meditate on inevitability and grow wise. But, where can we turn in our youth?

The wise men of antiquity give use clues. Wisdom, we are told, is centred on humanity but transcends the individual. Likewise, the sage is centred on himself but is aware of all around him. He is involved, but he is also detached.[3]* His wisdom is twinned with Compassion. 'The pain and joy of one are, inescapably, the pain and joy of all': this is the great truth on which he meditates, full realization of which he declares to be the source of his wisdom, the source of his compassion, the source of his detachment, his strength, his courage, his optimism, his integrity, his serenity and his joy. Wisdom without compassion is false: compassion without wisdom leads only to exhaustion: both are folly. This is what the sage teaches, gently and with tolerance. He teaches this to guide us. Which of us will turn away?

Strength, peace, joy and wisdom come from within ourselves and from the infinity around us of which we are part, of which we are integral—so say the Ancient Ones. If their wisdom reflects truth, where anyway could there be for us to turn?

As medical men and women, we are witnesses to suffering first, healers second. Perhaps natural, innate wisdom prompted us in the past to take up the work, and prompts us now to continue in it. Perhaps some part of us knows that here we are given a fine opportunity to see, recognize, experience and make real for ourselves in the fullest sense possible the first part, at least, of a great truth, thus: 'The pain of one is to be shared, inescapably, by all'. If we are at one with the wise men of old, we know ourselves to be blessed. Aware of half the truth, surely in time we will be vouchsafed knowledge of its complement. Pain and joy: when we accept both equally, wisdom follows. Wisdom follows and wisdom guides. If we allow it. In stillness and silence, wisdom surrounds us. For ordinary men and women, these are extra-ordinary ideas. They provoke anxiety. If serenity is paramount they may be better left alone. Yet together with wisdom comes confidence; confidence facilitates modesty; confidence and modesty in turn attract the trust of others who may come spontaneously to us for help. Trust breeds faith—and faith, hope. Bearing the faith and hope of others we deserve, and live up to, our motto. What is wisdom? Have we not answered this yet? Each who seeks will find their answer. Faith and hope have been mentioned. I would say wisdom is Love.

* An example from Chuang Tsu's *Inner Chapters* is as follows: 'The mind of a perfect man is like a mirror. It grasps nothing. It reflects but does not hold. Therefore, the perfect man can act without effort'.

REFERENCES

[1]ERIKSON, E. (1950) *Childhood and Society*. New York: W. W. Norton.

[2]LAO TSU (c 600 BC) *Tao Te Ching*. Translated in 1973 by Gia-Fu Feng and Jane English. London: Wildwood House.

[3]CHUANG TSU (c 400 BC) *Inner Chapters*. Translated in 1974 by Gia-Fu Feng and Jane English. London: Wildwood House.

'In Dublin's Fair City': The Mentally Ill of 'No Fixed Abode'

JOE FERNANDEZ, Consultant Psychiatrist, St Brendan's Hospital, Dublin.

In 1977 a number of considerations prompted a review of the facilities for the mentally ill of 'no fixed abode' in St Brendan's Hospital, Dublin. At that time the hospital had three clinical teams who serviced three geographically distinct catchment areas within the city and attended to the needs of patients with 'no fixed abode' on a rotational basis. There were complaints from community care agencies concerned with the care of the homeless which alleged that patients were discharged without adequate preparation or follow-up. However, this view was not shared by hospital staff, who instanced occasions when patients sought help in what seemed to be a psychiatric or social emergency, and then abused the service by discharging themselves shortly afterwards. The truth perhaps lay somewhere in between. Another complaint was that no single medical practitioner was clearly responsible for these disadvantaged individuals, thereby making it difficult for community care agencies to liaise with the hospital staff.

