Census of single homeless people in Sheffield

S L George, N J Shanks, L Westlake

Abstract

***Objective*—To determine the number of single homeless people in Sheffield and to examine their demography and social and medical details.**

***Design*—Census carried out between 8 am and 8 pm on one day. Participants completed a questionnaire designed to provide data relating to employment history, contact with welfare and health services, social state, prison history, medical history, and health state.**

***Setting*—Sites in Sheffield identified by local workers as being places of residence of homeless people.**

***Subjects*—340 single homeless people.**

***Main outcome measures*—Self reported history of alcohol or drug misuse, existence of a chronic medical condition, and use of general practitioner and hospital services.**

***Results*—The mean age of the population was 42·5 years and a quarter of the population were aged less than 30; there were 48 women. Significant differences were noted between men and women with respect to self reported psychiatric illness (77/266 men *v* 27/42 women), self reported alcoholism (83/273 *v* 4/44), prison history (152/255 *v* 8/41), and registration with a general practitioner (73/275 *v* 38/46). Various chronic medical conditions were reported, and the perceived health state of the population was low; 129 claimed to have been admitted to a psychiatric hospital. 220 people were registered with a general practitioner, and 179 claimed to see their doctor. Sixty five had attended or been admitted to a general hospital in the month preceding the study, 45 for accident and emergency services.**

***Conclusions*—The homeless in this population were younger than those found in previous studies. The prevalence of psychiatric illness was high in the population, and the overall health state was poor. Most subjects obtained health services from general practitioners.**

Introduction

Homelessness has received much public attention in the past few years. An exact estimate of the number of homeless people is difficult to obtain; official figures measure only those who come forward for help. In a 1988 House of Commons debate it was estimated that there were 100 000 homeless people in the United Kingdom in 1987.[1] In the same year, however, local authorities in England and Wales accepted some 120 000 households (350 000 people) as being homeless. This figure excluded most young, single homeless people, estimated by Shelter to number 150 000.[2] In a recent Salvation Army survey 532 people were discovered to be sleeping rough in a small area of central London.[3] We studied the single homeless people in Sheffield.

Subjects and methods

We did a census of single homeless people in Sheffield between 8 am and 8 pm on 12 December 1988, a date chosen to maximise the number of homeless people found indoors rather than on the streets. Previous attempts to obtain random samples from homeless populations have shown the difficulties of working without a defined sampling frame,[4,5] and so we chose a census approach.

Sites for conducting the census were identified in consultation with the Salvation Army; Sheffield City Council's homelessness team and environmental health officer with special responsibility for the homeless; voluntary workers from MIND and from the Campaign for the Homeless and Rootless (CHAR); staff at reception centres and special hostels for the homeless; staff of the probation and aftercare service (homeless division); and health visitors with responsibility for the single homeless living in cheap hotels and bed and breakfast accommodation. The police originally agreed to take part in the survey but withdrew before it started because they were concerned that the confidential relationship between themselves and the public could be jeopardised.

The census sites included Sheffield Salvation Army Hostel, a reception centre, seven hostels for the homeless, bed and breakfast and cheap hotel accommodation identified by Sheffield City Council workers and by health visitors as being used mainly by homeless people, and a probation day centre. We did not attempt to contact homeless people on the street, and some may have been in prison, in hospital, or working at the time of the census. Consultation with the organisations listed above and information derived from Department of the Environment quarterly housing activity returns (PG1 Hsg), however, suggest that over 90% of Sheffield's single homeless population was included in the census.

A questionnaire was distributed to all participants. Questions included demographic details, employment history, contact with welfare agencies, social details, prison history, own and family medical and psychiatric history, and contact with health services. Also included in the questionnaire was part I of the Nottingham health profile questionnaire.[6] This was designed as a population survey tool to measure perceived health state and has been shown to be valid and reliable.[7] It contains 38 statements requiring yes or no answers relating to six dimensions of social functioning: energy, pain, emotional reactions, sleep, social isolation, and physical mobility. Statements are weighted and combined to give dimension scores from zero to 100 (most healthy to least healthy). The dimensions are independent, and scores for different dimensions cannot be combined.[6] Part II of the profile relates to seven aspects of life activity that may be affected by perceived health, and we thought it was inapplicable to the group studied.

The questionnaire was distributed by workers familiar to the homeless in the sites studied and without compulsion or reward for its completion. The collected data were analysed with the statistical package for the social sciences (SPSSX) on an IBM mainframe computer. Differences between subgroups of respondents were determined by χ^2 analysis.

