tween these and the NAB, using observers who were not psychiatrists.

Many of the schizophrenics represent simply failures of 'community care'. They seemed to have been discharged (or perhaps absconded) from hospitals without further provision for treatment. The only surprise was that they had not yet re-entered the revolving door, presumably because of the tolerance of this kind of society and the minimum supervision that they received. None the less, in the course of the interviews other men often complained about their schizophrenic neighbours in the hostel beds. Although the figure for schizophrenia is high, it obviously only accounts for a minority who adopt this way of life; much the same observation was made (Noreik 1965) amongst a vagrant population in Norway.

The low figure of only 14 'normal' men (11·4%) corresponds to the high (but perhaps debatable) proportion with disorders of personality (62, i.e. 50·4%), a number that is likely to have been increased further by those who refused interview.

Sexual orientation and marital status reflect aspects of personality that seem characteristic of many of these homesless men. It is understandable that some men with highly ambivalent or 'uninterested' sexual attitudes will fail to establish or sustain a home. What is unknown, however, is the frequency of such attitudes among single men *with* homes, or the additional factors that contribute to a homeless way of life. Presumably they include amongst others, the anonymity, the support of the institution and its staff, and the tenuous character of personal relationships.

These attitudes towards women, apparently characteristic of homeless men, are reflected in the high proportion of those who had never married, 69·1%, that matches closely the 70% found by Edwards *et al.* (1968).

There are various practical implications of such a survey. The hostel population obviously consists of several subgroups for which particular provision must be made. This would be better achieved with, as has already been suggested (Edwards *et al.* 1968, *British Medical Journal* 1966) a national hostel service, into which the valuable contribution of voluntary bodies such as the Salvation Army is incorporated. To regard the homeless man as a 'blight', however, is to miss the cardinal point that he is not simply one who happens not to have a home, he is also a man who is incapable of sustaining one, and may be incapable of any other way of life than that which he has adopted.

He is himself likely to be the established product of an earlier generation's sexual and parental attitudes, or sometimes broken homes. There will always be such products of any society, who will have to be provided for, if only to ensure their employability, social stability, and continued existence outside prison.

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A USA–UK Comparison

The term 'Skid Row' derives from Skid Road in Seattle, Washington – 'the route along which the ox-teams skidded logs to Yesler's Hill . . .' (Morgan 1962). The area that is characterized by 'flop-houses', taverns and missions is still known as Skid Road in Seattle, and lies adjacent to the original. Elsewhere in the United States the equivalent area of town is usually known as Skid Row.

Bogue (1963) has identified such areas in 45 large American cities, i.e. almost every city of 500,000 or more and some under 200,000.

A recent survey (National Assistance Board 1966) identified approximately 30,000 homeless single persons in Great Britain; less than a thousand were sleeping rough, and about 1,200

Table 1
Comparison of data from HSP and Priest's surveys

	HSP (%)	*Priest* (%)
Never married	67	66
Age over 50 years	74 (Scotland)	76
On national assistance	67 (Scotland)	65
At same address for more than 6 months	62	65
In lodging-houses for more than 5 years	59	62

used the government-sponsored reception centres; the vast majority were living in lodging-houses and hostels. In fact, what is in the United Kingdom known as the common lodging-house – colloquially a 'doss-house' – is the equivalent of the American Skid Row hotel or 'flop-house'.

Edinburgh Study

I had the opportunity to compare the psychiatric aspects of homeless men on either side of the Atlantic when I went to the University of Chicago for a year's exchange visit from the University of Edinburgh; I had been studying the common lodging-house population in Edinburgh.

The interview was to a large extent structured and recorded on stereotyped sheets. Questions included demographic and social data, employment history, contact with the law, contact with welfare agencies, and personal habits as well as past and family psychiatric history. The interview incorporated two psychometric tests. The first of these was the Symptom-Sign Inventory (Foulds 1965, Foulds & Hope 1968). The SSI has been administered to newly admitted patients in mental hospitals and from this data a 'Personal Illness' scale has been derived which differentiates psychiatric patients from normal subjects.

This test is limited in relevance to functional conditions, and to screen for organic brain disease the second test used was the Isaacs & Walkey version of Inglis' Paired Associate Test (Isaacs & Walkey 1964, Inglis 1959).

In addition to the test results, mental examination and diagnostic formulation was carried out in the ordinary way.

The statistical test used routinely for the contingency tables derived from this study was Kendall's τ for tied ranks (Kendall 1962).

