use of 'speed' spread to most cities, being taken by a considerable number of teenagers in order to extend and intensify their weekends. Their use and popularity has declined in recent years, but still presents problems. The main dangers of chronic amphetamine usage are habituation and psychosis. The features of the latter are indistinguishable from schizophrenia and is treated by withdrawal of the drug and barbiturates. Facilities for treating speed freaks are as woefully inadequate as those for treating barbiturate addicts.

Heroin is the drug which seems to have created the most furore both inside and outside the medical profession. This might be considered a little out of proportion when one considers that there are just over 2000 registered addicts compared with about 400 000 alcoholics. There are of course many junkies who are not registered, and many who are supplementing their supplies with street heroin or other drugs, mainly barbiturates. Pure heroin is virtually unobtainable outside the addiction centres and the drug traffic concerns an impure version known as Chinese heroin. This contains a varying quantity of the actual drug and is frequently adulterated with chalk or talcum powder. It is hard to assess the real effects of the setting up of heroin addiction centres in 1968. Although the number of registered addicts has stabilized, since then, the morbidity and mortality of addicts seems hardly affected – mainly due to overdoses, suicide and septic complications. We at Release do not of course treat addicts, but provide general supportive therapy.

I said previously that there is no such thing as a drug problem, but I seem to have spent the entire time talking about drugs. I feel this was expected of me, but I am uncomfortable about it. I do not think drug use is confined to social misfits, whatever they might be. I see the Release client with a medical problem, who smokes cannabis occasionally and takes LSD twice a year, as no different from the business man in my surgery who smokes cigarettes and drinks too much at Christmas and on holiday. He is certainly doing himself less physical harm. Society has constructed pseudo-medical and social arguments to justify the hypothesis that unearned pleasure (i.e. drug use) is immoral. Release does not accept those arguments, and attempts to help people in a non-moralistic and non-patronizing way. I think we have a lot to learn from them.

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Homeless People as an At-risk Group

The social misfits I wish to discuss are homeless destitute people who live in Lodging Houses, Reception Centres, or sleep rough. They are part of the Registrar General's Group 5, but they are the very bottom end of it. The Registrar General's fifth group contains some seven million people and an estimate of the number of homeless people in 1965 was about 30 000, roughly 1 in 200 of group 5 and one in 2000 of the population.

Their medical care presents problems because not only are basic necessities like food and clothing in short supply in their case, but they are also homeless, without the usual comforts of family and simple possessions. They are also frequently friendless, and often without work. They are also usually single.

Table 1 shows how homeless people were accommodated in the United Kingdom in 1966 (National Assistance Board 1966).

Table 1

Accommodation of homeless people in the UK in 1966

	Men	*Women*	*Total*
Common lodging houses	26 884 (93%)	1905 (96%)	28 789 (93%)
Reception centres	9 232 (4%)	30 (3%)	1 262 (4%)
Sleeping rough	920 (3%)	45 (2%)	965 (3%)
Total	29 036	1980	31 016

It will be seen that men outnumber women by about 12 to 1, that Common Lodging Houses provide shelter for the majority, and that the numbers sleeping rough are not much less (in the case of women they are more) than those in Reception Centres.

As to marital status (David Tidmarsh 1972, unpublished communication), in Common Lodging Houses 67% were single, 18% were married, and 15% were widowed or divorced. The comparable figures for Reception Centre users is 71% single, 17% married, and 12% widowed or divorced. If one lumps in the single with the widowed or divorced, the figures for effectively single people becomes 82% for Common Lodging Houses and 83% for Reception Centres. However, even these figures are misleading for both types of lodging are sex-segregated, so that for practical purposes all homeless people are without close association with the opposite sex.

About work, the figures show the same decline from Common Lodging Houses, through sleeping rough, to Reception Centres, and prison experience is similar (Table 2).

I would have liked to fill in something of the historical background of homeless vagrancy.

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Table 2
Employment and experience of prison

	Common lodging houses (%)	*Sleeping rough* (%)	*Reception centres* (%)
Employed	47	40	20
Unemployed	53	60	80
Been in prison	20		60

Social attitudes have hardly changed since the dissolution of the monasteries, when the State and the parish took over from the Church the task of looking after the homeless, until the beginning of this century, but since then there has been change especially in the last ten or fifteen years. But though this is a fascinating story it would take up far too much of our time. Let it suffice that attitudes have changed and that we are still changing them and probably being changed by them.

These figures therefore show that, compared with the population as a whole, this group are homeless, without the society of the opposite sex, probably without work, and a high proportion will have been in prison. They are also likely to have a high incidence of illness. Since morbidity rises as the Registrar General's scale is descended it is not surprising to find very high morbidity levels at the very bottom of the scale.