Some change in existing practices was considered necessary. However, the direction and momentum of change had to be considered within the context of financial and spatial constraints. Further, it was felt that plans for an acceptable service for the homeless could be formulated only after assessing: (a) the number of patients utilizing the services; (b) past utilization rates—against which projections for the future could be made; and (c) the nature and extent of the range of concurrent psychiatric, medical and/or social problems often found in this group of patients. Unfortunately, the hospital statistics were unhelpful in identifying the numbers of homeless who came into hospital. In these statistics, the homeless were placed in a category referred to as 'others', which referred to a heterogenous group of individuals admitted to hospital from outside the defined catchment areas for a variety of reasons. Despite reassurances that this 'others' category consisted almost exclusively of homeless individuals, it was felt that statistical inferences drawn from this ambiguous grouping would not be acceptable.

https://doi.org/10.1192/pb.8.10.187 Published online by Cambridge University Press

Informal observations suggested that the majority of the homeless admitted to St Brendan's were ex-patients from the three other Health Board's psychiatric hospitals who were living in inner city hostels or sleeping rough. In view of this it was felt that any programme for the homeless should reverse the process of deinstitutionalization by providing these individuals with a stable geographical frame of reference. It was therefore decided that a Programme for the Homeless should provide: (a) residential accommodation in hospital, e.g. an Admission Unit; (b) ready access to accommodation outside hospital once the presenting complaints had eased; and (c) access to a stable base, e.g. a contact facility of a day centre within (and later perhaps outside) the hospital grounds.

At the end of 1977 it was agreed that St Brendan's Hospital would develop two inter-dependent services: a service to deal with patients who presented themselves at the Assessment Unit, irrespective of the catchment area they came from, and a Geriatric Service to deal with psychiatric patients over the age of 65 years. It was expected that the Programme for the Homeless and the above two services should be functional by 1 April 1979.

Regrettably there was no agreement as to how the term 'no fixed abode' was to be interpreted. Since some starting point was necessary, it was decided that the programme would cater exclusively for 'the mentally ill below the age of 65 years who resided in or were prepared to reside in' the inner city's nine hostels, which had accommodation for 644 males and 90 females. Using these criteria, a survey was conducted in St Brendan's Hospital from 1 January through to 31 December 1978, to determine the number and characteristics of those male and female admissions of 'no fixed abode'.

This survey concentrated on those who were likely to be dealt with in any future Programme for the Homeless. A total of 425 admissions (313 male and 112 female) were referred for review. Of these, 169 admissions (106 male and 63 female) were excluded from the survey for the following reasons:

1. Fifty-seven admissions (30 male and 27 female) did not meet the criteria for 'homelessness' as (i) they had a city address or were temporarily displaced from a flat or bedsitter or were between a change of address; or (ii) they were temporarily barred from returning to their homes by their spouses or parents; or (iii) they were temporarily displaced 'live-in' staff who worked in hotels or as housekeepers; or (iv) they lived in the Health Board's psychiatric 'half-way' hostels.
2. Sixty-six (49 male and 17 female) were patients from other Health Board districts who were, or were anxious to be returned to their home base or had to be returned to other psychiatric hospitals in the city or around the country, from where they had taken unauthorized leave of absence.
3. Nineteen admissions (12 male and 7 female) were patients over 65 years of age.
4. Nineteen admissions (12 male and 7 female) had been lodged overnight in hospital and had departed the following morning before they could be assessed or reviewed.
5. Eight admissions (5 male and 3 female) referred to those who lived permanently in mobile homes or caravans in existing catchment areas.

A total of 256 admissions (207 male and 49 female) met our criteria and were included in the survey. These 256 admissions referred to 143 patients of whom 115 were male and 28 were female. The main findings in our survey have been summarized in Table I.

Comment

While there were deficiencies in this survey, nevertheless it does represent the first known attempt to assess the needs and characteristics of the hospitalized mentally ill of 'no fixed abode' in the Republic of Ireland. While it gives little idea of the tragic underlife of those statistics, it does provide a rough outline of the problems. By early 1979 and in the light of our findings, a decision was taken on the necessity of providing separate programmes for the male and female homeless. In Ireland it is traditional in psychiatric institutions that male and female patients be nursed separately and only by members of their own sex.

It was felt that at least 120 males and 30 females would have to be provided for in any prospective programme for the homeless. It was expected that the treatment needs of homeless males could perhaps be met in a 14-bed Admission Unit, provided that 36 additional places could be made available in a day centre. Taking conventional minimum staffing requirements, the Admission Unit would need 12 male nurses and two attendants to provide 24-hour cover and to service the needs of approximately 120 patients; while the day centre would need five male nurses and two attendants. Unfortunately lack of staff and building resources meant that no facilities could be made available for homeless female patients.

