

in two-thirds, and less than a tenth reported a duration of abuse of more than three years. The most common route of consumption was smoking (74%), followed by 'chasing' which accounted for 17%. The intramuscular route was used by less than 2% of patients. Most of the patients also abused drugs other than heroin. The most preferred was cannabis (50%), followed by alcohol (46%) and raw opium (21%).

Fifty patients dropped out after initial assessment, while the remaining 55 entered the treatment programme willingly. Twenty-one were treated as in-patients, and the rest as out-patients, for management of acute withdrawal symptoms. There were no specified criteria for hospitalisation, except distance, although in the later half of the study the majority were treated as out-patients. This change resulted from a change in policy regarding hospitalisation of heroin addicts, in view of the limited availability of acute psychiatric beds and the gradually increasing numbers of addicts.

In the initial phase, gradual withdrawal was attempted but, subsequently, sudden and abrupt withdrawal under medical supervision was the rule. This was again due to a change in local policy. Of the 55 patients who entered the programme, 44% were abstinent after one week, and 48% were totally abstinent at one month follow-up. Observation suggested a poor outcome and frequent relapses on follow-up. This led us to reconsider the initial policy of mandatory hospitalisation. Subsequently, heroin withdrawal was attempted routinely on an out-patient basis. Withdrawal symptoms were managed symptomatically with minor tranquillisers and low doses of antipsychotics. Even ultra-short detoxification using clonidine was done on an out-patient basis in a few patients.

The rapid increase in the number of patients with heroin dependence in most of the South Asian countries (Adityanjee *et al*, 1984; Mendis, 1985; Mohan *et al*, 1985) has led to a situation in which the already inadequate psychiatric and general health services are suddenly confronted with a mass of heroin addicts. Since in our experience hospitalisation is not of much use, out-patient detoxification using clonidine may be the most economical model in countries with resource constraints.

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### No Fixed Abode

SIR: We were interested to note that the "no fixed abode" (NFA) patients described by O'Shea *et al* (*Journal*, August 1987, **151**, 267-268) had considerable physical morbidity and more legal records when compared with patients with a fixed abode.

We found a similar situation in two comparable studies, one of 100 persons of NFA and the other of 72 men composed of both those with NFA and those living in a Salvation Army hostel and a common lodging house (Weller *et al*, 1987; Weller & Weller, 1986). Of the respondents in the larger 1987 survey, 66% did not have contact with a GP, a comparable proportion to our 1986 survey (53.6%), and 36% were not receiving any of their benefit entitlements, a worse situation than in the earlier survey (9.1%).

We examined for the effect of active psychosis or previous in-patient treatment, which were found to be strongly associated with a history of imprisonment, an outcome befalling 78% of the combined groups of this NFA population in the 1987 survey, as against 42% of the residual population ( $P < 0.005$ ). The effect was yet more striking in the 1986 survey, of mixed NSF and hostel occupants (75% compared with 17%), the statistical significance being increased if the data from our two surveys are combined ( $P < 0.001$ ).

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