Evidence from Surveys

In a survey of Glasgow lodging houses, Laidlaw (1956) found that 12% of the men had significant physical illness, among them 29 who were blind. He did not report much psychiatric illness.

Scott *et al.* (1966) studied lodging house dwellers who attended a general practice in Edinburgh. They found them to be frequent users of medical services, and were referred to hospital three times as often as other patients of the practice. Chronic bronchitis, pulmonary tuberculosis and malignant disease showed a high incidence. Gross psychiatric disorders were found in 12% and chronic alcoholism in 9%. Their conclusion was that lodging house dwellers showed a higher than average morbidity.

A survey by the British Thoracic and Tuberculosis Association in 1971 noted six Common Lodging House residents who had died from unrecognized tuberculosis or to have been admitted to hospital in a moribund state. This raises the probability that for these people there is a low standard of care, and supports the opinion expressed by officials of the Salvation Army that medical care for their residents is hard to obtain.

In a 1964 psychiatric survey of Edinburgh Lodging House residents, Priest (1970) interviewed 77 men and found schizophrenia in 26%, personality disorder in 12%, alcoholism in 9%, organic brain damage in 7% and depression in 5%.

In another psychiatric survey, this time in a Salvation Army Hostel in England in 1969, Crossley & Denmark found 20% to be suffering from schizophrenia and 34% had been in mental hospitals. Personality disorders, mental subnormality, alcoholism, behaviour disorders and suicide attempts were all noted. These authors drew attention to the fact that untrained staff were dealing with a population with a very high proportion of mental illness.

Lodge Patch (1970) in a psychiatric survey of two London Salvation Army Hostels, found 15% of schizophrenia, 19% alcoholic, and no less than 50% showing personality disorders. He thought only 11% could be classed as in normal health. Table 3 summarizes the foregoing findings. David Tidmarsh, to whom I am indebted for much of the foregoing, sought to make an estimate on the basis of these surveys of the amount of psychiatric illness in this population. Urging some caution in using figures from such small surveys, he nevertheless concluded that the lodging house population of roughly 30 000 contained 6900 to 13 000 suffering from some mental disorder, and 2700 to 6300 alcoholics.

At all events it seems inescapable that homeless people using Common Lodging Houses suffer from a very high incidence of illness, both physical and mental, and it may be that they do not enjoy a very high standard of medical care. One may think that they live in a state of deprivation which most people would find intolerable.

People Who Live Rough

Not much is known about people who live rough. They live on the streets and sleep in derelict houses, building sites not guarded by guard dogs,

Table 3
Comparison of psychiatric surveys (percentages)

Sources	*Schizophrenia*	*Personality disorder*	*Alcoholism*	*Organic brain damage*	*Depression*
Priest (1964)	26	12	9	7	12
Crossley & Denmark (1969)	24				
Patch (1970)	15	50	19		

or on railway stations or park benches from which they are often evicted by the police. Some also sleep in church crypts and in buildings adapted as shelters by private organizations and charities.

Holloway (1970) studied a group of 25 such men under 30 in Leeds; 44% had lost at least one parent before they were 10, and of these 75% had a prison record compared with only 20% in those from more stable homes, 50% were severely inadequate, 8% psychotic, 12% depressed, 8% epileptic and 60% alcoholic.

Edwards *et al.* (1966) interviewed men attending a soup kitchen in Stepney and found a high proportion of alcoholics, of whom more than half were methylated spirit drinkers.

Obviously this group suffers from the same type of illnesses and tendencies as the lodging house inmates, and, I may add, those of Reception Centres as well. One may note the emergence of a broken family background as a factor.

The Reception Centres

I want now to turn to the Reception Centres because this is the area of my personal experience. I have been Visiting Medical Officer at the largest of this country's Reception Centres for the past twenty-four years. Some 8000 men pass through this Centre every year, and they represent almost half the total population in this category. They are even lower in the social scale than the lodging house dweller, and possibly even lower than those who sleep out.

Up till the National Assistance Act which came in with the National Health Act after the end of the last war, homeless and destitute people made use of the many casual wards dotted about the country, and so were a dispersed population. After 1948 they were centralized into much larger Reception Centres and this centralizing was further intensified, since the policy of the Assistance Board in those early years was to reduce the total number or Reception Centres as well. From 215 in 1948, the number has dwindled to 21 in 1970. Centralization has many disadvantages, but in this case the outcome has been almost wholly beneficial. For the first time it has been possible to study a hitherto scattered population, and in doing so a welfare staff has been collected who have been able to gain experience and skills which in former times would have been impossible. At all events much information has accumulated on the factors which lead to destitution and the medical problems have gradually emerged.