Table 2
Diagnostic findings of Edinburgh Survey (77 men)

	Diagnosis probable (*No. of cases*)	*Diagnosis definite* (*No. of cases*)
Schizophrenia	5	20
Alcoholism	7	7
Personality disorder	5	9
Mental subnormality	1	6
Organic brain disease	2	5
Depression	0	4

In Edinburgh I attempted to obtain a random sample of the 900-odd residents in the lodging-houses by selecting their bed numbers from random number tables. I selected 98 subjects, found 85 of them (87%) and had interviews granted by 79 (81%). Only 2 subjects refused to complete the interview after it had been started, but some of the subjects showed evidence of organic brain disease and were unable to answer all of the questions.

The subjects were selected from the 3 largest common lodging-houses, which together represent over 50% of the overall homeless population in Edinburgh.

Thus, although sampling was random from within each lodging-house studied, it is possible that the sample is biased by the restriction to just three sources. It is possible to obtain some idea of how representative the sample is by comparing various social and demographic data of the subjects in my series with those given for the sample in the national survey of homeless single persons (National Assistance Board 1966). Table 1 shows this comparison. The diagnostic findings are presented in Table 2. This leaves 19 subjects out of 77 who received no diagnostic label, and 12 received only a probable diagnosis.

As would be predicted, diagnoses of schizophrenia and depression were associated with high scores on the Personal Illness scale of the Symptom-Sign Inventory, and diagnoses of mental subnormality and organic brain disease were associated with impaired results on the Paired Associate Test.

Chicago Study

When I went to Chicago I attempted to replicate my study on Chicago's Skid Row. I ran into some difficulties, one of which was a less favourable reception by the lodging-house managers, but I was able to interview 50 subjects.

Results

This sample was very small in relation to the size of Chicago Skid Row population (6,000–7,000), and although it was randomly selected it is transparently non-representative in many ways (e.g. racial proportions).

My sample did not include any women in Chicago, although they formed 18% of my sample in Edinburgh ($\tau=0{\cdot}38$, $P<0{\cdot}005$ two-tailed). I did not come across any Skid Row hotels for women in Chicago.

The population was more transient in Chicago ($\tau=0{\cdot}34$, $P<0{\cdot}0001$). In Edinburgh 45 out of 78 had been in the hotel occupied at the time of interview for over a year, in Chicago only 15 out of 50, but there was no significant difference in the length of stay in the index city.

In Edinburgh the majority were single (53 out of 78) and in Chicago the majority were married (28 out of 49, $\tau=0{\cdot}25$, $P<0{\cdot}01$). Of those that were married there tended to be a difference ($\tau=0{\cdot}25$, $P<0{\cdot}08$) in the proportion of marriages that had ended in divorce or separation (23 out of 28 in Chicago, and 15 out of 25 in Edinburgh).

Edinburgh is a Protestant city and Chicago Roman Catholic, but only 13 out of 49 of the Chicago subjects were Roman Catholic compared with 34 out of 77 in Edinburgh ($\tau=0{\cdot}18$, $P<0{\cdot}05$). This result may be misleading, since the high proportion of negroes in this Chicago sample is not representative of Skid Row as a whole, and these tended to be adherents of the Southern Baptist Church.

The Edinburgh subjects were older ($\tau=0{\cdot}37$, $P<0{\cdot}00001$), 50 out of 79 being 55 years or more, compared with 9 out of 49 in Chicago.

There was a weak tendency ($\tau=0{\cdot}12$, $P<0{\cdot}2$) for a lower proportion of the Chicago subjects to report themselves as out of work (19 out of 49 compared with 39 out of 77 in Edinburgh). The labour situation is different in the two cities, and in Chicago there is a large 'spot-labor' market, by which men are employed by the day. In addition, it is much more difficult in Chicago for a man to obtain 'public assistance' than for an Edinburgh man to obtain National Assistance. Consequently men tended to be employed in a casual way for a few days a week, making it difficult to compare the two situations. The practical upshot of this as far as I was concerned was that I had to rise at 4 a.m. to interview subjects before they joined the lines outside the 'spot-labor offices'.

Fifteen out of 48 of the Chicago subjects denied ever having received assistance from a social service agency, compared with 1 out of 79 in Edinburgh ($\tau=0{\cdot}44$, $P<0{\cdot}00001$).

There was no difference in the proportions that had been to a general hospital and few men in either sample admitted ever having been in a mental hospital. The mental health department of the Illinois State Government kindly investigated this aspect, and found that there were records of admission to Illinois State mental hospitals during the previous ten years for only 2 of the 50 subjects of the series.

