

COMMENT

This study reinforces the evidence elsewhere that some lost skills may be recovered in demented patients and that care must be taken to consider how retained skills can be used as a foundation for intervention to support these people living in their own homes. This is an area where such pieces of 'therapeutic optimism' are sorely needed.

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## Medicine in Society

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P. J. Elton and J. M. Packer, 'A prospective randomised trial of the value of rehousing on the grounds of mental ill-health'. *Journal of Chronic Diseases*, 39 (1986), 3, 221-227.

Although 'social' interventions quite properly form part of the therapeutic armamentarium of the contemporary physician, few of these interventions have been subjected to the same degree or type of evaluation that a doctor would demand of drugs or surgery. There are many reasons for this including lack of confidence in the measurement of 'social' outcomes on the part of the doctor, and lack of faith in the relevance of evaluation and a certain vested interest in not evaluating their power base on the part of the professional purveyors of housing and social services. This paper from Salford represents a signal achievement in assessing the effects of rehousing on mental health by means of a randomised controlled trial, the gold standard of health and social services research.

The study presents some interesting ethical points. The generality of applicants for rehousing on grounds of mental health in Salford can expect less than 50% success. By entering the trial and agreeing to the randomisation process participants increased their chances to exactly 50%. However, it was considered that it would not be possible to carry out the study if the participants had to give fully informed consent so it was necessary to gain approval from 'their elected representatives'. In practice this seems to have been the Chairman of the City Housing Committee. It seems an alarming extension of the principles of local democracy for Councillors to consider it proper thus to act *in loco parentis* for individual adult citizens some of whom might well have voted against them at the last elections. On the other hand, to disburse public

resources without having demonstrated their efficacy is ethically even more questionable.

Those randomised were making their first application for medical priority, had been resident in their present accommodation for at least three years, were not in rent arrears and not suffering from psychosis or additional physical illness given as a reason for requesting medical priority. Standardised measures of depression and anxiety were employed. Of sixty eight potential participants, four refused or were unobtainable, six scored too low on the anxiety and depression scores for inclusion and two refused assessment or moved away. Fifty-six applicants were therefore available for paired allocation to priority or non-priority groups. The majority fourteen in the priority and thirteen in the non-priority group) were assessed as having neurotic depression, the other diagnoses being phobic neurosis, anxiety neurosis, simple depression and reactive depression. The two groups were comparable in diagnoses and in means and distributions of their anxiety and depression scales as well as in types and problems of their housing at presentation. The most common sources of distress were noise and the perceived threat of personal violence, burglary or vandalism. The only notable difference between the two groups was a larger number of widows who found that their accommodation awakened distressing memories of their dead spouse in the non-priority group (six compared with two), but this does not appear to have had an important effect on the results.

In a pairwise analysis the results were gratifyingly clearcut. Anxiety and depression scores improved significantly more in those subjects rehoused than in those not yet rehoused at the time of second interview. Taking a reduction of 50% or more in total anxiety and depression scales as clinically significant, among seventeen pairs of which only one member was rehoused at the time of second interview, fourteen of those rehoused showed improvement compared with only five in those not rehoused. The differences attributable to rehousing were maintained in the group of eleven pairs in which twelve month follow-up was possible.

The ideal randomised controlled trial is the 'double-blind' design in which neither the investigator nor the subjects know whether active intervention is being offered or not. With rehousing as the active intervention, this design is clearly impossible. Bias due to the observer knowing the subject had been rehoused was reduced in this study by the main assessment schedules being completed by the subjects themselves. Bias arising from the non-rehoused exaggerating their symptoms at second interview in the hope of strengthening their case for rehousing could not be excluded. However, there was no direct

evidence that this had occurred, for anxiety and depression scores among the non-rehoused showed an insignificant improvement, rather than a deterioration, at second interview. Both anxiety and depression are known to undergo spontaneous remission in a proportion of cases, so this finding, although reassuring to some extent, does not exclude bias. Nonetheless, the findings of this study effectively exclude the idea that rehousing has no effect on the natural history of housing-induced anxiety and depression as assessed by the victims. That is perhaps all we need to know. Let us hope that Local Authorities will find the means to respond appropriately.

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