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Corridor People

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People found in mental hospital corridors are various: some have purpose, some are aimless, and many are unkempt and hardly decorative. In 1982, in the Royal Edinburgh Hospital, concern was expressed about security and there were complaints ranging from the general to the specific, about people's behaviour in the open areas of the hospital. Whilst it was unclear who was responsible, or indeed if any one group of people were to blame, suspicion rested easily on those people whose reason for being in the building was not clearly identifiable, and action of some kind was sought. As a preliminary to formal discussion of this issue, we set out to identify the people concerned and the problems, if any, that they posed.

The Corridor

The Royal Edinburgh Hospital, Edinburgh's only adult mental hospital, occupies a spreading campus, approximately two miles from the city centre and in a densely populated area. In the main building, an irregularly shaped corridor connects the acute admission wards and out-patient reception area at one end to the psychogeriatric wards and snack bar for patients and their visitors at the other. The corridor gives access to other areas and is a busy place, which may be seen as the spine of the hospital.

Four areas of particular activity may be identified. The first is that of the out-patient department, with access to social work offices and continued-care clinic. Secondly there is a carpeted area with notice-boards, at the telephone exchange, beside another entrance, from which an internal hospital bus service operates. The third area is beside the hospital shop and staff canteen, opposite the Physician Superintendent's office. Finally, there is an area at the far end of the corridor, around the snack bar.

Use of the Corridor

During week-days, the corridor teems with staff, patients (in-patients, out-patients and day-patients), relatives, and visitors. We were interested in those individuals who did not readily fit any of these categories, who had no apparent reason for being there, but who might claim to be patients and give the appearance of being so. These we called 'Corridor People'.

Method

Possible individuals for study were identified by obtaining means from the following sources: (1) The Medical Records Officer noted people known to out-patient reception and medical records staff. (2) The telephone switchboard operator named those frequently seen in the area. (3) The Physician Superintendent provided the names of those about whom complaints had been made. (4) The staff of the continued-care clinic (who provide out-patient follow-up for many chronic patients) listed those they had found difficulty with, either through their defaulting or through complaints being received about them from other areas of the hospital and general practitioners. (5) One of us (TD), over a period of a week, took the names of those sitting or waiting at the four identified points on the corridor at three times in the day—before lunch, in the mid-afternoon, and after 5 pm.

Those who had reason for being in the corridor were excluded, the remaining names were compared between sources, and their case-notes were sought. Details of age, marital status, employment status, personal, psychiatric and criminal history, the number of doctors they had seen, and their present social circumstances were taken from their case-notes.

Results

The total number of names collected from the various sources was 15, of which there was no agreement on four. Of the remaining 11 patients, one was found to be an in-patient, and one a day-patient; we were unable to trace the

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notes of a third. The final number of corridor people on whom data were collected was eight, including seven males; six of these people were single, one widowed, and one divorced.

All were of no fixed abode, and some had been banned from public lodging houses. They appeared to be rarely admitted to hospital, but often referred by doctors and social workers to the city Housing Department, where they were refused housing because of their previous history of evictions.

All had had previous admissions, mostly with self-discharge after a few days. None had been admitted during the previous three years, except for one, who had been in the hospital for assessment from Court two months previously. They had all been seen in various departments of the hospital at some time, but with very poor attendance. They had a tendency not to attend organised out-patient clinics, but to turn up as 'emergencies' to see the duty doctor. The presenting problem was usually social, i.e. wanting somewhere to stay or some money.

Diagnoses were unstable, most patients attracting more than one. There were seven diagnoses of schizophrenia, two of mild mental handicap, one of deafness, and four of alcohol abuse.

All had a history of some trouble with the law, but mostly for minor offences over a long period of time.

Two illustrative cases

Mr. A. M. is a 60-year-old man who has never been in regular work; he never knew his father and was brought up by his mother, who died when he was 36 years old. His first admission to a psychiatric hospital was in the following year, 1959. Between then and 1976, he had 19 admissions to hospital with diagnoses of schizophrenia and delinquent behaviour. There are records of his having seen four consultants and 24 junior doctors over the years; he receives Modecate at a community clinic near his lodging house.

He had 39 court appearances between 1934 and 1977, namely for theft, attempted fraud, wilful damage, and vagrancy; he had been in prison 19 times, spending a total of 48 months there. However, since his last discharge from hospital, in 1976, there has been no recorded criminal record. Since 1959, he appears to have spent his life between hospital, private lodgings, lodging houses, prison, and sleeping rough.

Mr. J. P. is a 43-year-old single man, who was born in Glasgow and has lived a vagrant life since he was 18 years old, when his mother left home. He was the second of seven children, four of whom were brought up in an orphanage; his father died early in his life, and he has no contact with any of his family. He is of no fixed abode, and usually finds a place in one of the large lodging houses in the city. He has a long criminal record, dating from 1957, most convictions being for theft, assault, and fraud.

