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No Fixed Abode

A Comparison of Men and Women Admitted to an East London Psychiatric Hospital

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There is little information available on psychiatric disorder in homeless women. This study compares clinical casenote information of all homeless women admitted to an East London psychiatric hospital from 1971–1980 inclusive, with information on a cohort of homeless men admitted during the same period. The results show that the women appear to have been socially more stable than the men prior to admission and yet they have less satisfactory admissions to hospital. Possible reasons for these apparent inconsistencies are discussed.

The relationship between homelessness and psychiatric morbidity has been studied by many people. Although there have always been people who have adopted a wandering lifestyle by choice, some of whom have written about their experiences (Davies, 1908; Orwell, 1933), others, less fortunate, have adopted a nomadic lifestyle as a result of illness. Ødegard (1932) studied the link between emigration and insanity and found that Norwegians in Minnesota were more likely to be suffering from schizophrenia than those in Norway and some of those who had emigrated were ill before they did so. The relationship between high admission rates for schizophrenia and populations living in impoverished inner city areas has been elucidated by Faris & Dunham (1939) in Chicago, Gerard & Houston (1953) in Worcester, Hare (1956*a*,*b*) in Bristol and Dunham (1965) in Detroit.

Research in the UK has been mainly centred on people living in common lodging houses or hostels, people living rough or using soup kitchens and people with no permanent address who are in prison or hospital. This last group are often referred to as of 'no fixed abode' (NFA) for the purposes of record-keeping. Operational definitions of homelessness are often of limited value as the boundaries are unclear. A survey carried out in 1965 of 'homeless single persons' (National Assistance Board, 1966) demonstrated the overlap between the populations of various establishments with those who slept rough. In general, the lower the standard of accommodation, from lodging house, to hostel, to reception centre, to the street, the greater is the proportion of physically and mentally disabled people found.

Surveys carried out in Salvation Army hostels (e.g. Crossley & Denmark, 1969; Lodge Patch, 1970) have generally concentrated on the assessment of men. However, Priest (1971) interviewed men and women in common lodging houses in Edinburgh and found that the residents were typically men in their 50s or 60s, who had resided in lodging houses for several years. There was a preponderance of Catholics from Scotland and Ireland and half the residents were unemployed at the time of interview. Psychiatric morbidity was diagnosed in 58 (78%) of the residents and the most common diagnosis was schizophrenia, in 25 residents (32%). Alcoholism was diagnosed in 14 residents (18%) and personality disorders in a further 14 (18%). Priest (1976) then compared the characteristics of men and women in Edinburgh lodging houses with patients from similar accommodation who were referred to a psychiatric hospital. Both populations were predominantly male, with approximately 18% of women. He showed that the patients presenting to hospital were likely to be younger and have a history of law-breaking, and were more likely to be diagnosed as alcoholic or personality-disordered. The lodging house residents not presenting to hospital were more likely to be older and suffering from schizophrenia. However, these studies did not attempt to compare diagnostic and social data of men and women.

A retrospective survey of patients admitted from NFA to a Birmingham mental hospital from 1961–1965 was made by Berry & Orwin (1966). The figures for 105 men and 40 women were combined and, in all, 49% of patients were diagnosed as suffering from schizophrenia and 28% were diagnosed as having a personality disorder. Some 90% of the patients were unemployed, 75% had been homeless for one year and 37% had a criminal

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record; 74% of patients had been previously admitted to a psychiatric hospital.

Reception centres were set up by the National Assistance Board after its inception in 1948 and were designed to give temporary shelter to 'persons without a settled way of living'. Surveys by Edwards *et al* (1968) and Tidmarsh and Wood (1972) demonstrated the high degree of social and psychiatric morbidity among the residents of the Camberwell Reception Centre. However, the demand on services there were such that nearly two-thirds of the mentally ill, three-quarters of the alcoholics and half of the physically handicapped new cases did not receive medical treatment at the centre and most were not referred elsewhere (Wood, 1976).

