Health Care in a Destitute Population: Christmas 1985

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The closure of the Camberwell Resettlement Centre, the largest in Europe, in September 1985, followed the closure of an estimated 2,000 common lodging houses and low cost accommodation in London between 1982 and 1984. Over a two year period only 14 out of the 25,000 who passed through the Centre had been rehoused.[1] To aggravate the problem there had been a fall in local authority residential places in the six years up to 1982, accompanied by a decrease in the provision of home helps and meals on wheels, despite an increasing proportion of elderly in the community. Of those who had utilised Camberwell Reception Centre 79% had slept rough[1] and 19% had tuberculosis (personal communication of the staff).

These problems have been intensified by the contraction of beds at Bruce House and the recent requirement of prior registration to obtain a place. Originally Bruce House had 800 beds but only 180 were occupied on Christmas Eve 1985. Attempts by Westminster Council to convert Bruce House into a hotel, with three compulsory meals a day, at £70 per week, have been temporarily frustrated by a High Court injunction.

In order to assess the effects of these reductions in accommodation for the homeless, the conditions in two permanent hostels and a temporary hostel were investigated over the Christmas period.

The Study

Out of 79 people who were approached, 72 were interviewed; 26 at Bruce House, 16 at Great Peter Street Salvation Army Hostel and 30 in and outside Crisis at Christmas. The interviews mainly took place on Christmas Eve and Day, with 11 on 30 December 1985. The interviews were unstructured but where possible covered the points itemised in the results, each interview taking a modal time of about 15 minutes but several much longer. (See Table).

We had difficulty getting permission to interview people at Crisis at Christmas, having to conduct nine of the interviews outside the premises. This introduced a bias towards those with their own accommodation, since all those so interviewed were leaving.

We could not always obtain a complete psychiatric history and hence reliably distinguish between those with and without a history of psychiatric illness. Of seven who admitted an alcoholic problem over half had additional psychopathology.

The prevalence of *mental illness* leading to psychiatric treatment was about four times that expected (27 out of the 42 who replied to this question), conforming to estimates of half the destitute in New York. The prevalence of mental illness was one out of three for those born in Greater London, six out of 21 from elsewhere in the UK, and three out of 11 for those from abroad, demonstrating a gravitation of the mentally ill to London.

The prevalence of *schizophrenia* is three to four per thousand of the population with a substantial proportion in hospital. Twenty-seven agreed to discuss their psychiatric history fully and four (14.8%) confessed to hearing voices discussing them. On the basis of this single question about a first rank symptom, schizophrenia was vastly above expectations even though schizophrenia was probably being underdetected. Nevertheless the proportion of schizophrenics was somewhat lower than we had expected on the basis of earlier studies and the continuing reduction in psychiatric hospital beds. We fear that our findings do not necessarily reflect an improving situation but may indicate that schizophrenic men are no longer finding shelter as readily in these traditional provisions, making residence less likely, particularly for the most disturbed.

A number without overt psychotic symptoms were possibly suffering from schizophrenia simplex. The vagueness, autistic and introverted manner, social withdrawal and deterioration, the apathy, indifference to discomfort and emotional flatness combined to produce a typical picture.

The downward social drift associated with schizophrenia is exemplified in our sample, in which there is striking over-representation of schizophrenia in this deprived population.

As regards *social isolation*, the lack of structured activity was prominent, with people aimlessly wandering the streets, saving up for a bath, or as one told us, visiting St James' Park to look at the ducks. The long separation from family, averaging 14.6 years, or 45% of adult (over 18) life, was striking. Over half the population had no friends, even amongst those with whom they had lived, often for long periods.

General practitioners and opticians visited Bruce House and the Salvation Army. At Crisis at Christmas over half of those interviewed were not registered with a GP, despite the fact that many had minor and sometimes major ailments. Nearly half had physical complaints needing treatment. Mercifully the four with tuberculosis were registered, although a further person who had had tuberculosis was not registered and did not have check-ups.

One man, bedded down under the arches at Charing Cross (not included in the Table), volunteered that he received treatment from a hospital for tuberculosis but his medication had been left at a Salvation Army hostel when he was evicted after an argument with the Captain there. The fact that he knew his medication included streptomycin added verisimilitude to his account.

TABLE
Summary of Interview Data (time intervals in years)