His first psychiatric contact was in 1969, when he was admitted to a hospital in England with a diagnosis of schizophrenia. In the same year, he was admitted to another hospital with the same diagnosis plus personality disorder. Between 1970 and 1976, he was admitted on six occasions to the Royal Edinburgh Hospital with varying diagnoses of psychopathy, inadequate personality, and residual schizophrenia; failure of rehabilitation was attributed to his lack of co-operation. Since 1970, he has seen six different consultants and 44 junior doctors. He sees a junior doctor at least once a month, usually to demand admission because he has nowhere to stay, no work to go to, or no money. He is supposed to attend the continued-care clinic, but does so erratically, no positive evidence of acute psychosis has been observed.

Discussion

Since the days of unlocking of mental hospital doors, there has been recognition of the 'side-effects' of this process, illustrated most clearly by the people described by Gunn (1974, 1977) and Rollin (1974). Previously inhabiting long-term wards of asylums, and described as 'institutionalised', these people are now found wandering between a variety of institutions, including hospitals and prisons. Our corridor people appear to be a part of that 'stage army'.

They are people with no close relationships or family ties, who appear to have difficulty forming reasonable meaningful attachments, and thus reject proferred help, which generally includes a relationship of some degree with a person or group. Thus, most have been offered care under one doctor, but choose to appear at times when only the duty doctor is available. The hospital, by virtue of its accessible urban location and 24-hour walk-in clinic, is clearly open to this sort of use, and as the hospital's catchment area is sectorised, people of no fixed abode are rarely consistently attached to any one clinical team. The corridor people lay themselves open to being seen as abusing the system, and to provoking extremes of management, such as rejection or detention. Evidence for this can be seen in their interactions with lodging houses and prisons, quite apart from their interaction with the hospital itself.

Our corridor people, like their counterparts up and down the country, keep a relationship with a part of a building, or even with the cats, in the same institution where they avoid treatment in its usual sense. They are known by no one, yet recognised by all, and are often attached to other places such as day centres or churches in an equally anonymous fashion. While they may seem to be loitering to no purpose, they are spreading their attachments very thinly, so that they can take what they need, whilst

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apparently taking nothing from any one person. In these terms, to stand in a corridor and say "hello" to everyone that passes is to belong, and to ask for a cigarette or a light is to have a relationship. The relationship with the corridor is reminiscent of the baby's relationship with the mother's breast (Klein 1977) i.e. watching and taking in orally from the breast/corridor, without a relationship with the whole person/hospital.

In Winnicott's (1971) terms, too, the hospital can be seen as having a mothering function. As the mother holds her infant, the hospital 'holds' the patient psychologically, and sometimes also physically by admission. Treatment and rehabilitation can be seen as a process of feeding and weaning from the hospital. Corridor people are unable to develop in this way. They will never have the capacity to form whole object relationships, and thus can neither accept the help offered nor be weaned. We shall be frustrated and they will be misunderstood unless we accept them as they are, both in terms of their internal objects and geographically. By its very nature, this is what the corridor does.

It is this part-object relationship that is difficult for a general psychiatric hospital to recognise and allow. The hospital gives something that the patient can accept, and yet is unwilling to call it treatment. Perhaps part of the reason for the difficulty is that whilst the Butler Report (1975) sanctions a wide definition of treatment ("to cover all measures employed in the management of a case"), there is a widespread expectation that any treatment should be a clear and encapsulated phenomenon, justified by theory and outcome. In this case, without the use of a psychodynamic theory, a form of treatment may pass unnoticed and a group of people denied its benefits. Perhaps we are, as Gunn suggests, "too keen on curing and not keen enough about tolerating."

Conclusion

This study of 'corridor people' arose out of administrative complaints of people causing disturbances or being seen loitering. There was no evidence to direct blame towards them, other than the fact of their being there to no apparent purpose and being untidy. At the ensuing meeting of consultants and senior registrars, held to discuss the problem, it was agreed that despite the failure to give traditional treatment, and our lack of legal responsibility for them, they are entitled to such treatment as they are able to accept.

Rather than ban them from the hospital or detain them (two extreme but tidy alternatives), it was agreed that we should meet them where they are. Thus, while we might discourage their use of the out-patient department for loitering or sleeping, by placing seats with arms so that they could not readily lie down, we might encourage them to use other areas of the corridor, where they would cause less obstruction, by specifically placing seats on which they might sit or lie, whilst remaining involved in the daily life of the corridor.

It was accepted that to expect them to see the same doctor at each visit was unrealistic, but it was agreed that they should each be placed under one specific consultant's care, overriding the sectorising system. Any contact with another doctor would then be reported to the responsible consultant, so that one person at least should be in a position to take an overall view. An occasional elective admission for social reasons, such as a good meal or a wash, might then be possible.

Identification of this group of people, whom we have called 'corridor people', and an understanding of their particular difficulty in relation to the institution, enabled us to formulate a strategy for management.

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