay on this injection, dear, they will certify me, I was warned. And I didn't want them to certify me ..

Ewan: I got an injection, off the doctor.
What was that for?
Nerves.
When did you get that?
I was getting it once a month, the last seven.
The last seven years?
Yes.

Do you still get that?
No.
What happened that you stopped?
Just they told me to go back to the doctors.

One complaint made of psychiatric services - and it is by no means unique to this study - is that no-one listens.

Neil: About six suicide attempts but nobody investigated why I had done them.

Ewan: They don't listen to you in here. Once they know you are a junkie, that is you, they don't want to know. And the doctors in here are a waste of time.

Philip: I saw (my doctor) today.
Does he help you?
Yes, he does. But he hardly ever speaks to me.

However, there were also many positive comments about the support provided by the health service:

What sort of support do you think that (the psychiatric nurse) provides?

Gary: Emotional support, a lot of emotional support, he will tell you if you are wrong or you are right. He works things out for you, he will tell you what to say or how to behave. Just things that you know aren't going to come naturally.

Philip: I did have a lot of help, I was quite pleased.
What sort of help did you get?
I got help from doctors and nurses, both helped me. Give you some freedom in the hospital..

Neil: The senior psychiatric nurse ... was concerned for me and said that she didn't want me to do any more suicide attempts because if you do, I've failed in my job. She was concerned ... I said that that was nice of her ...

Day centres providing services for homeless people and for people with mental health difficulties were lifelines for many of our respondents. They gave practical support and advice on topics ranging from housing through benefit claims to medical services. Some centres operated regular clinics at which GPs, psychiatrists and community psychiatric nurses would be present for consultation, and many of those we spoke to were administered their medication from these clinics. Centres also provided regular meals at reduced prices and offered social and leisure facilities which many of the people we interviewed valued very highly.

Social work

Social work assistance features only intermittently. Some people had not seen social workers:

Do you see a social worker now at all?

Jane: No, I wish I had one,

Why?

Because it would get you out of that.

What do they do?

God knows.

Did anyone try to help with more permanent accommodation?

Neil: Not really. I wasn't even introduced to a social worker.

Some had seen social workers, but had not received help:

Alex: I had a letter from the hospital Social Work Department saying that there would be a home care officer coming to see me. I saw her once at the beginning of the four years and she didn't come until about four years later

Robert: Social welfare will help women with kiddies but I've never known the social services to go out and help an entire body on its own. If a man went in and said "I'm homeless" they would just give him a sheet of paper and tell him where to go for something to eat. They gave me a list of all the handouts in Edinburgh.

Ewan: I was trying to ge a hold of the Social Worker, but he is fed up with me. ... he has just given up with me.

Others had had extensive contact:

Alan: My disabilities are quite numerous ... I was born blind and paralysed. Well, the social worker, she has got everything from the day I went to school. ... But while I was in the hospital (my social worker) couldn't do very much for me.

Heather: I've had seven social workers

When you were in hospital, did anyone ask you where you were going to live when you left hospital?

Elaine: Oh, yes.

Who helped you?

The social workers. There was a big Social Work Department and Department of Psychological Medicine. ... They were all very nice and the Talbot sent me to Osborne Street and they got me a room and I went to the Hamish Allan, they got it for me permanently. ... I've been taken into hospital for a week a couple of times until I found digs, 'til the Social Work and I found digs. They've taken me in 'cos it

was extremely bad weather and I was homeless, I think they were frightened I would die because I was ill enough you know.

Voluntary organisations (notably the Samaritans and the Terence Higgins Trust) had also helped some of our respondents.

Social security

Financial problems crop up on occasions - perhaps less often than one might imagine. People who have lived for a long time on very low incomes, often including stays in hospital, seem to get used to having no money.

Neil: Previously I was on sickness benefit when I was in psychiatric hospitals, then I was on income support for a few months, then on to unemployment benefit. Roughly I get £108 per week including my rent. Once I've deducted my rent I've got £44, I've got £3 so many pennies to pay so I'm left with the remainder of £41 per week which I don't find it a struggle to survive on.