	Overall interviewed	*With psychiatric disorders*	*Remainder*
Total number replying	72	27 (out of 68; 39.7%; 3 had only alcoholism)	
AGE			
Number	72	27	45
Mean (S.D.)	51.4 (13.7)	46.0 (12.9)	54.5 (13.3)
LENGTH OF STAY			
Number replying	35	5	30
Mean (S.D.)	4.5 (6.5)	10.3 (13.1)	3.5 (4.4)
TIME SEPARATED FROM FAMILY			
Number replying	66	27	39
Mean (S.D.)	14.6 (13.2)	13.8 (14.2)	15.2 (12.6)
NUMBER WITHOUT A FRIEND			
Number replying	61	23	38
Number	31 (50.8%)	11 (47.8%)	20 (52.6%)
NUMBER NOT IN RECEIPT OF BENEFITS			
Number replying	66	22	44
Number	6 (9.1%)	3 (13.6%)	3 (6.8%)
NUMBER WITHOUT A GP (Crisis at Christmas only)			
Number replying	28	19	9
Number	15 (53.6%)	10 (52.6%)	5 (55.6%)
NUMBER REQUIRING NON PSYCHIATRIC MEDICAL TREATMENT			
Number replying	65	25	40
Number	27 (41.5%)	10 (40.0%)	17 (42.5%)
TIME SINCE DENTAL TREATMENT			
Number replying	55	20	35
Mean (S.D.)	20.0 (20.5)	19.2 (19.0)	20.5 (21.6)
TIME SINCE EYES TESTED			
Number replying	49	23	26
Mean (S.D.)	21.9 (21.6)	14.9 (19.4)	28.1 (21.9)
NUMBER WITH PREVIOUS IMPRISONMENT			
Number replying	32	20	12
Number	17 (53.1%)	***15 (75.0%)	2 (16.7%)

***$\chi^2 = 8{\cdot}04$; $P < 0.005$ two tailed

The average time from the last dental appointment was about 20 years, many wore glasses they had acquired from barrows or market stalls, in some instances even at Bruce House and Great Peter Street, where ophthalmic services were available.

A sub-group of 32 advised us as to whether they had both received a *prison* sentence and were, or had been, psychiatrically unwell. Of the 32, 20 had a positive psychiatric history or were mentally ill at the time of interview, and 15 of these had been to prison, as against only two who had been to prison and who were not, or had not been, psychiatrically unwell.

Using the most conservative statistic, i.e. X^2 with Yates correction, and using a categorisation system where only definite information was used, we found that there was a very strong association between previous psychiatric disorder and previous imprisonment ($X^2 = 8.04$, $P = 0.005$ two tailed). If there is an error in the extent of the association, it is one of understatement.

Of the 15 in the psychiatric group who had been to prison nine had received in-patient treatment and one was asking directions to a drug addiction unit. Three were psychotic at the time of interview but had never received psychiatric treatment. One of the two who had been in prison, not included in the psychiatric group, was unsure as to whether or not he had heard voices, the other had been treated in a neurological unit for brain damage and had a very poor memory being unable to remember whether or not he had had psychotic experiences.

Comment

Local authorities have a duty to house the vulnerable homeless, including those discharged from psychiatric hospitals. Although the deluded and hallucinated may not

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be held to have testamentary capacity to enter into binding contracts they are held to have this capacity if they quit their accommodation and cease to be the responsibility of any Local Authority. It is difficult to find supervised accommodation at all, which should be provided if required by entitlement under Part III of the National Assistance Act 1948. Despite the clear expectations of the Act there is no Local Authority known to the authors which makes such provision, except for people over the age of 65. It is in the nature of psychosis that wandering is common, as a consequence of delusions, imperative hallucinations, confusion and pathological restlessness. Hence the existing legislation and the difficulty in tracing peoples' whereabouts may lead to destitution.

The pressure to discharge patients from long-stay psychiatric care is leading to unsuitable arrangements. The coordinator of the night shelter in Manchester expressed a general concern, 'Staff at the Manchester Night Shelter are daily amazed at the attempted referrals made by hospital staff who are trying to discharge patients to our completely unsuitable, common lodging house'.[2]

The Salvation Army Hostel had a rather warmer atmosphere than Bruce House but it was at best rather bleak and it seems unsatisfactory for men to spend many years in such circumstances, even though efforts had been made to provide at least some homeliness.

The Crisis at Christmas team ran a programme, in a converted garage, that must have greatly ameliorated the plight of many who would otherwise have suffered great hardship and the realisation of this task is a tribute to the dedicated work of those running the organisation. Nevertheless this splendid voluntary activity will be difficult to sustain, although it demonstrated how needful it had been and how it might be perpetuated at a very modest cost.

The problems of homelessness are not an indictment of the men's lack of initiative so much as an indication of their pressing needs, their inability successfully to sustain any other mode of life, to utilise available facilities, to manage within their meagre resources, or even to claim their entitlements, 13.6% of those with a psychiatric disorder failing to do so. The large proportion of physical and psychiatric problems and the frequency that men reported they had slept rough, 70% of the Crisis at Christmas sample (a similar proportion to a Camberwell reception centre sample[1] indicates a gross failure within existing social and medical frameworks. We fear that this situation is likely to deteriorate with further reductions in cheap accommodation and as psychiatric hospital closure plans are realised. The RAWP (resource allocation working party) policy of taking health service money away from London, including money for psychiatric services, further erodes existing facilities contemporaneously with a drift of psychiatric problems to London, without necessarily alleviating it elsewhere.

ACKNOWLEDGEMENT

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REFERENCES

[1] SOUTHWARK FORUM FOR THE SINGLE HOMELESS (1979) *Report on Reception Centres*, section 4.

[2] ROSSINGTON, J. (1984) (Coordinator, Night Shelter Manchester). Out of hospital and into a twilight world. *Guardian*, 18 July.

The Mental Health Film Council

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