On 1 April 1979 the Programme for the Homeless was initiated to run in tandem with the concurrently established Assessment Service and Geriatric Service. Operationally it was anticipated that:

(a) Homeless patients who needed help in an emergency would first be screened by the Assessment Service;
(b) Homeless females, as also those who did not meet the criteria for 'homelessness' but who needed admission to hospital, would be treated in the admission wards of the three catchment area teams on a rotational basis.
(c) Homeless males over the age of 65 years would be referred to the Geriatric Service.
(d) Homeless males who met the criteria for 'homelessness' would be referred to the Programme where a decision would be taken as to whether hospitalization or day care was more appropriate.
(e) If admission was considered necessary, this would be to

https://doi.org/10.1192/pb.8.10.187 Published online by Cambridge University Press

TABLE I

	Male %	Female %
*Age of Entry**		
(a) 18–30 years	20.9	28.6
(b) 31–50 years	62.6	53.6
(c) 51–65+ years	16.5	17.8
*Median age on entry (in years)**	40.5	37.0
*Religion (RC)**	94.0	93.0
*Marital status**		
(a) Single: Unmarried	73.9	64.3
(b) Single: Separated/Divorced	3.5	21.5
(c) Single: Widower/Widow	2.6	7.1
(d) Married	19.1	7.1
*Having no dependents**	89.6	64.3
*Having relatives but no contact with them**	80.0	89.3
*Occupation**		
(a) Unskilled manual/factory workers	60.0	50.0
(b) Semi-skilled workers	21.8	10.7
(c) Skilled workers	13.0	7.1
(d) Retired from work with a pension/disability benefit	3.4	Nil
(e) Housewives	—	17.9
(f) No stated occupation (M) or in an unregistered profession (F)	0.9	14.3
*Currently unemployed**	91.3	71.4
*Length of unemployment prior to hospitalization**		
Range in months	0.5 to 375	1.5 to 101‡
Median in months	24.5	40.5‡
*Having a current medical card**	17.4	39.3
*History of multiple admissions to psychiatric hospitals in the past**	70.4	85.7
Compulsorily hospitalized†	10.0	22.5
Reason for admission†		
(a) Psychiatric problems	45.0	30.6
(b) Psychiatric ± medical ± social problems	48.8	59.2
(c) Medical ± social problems	6.2	10.2
Primary problem/condition which needed attention†		
(a) Alcohol abuse	46.0	4.1
(b) Psychotic illness	33.3	34.7
(c) Mainly social problems	7.2	10.2
(d) Alcohol + drug abuse	4.3	Nil
(e) Depressive illness	2.9	14.3
(f) Dementia	1.9	Nil
(g) Epilepsy	1.9	Nil
(h) Mainly medical problems	1.5	Nil
(i) Personality disorder (in those not belonging to any of the above sub-groups)	1.0	36.7
*Welfare benefits**		
(a) On welfare benefits	55.6	39.3
(b) Not on any benefits	17.4	10.7
(c) No information available	27.0	50.0
Length of hospitalization†		
(a) Range in days	0.5 to 293	0.5 to 345
(b) Median in days	9.1	10.5
Mode of discharge†		
(a) Discharged by staff	81.0	61.2
(b) Absconded from hospital or self-discharged	12.6	22.5
(c) Still in hospital	3.0	8.2
(d) No data available	3.4	6.1
(e) Died during survey	Nil	2.0
*Number of admissions**		
(a) Range of admissions	1 to 7	1 to 5
(b) Median number of admissions	4	3
(c) Percentage of patients having only one admission during 1978	60.9	60.7

* n = 115 male and 28 female patients.
† n = 207 male and 49 female admissions.
‡ These figures refer to only 14 females. The remaining 14 patients in this group were excluded (a) by virtue of their being 'housewives' or 'ex-housewives' who were not in employment since their marriage, separation or widowhood, or (b) because some patients could not recall when they last worked, or (c) because some patients were in an unregistered profession.

the Admission Unit where, following treatment, specific predischarge and follow-up procedures would try to safeguard the patient's physical, mental and social well being.

(f) Patients discharged from the Admission Unit would be found accommodation in the city's hostels—subsidized if necessary by the Programme for the Homeless until problems associated with welfare benefits had been sorted out.

