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Psychiatric clinics in homeless hostels – your flexible friend

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The increasing awareness that serious mental disorder is common among men residing in homeless hostels has acted as a fillip towards providing new services for this disadvantaged group. Conventional psychiatry frequently fails to meet their needs, not least because of the formality and inaccessibility of the contact. Detailed psychiatric history taking, for example, is often perceived as a barrier to communication with no intrinsic benefit for the homeless. Indeed psychiatrists often appear distant to hostel staff. The Salvation Army have gone so far as to suggest to the House of Commons Social Services Committee that community psychiatric nurses are effective because of their ability to mediate with consultant psychiatrists.

Some workers have advocated the development of dedicated multi-disciplinary teams in an effort to plug the gaps left by existing statutory services. Dedicated teams for homeless people, however, are expensive to develop and run. They are obviously least likely to be successful when they confine their activity to office hours. They may also duplicate existing resources and paradoxically can disenfranchise voluntary and non-statutory agencies which already work very effectively with this group.

The size of the problem is not contested. At least one quarter of longer term residents in Salvation Army accommodation have significant psychiatric disorders requiring ongoing treatment. In 1985 over 25,000 homeless men, women and families sought admission to these facilities which numbered 4,500 beds. In a separate study, Marshall (1989) suggested that some hostel workers were having to care for the equivalent of two long-stay psychiatric wards but often without the expertise of a psychiatrist until such point as admission to hospital is required.

Existing psychiatric services in inner city areas are hard-pressed and do not find it easy to meet the challenges involved. Additional resources may be limited and need to be put to good effect. This paper describes the setting up of an informal clinic at a local Salvation Army men's hostel which may offer a useful model for other areas with similar problems.

The hostel

The hostel is located in the inner city, has 130 beds provided mainly in cubicles, and is for men only. Of the specialist staff, four female care assistants provide support, especially to older residents who are considered to be in need of extra help. A psychologically vulnerable or physically sick resident would be included in this category. A trained nurse attends each morning and there is a social worker with responsibility for running a rehabilitation unit for training in domestic skills in preparation for moving into their own accommodation. On average the hostel takes 62 new admissions each month of whom 40% stay only one night. The majority are aged 20 to 55 on admission, but the average age of residents is older with many pensioners having lived there for over ten years. The hostel is run by the Salvation Army according to their usual practices and is an important resource facility for homeless men in this area.

A previous study identified significant psychiatric morbidity in this group. Admissions to the psychiatric hospital tended to occur in crisis and it was difficult to provide sustained psychiatric input when the men returned to the hostel. It was therefore decided to establish an informal psychiatric clinic in the building staffed by a fully trained psychiatrist from the mental health team serving the area. The clinic was held between 4.00 and 7.00 p.m. – a time to suit the men who use the facility to meet or have tea. They were invited to drop in for a short chat or a longer psychiatric consultation if they wished. Appointments were not necessary but could be made by the residents or staff involved in their care.

The main aim of the clinic was to increase accessibility for residents and break down the contact barrier. This was necessary to reach those known to be ill but reluctant to receive treatment. Also, the process of establishing a clinic would improve liaison between the hostel staff and the mental health team generally so that contact did not occur solely at times of crisis, admission and hospital discharge. An effort was made to coordinate activity with the general practice team responsible for providing general medical services. Similar efforts were made to establish working relationships with another mental health team already assisting homeless people throughout the city.

Activity of the clinic

A wide variety of diagnostic categories were seen including schizophrenia (9 patients), organic syndromes (9), substance abuse (17), neurotic disorders (13), subnormality (4) and personality disorder (6). During the year that the clinic was established 58 men were assessed of whom only 26 gave no history of previous psychiatric involvement. Of the remainders, 19 had received psychiatric treatment in another part of the country, confirming the mobility of this group of men. In all, 206 contacts were made during the course of the year, 37% focused on long-term treatment. Initially the take up of the clinic was slow but the regular visit to the hostel with "an open door policy" gradually led to an increase in demand. Of the long-stay residents, two new cases of schizophrenia were discovered. Alcohol abuse was by far the most under-diagnosed problem which then became a focus of further intervention. In all, eight residents responded positively to psychiatric treatment which otherwise would not have been available. A worrying aspect was that a number of severely disturbed patients from other parts of the country visited the hostel but only stayed one night. Efforts to trace them proved unsuccessful and there must be concern that there are psychiatrically ill patients in an acute psychotic relapse who wander from one facility to another without effective treatment.

Comment

It is difficult to assess the benefits of such a clinic using conventional measures of outcome. By its definition it was flexible and informal. Some of the contacts were of very short duration and only provided a brief glimpse of mental state. They had to be used to screen for significant disorders or to establish a tentative relationship which could later be built into something more productive. The number of men seen towards the end of the year indicated a perceived value from the residents. Certainly a significant proportion of people were by that time in receipt of treatment who otherwise would not have found their way into the standard psychiatric services.

An undoubted benefit was improved liaison between hostel staff and the mental health team. Many became familiar with one another and shared information about the services each offered. Hostel staff expressed universal approval at the end of the year. Only three admissions were required during the course of the year, in itself a worthwhile outcome.

Of great value to the mental health team was awareness that hostel staff show much empathy and concern for their residents. Although the surroundings were spartan there was an impression of real care and goodwill. A hostel of this sort undoubtedly provides for men who previously have lived in long-stay wards. This, however, should not lead to complacency but rather a re-appraisal of how we deliver psychiatric care to homeless men who need it.

The setting up of a clinic in such circumstances, particularly in inner city areas which brings the psychiatrist to the homeless on a regular basis, appears to be both feasible and worthwhile. It allows for the detection and treatment of psychiatric disorders which would otherwise be missed. It improves support and provides liaison with carers in the voluntary sector but has to be based on flexibility and informality. With the closure of long-stay mental hospitals it is a further extension of community care which has become necessary for inner city psychiatric services to consider.

Reference

MARSHALL, M. (1989) 'Collected and neglected': Are Oxford hostels for the homeless filling up with disabled psychiatric patients? *British Medical Journal*, **299**, 706–709.