

## Case conference

### Hallelujah, I'm a bum: a story from the post-Christian era

#### The case

Jimmy Sparrow was thirty four when he died. The following account of that relatively brief span has been reconstructed from such records as exist in available official files.

Jimmy was the third in a family of eight children born to a coalminer's family in Durham. Although it was wartime, Jimmy's father had been kept to the coal-face, but married late in the war and so Jimmy joined the baby boom of peacetime. He did well at the crowded schools, and seems to have made the extra headway that took him to Grammar school and eventually to a clerical job at Teeside in a chemical concern. He married at twenty and appears to have been making a success, in conventional terms, of his life when his first illness occurred, and he was admitted to the local mental hospital after having been off work for some weeks, and having attempted to take his own life using gas. The diagnosis at the time was depression and he was in hospital for three months. It is interesting to note that after discharge he was maintained for some months on amphetamines by his family doctor. Some six months after discharge, having lost his job, he became agitated and paranoid and attacked his wife with a knife, severely injuring her. At this stage he was clearly psychotic, and was readmitted compulsorily to his psychiatric hospital. This time he had florid schizophrenic symptoms, was hearing voices, and his thinking was grossly disorganised. In spite of this, however, with chlorpromazine treatment he appears to have settled down and was fit for discharge three months later. His wife would not have him back, however, and had returned to live with her own mother, taking their two young children with her. Jimmy's parents were dead, and it seems that little help was forthcoming from any of his family except his youngest sister, who took him in for a while. But this did not last for long: without wife and family or job, Jimmy's behaviour was disorganised, and it was made considerably worse by mixed usage of amphetamines and drink. At twenty-six he finally had to leave, and began to drift about the country.

From then on, his life was charted for us by a series of mental hospital admissions and appearances at hostels and reception centres around the country, but particularly in South London. Over the next eight years of his life, he had just under thirty admissions to hospitals of various sorts, and had an increasing number of physical problems to add to his mental 'illness'. His drinking had often become the major problem, and aged thirty he had a serious road accident which left him with persistent back pains, a weak and clumsy right leg and post-traumatic epilepsy. The following year he had a massive haemorrhage from an acute erosion in the stomach, which was controlled by operation. He was unable to take consistently his anticonvulsant drugs when not supervised, and so was often found fitting and thus was taken to hospital for brief spells. Usually on discharge such arrangements as were made for him were frustrated by his drinking and his mental state, and he would rapidly become homeless again.

His mental state appeared to be the major rehabilitation problem. Without drink, he settled well and his thinking was reasonably clear, and his mood normal. When he began to drink, however, paranoid features would emerge, which might for a time be controlled by drugs, but unless this phase was cut short the results were inevitable. If he were in a common lodging place his behaviour became intolerable and he would be put onto the street. On occasions he was admitted under compulsion by doctors or police to mental hospital, but it seems to have been difficult for any consistent policy to be applied as no one hospital would accept responsibility for him.

On two or three occasions however, he settled well at hostels and made spectacular progress. He was last seen at a DHSS Reception Centre, where he remained 'dry' for several weeks, and with regular depot phenothiazine treatment his mind cleared and he was working regularly in the workshop, and seemed, in spite of his physical handicap, to be on the edge of being fit for work for the first time for several years. On this occasion it was clear to the medical officer that he still had a bright and alert mind, in spite of all the assaults it had suffered. However, one weekend he returned to the hostel drunk, assaulted an assistant, and was cast onto the street. From here it seems he drifted to sleeping rough in some empty houses awaiting

demolition in South London. Here a gang of youths chanced on him, and he was badly beaten up by three of their number. He was left unconscious but the leader returned two hours later, and in a fit of remorse, 'to finish the job', dropped a large lump of concrete on Jimmy's bare skull. It is hoped he died at once, for his body was not found for eight days.

## Discussion

### SOCIAL WORKER

If I may break the silence that followed the telling of this ghastly tale, I should like to single out two very practical, but separate issues here. One is that of the long term care of the mentally ill in the community and the other is that of the care of the homeless. In Jimmy's case these two problems crossed, but I think this is by no means unusual. Looking at the issue of mental illness first, it seems that Jimmy was in many ways the victim of our modern 'enlightened' community care system. One imagines that in days gone by he would have become a long-term mental hospital inmate, with all the possible attendant horrors of institutionalisation. However, in this story there never seems to have been that possibility, and although I welcome the idea that he should have been placed back in the community, there was no place for him, indeed no community.