The studies dealing specifically with homeless or destitute women are few, and to date there has been little work delineating the characteristics of destitute women who are admitted to psychiatric hospitals. Higgs & Hayward (1910) described the generally poor working conditions and low wages which employed women endured. Low wages or an unwanted pregnancy could force women into common lodging houses or workhouses, where they lived with prostitutes and the mentally ill. In 'casual wards' for vagrants they were subjected to a dehumanizing regime, and in 1905, 9% of vagrants thus 'relieved' were women. Between the wars there were adequate numbers of lodging house places for women (Menzies, 1927), in which charges were higher than in similar institutions for men and the institutions were generally dreary. It was said that the women were more destructive than the men, were likely to steal the sheets and spent longer indoors, thereby increasing staffing and heating costs. Laidlaw (1956) surveyed women and men in Glasgow lodging houses and found that the women residents were more likely than the men to be or have been married and fewer of the women had been in prison. Few residents of either sex were employed and about 25% of all residents were mentally ill or mentally handicapped.

Digby (1976) in a nation-wide survey of hostels and lodging houses estimated that approximately 2200 women were living in such settings compared with 23 300 men. He found that the women were socially more stable than the men on several criteria including maintaining contact with relatives and holding a job. In contrast, a study of the residents of a hostel for homeless women (Brandon, 1973) describes markedly disturbed behaviour by the residents when the community opened, with violent acting out, overdoses and slashed wrists. Some social and psychiatric characteristics of destitute men and women in Dublin have been delineated by Fernandez (1984) in a survey designed to assess the needs of the homeless mentally ill, but there is a general lack of information about NFA women (Herzberg, 1984).

It is apparent that people of no fixed abode do not form a homogeneous group and rehabilitation strategies will depend on the availability of resources allocated to medical and social services. The situation is further complicated by a general lack of low-cost accommodation. Digby (1976) showed that there was a 17% loss of beds in hostels and lodging houses between 1965 and 1972. Furthermore, the number of reception centres throughout the UK had fallen from 270 in 1948 to 17 in 1970. However, moves have been made to establish smaller reception centres with the aim of providing a better assessment of the needs of referred clients. Leach & Wing (1980) found that these smaller centres were considered more acceptable by both staff and clients. Although the Housing (Homeless Persons) Act 1977 does state that priority for rehousing should be given to the mentally ill, homeless families generally take precedence over the single homeless.

There is evidence that destitute alcoholics can be helped by hospital rehabilitation programmes (Myerson & Mayer, 1966) or through contact made in 'shop fronts' leading on to placement in long term hostel accommodation (Cook, 1975). A flexible attitude to service provision is necessary when dealing with the needs of the destitute. Leach & Wing (1978) and Leach (1979) found that the effectiveness of the St Mungo's service for helping destitute men was improved by the use of 'action research' techniques where research findings were used to modify the original project. They found that the men who were suitable for placement in a rehabilitation scheme were assessed more effectively from a night shelter than a soup run. Similar flexibility in approach was shown to be helpful by Brandon (1973), who found that violence in a hostel for destitute women was reduced by the introduction of encounter groups and relaxation therapy.

The provision of rehabilitation facilities for mentally ill patients in the community is often inadequate, and official estimates of the number of hostel places required have been too low (Christie Brown *et al*, 1977). There is currently much worry about the move of patients from long stay hospital care into a community with a widespread lack of after-care facilities. There is anecdotal evidence that in the USA, where a programme of 'deinstitutionalisation' is well under way, the night shelters are filling with the mentally ill homeless (Bassuk, 1984).

Leach & Wing (1978) describe an 'enabling model' of rehabilitation for the destitute, with contact services on the street, leading on to chains of housing and vocational opportunities at closely spaced levels,

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with the necessity to provide facilities for those who cannot move upwards from any one level. They state that this policy would require adequate assessment of the projected need for facilities, proper funding and close co-operation between government, local authority and voluntary agencies.