David Tidmarsh (unpublished communication), who carried out a survey between 1970 and 1972, described the inmates thus:

'Men who use Reception Centres are likely to have come from families which are poor, large and disrupted, or in which problems occur during their childhood. They possess few skills with which to enter the labour market, becoming unskilled manual workers moving around in search of work. They are concentrated in single sex occupations which isolate them from the rest of society. They are generally out of touch with relatives even where they exist and their single status increases their vulnerability. In addition to these handicaps they are very likely to acquire a handicap due to illness which further reduces their ability to compete for jobs and homes. We have shown that those who remain homeless and destitute for a long time and those who use the Centre most are likely to have more handicaps of every kind than those for whom destitution is a temporary or short-lived experience.'

Lack of Primary Care

This depressed population lacks the services usually obtainable from a family doctor, and it seems to me that the provision of primary medical care for them must be the first step in solving their problems. Incidentally, 13% of men using the Centre have never been on a doctor's list: 24% had been on such a list but had left it; leaving 63% who were nominally on a doctor's list. Almost all of these, however, have doctors so remote from the Centre, often in other towns, or even in Scotland or Northern Ireland, that for practical purposes they do not have a family doctor. With this deficiency in their medical care it is not surprising that they tend to seek advice, if at all, at a much later stage in their illnesses than we are accustomed to, and their maladies are therefore correspondingly further advanced. Many years ago I was called to a man who fell down dead in the yard after eating his dinner in the dining hall. Post-mortem showed acute tuberculosis pneumonia. Caring for people who have no home requires some ingenuity and flexibility. They have no private bed of their own to retire to, no wife or other relative to give them a cup of tea or a hot water bottle, or indeed any of the kind of social back-up which one takes for granted in one's ordinary patients.

The illnesses of the destitute: Those illnesses they are especially associated with are: Vermin, such as lice infestation, malnutrition, pulmonary tuberculosis, physical handicaps: loss of limb or lessened sensory acuity, mental illness and mental defect and brain damage, epilepsy, enuresis, alcoholism and drug abuse, personality disorder.

I don't propose to go into these in any detail but some points are worth raising. Of the men using the Centre 20% are physically disabled. This can only mean that the normal arrangements made under the welfare state for caring for disabled people has broken down in some way or another. Similarly with the 2.8% who suffer from epilepsy.

One would have expected that some welfare system would have looked after them at an earlier stage. This figure of 2.8% is about six times the rate of incidence of epilepsy in the population as a whole. Men who fail to come to terms with their fits easily decline into destitution. Often they have lost job after job because their fits are so frightening to lay people, and are feared especially by employers anxious about possible accident claims. On the social side the epileptic's decline is just as catastrophic. Most are subject to incontinence of urine in nocturnal fits. In lodging houses, Rowton Houses, Salvation Army or Church Army Hostels, the penalty for a wet bed is dismissal, and often semi-permanent 'barring'. If rent has been paid in advance, the balance is retained by the management to help defray the necessary treatment of the mattress. The result is that the incontinent epileptic is faced probably in mid-week with no money and no lodging. His recourse is to the Reception Centre.

The same social problem dogs the adult enuretic. Stone (1973), who regards enuresis as a stepping stone to homelessness, estimates that there may be as many as 77 000 adult enuretics.

For epileptics and enuretics alike, the manifest connexion between their disability and their destitute state inevitably begets a sense of injustice and despair, and not seldom a depressive illness as well. They need long-term continuing medical supervision, and as we have seen, this is difficult to provide for the homeless.

Hospital Admissions from the Centre

Admissions for pulmonary tuberculosis rose steadily until 1956. This was mainly because of a campaign to detect this infection after it was recognized, mostly due to the work of J M K Marsh (1955, 1957) that Reception Centres and Common Lodging Houses provided a hidden pool of tuberculous infection. Frequent mass X-ray surveys at the Centre and radiological screening, where practicable, of new arrivals revealed a tuberculosis rate of 20 per 1000. The average found by the mass X-ray service for the general population in 1961 and 1962 was 1.3 per 1000, so the Reception Centre rate represents about 15 times the normal.

The decline in hospitalization after 1956 probably reflects the effect of chemotherapy for this disease, but the screening procedures still show a rate of infection more than 10 times the normal.

Mental Illness

Mental hospital admissions have risen steadily since 1950, and especially since 1959. This probably reflects the tendency fostered by the Mental Health Act of 1959 to return some long-stay patients to community care, that is to say to the care of their families with some support from mental welfare services. For the homeless, of course, the essential factor here is missing – that of family back-up, and a large number of chronic schizophrenics discharged after 1959 from mental hospitals soon joined the ranks of the destitute and gravitated to the Reception Centres. Once there, they inevitably deteriorated and required readmission. Improved by hospital care, they once more came up for discharge and the whole cycle started again. There is, however, a more cheerful aspect emerging in recent years when the readmission rate has been substantially cut because the use of long-acting phenothiazines has enabled the benefits of hospital treatment to be maintained outside hospital. But it remains an unsatisfactory situation that something over a third of the users of Reception Centres have severe mental illness.

