

currently, 218 of the 291 cases are in intravenous drug misusers, who have an estimated infection rate of 20-30%. This pattern of spread is similar to that in Edinburgh but differs from that in the rest of Scotland.⁴ Our results reflect the pattern seen in the wider population.

We found no unexpected positive test results. Others suggest that only 40% of the deaths among men positive for HIV antibody are in men who are known to be positive by the time they die,⁵ which has important health and safety implications for all forensic facilities. Our results show that selective testing of subjects with known risk factors could satisfy health and safety needs.

Currently about 8.5% of all deaths in Scotland

and 23% of all deaths in England and Wales come to medicolegal necropsy. Although not randomly selected, this population contains an appreciable number of subjects at high risk of HIV infection and more general testing might provide useful epidemiological information.²

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(Accepted 1 October 1991)

Psychiatric morbidity and substance abuse among residents of a cold weather shelter

Alison Reed, Simon Ramsden, Jane Marshall,
Jane Ball, John O'Brien, Andrew Flynn,
Naomi Elton, David El-Kabir, Philip Joseph

Single homeless people are recognised to have a high prevalence of psychiatric morbidity. Schizophrenia is particularly common, with most British studies suggesting a prevalence of 20-40%.¹⁻³ Alcoholism is usually slightly lower at 15-20%.^{1,2} Most clinics and research projects have concentrated on hostels and day centres; little work has been reported on those who sleep rough. During severe cold weather in January 1991 the government decided to make shelters available to people sleeping on the streets of London. We assessed the health and circumstances of the residents of one such shelter.

Subjects, methods, and results

All residents of the shelter between 9 am and midnight on 15 January 1991 were approached for interview; 96 consented, five refused. The interview included a semistructured questionnaire on demography, history of homelessness, psychiatric illness, substance abuse, and criminal history and an assessment of current mental state. The clinical assessment was supplemented by use of standardised instruments: the brief psychiatric rating scale, the brief Michigan alcohol screening test (10 item version), and the severity of alcohol dependency questionnaire. The table summarises the results.

For those who had ever attended Great Chapel Street Medical Centre, Soho, data on place of birth and marital status were compared to clinic records. The overall agreement was 84%, suggesting that these data items were reliable and repeatable.

Comment

The demographic features of the study population are similar to those of previous studies of homeless people. The group was well defined, though not necessarily representative of all who sleep rough. Before entering the shelter 83% had been sleeping rough. The data described therefore apply to homeless people who sleep rough rather than the hostel dwelling populations generally studied. Possibly some of those

Characteristics of residents of a cold weather shelter

	No (%) of residents (n=96)	Mean/median values
Mean age (years)		40 (range 18-65)
Men	94 (96)	
Sleeping rough previously	80 (83)	8.5 months (range 3 days-24 years)
Median duration		
Never married	71 (74)	
<i>Mental illness</i>		
Previous psychiatric contact	28 (29)	
Previous psychiatric admission	17 (18)	
Presence of psychosis (brief psychiatric rating scale):		
Definite	8 (8)	
Possible	4 (4)	
<i>Substance abuse</i>		
Lifetime illicit drug use	34 (37)	
Daily alcoholic consumption (g pure alcohol)		Mean 185, median 80 (range 0-820)
Alcoholic (brief Michigan alcohol screening test, score ≥ 5)	51 (53)	
Alcoholic dependent (severity of alcohol dependency questionnaire, score ≥ 30)	26 (27)	
<i>Criminal history</i>		
Previous convictions	68 (71)	Mean 8.7, median 4
Custodial sentences	50 (52)	
Sleeping rough on last release	27 (54)	

sleeping rough did not use the shelters, introducing a selection bias, but our impression from clinics for homeless people was that few remained on the streets.

The prevalence of alcoholism and alcohol dependency was strikingly high, and all those interviewed had longstanding alcohol problems. The Los Angeles Skid Row study similarly reported that 63% had at some time met criteria for alcoholism and 41% had a current diagnosis.⁴ This profile differs from that of homeless men in hostel and lodging house studies, where the proportion of men with psychosis has been found to be higher and alcohol problems lower.^{1,2} This may be because men with serious alcohol problems are not tolerated in such settings.

We were surprised by the low level of current psychosis, but of the 12 non-psychotic patients who had previous inpatient stays, only one proved to have a past diagnosis of psychosis. This supports the finding of a low prevalence of psychosis in the sample.