Method

The study was based at the London Hospital (St Clement's), the psychiatric unit of an East London teaching hospital, which offers a catchment area service to Whitechapel, Stepney, Bethnel Green, Poplar and the Isle of Dogs. This is an impoverished Inner London catchment area which at the time of the 1981 census had the highest proportion of unemployed men of any of the Inner London boroughs (Office of Population Censuses and Surveys, 1982). The area contains a large number of hostels and lodging houses for homeless people.

Various studies of the homeless have used different definitions of homelessness. For example, the National Assistance Board (1966) survey included persons sleeping rough, and those using reception centres, lodging houses, shelters and hostels, together with the people seeking financial aid from the Board's offices. The present survey took the form of a retrospective casenote study. The entry of a patient into this study was initially determined by the patient being recorded as homeless on admission and therefore noted as NFA in hospital admission books kept in the medical records department. Thus the type of accommodation previously used did not determine initial entry into this study and neither did the length of time for which the patient had been homeless. However, attempts were made to note the duration of homelessness and previous use of hostels and reception centres in the subjects who were finally included in the study.

When the casenotes were studied in detail it sometimes transpired that patients recorded as NFA in the admission books did in fact have an abode to which they could return on discharge, but this information had not been available at the time of admission. It was decided to study only those patients who were homeless at the time of admission and who had no home to return to on discharge. Furthermore, it was apparent when studying the casenotes that some NFA patients had been transferred to hospital from prison, but otherwise met the criteria for entry into the study (i.e. they were homeless offenders who subsequently were thought to require hospital treatment). These patients, 10 men and 3 women, were included in the study and allowance was made in the analysis of the results where their admission from prison was likely to have affected the data.

Inspection of the admission books showed that between 1971 and 1980 inclusive, 79 NFA women had been admitted. Exclusion of cases not meeting the above criteria gave a final sample of 50 women.

Inspection of the admission books showed that 272 NFA men had been admitted in the same period. A subsample of every third admission during this period was taken to provide a sample of men of approximately equal size to the sample of women. The subsample of men chosen (90) was similar to those not chosen (182) in respect of age ($P<0.4$), number of previous admissions to the index hospital ($P<0.95$) and whether the current admission was on section ($P<0.3$). Exclusion of cases from the subsample not meeting the entry criteria gave a final sample of 63 men.

A schedule was drawn up to record the wide range of information found in the medical and nursing notes. For convenience, information is presented on the whole group of 113 subjects where there is no appreciable difference between the sexes for a specific item. It is acknowledged that information obtained from casenotes retrospectively may be unreliable in detail and that prospective studies are likely to yield the most accurate results. However, retrospective casenote studies of the hospitalised homeless have yielded valuable information in this field (e.g. Whitely, 1955; Berry & Orwin 1966). Information about individual items was not obtained for every subject, and percentages, where stated, refer to the percentages of valid cases (i.e. those cases where the information was available for a given item). Where there are significant differences between the sexes these are delineated and have been subject to non-parametric statistical analysis using a χ^2 test. For items where two by two tables were obtained, a Yates correction was applied. Only one item on the schedule, namely, age of subjects, was analysed by parametric statistics using a *t*-test. Statistical computations were performed using the Statistical Package for the Social Sciences (Nie *et al*, 1973).

Results

Social data

The mean age of all subjects was 38.6 years (s.d. 12.2). The mean age of the women, 36.3 years, was less than that of the men, 40.5 years. This result tended towards, but did not reach, statistical significance ($P<0.07$).

Thirty-eight men (61.3%) were single, compared with 18 women (36.7%). Only 24 men (38.7%) were currently or previously married, compared with 31 (63.3%) of the women. The women were significantly more likely to be married than the men ($P=0.02$). Thirty-two women (72.7%) had one or more children compared with 19 men (34.5%); significantly more women than men had children ($P<0.005$).

Virtually half of all the subjects, 53 (48.6%) were born in England, 17 (15.6%) were born in Scotland and 13 (11.9%) in Eire. Five subjects (4.6%) came from other parts of Ireland. Only 22 subjects originated from London. There were as many subjects registered Catholic, 42 (44.7%) as Church of England, 42 (44.7%).