### PSYCHIATRIST

I dispute this from the account we have been offered, which is unfortunately very short on precise details which enable us, retrospectively, to make a judgement of his mental state and make an approach to a diagnosis. However, when he assaulted his wife there seems clear evidence that he had a psychotic paranoid illness, although the assumption that this was due to schizophrenia can be questioned – he could have been abusing amphetamines enough, for instance, to create this picture. On this occasion he was offered 'asylum' for three months and made good progress, and seems to have been discharged to as good a home situation as it was possible at that time to find.

### PSYCHIATRIC NURSE

I see his drinking as being the major problem, and he clearly had a personality disorder as well. These patients are very difficult because one is repeatedly asked to take them in, and no progress is made because the condition is untreatable – I mean the personality disorder. This in itself creates enormous difficulties for treatment because the patient cannot or will not co-operate with any fixed regime of therapy.

### GENERAL PRACTITIONER

I'd like to scotch this issue of the diagnosis once

and for all. I cannot see it as having major relevance, certainly here. What we are seeing repeatedly in this story is disturbed, bizarre and dangerous behaviour that needs to be controlled for the patient's own good – the ethical issue of the compulsory admissions is a third topic we could tackle – and for that of society. The treatment that is evolved is not only logical but effective, and when maintained Jimmy does well. What does it matter whether he has schizophrenia, a schizophreniform illness, personality disorder or alcoholism provided that the treatment is logical, correct and effective? However, to the outsider it seems that once the diagnosis of schizophrenia has been doubted, the psychiatric staff lose interest, and worse, refuse to readmit should the patient relapse. Everyone understands that a specialist must care most carefully for his most dangerous diseases, but I detect in this story a feeling I have met elsewhere, and that is that *readmission* without a major diagnostic label is a sign of scientific weakness and cannot be tolerated. What would we do if chest physicians refused to readmit chronic bronchitis or the orthopaedic surgeon the motorcyclist who had already had four road accidents? It's not the label that matters but the clinical condition that the label is trying to describe.

### COMMUNITY WORKER

I certainly agree that labelling in psychiatric cases causes other workers in the same field and the patients great difficulties sometimes. I believe that some studies have shown that these labels are very often changed during a psychiatric admission and my experience is that they seem often to tell us more about the psychiatrist than the patient! However, that being said we must avoid the stigmatic effects of labels both in the community and hospitals, so I would prefer none at all to wrongly created ones. Stigmatising mental illness, and all the communities attitudes to it, seem to be the major obstacles to us obtaining the type of community care that Jimmy needed, and perhaps obtained in a small way, in the last few months of his life.

### PHYSICIAN

Yes, a recent publication on vagrancy has an horrific description of a public meeting which totally rejected an attempt to start a local hostel for vagrants. Very often there seems to be opposition in this way and so community projects like these are rejected by everyone and so finally shelved. It seems impossible to show an enlightened lead.

### PSYCHIATRIST

Somehow I feel that we should be showing one, but bed shortages, and catchment area problems get us bogged down. However, we do have to throw the issue of the homeless back into the

community arena – we are hospitals not housing associations.

**SOCIAL WORKER**

Jimmy is caught in a series of interlocking 'Catch 22's'. He is epileptic, he has a fit, he wets the bed, he is cast out of the lodgings. He has a drink problem, he gets drunk, he is cast out of the reception centre. He finds his way to a place where he can be treated, he is treated, he gets better, he is no longer sick so he is cast out of there too! And so we go on. Someone has to decide to bend the rules and give him a chance.

**PSYCHIATRIC NURSE**

But if you are bending the rules in a unit dealing with alcoholics, soon you find everyone is drinking and the unit is useless!

**GENERAL PRACTITIONER**

We cannot escape grappling with the fact that Jimmy is one of society's rejects on at least three counts, and so I think we have to look at the basic

philosophy of our welfare system. It is unlikely that the average man in the population is going to want to go out of his way to actively help Jimmy – so, as we feel he has to be helped, the state must do so, in an altruistic sense, for society as a whole. This is not dodging the issue, it is surely the basis of a welfare system. It is up to the state in dealing with any group that society would otherwise forget or reject – like the old, the mentally handicapped, the vagrant – to find the right institutions or arrangements and make sure they work. It is not up to the state to set up another set of barriers so that there is a double rejection. I'm afraid that is what much of the present welfare legislation does, or at least that is how it is operated, so that the original intentions are lost. To quote in part Titmuss, a society founded on efficiency must increasingly employ only the efficient, and a society attempting through its political machinery to eliminate inefficiency will eliminate the inefficient too. Jimmy cannot help being one of those, as far as we can judge. Who will speak for him?