Alcoholism

Another third of this population is made up of alcoholics, but I do not propose to say anything further about this vast problem, because it is the subject of another contribution (Pollak 1974).

The Idea of an At-risk Group

It is becoming apparent that this very depressed group at the lowest end of the Registrar General's fifth group presents certain characteristics and are at risk for certain diseases. (Table 4.)

These people do not take kindly to appointment systems, often create difficulties with receptionists, and are shunned by other patients in the waiting room. Furthermore, they do not fit into NHS clerical arrangements, being of no fixed abode, usually lacking a medical card, and having no medical records. They therefore tend to start on the wrong foot and to irritate doctors.

But this adverse reaction should alert one, and if further enquiry elicits some of the characteristics we have listed, the realization will take shape that here is a patient with serious problems, who is in danger of a defined group of illnesses, and is liable to complete social decline. To prevent these consequences, and to bring effective treatment to bear in spite of the lack of social back-up,

Table 4

Characteristics of an at-risk group

Characteristics	*Risks*
Homelessness	Vermin infestations
Single status	Poor nutritional state
Lack of family and deprived background	Tuberculosis
	Epilepsy and enuresis
Poor employment record	Physical handicap
	Mental illness or defect
Possible prison record	Alcoholism, drug abuse
	Personality problems

requires considerable and imaginative endeavour on the part of the primary care physician. It usually means mobilizing the social services on the patient's behalf and trying to overcome the adverse reactions which these angular customers evoke just as inevitably in social workers as in ourselves.

I think one may say that enough is now known about destitute homeless people, their characteristics and problems, the risks they are exposed to, and the difficulties in the way of helping them; and that being quite a large group they offer a serious challenge to family doctors.

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The Vagrant Alcoholic

Some months ago, I was asked to see a 49-year-old Scotsman, at the Maudsley Clinic for Alcoholics. The consultation was somewhat bizarre – the patient was flanked by two sturdy prison warders and handcuffed to one of them. All 3 had come 80 miles from the remand prison of a small coastal town. The judge who was trying the case, had requested an expert opinion on the suitability of the prisoner for intensive, rehabilitative hospital care instead of a long-term prison sentence.

The prisoner had been brought up in a small Scottish town. His father had abandoned the family when the prisoner was 5, leaving his mother to fend for herself and her 5 children. On leaving school at 14, he had a variety of unskilled jobs, before joining the Fleet Air Arm at 19. It was here that he learned to drink heavily. He discovered that drinking helped him to overcome his painful shyness and lack of self confidence. After the War, he had a series of jobs, including nursing, but drink now dominated his life. He could settle at nothing, and girls shied away from him. When he was 29, his family arranged for him to emigrate to Australia, where another brother had successfully settled, but, 18 months later, he was deported back to England, with 18 charges of drunkenness and petty thieving.

By now, he was estranged from his family and life was at Skid Row level. For example, at the age of 35, he had a record of 47 convictions with increasing prison sentences. Last year, he was caught stealing 4 pairs of ladies' tights in a supermarket. He was given a suspended sentence. He joined a rehabilitation course for alcoholics, and, for the first time in years, he was 'dry', for a few weeks. He managed to join a firm of solicitors as a messenger, but was dismissed within a month for drinking. Whilst he was collecting his cards in his employer's office, he stole a cigarette lighter. It was on account of this theft that he was in prison, awaiting a four-year sentence, unless my report recommended the judge to consider other, perhaps more effective, methods.

I asked my patient why he insisted on these repeated, clumsy, unprofitable acts of thieving, when, at no higher risk, he could try his hand at a lucrative bank robbery. He replied, with indignation 'I am not a criminal!' He was, of course, quite sincere in his belief, and, assessing this man's history, I have no doubt that his so-called criminality is part of his alcohol dependence. He is right – no self-respecting criminal would allow himself to be locked away for a cigarette lighter or 4 pairs of ladies' tights.

I felt ashamed of my inadequacy to help this man. I had no hesitation in advising the court that a renewed prison sentence could never correct this patient's disorder, but, at the same time, I was well aware that specialized hospital services for alcoholics have no place for alcoholics of this type. Our own alcohol unit at the Royal Bethlem has only 12 beds, and these are booked months ahead. The few other alcohol units in the country operate a highly selective admission system, and a homeless, and hopeless, alcoholic such as this, would hardly qualify for consideration.

Nor is this an isolated case. Each year, 80 000 cases of drunkenness offences alone file through the courts, which are, therefore kept busy with chaotic life situations of this kind.

In 1967, the Criminal Justice Act made provision that drunkenness offenders need no longer go to prison, provided the Home Secretary was

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