(g) Patients discharged from the Admission Unit would be offered the option of attending at the day centre in the grounds of the hospital. This would be open daily from 8 am to 8 pm with meals, medication and out-patient contact provided. The latter facilities would also be available to those for whom hospitalization was not necessary and for whom day care was more appropriate.

To date the Programme for the Homeless in St Brendan's Hospital has been operating for over five years. Data from 1

https://doi.org/10.1192/pb.8.10.187 Published online by Cambridge University Press

April 1979 to 31 March 1984 indicate that 348 homeless males passed through the programme. Of these, 330 males were responsible for 743 admissions following which they were discharged to the day centre where, currently, on average 78 patients attend each month.

The successes and failures of the programme, its problems, deficiencies and limitations, the factors which may militate against its future effectiveness or against the continuance of the programme as it stands and considerations which might provide a basis for the setting up of other cost-effective hospital and community-based alternatives will have to be the subject of other publications.

*The Aftermath of the Mental Health Act 1983: Some Preliminary Impressions**

T. W. FENTON, Consultant Psychiatrist and Medical Director, Hollymoor Hospital, Northfield, Birmingham

A survey of the views of consultant psychiatrists concerning possible difficulties for the practising clinician in the early aftermath of the Mental Health Act 1983 is presented. The number of consultant psychiatrists written to was 118 and the breakdown of responses was as follows: 37 of 79 general psychiatrists replied; 4 of 8 psychogeriatricians replied; 2 of 9 consultant adolescent psychiatrists replied; 2 of 4 forensic psychiatrists replied; and 5 of 18 consultants in mental handicap replied. The letter asked eight questions concerning specific aspects of the Act and invited any comment.

Question 1

A person may not be regarded as suffering from mental disorder by reason only of dependence on alcohol and drugs. Has this provision had any important consequence for your clinical practice or is it likely to have such consequence in the future?

Thirty-six respondents replied in the negative. Only five foresaw difficulties in the future. There was comment that the exclusion of drug addicts and alcoholics is not likely to cause particular difficulty as persons who, as a result of their addiction have psychotic episodes, may be admitted under appropriate sections of the Act. Some respondents commented that they were not prepared to detain on the grounds of alcohol and drug dependence alone under the provisions of the 1959 Act.

Fear was expressed that social workers may interpret the new provisions too strictly, rejecting compulsory admission if psychosis is the result of alcohol or drug dependence. Two writers described the admission of patients under Section 2 exhibiting alcohol dependence; in one case it was feared DTs might develop if no action was taken, in the other that there was a serious risk of rapid physical deterioration. Both patients applied to a Tribunal and in both cases the Tribunal felt that the Act had been misused. Another respondent described the concern of relatives of two alcoholics that there were no compulsory powers by which patients could be treated although they were creating havoc within their families.

Question 2

A patient admitted under Section 2 has the right to apply to a Mental Health Review Tribunal within 14 days of admission. The nearest relative can discharge the patient unless the RMO bars discharge by appropriate certification. Have you found that these provisions limit the usefulness of a Section 2 order as a short-term treatment order or are likely to do so in the future?

The majority of respondents found no particular difficulty here, 32 replying in the negative and only nine anticipating some difficulty in the future. Such dissatisfaction as was expressed mainly concerned the time needed for the preparation of reports for, and attendance at, Mental Health Review Tribunals.

Question 3

Has it been your experience so far, or do you envisage that it will be your experience in the future, that you use a Section 2 order less frequently than the old Section 25 order, and the Section 3 order more frequently than the old Section 26 order?

Patients detained under Section 3 of the 1983 Act can be treated with medication for three months without their consent or a second opinion. The great majority are likely to be well enough to be discharged or treated informally within three months. Given that this, and the possible deterrent of the right of appeal to a Tribunal under Section 2 is so, I wondered if there was a trend towards admitting patients under Section 3 rather than Section 2 and discharging or regrading them to informal status before three months of the order have run. (A Section 3 patient can, of course, also appeal to a Tribunal, but there will be a lengthier delay before the hearing.)

Twenty-six respondents were definite that they did not expect, and 13 that they did sense or anticipate, this trend.

** This article is based on a paper presented at the Spring 1984 meeting of the Midlands Division of the College.*

https://doi.org/10.1192/pb.8.10.187 Published online by Cambridge University Press