ORIGINAL PAPERS

A psychiatric service for the homeless mentally ill: the first two years

Stephen Merson

The characteristics of 452 patients referred over a two year period to a psychiatric service for the homeless population in inner London are described. The majority of patients were male and Caucasian, and tended to be referred through voluntary sector as opposed to statutory services. Fifty-nine per cent were sleeping rough at the time of first contact, 80% had a previous history of psychiatric treatment, but only 6% were currently in contact with psychiatric services. Serious psychiatric disorders predominated, with 52% suffering from schizophrenia or delusional disorders.

The perceived accumulation of the severely mentally ill among the homeless population (Weller *et al*, 1989) has encouraged government funding for mental health initiatives specifically targeting this group. The Joint Homelessness Team (JHT) represents one such initiative involving North-West Thames Regional Health Authority and two local authorities in central London. The remit of this initiative is to treat and resettle those among the mentally ill who are homeless (particularly sleeping rough) and lacking current contact with health and social services.

The initiative was planned to include two elements: supported residential places and a multidisciplinary mental health team. For the period considered in this article only the latter was in existence and comprised psychiatrists (1.5 of senior registrar grade), two community psychiatric nurses, two social workers and two social work assistants with experience in housing and welfare issues. The team operated according to the "joint accountability" model described by Ovretveit (1990) and incorporated a key worker system with some retention of disciplinary roles.

The lack of contact with statutory services and the paucity of social networks characteristic of this group necessitated a pro-active posture. Epidemiological work (Cantor *et al*, 1990) suggested the likely location of prospective clientele, which includes night shelters, direct access hostels and voluntary sector day centres providing shelter, food and clothing. These represent the sites for much liaison work allowing referral of individuals and an increased likelihood of sustained contact during the subsequent treatment phase. The objective of this paper is to describe the individuals referred between October 1990 and September 1992, and the outcomes of subsequent interventions by the JHT.

The study

All patients conforming to the team's criteria underwent a semi-structured clinical interview conducted by a member of the team as part of their routine assessment. This included the standardised recording of personal and socio-demographic details and psychiatric and social histories. All patients were given an ICD-10 diagnosis by the author on the basis of multidisciplinary discussion and formulation at the weekly clinical meeting: not all patients were interviewed by a psychiatrist.

Findings

Referral

Of the 452 individuals referred to the team in this period, 82% were male and 87% were white. The average age was 39.5 (s.d.=15.3) years.

One hundred and twenty-two of the 452 individuals (27%) were contacted in direct outreach by team workers, usually in the setting of a night shelter or day centre. Twenty-six patients (6%) referred themselves in these settings. Of the 304 individuals referred by staff in these settings, most (246, 81%) originated from the voluntary sector in contrast to 58 (19%) from statutory agencies. The sources are shown in detail in Table 1.

The reasons for referral, or presenting problem in the case of self-referrals, are shown in Table 2, and reflect the prevalence of evident mental illness in this population.

Of the 452 individuals coming into contact with the team, 362 were subject to complete assessment. Ninety individuals were unable to supply full information and are not described further.

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Table 1. Distribution of source of referral for 452 patients

Source of referral	n (%)
Self-referral	26 (6)
Team outreach work	122 (27)
Referred by other agencies	304 (67)
Day centre	159 (35)
Hostel or night shelter	87 (19)
Police or Magistrates' Court	19 (4)
Social services	8 (2)
General practitioners	7 (2)
Other psychiatric services	5 (1)
Other	19 (4)

Table 2. Reasons for referral, including self-referral, in 452 patients

Reason for referral	n (%)
Mood disturbance (including actual or threatened deliberate self-harm)	118 (26)
Odd behaviour	80 (18)
Delusions or hallucinations	68 (15)
Housing or financial problem alone	46 (10)
Previous history of mental illness alone	34 (8)
Substance misuse alone	23 (5)
Aggression	20 (4)
Other (including requests for counselling)	63 (14)

Housing histories

Of the 362 fully assessed individuals, 214 (59%) were sleeping rough at the time of first contact with the team. A further 33 (9%) were resident in direct access hostels and 25 (7%) had no accommodation other than temporary lodging with friends or parents. Fifty-eight (16%) theoretically had access to their own tenancies. Seven (2%) and 8 (2%) individuals stated prison and hospital respectively as their most recent address. In 17 (5%) there was no reliable data.

One hundred and twenty individuals (33%) had achieved stable accommodation in the form of an independent tenancy since leaving their parental home. Thirty-three (9%) had previously only lived with parents, 11 (3%) had been long-term hospital residents and 83 (23%) had never known accommodation more stable than a direct access hostel in adulthood.

The reasons given for the most recent episode of homelessness were varied and sometimes vague, with 30% simply stating "moving on", with no clearer cut reason being evident, but 24% stated relationship problems and 8% financial reasons. Eleven per cent gave a clear history of behavioural disturbance related to mental illness as being directly implicated in eviction or leaving home and only 8 (2%) and 4 (1%) individuals respectively became homeless after discharge from psychiatric hospital or release from prison.

Psychiatric history

Only 20% of individuals lacked a psychiatric history. Of the remainder 78% had a history of in-patient treatment, but few described lengthy periods of hospitalisation; 17 individuals (5%) had spent more than 2 years in total as in-patients and nearly half (49%) reported lifetime aggregated totals of in-patient treatment of less than 6 months. Only 6% had current contact with psychiatric services following their last illness episode: 33% had not been offered follow-up, but 11% had taken their own discharge from in-patient care and 25% had defaulted on planned out-patient treatment.

