Correspondence

Change in adult health following medical priority rehousing

Sirs,

The informative study by Blackman et al.1 comes to the conclusion that medical priority rehousing has an important role in reducing the prevalence of mental health problems.

The study does not allow such a conclusion to be made.

I was co-author of the study2,3 quoted by Blackman et al. In addition to the randomized controlled trial, using an intention to treat analysis, which compared 28 people with mental health problems who were given medical priority with 28 controls who were not, a parallel study was done. This compared people who claimed medical priority with those who wished to be rehoused but did not claim medical priority. Out of 26 people who wished to be rehoused but did not claim medical priority, 18 scored 3 or more on the DSSI/sAD4 scale suggesting mental health ill-health. Of these, 11 were rehoused compared with 41 who had claimed medical priority. Although these claiming medical priority had somewhat higher initial mean DSSl/sAD scores (15.4 versus 10.5), these scores were reduced to lower levels in both groups (5.3 versus 2.8) after rehousing.

The allocation of medical priority for mental ill-health will lessen the chance of rehousing for others on the waiting list who may have equally severe mental ill-health. As such, the potential of medical priority rehousing to reduce the prevalence of mental health problems will be limited.

References


Reply

Sirs

Although Peter Elton’s conclusion is based on a very small sample, it is likely that many applicants for social housing will have mental health problems, not just those who apply for medical priority rehousing (MPR). There is an issue about applicants knowing that an MPR route exists and is appropriate, i.e. that the health problems are housing-related. Many housing application forms now ask a range of diagnostic-type questions linked to a points system for awarding priority. It is then an issue of the adequacy of the information supplied to inform the rehousing decision and the type of re-lets available.

Like many public services, there is an issue of take-up with MPR and, of course, a problem of supply. However, the main purpose of our study – to start establishing evidence to inform triage – remains valid. For example, we cast doubt on whether respiratory conditions are effectively addressed by MPR, especially if this uses re-lets that could help applicants with mental health problems, possibly particularly if they are aged under 50, but we need more evidence about this.

There is still a lack of healthy housing for vulnerable and low-income groups in the United Kingdom. A range of housing action is needed, including realizing the potential of neighbourhood improvements,1 although levels of ill-health remain high compared with the general population. MPR has its place but there are indeed issues of take-up and triage that need more attention.

Reference


Yours faithfully,

Tim Blackman
Professor, School of Social Sciences and Law
University of Teesside,
Middlesbrough TS1 3BA
E-mail address: t.j.blackman@tees.ac.uk

Yours faithfully,

Peter Elton
Director of Public Health
Bury NHS Primary Care Trust,
21 Silver Street,
Bury BL9 0EN
E-mail: peter.elton@burypct.nhs.uk