Forty-five subjects (49.5%) had experienced a separation of greater than 3 years from one or both parents before the age of 15, and further information was available in 41 cases. Of these, in 17 (41.5%) the separation was due to the death of a parent and in 18 (43.9%) it was due to the separation or divorce of the parents. Only in two cases did the separation appear to be attributable to delinquent behaviour by the child. In general, the subjects came from large families with a mean of 3.5 siblings (s.d. 3.1).

The subjects left school at an early mean age, 15.3 years (s.d. 1.9), and left home at a mean age of 18.1 years

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(s.d. 3.7). It was noted that 21 of the men left home to join the armed services or the merchant navy and the records suggest that four of these men were subsequently dishonourably discharged. Eight women left home to get married or live with a boyfriend and four left for residential jobs as cleaners or nannies. Five women left home to attempt training as student or pupil nurses and another two women subsequently attempted such training. Further information available on six of these trainee nurses suggested that only one actually completed her training.

Nearly two-thirds of all subjects, 60 (64.5%), had been in London for more than 1 year, and relatively few, 12 (12.9%), had arrived in London within a week of their admission to hospital. Twenty-eight subjects (45.2%) had been in accommodation within a week of their admission to hospital and a further 19 subjects (30.6%) had been in accommodation within a month of their admission. Fifty-six subjects had previously used hostels and four subjects, all men, had used facilities for destitute alcoholics. Only one subject was recorded as having used a reception centre, but the index hospital was situated relatively far from reception centres. Only 37 subjects (32.7%) had definitely been living rough prior to admission and 24 of these had lived rough for less than one week. Places used included streets, parks, under bridges, shop doorways and a bombed site.

Fourteen men (29.8%) were in contact with their families compared with 18 women (64.3%). Contact was loosely defined to include any known personal contact or contact by telephone or letter within the previous 12 months. Women were significantly more likely to be in contact with their families than men ($P<0.008$).

Only two subjects were currently in employment at the time of admission. The mean time of unemployment for subjects was 25.6 months (s.d. 41.0). It was noted that 22 men had done casual labouring or building site work and 5 had been kitchen porters. Three men had been barmen, all of whom were diagnosed as alcoholic at the time of admission. Only nine men held a skilled or semi-skilled job when they last worked. Few jobs were coded for women. Seven women had worked in factories, three had done domestic work and three had worked in laundries. The notes suggested that nine of the women had earned money by prostitution.

The mean number of known admissions to other psychiatric hospitals was 2.5 per subject (s.d. 2.9). One subject had at least 20 previous admissions and only in 19 subjects was there no history of previous admission. In addition, 28 subjects (24.8%) had previously been admitted to the hospital under study.

Forty-one subjects (53.9%) had a history of imprisonment and 13 of these subjects (ten men and three women) were transferred to hospital from prison on the index admission. When all 113 subjects were considered, the men had a higher mean number of terms of imprisonment (1.5) than the women (0.6), and women were significantly less likely to have a history of imprisonment than men ($P<0.04$). However, when the data were renanalysed excluding the subjects transferred from prison, this result tended towards, but failed to reach, statistical significance ($P<0.1$).

Referral to hospital

In the following section only data on those subjects admitted to hospital from the community (53 men and 47 women) will be considered. Forty subjects (40.0%) were referred by doctors, who were generally casualty staff, 25 (25.0%) were self referrals and 28 (28.0%) were referred by the police. Overall, seven men (13.2%) were referred by the police compared with 21 women (44.7%). The women were significantly more likely to be referred to hospital by the police than the men ($P<0.001$). It was also apparent that Section 136 was being used more frequently by the police for women than men, although this result could not be subject to statistical analysis due to low cell frequencies in the χ^2 table. However, 16 women (34.0%) were admitted under Section 136 compared with 6 men (11.3%). In addition, women admitted from the community were significantly more likely than men to present via the emergency clinic rather than organised channels of referral ($P<0.02$).