The main issue was making sure that benefits were received:

What did you do for money?

Jim: Invalidity benefit.

You got that even though you were sleeping rough?

Yes, I got my giros sent direct to the Post Office

You weren't getting any unemployment benefit?

Neil: I didn't actually sign on at the time because I did have an address and I thought to myself that I could just get by for food ... I used to take (bottles) to places to get deposit money for them. I just lived on chips for about a week and people's dog-ends. ... I wasn't keen on the idea of me going to the DHSS and Unemployment Benefit Office saying I was homeless because ... I knew at the back of my mind that I would get accommodation somewhere

Gary: I ended up going back to the Kings Cross address to get my giro and the postman wouldn't give it to me. He says I want proof, this is to go through the letterbox, I can't just hand it to you.

So you sort of turned up waiting for the postman.

That's right (laughter). He wouldn't give it to me so I ended up with no money.

Stuart: When I was first ill, I just completely left my DHSS benefits, I never bothered with them. I was living at home for about six months before my CPN [community psychiatric nurse] found out I wasn't getting any money off the DHSS. So if I hadn't been living at home, I would have been really up the creek. ... I'm pretty sure my

family needed the money for food and stuff but I wasn't going out, I wasn't buying anything.

6. Housing

It was difficult, in practice, to trace what had happened to people's housing. Some people were clear enough:

John: I was living in a bed and breakfast ... it is actually a hostel for the homeless. I got the address from the Social Services. ... I said to myself that I don't want to go back to bed and breakfast ... so I moved into the Salvation Army Hostel one time. Then after that for three weeks I went to (another hostel) for two weeks and then I came back here again.

Richard: That's when things started to go wrong, when I lost my job and that. I was in hospital for about six or seven months. When I came out I went to live in (one city) ... because I've got very good friends there, and I thought, well a change is as good as a rest. ... Then I thought that I'd better move on, I mean they've got their own separate lives and that, so I moved on [to another city]. I was there for about two and a half years until I ended up in hospital again and then I went back there last November for about a month until I sorted out what I was going to do and that. Then I came up here at the end of November.

Others were not. Their stories were complicated; they had often moved from pillar to post; their memory was sometimes hazy.

Jim: I have been moving about so much that I can hardly remember where I have been.

Neil: Wherever I've been it was only a few months, some of these jobs. This time I intend to really try and settle down somewhere.

People had often given up previous housing. Examples included experiencing a burglary and a fire; sometimes it happened through a change of family circumstances; but it is difficult to separate this out from the course of the illness.

Why did you give the flat up?

Richard: Well, I just didn't feel that I could keep it on any longer. Everything in the flat was totally ruined. These lads had came in and done it over, everything was ruined.

Tony: Well, I went to the housing office and said 'there's my keys and I'm coming out of the flat'. ... I didn't want to go back to Dundee, there's too many rough people there, too many drugs and that going about. I was admitted into hospital because of drugs you know, because of using drugs and I think it just built up from there, too much pressure got to us and then it progressed and I got admitted to hospital and eventually they let us out, about five weeks later then after that I was getting

hallucinations and that so I had to go back in again then I was in for another three months then eventually they let us out again.

As mentioned before, some had slept rough:

Elaine: on the Sunday night I had to walk all the way into town and I went to Central Station again at twelve o'clock at night. The British Railway police put out me out at twelve. ... I had to walk the Streets again.

Neil: I was homeless with nowhere to live only on two occasions. That was about three years back, I just lived near where my mother used to live ... just slept there for two or three nights nearby where my mother lived, just under the steps.

Carol: I stayed at the Salvation Army for two nights ... the Royal Victoria said they didn't have any room ... I winded up walking the streets.

Robert: I done a lot of skippering when I was young ... I just done it but I couldn't handle it now because as you get older, you know what I mean. When you're a young boy about 17/18 you're open to any elements, you can take it. You can't really be a skipper in Scotland 'cos you've not got the proper weather for it.