The high prevalence of previous convictions was in keeping with previous studies.³ Most subjects had a negative view of their experience of prison, and few felt they had had any help on discharge; this suggests that an opportunity of therapeutic aftercare was missed.

Many of those with immediate health problems or alcohol abuse were reluctant to see doctors and accepted illness as part of their lifestyle. However, evidence

Institute of Psychiatry,
London SE5 8AF
Alison Reed, research worker
Jane Marshall, lecturer
John O'Brien, registrar
Naomi Elton, registrar
Philip Joseph, senior research fellow

Great Chapel Street
Medical Centre, London W1V 7AL
Simon Ramsden, general practitioner
Jane Ball, manager
Andrew Flynn, medical student
David El-Kabir, general practitioner

Correspondence to:
Dr S Ramsden.

BMJ 1992;304:1028-9

from a mobile surgery for those sleeping rough suggests that after contact and rapport have been established patients will consult with those doctors.⁵ What is clear is that one major barrier to sustained housing, alcoholism, is present in over half of the group. In this sense, housing and health care are interdependent. Close liaison between the shelter staff, care agencies, and medical staff is the most likely means of providing effective social and medical care to these needy people.

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(Accepted 18 November 1991)

Is duplicate publishing on the increase?

Tony Waldron

British Journal of Industrial Medicine,
London WC1H 9JR
Tony Waldron, editor

BMJ 1992;304:1029

Duplicate publication occurs when the results of a single study appear in more than one journal. In its most extreme form, two or more journals may publish identical papers. At the other extreme is salami or meat extender publication, in which the results of a single study are parcelled out to different journals rather than being published in a single comprehensive form.¹ Although duplicate publication has been described as redundant^{1,2} and as a waste that must stop,³ most editors know that it continues. I set out to determine its extent in the *British Journal of Industrial Medicine*.

Method and results

For all authors publishing in the *British Journal of Industrial Medicine* during the years 1988-90, bibliographic details and abstracts of all papers cited by Medline were obtained by a search on a compact disk system. If the abstract showed that a paper was similar to one published in the *British Journal of Industrial Medicine* the entire article was inspected to make a full comparison.

In 1986, six of the 110 main articles in the *British Journal of Industrial Medicine* had been published elsewhere; in 1989 the proportion was 10 of 128 and in 1990, 15 of 126 (6%, 8%, and 12%, respectively), suggesting a substantial increase over time. A total of 121 authors from 10 countries had their names attached to the suspect papers (table). Few of the papers were published in their entirety in another journal, the great majority (about 80%) reporting the findings in a slightly modified form, usually with the authors listed according to the specialty of the journal. Thus if an epidemiologist and a radiologist were the authors, the epidemiologist would appear first for the epidemiological journal and the radiologist for the radiological journal.

Comment

Duplicate publication is time wasting, involving editors and reviewers in unnecessary work; it is also dishonest and colludes with the notion that publication is in itself meritorious and desirable. It may also have untoward scientific consequences as it will tend to give

Number of duplicate publications and authors by country, *British Journal of Industrial Medicine*, 1988-90

Country	No of publications	No of authors
Sweden	7	31
United States	6	27
United Kingdom	5	15
Canada	3	11
Finland	3	13
Japan	2	6
Norway	2	5
China	1	6
France	1	4
Italy	1	3
Total	31	121

undue weight to those observations that are being reported over and over again. Editors know that the practice is common, but there are few quantitative data showing how common, although Bailey is reported to have found over an eight year period that 228 authors submitting to the *Archives of Otolaryngology—Head and Neck Surgery* had published duplicate articles.⁴

Although duplicate publication may be permitted under some circumstances, most notably when a paper has appeared in a minority language, journals usually insist that papers should not be submitted for consideration elsewhere. Some require authors to sign a statement to that effect, but this does not work as an effective deterrent. Reviewers have a part to play in prevention since they may be asked to look at manuscripts by several journals, but this is altogether too haphazard a means of detection. A few journals run literature searches on authors whose papers they propose to publish, but this can never be a routine procedure for all journals. Editors may remonstrate with authors found to publish the same data more than once, or they may publish retraction notices.

The most effective deterrent to duplicate publication may be to require applicants for posts or grants to submit copies of their half dozen most important papers, which the committee can then read. This requirement would lay emphasis on quality rather than quantity and remove one of the driving forces behind duplicate publication. There are some indications that this is now beginning to happen and it will be interesting to see how this affects authors' behaviour.

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(Accepted 20 December 1991)