The reasons for admission under Section 136 are noteworthy. Six subjects were walking or running dangerously through traffic five women and one man) and four subjects (all women) were admitted following assaults on people or property. Three subjects (two women and one man) were admitted having been found in varying degrees of nudity in a public place and three other subjects (one woman and two men) had been talking to themselves. Two subjects (both women) had been found on a railway track and two others (one woman and one man) had been fire-setting. One subject (woman) told the police that she was in America and demanded that they take her to India, and another subject (man) was found cutting his wrist. Seven out of the 16 women admitted under Section 136 (43.8%) were subsequently diagnosed as schizophrenic and a similar proportion of the men, three out of six (50.0%) of those admitted under section 136, were also diagnosed as schizophrenic. Two thirds of the non-schizophrenic men and women admitted under Section 136 subsequently received a diagnosis of personality disorder. The patients' diagnoses did not correlate with the behaviour precipitating their referral by the police. Violent, potentially self-destructive and bizarre behaviours seemed equally prevalent among the schizophrenics as the personality-disordered.

Admissions

The mean length of admission for all subjects was 30.7 days, with a large standard deviation (s.d. 35.8). Seven subjects had a stay of 24 hours or less and the maximum length of stay was 170 days by one subject.

Symptom/sign combinations were coded for each subject but were not analysed due to low cell frequencies. A summary of these findings is given in Table I.

Seventeen subjects had physical illnesses needing treatment (Table II) but only two subjects, both women, were transferred to a general hospital. One subject had a previously undiagnosed carcinoma of the breast and the other had a pyrexia of unknown origin which did not require treatment. Four of the 63 men (6.4%) suffered from epilepsy, a condition with a high psychiatric morbidity.

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TABLE I
Symptoms and signs by sex[1]

	Men	*Women*
Depression	29 (50.0%)	19 (41.3%)
Suicidal ideation	10 (17.2%)	9 (19.6%)
Delusions/hallucinations	16 (27.6%)	19 (41.3%)

1. Valid cases: 58 men, 46 women.

A diagnosis had been coded in the casenotes of 110 subjects and was recorded for this study, but the casenote diagnosis was not subject to formal validation by standardised measures. Where more than one diagnosis was coded, the primary diagnosis was used. Thirty-six subjects (32.7%) were diagnosed as schizophrenic, 26 (23.6%) as alcoholic and a further 32 subjects (29.1%) were diagnosed

TABLE II
Diagnosis by sex[1]

	Men	*Woman*
Schizophrenia	16 (25.8%)	20 (41.7%)
Depression	3 (4.8%)	6 (12.5%)
Mania	0 (0.0%)	1 (2.1%)
Alcoholism	22 (35.5%)	4 (8.4%)
Personality disorder	16 (25.8%)	16 (33.3%)
Organic	2 (3.2%)	0 (0.0%)
Other	3 (4.8%)	1 (2.1%)

1. Valid cases: 62 men, 48 women

as personality-disordered. Relatively few subjects, nine (8.2%), received a primary diagnosis of depression. Of the 13 subjects transferred to hospital from prison, seven (53.9%) were schizophrenic. A breakdown of diagnostic data by sex is given in Table III.

Excluding the use of benzodiazepines for night sedation, 82 subjects (72.6%) were treated with drugs and eight (7.1%) received ECT. The rest received milieu therapy with or without a benzodiazepine night sedative. Of the eight subjects (four women and four men) who received ECT, five had a primary diagnosis of depression and two others (one alcoholic, one personality-disordered) had attempted suicide prior to admission and were suicidal on admission. The other subject had a paranoid psychosis which was not diagnosed as schizophrenia.

Nineteen women (54.3%) were noted in medical or nursing notes as co-operating poorly with treatment, compared with 19 men (31.7%). Women were significantly more likely to co-operate poorly with treatment than men ($P=0.05$). Furthermore, 23 women (46.0%) took their own discharge, compared with 13 men (21.0%); women were significantly more likely to discharge themselves from hospital than men ($P<0.02$).