A profound difference in the medical care provided for these men is shown by the fact that, if medical attention were required, 40 out of 41 men in Chicago said they would go straight to hospital, compared with only 6 out of 73 in Edinburgh (χ^2, corrected for continuity, $=83{\cdot}4$, $P<0{\cdot}0005$). Of the remaining subjects in Edinburgh 33 opted for the General Practice Teaching Unit of Edinburgh University (situated conveniently near the main common lodging-houses) and 34 for other Edinburgh general practitioners. In Chicago payment is required for the services of a general practitioner, whereas treatment at the County hospital is free to the indigent.

Table 3
Diagnosis of schizophrenia

	Chicago (*No. of cases*)	*Edinburgh* (*No. of cases*)
Schizophrenic	7	20
Probably schizophrenic	5	5
Not schizophrenic	36	52

Table 4
Diagnosis of alcoholism

	Chicago (*No. of cases*)	*Edinburgh* (*No. of cases*)
Alcoholic	18	7
Probably alcoholic	5	7
Not alcoholic	25	63

There was a higly significant ($\tau=0{\cdot}28$, $P<0{\cdot}001$) difference in the length of time that the subjects had been living in lodging-houses. Typical was the fact that 47 out of 77 of the Edinburgh subjects had been in this situation for over five years, compared to only 12 out of 44 of the Chicago subjects.

Although only a small minority of the Edinburgh subjects (17 out of 77) admitted conflict with the law (fines, prison, &c.), nearly half (23 out of 47) of the Chicago subjects gave such a history ($\tau=0{\cdot}28$, $P<0{\cdot}001$).

The proportion of the subjects diagnosed as schizophrenic was higher in Edinburgh than in Chicago, but the trend did not approach statistical significance (*see* Table 3).

Fewer Chicago subjects denied use of alcohol ($\tau=0{\cdot}29$, $P<0{\cdot}01$) – 2 out of 47 compared with 16 out of 62. Table 4 shows that correspondingly more were identified as suffering from alcoholism ($\tau=0{\cdot}33$, $P<0{\cdot}001$).

There was no significant difference in the proportions of personality disorder, mental subnormality, organic brain syndrome, or affective disorder between the two populations.

The scores in the Paired Associate Test were rather higher ($\tau=0{\cdot}15$, $P<0{\cdot}08$) in the Chicago series, and the numbers scoring less than 16 (i.e. presumably showing impaired cerebration) were 19 out of 46 and 16 out of 75 in Chicago and Edinburgh.

The Personal Illness score of the Symptom-Sign Inventory gave somewhat higher figures in the Edinburgh subjects, but the trend was not significant. Whereas 29 out of 74 subjects in Edinburgh exceeded the cut-off point, only 13 out of 46 did so in Chicago.

Discussion

It is rare to have the opportunity to carry out a cross-cultural study that is not beset with problems of validity in terms of definition, diagnostic criteria, or experimental design. It is possible to avoid all of these by having the same person carry out the research in both cultures. On the other hand, one still encounters the problem of language. This time it is not the problem of 'do my collaborators over there know exactly what I mean', but 'do the subjects that I am talking to in Chicago understand the same things by my questions as the subjects that I spoke to in Edinburgh?' This is an imponderable. My impression is that the extent of distortion from this point of view in the structured tests was small, but I must confess that I am still happier about detecting formal thought disorder in someone using a thick Scottish brogue than when faced with a poorly articulated American drawl.

In the following paragraphs extensive reference is made to the study of Chicago's Skid Row by Bogue (1963) and the survey of Homeless Single Persons carried out by the British Government (National Assistance Board 1966). These will be referred to simply as Bogue and HSP.

As far as is known, this is the first time that these two definitive studies have been subjected to comparison in a scientific paper. Figures are compared from these two sources to elucidate the findings of the present study.

I found more women in Edinburgh by virtue of finding none in Chicago. Bogue did claim 3·7% of women in his sample, using a slightly different definition of 'Skid Row'. HSP records an average of 6·7% of women in Great Britain's lodging-house population, but the proportion was higher in Scotland, and in Edinburgh both C Holtom (1959, unpublished) and I estimate women to form about 14% of the lodging-house population. In any event, it is clear that Skid Row is a male-dominated area on both sides of the Atlantic.

Is the Chicago population more transient? Maybe not; certainly mobility is surprisingly low in both countries. Exact comparison is not possible, but 63% of HSP subjects had been at the same address for 6 months and 68% of Bogue's sample had been in the same hotel or residence the previous year (Bogue, page 15).

Are they less elderly? HSP found 35% were aged 60 years or more, compared with 31% in Bogue, so there is no great overall difference. However, HSP also showed that the population is more elderly in Scotland, which may explain my finding.

Are they more likely to have been married? This suggestion is confirmed – 51% of Bogue's sample were single compared with 67% of those in HSP.