Harry: I ran away again. I went through to Edinburgh, I was just skippering out.
You slept out?
Yes, in the Grassmarket.
What about the hostels in Edinburgh?
No, you can book in the Sally for two nights and that.
How long were you sleeping out for?
Two years.
Were you seeing anybody during those two years?
No.
Were you getting any medication?
Aye, Largactil, I was getting Largactil. You know that sort of Grey stuff?

For others, the main experience had been of bad housing:

Alex: I moved to other digs, stuck for four years, they were clean digs but otherwise they weren't very good. I was paying rent money and the landlady was complaining about using the sink for washing early in the morning, it was 6 o'clock. I had to get up for work, get myself ready. For quite a number of months I was going downtown and shaving in the public toilets. They were hiding the toilet paper in the house and I had an awful lot of hassle. This was in the second place. ... I was sharing a room ... I had a pretty awkward time for that four years. It was hassle.
You were sharing a room for four years?

I was sharing a room. I talked to my GP about it and he said 'What are you doing sharing a room with a bloke like that?' You know what life's like sometimes.

Some people were waiting for housing, from district councils or housing associations.

Gary: I was on the Housing Association and I said I'm HIV positive. They treated it with confidence and confidentiality. It was incredible, there was people getting more points than me. I've got a life-threatening disease, I could have popped off by now considering the amount of time I've had this thing. We still haven't heard a thing from them.
Have you been asking?
Now, I'm in my own flat. Yes, we've been on to them, we've pestered them, we've said how many points have I got? And eventually they said, To be truthful you're going down the list instead of up the list.
How did they explain that one?
They said, We've got a woman with twenty babies and all this sort of stuff, these pregnant women. Single parent families that need homes. I couldn't believe it.

Stuart: Actually my application for the District Council disappeared, they don't remember ever receiving it. So I had to check with my social worker, he was quite adamant that he had sent it in because he had sent someone else's at the same time and theirs was alright.

One person said she had been refused, but it is difficult to know quite what happened here:

Are you on the housing list at the moment?
Wendy: No, well they said they can't put me on it.
Did they give you any reason?
All they said is, you're having your injections.

Surprisingly, it turned out that several of the people we interviewed had been offered permanent housing, and refused it.

Neil: I thought No, I don't want Easterhouse. The second one was the Gorbals where Jimmy Boyle was from, a bad reputation there so I thought No, I don't want that. So I got a social worker to help me with this third selective area. She was quite diplomatic and friendly, went with me to the Town Hall ... and said, 'He's got one more choice left and I'm here to advise him on the best areas of Glasgow where he won't feel so misplaced because he's English'. I tend to think people are against me because I am English and I'm here in Scotland. There's so many drugs probably around these areas, like Easterhouse, the Gorbals and I don't want to be persuaded into drugs. I thought that with her help I would try and get a selective area. The selective area that they tried was Parkhead, there were too many, Parkhead Football Ground, Rangers play there (sic). So I thought to myself that I didn't fancy that area

so eventually I got down to the Town Hall on my own and saw the chap and I said that there was one more choice left, I've had the help of a social worker but I've got news for you, I'm leaving Glasgow, just score my name off the list.

Tony: She was saying to me they've got me a place in Niddrie and I said well "Niddrie, you can forget it" I said "Niddrie is a wild place" there's no way I would go near Niddrie so they've taken the Niddrie area off. They asked where else I would like to go, they said Westerhailes, no - Little France, about this area, Gorgie or a little bit.....

Were you offered a place?

Alex: Yes.

Why didn't you move?

I felt they would find out too much about my financial situation. I wasn't feeling fit to move.

John I didn't like them.

What is wrong with them?

A lot of the places were boarded up, places I won't want to be in during the day let alone at night. The windows were smashed.

Choices for housing

People have few alternatives. There are certainly some who would love to have somewhere to live - and the opportunity it offers to live a normal life.

Stuart: I don't think I would be on anti-depressants if I'd got a house.

Andrew All I want is a wee house.

... what are you going to do about it?

Christ knows. ... You see if I got a good woman, a good house, I would be a normal man again.