Sixty-three subjects (36.8%) were considered to have an improved mental state on discharge, while 48 subjects (43.2%) had not shown improvement. Follow-up was arranged for 35 subjects, of whom 17 subsequently attended.

In general, the hospital-based social workers attached to each consultant firm were involved in facilitating the after-care arrangements for the subjects who had a planned discharge. During the period covered by this study there was only one small psychiatric after-care hostel in the vicinity of the hospital under study and there were no group homes nearby. Of necessity, most subjects would be referred to voluntary agencies such as the Salvation Army for accommodation after discharge.

TABLE III
Physical illnesses present in the subjects

Sex	*Illness*	*Number of subjects*
Male	Epilepsy	4
	Tuberculosis	2
	Ischaemic heart disease/ chronic bronchitis	1
	Alcoholic gastritis	1
	Deep vein thrombosis	1
	Hypertension	1
Female	Carcinoma breast	1
	Pyrexia of unknown origin	1
	Epilepsy	1
	Buttock abscess	1
	Vaginal discharge/pelvic inflammatory disease	1
	Oedematous legs (? cause)	1
	Diarrhoea	1

Discussion

Despite the limitations imposed by undertaking a retrospective survey from casenotes, the results of this study correlate well with other studies of the destitute. The typical male subject in this study is aged 40, and single with no children. A significant proportion of the subjects are of Irish or Scottish origin. The fact that just under a half of all subjects were separated from their parents in childhood is similar to findings by Edwards *et al* (1966) and Priest (1976). The finding that nearly half the subjects had been in accommodation within a week of admission and only a third had been living rough, substantiates the clinical impression that NFA subjects often present to emergency hospital services when their accommodation has been lost. This is not to say that all homeless people behave in this way, as there is little doubt that many, including those who are ill, avoid all helping agencies completely.

Edwards *et al* (1966) noted that skid row alcoholics have often been in the merchant services and in this study 21 men had been in the armed or merchant services, although the contribution of conscription

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to this figure cannot be evaluated from the data. Of more interest is the finding that seven women had attempted nurse training. It may be that this group, having experienced emotionally impoverished childhoods, sought a sheltered, hierarchically determined environment similar to that provided by the armed or merchant services for men. Presumably all but one of the women were unable to cope with the emotional and intellectual demands made on them during the training.

Many subjects in this study had a history of previous periods in hospital and/or prison; these findings were similar to those of Berry & Orwin (1966). The use of Section 136 to admit many of the subjects, particularly women, is noteworthy. Szmukler *et al* (1981) reviewed all compulsory admissions in a London borough and found that NFA patients were over-represented among those on sections. They found that Section 136 patients were younger than those on other sections, often male and with a short episode of disturbance prior to admission. These patients often had brief admissions, and presented a nursing problem. They were also likely to abscond, a finding previously described by Sims & Symonds (1975). There are suggestions in the literature that NFA personality-disordered patients often know how to secure an admission (Berry & Orwin, 1966), and this may be particularly true of Section 136 patients (Szmukler, 1981). The finding that most subjects in this study were admitted through the emergency clinic is not a surprising one. Lim (1983) notes in a survey of the Maudsley Hospital emergency clinic that use of emergency services are often the only way that NFA patients can get help.

The actual determinants of the admissions for all patients were not specifically elicited in this study, but a third of all subjects were psychotic (i.e. deluded or hallucinated) and by definition were suffering from severe mental illness. The patients who were admitted on Section 136 had generally shown marked behavioural disturbance prior to admission. Patients fell into three main diagnostic categories, namely, schizophrenia, personality disorder and alcoholism, a feature in common with all other studies in this field.

When comparing the NFA men and women, the findings of this study appear paradoxical. The women appeared socially more stable than the men prior to admission, a finding similar to that of Laidlaw (1956) and of Digby (1976). Women were more likely to have been married, to have had children and to have remained in contact with their families. Furthermore, proportionally fewer women had been in prison than men. However, at the time of admission, women were more likely than men to have been referred by the police on a Section 136, and they co-operated less well with treatment and were more likely to discharge themselves. The comparison of diagnoses of the men and women (Table III) shows that proportionally more women were schizophrenic than men, and that more men were alcoholic, but this does not appear to provide an answer for all these differences. Social and attitudinal explanations should also be considered.

