the amphetamines, by great statesmen can give rise to great alarm in their colleagues. This is because, if there is a sudden increase in dosage or if addiction occurs behaviour can become quite unpredictable, and can change from minute to minute.* One must distinguish between the heavy drinkers, such as Asquith and Churchill, and the compulsive alcoholic who cannot stop drinking once he has started on a bout. Family histories of compulsive drinking are not uncommon in those achieving the highest political offices in Britain.

Medical histories, and especially psychiatric ones, of the great in public life, are hard to come by. Medical records are often destroyed. Certain facts are deliberately omitted from medical notes by doctors fearful of their position and afraid of what would happen if they were found and read by anyone else. In consequence it is difficult to build up a factual body of knowledge on which to try and base certain rules which could minimize the chance of man destroying himself on earth though the choice of a potentially politically mad or drugged leader. From the Eagleton controversy it would seem to be the American view that a history of depression treated by ECT excludes one from office, but if treatment is by psychotherapy, as was the case with one prominent politician, election to the highest office is permissible. This is irrational and dangerous, for it may be purely a matter of chance to which kind of psychiatrist with what training one happens to be sent.

What is to be done? To eliminate all those in high public position in Great Britain who have had ECT, for instance, would deplete our ranks of some very competent people indeed, still more so if one extended the ban to all with a history of depression.

The onset of severe depression is generally obvious to those around the person concerned, and steps can be taken to cope with the situation. Indecisiveness rather than aggression, except against the self, is the most common result of depressive illness. Attacks of depression are consistent with complete recovery and with the highest degree of future efficiency and balanced judgement in between attacks. But switching to hypomania from the depression, as happened in a candidate for one of the highest offices in this country, can be very worrying indeed to all concerned. Fortunately, hypomania is a much rarer illness than depression and shows itself early in life in most instances. Even in dictatorships depression is not to be feared as much as is mania, drugs, or paranoia. Severe paranoid symptoms may occur for the first time in a depressive illness, as happened in the case of Forrestal who committed suicide after World War II. Here suicide probably only resulted because ECT was withheld.

Secret Service or Press knowledge of mental illness in candidates for high office is rarely available to the electorate, and if it were could be put to misuse by one politician trying to discredit another. Such information can only be used, as at present, in trying to avoid the wrong people getting selected for the highest non-political administrative and government posts. But even here one of the writer's own leucotomized patients obtained a high security clearance, showing that even the Secret Service agencies can be misled.

What of the doctor's duty to the patient in keeping his psychiatric secrets if he is a person in high office, or a candidate for it, and where national or international damage could be done? Here the highest psychiatric skills are needed to assess when somebody is, or is going to be, dangerous, and decisions should not be made by others than specialists. And where should the line be drawn about informing people of one's fears and possibly destroying a patient's career as a result? Modern psychological test techniques are certainly not the answer—in my own experience such tests have missed very disturbed patients under treatment by large amounts of drugs, who have been declared suitable for high administrative posts in industry at home and abroad.

WILLIAM SARGANT.

* Last month's revelations in the *New York Times* concerning President Kennedy are relevant here.

THE HOMELESS

The population of homeless persons, as seen in Chicago, was classified by Anderson (1923) as: (a) hoboes—itinerant workers; (b) tramps—itinerant non-workers; and (c) bums—non-itinerant non-workers. In this country, until a few years ago this population was showing a steady reduction in numbers. There were certainly fewer of these men and women than in the nineteen-twenties and thirties, when there was large-scale unemployment.

In the post-war years they were also less conspicuous. The legislation in force before the war encouraged men to drift round the country as tramps, sampling the handouts of one local authority after another. They lived for two days at a time in the casual ward of the Poor Law Institution (the 'spike') before tramping on the twenty miles or so to the next one.

After 1948 the policy of the social services was to

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encourage a settled way of living for these vagrants. The men were, as a result, better off if they stayed in one place—usually a common lodging house or mission hostel—where they were looked after by the local representative of the National Assistance Board (N.A.B.).

This policy was at least successful in making the countryside tramp a figure of relative rarity. In the survey on 'Homeless Single Persons' carried out by the N.A.B. in 1965 less than a thousand were found 'sleeping rough' on the night of the survey; less than two thousand were occupying that post-war successor to the 'spike'—the Reception Centre. The remainder of the 30,000 homeless were living in lodging houses and hostels, and of every hundred living in such a hostel on that day 62 per cent would have been living in the same hostel six months previously. At that time the numbers of men in these hostels seemed to have been falling gradually ever since the war.

Since 1965, however, there has been increased concern over the 'revolving door' through which passes the stage army of men, at one time mental hospital patients, at another petty recidivists, or yet again to be found in the anonymous world of the common lodging house. And now the voluntary organizations that help care for homeless men (and women) have claimed that the numbers of homeless have increased enormously.

The most recent pamphlet to appear on the subject is *Mind* Report No. 7, with the title of 'Hospital, Prison or Pad'.* Put out by the National Association for Mental Health, it claims that the number of rootless people is growing, and asks both central Government and local authorities to tackle the problem. It quotes a Christian Action survey putting the total number now at 50,000, and it gives an estimate (from St. Mungo's Community) that in September 1971 there were 20,000 'sleeping rough' in London. Clearly these figures demand careful checking, but it would be generally admitted that 'neither central Government nor the Social Services Departments have as yet come to grips with the problem'.

Efforts are certainly being made, and four Government-sponsored reports have appeared on the homeless in the space of eighteen months (D.H.S.S. 1971; D.H.S.S. 1972(a); D.H.S.S. 1972(b); Welsh Office 1972).