Heather: I think it is high time that I did get a flat because I want my own toilet because I'm clean, you know. I want my own toilet and my own privacy. I want my own bed because my back's been sore. I want my own quilt, you know, I mean it's blankets that I've got just now, I've not grumbled or anything you know. It's just ... and I want to do my own cooking. Make my pot of soup, my homemade soup. I'm really good at cooking.

When they do have the opportunities, though, they do not always use them. A large part of the problem seems to be that the respondents do not feel that they can cope in housing on their own.

Alex: My housing situation at the moment, I have refused a couple of houses but there's a medical line from the doctor saying he's not sure whether I was fit to live in the house by myself.

Have you thought about going to the council and asking them to help you find accommodation?

Robert: No, I couldn't live on my own. It would drive me nuts.

Would you like to have your own house?

Paul: I don't know. I might take ill again, you know. If I take another house and lose it again, I don't want to ... you know ... it's not bad here, you know, you get your meals and that, it's not too bad, you know. ... I don't really like staying with other people, you know. But I've no choice really.

Jim: My brother offered to find a flat for me. I have been thinking about that but I don't think I'll be taking him up on the offer.

Neil: I've thought about having a tenancy ... I gave up the idea because kept thinking back in retrospection of my burglary. ... I don't know if I could cope living on my own. If I started dating a lady and we liked each other, then I might think of a relationship, then I might think of applying for a council flat but not until then. Here it's not too bad.

Jane: I think if I get a place of my own ... I would go crazy.

The same doubts assail those who would like housing:

Elaine: If I'm well enough to live alone, I'd love to have my own house.
Do you think you're well enough to live alone?
That's a difficult one. I could starve to death quite easily, not getting out for food you know.

This led them to accept what they had - a place in a hostel:

If you were able to choose out of all the possibilities you can imagine what sort of housing would you most like to have?

Jim: Thinking about it I am quite happy here.

What has happened with your housing situation since you moved in here?

Philip: I don't know. I am just staying put. I'm going out again in six months time.
Where are you going?
I don't know.
Has anyone helped you to work out where you will be going?
They haven't yet.
What are you going to do?

I don't know, I'm going to be lost again.

Probably the best alternative is supported housing - that is, housing with specialist workers to offer support.

Mark: I want a sheltered house. ... I don't want to live by myself, no. I can't look after myself. No. I need a sheltered house with a caretaker. ... The caretaker looking after you - they give you your dinner and all that. I want somewhere you can get your meals so you don't have to cook for yourself. That's right. I had that before you know.

This still received a very mixed reception:

Did you move into any of the places that they found?

Robert: Aye, but I didn't stay long because you've got people that were worse than yourself, they were head cases.

What do you feel about living here?

Alex: I feel you're being fed here, which you don't have to bother about. You are free to come and go as you please. I suppose they would offer you help here if you wanted it.

Anything you don't like?

I feel in some ways you might feel a little bit institutionalised but it seems to suit me at the moment.

What do you think of this place?

Jake: It's alright, quite like it, better than the mental hospital, at least they don't (treat you) like a boy here.

Is that what happens?

Aye. Give you 50p to send you for sweeties on a Friday!

This is not really what we expected people to say before we started this research. There are two positions commonly taken by housing campaigners in this field. One view is that housing has to be sorted out irrespective of the progress of someone's psychiatric care; people still need somewhere to live, and support can be arranged once they have been found somewhere. Clearly, this does not work - too many people are not ready to take housing on their own. The alternative view - put by one of us in a previous piece of research for Shelter[10] - is that housing and support have to be developed and arranged together. But a number of these people feel uncomfortable about this as an option. It seems clear that neither of these approaches is going to work for everyone. We need a range of options, so that everyone can find an arrangement which is appropriate to their needs.

7. Conclusions

People who have been in psychiatric care are particularly vulnerable to homelessness. Mental illness disrupts people's lives, and psychiatric patients cannot always rely on the kinds of social networks - family and friends - which other people have. The people interviewed in this report had often become homeless because their living arrangements had fallen through. In principle, discharge should be backed up by a care plan; but our respondents were people for whom this procedure had, for whatever reason, failed to meet their needs. Several of the people we interviewed had spent some time on the streets. They had moved to hostels by default, which they were likely to see as the best alternative from a range of very unsatisfactory options.