It is possible that people dealing with destitute women are prepared to tolerate a greater degree of behavioural disturbance than they would from a similar group of men. This could explain why the women were more likely to have remained in contact with their families and were less likely to have been in prison. However, this does not explain why significantly more women were referred to hospital by the police and why more use was made of Section 136 in the case of the women, as the men and women admitted on this section seemed equally disturbed, and similar percentages of the men and women admitted on this section were schizophrenic.

It is interesting to question whether the police perceive similar disturbed behaviour by men and women differently, or indeed handle it differently. The study was not designed to answer this question and there certainly seems little difference between the men and women admitted under Section 136. It is possible, however, that the police are more likely to perceive a woman behaving strangely as 'sick' and initiate a hospital disposal in circumstances where a man is likely to be charged and remanded to prison. Indeed, 10 out of 63 men (15.9%) in this study were transferred to hospital from prison, whereas three out of 50 women (6.0%) were similarly transferred. It is therefore possible to suggest that the women who become NFA and get admitted to hospital are a more disturbed group than NFA men who get admitted to hospital, for two reasons. Firstly, in this study, proportionally more women than men were schizophrenic and secondly, many disturbed men may have ended up in prison. These suggestions could explain why the women's admissions appear to have been less satisfactory than those of the men.

The availability of money for rehabilitation facilities is obviously linked to the economic health of the country as well as to the prevailing political climate. The deteriorating economic climate of the 1970s seems not to have affected the numbers of NFA admissions to the index hospital during the period under study. NFA admissions were in double figures from 1971 to 1975 inclusive, but only reached double figures in one subsequent year under study. It is sad to note the dearth of group home and small

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hostel accommodation during the 1970s, in an Inner London teaching district which has been a traditional haven for many destitute men and women. Unfortunately this situation has not changed in the 1980s.

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References

BASSUK, E. L. (1984) The homelessness problem. *Scientific American*, **251**, 28–33.

BERRY, C. & ORWIN, A. (1966) No fixed abode: a survey of mental hospital admissions. *British Journal of Psychiatry*, **112**, 1019–1025.

BRANDON, D. (1973) Community for homeless women. *Social Work Today*, **4**, 167–170.

CHRISTIE BROWN, J. R. W., EBRINGER, L. & FREEDMAN, L. S. (1977) A survey of a long stay psychiatric population: implications for community services. *Psychological Medicine*, **7**, 113–126.

COOK, T. (1975) *Vagrant Alcoholics*. London: Routledge & Kegan Paul.

CROSSLEY, B. & DENMARK, J. C. (1969) Community care: a study of the psychiatric morbidity of a Salvation Army hostel. *British Journal of Sociology*, **20**, 443–449.

DAVIES, W. H. (1908) *The Autobiography of a Supertramp*. London: Jonathan Cape. (Republished Oxford: Oxford University Press, 1980).

DIGBY, P. W. (1976) *Hostels and Lodgings for Single People*. Office of Censuses and Surveys. London: HMSO.

DUNHAM, H. W. (1965) *Community and Schizophrenia*. Detroit: Wayne State University Press.

EDWARDS, G., HAWKER, A., WILLIAMSON, V. & HENSMAN, C. (1966) London's skid row. *Lancet*, **1**, 249–252.

——, WILLIAMSON, V., HAWKER, A., HENSMAN, C. & POSTOYAN, S. (1968) Census of a reception centre. *British Journal of Psychiatry*, **114**, 1031–1039.

FARIS, R. E. & DUNHAM, H. W. (1939) *Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses*. Chicago: University of Chicago Press.

FERNANDEZ, J. (1984) "In Dublin's fair city": the mentally ill of 'no fixed abode'. *Bulletin of the Royal College of Psychiatry*, **8**, 187–190.