Had they spent a shorter time in the Skid Row way of life? Bogue gives 52·5% as having lived this life for 5 years or more (Bogue, page 112), the figure from HSP being 59% (HSP, page 40) rising to 70% in the case of those aged 50 or over (HSP, page 42). Clearly the age factor may have played a part in the difference that I found.

Conclusions

Despite their imperfections there are striking agreements between the results of my own study and the results of comparing Bogue and HSP. To start with there are strong similarities in the general characteristics of homeless persons in Britain and the USA. This population is predominantly male, and elderly. Many of the men are retired, but on any one day a substantial number of them will be employed. The average man, more likely than not, will have been living at the same address a year ago. The tramps have largely disappeared from Britain, as have the hoboes from the United States. We are left with the non-migratory non-workers and the non-migratory workers, but many men are working one day and are unemployed the next. This is less so in the UK where the generous state welfare services prefer to sponsor a 'settled way of living' than in, for instance, Chicago, where the less generous city authorities do not pay the piper, and the free enterprise spot-labour market, with its humiliating daily queues, calls the tune.

The men, then, not to say the hotels that they live in, are remarkably similar in both countries.

The similarities are certainly more striking than the differences. In Britain, two-thirds of the men are likely to be single, whereas about half of the men in Chicago were married at one time. Other differences are less in degree – the US homeless population being not quite so old, but even more male dominated.

In these findings my study is in agreement with the larger studies. Neither HSP nor Bogue's study incorporated routine mental examination by a qualified person. From the psychiatric point of view, when I compare my Chicago sample with my Edinburgh sample, the similarity

is again more striking than the differences. The main similarity is, of course, that in both samples the majority of the subjects were suffering from psychiatric morbidity demonstrable at a single interview. In Chicago alcoholism was more common than in Edinburgh ($P<0{\cdot}001$), the prevalence of schizophrenia tended to be lower, but neither this nor the differences in the rates for personality disorder, mental subnormality, organic brain syndrome nor affective disorder were statistically significant.

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As Dr Priest says, the similarities are more striking than the differences between the doss-houses of Chicago, Edinburgh and London. Moreover, such differences as are present in, for example, the employment status, civil state, racial and religious affiliations and prevalence of alcoholism, reflect the general population of the cities and their surrounding countryside from which are drawn the inhabitants of these homes, rather than any different philosophy or organization within them. They are full mostly of older single or formerly married men with poor work records, starting from families often belonging to the lower social classes and with greater than average instability. The men have few endowments of their own as regards intelligence and character, many developing later further handicaps of frank psychological illness and/or physical disorders such as epilepsy. Though neither author has much information, it is probable also that many of them have criminal records, usually for petty offences. There do, however, appear to be a few apparently 'normal' men, to whom the doss-house life appeals, perhaps because it is fundamentally asocial, anonymous and undemanding.

One of my former students, now Dr A K Clarke, carried out a few months ago a brief census of the inhabitants of Booth House, the Salvation Army Hostel a few yards from The London Hospital, and most of his findings confirm what we have already heard. This house has the same mixture of transients, some of whom are drifting, psychiatrically ill and often unemployed, but others are passing through, usually for sound employment reasons. In contrast to the general population of Tower Hamlets, there were almost no Indians, Pakistanis or Jews, perhaps because in these groups family ties are still very strong.

These surveys pose a number of interesting psychosocial questions that are easier to put than answer, since we know how difficult these men are to interview. Their tenuous relationships with society make it difficult to contact their families, if they have any, and any other social agencies with which they may have been involved, in order to fill out their own rather meagre stories.

(1) Is there a 'stage army' of men revolving around prisons, mental hospitals, casualty wards and doss-houses, who in total at any one time are not numerous but give much trouble to numerous authorities? The Elizabethans spoke of rogues and vagabonds, so this group has long been recognized.

(2) Why do only a small percentage of patients suffering from alcoholism, schizophrenia and personality disorders adopt this way of life?

(3) What happens to women suffering similar deprivations and illnesses? Do they keep up the numbers in the back wards of chronic mental hospitals, which are well known to contain more women than men in this country, or can women more successfully live alone in digs or lodgings?

(4) Doss-houses clearly provide an important social service, largely as the result of the devoted work of voluntary agencies. It is most important to know whether the mental health services could do more: (*a*) to diminish the numbers of people drifting down into doss-houses; (*b*) to help the men in them to rehabilitation or a more satisfactory social adaptation elsewhere; (*c*) to improve the quality of the care while they are there. In this last area, I suspect that staff training and support are perhaps more important than individual casework with particular men. There may also be a case, as Dr Lodge Patch says, for considering smaller hostels specializing in particular subgroups now all mixed up together, for example, the transient workers, the chronic psychiatrically ill, the elderly and infirm.