There are two points at which policies need to be reviewed. The first problem is what to do for the people who are homeless now. The problems which they have make the usual channels of applying for housing extremely difficult to negotiate. People who are homeless after receiving psychiatric care are clearly vulnerable, and they should be considered as a priority group in the terms of legislation for homeless people. But the problems they have stretch far beyond the simplest solution, of offering them a place to live; even if such a place was offered, it is possible that they would turn the places down, or that they would later be unable to hold on to the tenancy.

For as long as they are likely to remain in hostel accommodation, it is important to make the best of the hostels; the hostels may be limited in what they can do by way of support, but they have to maintain minimum standards. Some of the hostels are appalling; physical conditions have to be made decent. Staffing should reflect the special needs of the people using the hostels, and should offer some individual contact wherever possible. Ultimately, the aim should be to arrange for decent housing for everyone who is homeless. For the people here, that is going to require not just provision of accommodation, but also support which is informed by specialised knowledge and skills.

Secondly, and more fundamentally, we need to prevent the situation arising. Housing has to be considered at a much earlier stage, in the care plans made before discharge, for acute as well as long-term patients. Discharge into temporary accommodation does not work, because often there is nowhere to move onto afterwards; and it is not enough to check that people have somewhere to go, because such arrangements can easily break down. The same solutions will not work for everyone; there needs to be an element of choice in the housing options for patients when they are discharged. The infrastructure of services which might be able to help people in this situation is sadly lacking.

In drawing conclusions, it is important to recognise that the situation is neither straightforward nor easy to resolve. The problems of people discharged from psychiatric care are complex and long standing; but irrespective of the difficulties, the case for action is strong. These people are entitled to receive support appropriate to their needs, and they should be receiving it.

Notes

1. Social Work Services Group, 1988. Discharge of patients from mental illness and mental handicap hospitals, Circular SW10/1988, Edinburgh: Scottish Office.

2. I Taylor, 1992. Discharged with care, Edinburgh: ~Lothian Health Board/Scottish Council for the Single Homeless.

3. K Sone, 1992. The luck of the Draw, Community Care 30th January, pp 18-19.

4. C McLean, 1987. Essex Hospital Discharge Survey, Essex County Council Social Services Department.

5. I Laing, 1993. Single homelessness and mental health issues in Glasgow, Glasgow District Council City Housing/Richmond Fellowship, Glasgow, p.29.

6. J Geddes, R Newton, G Young, S Bailey, C Freeman, R Priest, 1993. The Edinburgh homeless revisited: prevalence of psychiatric disorder, previous psychiatric contact and time trends, Unpublished working paper: Royal Edinburgh Hospital.

7. See R Walker (ed.), 1985. Applied qualitative research, Aldershot: Gower.

8. A Rogers, D Pilgrim, R Lacey, 1993. Experiencing psychiatry: users' views of services, Basingstoke: Macmillan.

9. Taylor, 1992, op cit.

10. P Spicker, 1993. Housing and community care in Scotland, Shelter (Scotland).

Appendix: the questionnaire

This was a 'semi-structured' interview, where the main intention was to invite people to talk about their housing history and its relationship to the experience of psychiatric care. The questionnaire provides no more than a starting point for this kind of discussion, and the questions asked were not necessarily those outlined here.

1. What sort of place did you live in before you started getting treatment for your illness?

2. Did you spend time in a psychiatric ward or hospital? If you did, about how long was it for, and how long ago?

3. Were you able to stay at, or go back to, the place you'd been at before?

    3a. If the answer is yes:

        i. What was it like?

    3b. If the answer is no:

        i. Why not?

        ii. What sort of housing did you have when you came out?

4. What's happened in your housing situation since then?

5. How have you been treated by the officials concerned with your housing?

6. What sort of housing do you think you're likely to go to now?

7. If you were able to choose, what sort of housing would you like to have?

8. Do you have any other comments?