GERARD, D. L. & HOUSTON, L. G. (1953) Family setting and the social ecology of schizophrenia. *Psychiatric Quarterly*, **27**, 90–101.

HARE, E. H. (1956*a*) Mental illness and social conditions in Britain. *Journal of Mental Science*, **102**, 349–357.

—— (1956*b*) Family setting and the urban distribution of schizophrenia. *Journal of Mental Science*, **102**, 753–760.

HERZBERG, J. L. (1984) No fixed abode. *British Journal of Hospital Medicine*, **32**, 24–26.

HIGGS, M. & HAYWARD, E. E. (1910) *Where Shall She Live? The Homelessness of the Woman Worker*. London: P. S. King and Son.

LAIDLAW, S. I. A. (1956) *Glasgow Common Lodging Houses and People Living in Them*. Glasgow: Corporation of Glasgow.

LEACH, J. (1979) The evaluation of a voluntary organisation attempting to resettle destitute men: action research with the St Mungo Community Trust. In *Vagrancy: Some New Perspectives* (ed. T. Cook). London: Academic Press.

—— & WING, J. K. (1978) The effectiveness of a service for helping destitute men. *British Journal of Psychiatry*, **113**, 481–492.

—— & —— (1980) *Helping Destitute Men*. London: Tavistock Publications.

LIM, M. H. (1983) A psychiatric emergency clinic: a study of attendances over six months. *British Journal of Psychiatry*, **143**, 460–466.

LODGE PATCH, I. C. (1970) Homeless men: a London survey. *Proceedings of the Royal Society of Medicine*, **63**, 437–441.

MENZIES, F. N. K. (1927) *Common Lodging Houses and Kindred Institutions*. London: London County Council.

MYERSON, D. J. & MAYER, J. (1966) Origins, treatment and destiny of skid row alcoholic men. *New England Journal of Medicine*, **275**, 419–425.

NATIONAL ASSISTANCE BOARD (1966) *Homeless Single Persons*. London: Her Majesty's Stationery Office.

NIE, N. H., HULL, C. H., JENKINS, J. G., STEINBRENNER, K. & BRENT, D. H. (1973) *Statistical Package for the Social Sciences* (2nd edn). New York: McGraw Hill.

ØDEGARD, Ø. (1932) Emigration and insanity: a study of mental disease among the Norwegian born population of Minnesota. *Acta Psychiatrica et Neurologica*, suppl. 4.

OFFICE OF POPULATION CENUSES AND SURVEYS (1982) *County Monitor: Inner London*. London: Government Statistical Service.

ORWELL, G. (1933) *Down and Out in Paris and London*. Gollancz. (Now published Harmondsworth: Penguin Books.)

PRIEST, R. G. (1971) The Edinburgh homeless. *American Journal of Psychotherapy*, **25**, 194–213.

PRIEST, R. G. (1976) The homeless person and the psychiatric services: an Edinburgh survey. *British Journal of Psychiatry*, **128**, 128–136.

SIMS, A. C. P. & SYMONDS, R. L. (1975) Psychiatric referrals to the police. *British Journal of Psychiatry*, **127**, 171–178.

SZMUKLER, G. I. (1981) Compulsory admissions in a London borough: 2—Circumstances surrounding admission: service implications. *Psychological Medicine*, **11**, 825–838.

——, BIRD, A. S. & BUTTON, E. J. (1981) Compulsory admissions in a London borough: 1—Social and clinical features and a follow up. *Psychological Medicine*, **11**, 617–636.

TIDMARSH, D. & WOOD, S. (1972) Psychiatric aspects of destitution. In *Evaluating a Community Psychiatric Service* (ed. J. K. Wing and A. M. Hailey). Oxford: Oxford University Press.

WHITELEY, J. S. (1955) Down and out in London: mental illness in lower social groups. *Lancet*, **2**, 608–610.

WOOD, M. (1976) Camberwell Reception Centre: a consideration of the need for health and social services of homeless single men. *Journal of Social Policy*, **5**, 389–399.

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