Diagnosis was limited to the axis of mental state disorders and the distribution is shown in Table 3.

Outcomes

Of the 362 patients where full data is available, 278 (77%) were accepted into treatment, involving access to a multidisciplinary team offering a

Table 3. ICD-10 diagnoses of 362 fully assessed patients

ICD-10 Diagnoses	n
F00-09: Organic disorders	7
Including	
dementia	1
organic delusional disorder	5
F10-19: Disorders due to psychoactive substance use	34
Including	
alcohol dependence	17
alcohol-related psychotic disorder	6
F20-29: Schizophrenic, schizotypal and delusional disorders	189
Including	
Schizophrenia paranoid	124
hebephrenic	17
residual	11
persistent delusional disorder	33
F30-39: mood disorders	41
Including	
bipolar disorder currently mania	7
currently depression	4
depressive episode	19
recurrent depressive disorder	10
F40-49: Neurotic disorders	7
F50-59: Syndromes associated with physiological disturbances	1
Including	
bulimia nervosa	1
F60-69: Disorders of adult personality	68
Including	
dissocial	11
emotionally unstable	25
F70-79: Mental retardation	12
No psychiatric disorder	3

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range of social and psychiatric interventions. Eight-two individuals were fully assessed but not offered further contact with the team for the following reasons: existing contact with appropriate service, 29 (35%); inability to sustain further contact with team, 19 (23%); no treatment judged to be beneficial or realistic, 15 (18%); not homeless, 10 (12%); not psychiatrically ill, 4 (5%); no data available, 5 (6%).

Of the 278 cases taken on for further treatment and re-settlement their status in relation to the team either at the point of last contact, or in September 1992, whichever was the most recent, was as follows. Fifty-four (19%) were still active cases; 127 (45%) had been referred on to local mainstream services and 97 (34%) had discontinued contact prematurely and their whereabouts remained unknown. Thirty-four (13%) had been admitted to hospital at some point during their contact with the team, and in 23 cases (8%) this was on a compulsory basis.

In terms of housing outcome, in 169 (61%) cases contact with the team led to either no improvement in housing status or housing status being unknown due to loss of contact and was assumed to be unimproved. Twenty-eight (10%) cases had been re-settled into independent accommodation and 36 (13%) into sheltered housing schemes of a permanent nature. A further 45 (16%) were judged to be occupying more suitable, though not necessarily stable or permanent, accommodation.

Comment

The 90 individuals who evaded full assessment were likely to be persistent rough sleepers, lacking regular contact with voluntary sector services and wary of engaging with services. Our experience suggests that they are likely to have severe disorders and to be chronically homeless.

Nevertheless the patients taken on for treatment by the team had serious disorders, particularly when compared with the clientele of other services providing open access to psychiatric services. Lim (1983) found a diagnosis of psychosis in 24.5% of index attendances at an emergency clinic and Onyett *et al* (1990) recorded ICD-10 diagnoses of schizophrenia and related diagnoses in 23.5% of referrals to a community health team. More than half of our patients received diagnoses within the ICD-10 major group of schizophrenia and related disorders. The second largest major group was the personality disorder group. Personality disorder diagnoses were given as alternatives to mental state diagnoses; if a multi-axial system had been used the rate of abnormal personality status would certainly have been higher.

Most referrals originated from voluntary sector as opposed to statutory services. Despite the very obvious and severe social dysfunction, social problems *per se* represented a relatively small proportion of the reasons for referral or contact. A large number of patients had chronic housing problems; in a sense they had never become homeless but had simply failed to establish independent accommodation after leaving their parental home or, as was frequently the case, an institution. They had continued to rely upon semi-independent forms of housing; hostels for itinerants, accommodation tied to work, or simply staying with friends or in squats.

Although a small minority of patients were strikingly mobile, most had long-standing connections with the locality, albeit through alternative channels of voluntary sector agencies. The tag of nomadic seems to help statutory agencies to justify the difficulty they have supplying services to clientele who fail to respect their administrative boundaries.

Certain widely held notions concerning the homeless mentally ill were quickly dispelled. Most of our patients, although ill on average for many years, had not been long- or even medium-stay patients in psychiatric hospitals. Rather they were individuals who had failed to establish continuing contact with social and medical agencies for reasons including severity of illness, personality factors and pre-existing social and family instability.

Although the initial commitment of the team was to informal treatment, we came to regard continuation on the streets for psychotically ill individuals to be indefensible because of the inherent severe risk to health. Accordingly our threshold for use of the Mental Health Act fell, in keeping coincidentally with the views of the Department of Health regarding the Code of Practice of the Mental Health Act, and a small but significant group of patients (8% of the total) were therefore referred for compulsory treatment.

The relatively high rates of patients losing contact with our service reflects another risk of non-compliance in this group which led to the use of compulsory treatment. We noted the pressures on patients to return to the familiar, albeit uncomfortable, lifestyle of the street. Paradoxically the institutional life against the background of the street, the soup kitchen and the night shelter mirrors that of the mental hospital back ward.

These risks encouraged the team to keep cases open, in favour of referral to generic services which lacked a network of liaison contacts among the agencies serving the homeless. This naturally reduced resources available for outreach work for new referrals. We recognise the need for increased awareness among generic psychiatric services in inner cities of this group of potentially

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marginalised patients, which may lead to the advent of services using a network of contacts among both statutory and voluntary sector organisations to sustain contact with these difficult patients.

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