There are a number of things that are still not clear. Firstly, what is the reason for the emergence of the problem? The *Mind* Report notes how limited are the facilities for the psychiatric treatment in prison of offenders and those on remand—'Too often short-term prisoners are not referred to a consultant because of the financial implications'. What about premature discharge of psychiatric patients from hospitals? One of the Government reports (D.H.S.S. 1972(a), p. 29) recommends that 'Hospitals should not discharge their patients unless they are sure that suitable accommodation is available for them in the community', a recommendation that is obviously laudable, but is strangely piquant in view of the delicate relationship that exists at present between hospital psychiatrists and local authority (generic) social workers.

Although it has been established now beyond reasonable doubt that the majority of homeless single persons are suffering from overt psychiatric morbidity (Priest, 1970, 1971; Lodge Patch, 1971), it is not certain how many have had formal psychiatric treatment for their condition. In a random survey only 14 per cent admitted mental hospital admission —by comparison 22 per cent admitted conflict with the police (Priest, 1971). It may well be that a large number of homeless men opt for the common lodging house way of life rather than seek the help of orthodox psychiatric services.

Another point that is not clear is what a psychiatrist would do with this population if he were given a free hand. Apart from the small numbers of men with organic brain disease and mental subnormality, does he have really effective treatment for the larger proportion of subjects with personality disorders or Skid-Row alcoholism? The numbers who show straightforward depressive illness are small. An intriguing problem is that of the schizophrenic, which may be untreated virgin territory, but on the other hand may have the poor prognostic feature of chronicity. Perhaps someone can be persuaded to take on an unselected sample of homeless men for treatment. At present those coming up to soup kitchens and welfare agencies are far from representative.

'Hospital, Prison or Pad' calls for a new Government survey to get up-to-date facts, for more facilities for treatment and social work support, and for more accommodation for single homeless people. The last of these may be necessary, but this has yet to be proved. The first two recommendations are eminently reasonable.

Will these proposals do more than contain the problem? We still do not know sufficient about why men get on to Skid Row, nor how to get them out again. The new reports brings us squarely face to face with the problem. They do not give us the answers.

R. G. Priest.

* Obtainable from the N.A.M.H. Bookshop, 39 Queen Anne Street, London W1M OAJ, price 8p including postage.

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PSYCHIATRY IN THE 1870s

Chloral Hydrate

[from the Journal of Mental Science 1871]

[July 1871, p. 238]

In the report of the Royal Glasgow Asylum, Dr. Mackintosh says:

'The patients capable of giving correct answers say its effects are most soothing and agreeable to their feelings . . . In many instances, especially in acute mania, it has completely failed, and markedly so in cases of recurrent mania.'

In the report of the Joint Counties Asylum, Carmarthen, Dr. Hearder remarks:

'As regards the remedial value of medicines used, the chloral hydrate certainly claims the foremost place. In the majority of cases it can be relied on to produce sleep . . . In several cases I have noticed that it has caused a state of chronic lachrymation, the features being contorted as in uncontrolled grief . . . One female suffering from chronic mania, the most violent and ungovernable patient in the house . . . became most markedly affected in this manner, calling in agonized tones on her "dear mother" and shedding tears copiously . . . the effect passed off in about an hour . . . This woman has become quiet, harmless, patient and obedient.'

[October 1871, p. 434]

In the *Archivo di Psychiatria*, Drs. Valsueni and Verga have published a series of experiments . . . They consider that the effects of chloral are similar to those of section of the cervical sympathetic, that it produces congestion of the optic thalami and corpora quadrigemina, and ultimately diminishes the heart's action.

January 1872, p. 519]

On the Relative Efficiency of Tincture of Hyoscyamus, Bromide of Potassium and Chloral, in Single Doses, on Maniacal Excitement. By John A. Campbell, Assistant Medical Superintendent, Garlands Asylum, Carlisle.*

'The method I adopted was this: I gave, first to all the excited, and second, to all the simply sleepless patients, on consecutive nights Tr. hyoscyami, pot. brom., and chloral, frequently repeating these experiments . . . I supplied the night attendant with forms showing the interval before the appearance of effects, and how long they lasted . . . The results show that chloral is the most certain sleep-producer, and acts more quickly. Bromide of potassium is a sedative and to a certain extent an hypnotic, yet it is not sufficiently powerful to allay intense excitement or to compel sleep where great insomnia exists.'

[*Chloral addiction.* Chloral hydrate became a drug of addiction very soon after its introduction in 1869. One of its best-known victims was Dante Gabriel Rossetti, who is said to have been introduced to its use in 1870 by James Stillman, an American artist. His friend, F. Shields, also a painter, likewise became addicted, but was able to wean himself from the drug after some five years. Oswald Doughty, in his life of Rossetti, quotes Shields as saying: 'It gives only death-like stupefaction without restorative power. The suicidal despondency produced by chloral I know too well.' In June, 1872, Rossetti suffered a psychotic episode, with persecutory delusions and auditory hallucinations. He was looked after mainly by his friend Dr. Hake, but Henry Maudsley was called in in consultation. Before the episode was over, Rossetti had made a suicidal attempt by swallowing a bottleful of laudanum.

Chloral hydrate was also given, ineffectively, as an analgesic. Napoleon III was being given large doses of it during the disastrous Sedan campaign of 1870 to alleviate the pain caused by stone in the bladder.]

ALEXANDER WALK.

* Of which T. S. Clouston was the Medical Superintendent—the work evidently inspired by Clouston's advocacy of therapeutic trials.

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