The Nottingham health profile data were difficult to analyse. The authors of the profile gave standards for each dimension score based on a Nottingham population and recommended comparison of mean values for each dimension to determine differences

Departments of Public Health Medicine and General Practice, Division of Community Medicine, University of Sheffield Medical School, Sheffield S10 2RX
S L George, MB, *lecturer in epidemiology*
N J Shanks, MRCGP, *lecturer in general practice*
L Westlake, BSC, *statistician*

Correspondence to: Dr George.

BMJ 1991;302:1387-9

between the standard and study populations.[6] Given the non-normal distribution of dimension scores, however, we decided to use non-parametric methods to determine differences. Individual data for the original standard population were not available, and the cost of obtaining contemporary data on a Sheffield standard population was prohibitive. We therefore chose a London residential population surveyed with the profile in 1982 as our standard.[8] A comparison group matched for age and sex was selected from this population, and differences between it and our study population were tested using a Mann-Whitney U test.

Results

A total of 379 questionnaires were collected. Nine people refused to complete the questionnaire. Of those collected, 39 were duplicated, defaced, or had less than two thirds of the questions completed and were excluded, leaving 340 questionnaires for analysis. Twenty eight of the population were illiterate and had to be helped to complete the questionnaire. The remainder of the questionnaires were self completed.

Table I shows the age and sex of our population. The mean age was 42·5 years, 85 (25%) being less than 30. Forty eight were women. Table II shows that women were more likely than men to be registered with a general practitioner, to have self reported psychiatric problems, and to have been admitted to a psychiatric hospital. They were less likely to have been in prison, however, or to have a self reported history of alcoholism.

TABLE I—*Age and sex of census population. (Figures in brackets are percentages of totals, excluding missing values)*

Age (years)	Men (n=292)	Women (n=48)	Total (n=340)
<25	43 (16)	10 (22)	53 (16)
25-34	51 (18)	7 (15)	58 (18)
35-44	56 (20)	8 (17)	64 (20)
45-54	67 (24)	11 (24)	78 (24)
55-64	29 (10)	5 (11)	34 (11)
≥65	31 (11)	5 (11)	36 (11)
Missing data	15	2	17
Mean age	42·5	40·0	42·5
Median age	42	42	42

Most of the homeless (320) were white people. Thirty eight were Scottish, 20 Irish, and 260 were born in England. Seventy four (22%) were Catholic, a considerably greater proportion than the 5% in Sheffield as a whole (Rt Rev Gerald Moverley, Bishop of Hallam, personal communication).

Only 14 respondents reported being married, with 75 being separated or divorced and 150 never having married. Two hundred and six reported having no contact with any member of their family and 16 reported that at least one other family member was homeless. Nearly half of the population (165) had been in prison. Sixty five had been discharged within the five years preceding the study.

The reliability of the reasons given for being homeless is doubtful, as response was to an open ended question that produced answers that were sometimes difficult to interpret. However, 27 people mentioned eviction as the reason for homelessness, and 12 described themselves as "travellers." Sixty eight had been homeless for less than six months, although the median length of time homeless was four years. Two hundred and five had been at their present lodging place for less than six months, and 71 for less than one month. Twenty had been in paid employment during the seven days preceding the study, and 161 were registered as unemployed.

Participants were asked whether they had ever suffered from various conditions, including alcoholism and drug misuse. We realise that the response is a subjective self assessment, but it is nevertheless the best that can be achieved without expert history taking, physical examination, and access to medical records. Table III shows that over one third of people reported a history of psychiatric illness, and over one quarter reported problems of alcoholism.

TABLE II—*Analysis of participants by sex against other demographic, social, and medical variables*

Group	Men	Women	χ^2 For difference between groups (df=1)	p Value
Registered with general practitioner*	173	38	6·79	<0·01
Not registered with general practitioner	102	8		
Self reported history of alcoholism	83	4	8·64	<0·01
No history of alcoholism	190	40		
Been in prison	152	8	22·86	<0·01
Not been in prison	103	33		
Had been admitted to psychiatric hospital	97	25	5·1	<0·05
Not admitted to psychiatric hospital	176	21		
Self reported psychiatric problems	77	27	18·7	<0·0001
No psychiatric problems	189	15		

*Nine people of unknown gender also reported being registered.

TABLE III—*Self reported medical history of census population. (Percentages are of total number for whom data on variable were obtained)*

	No (%) with history	No (%) with no history	Missing data
Epilepsy	13 (4)	319 (96)	8
Tuberculosis	11 (3)	314 (97)	15
Alcoholism	92 (28)	241 (72)	7
Drug misuse	31 (9)	299 (91)	10
Psychiatric illness	110 (34)	213 (66)	17
Other	73 (22)	254 (78)	13

Questions on the use of medical services showed that 220 were registered with a general practitioner in Sheffield and, more importantly, 179 (53%) claimed to see their general practitioner. The sex of nine people registered with a general practitioner ws not recorded. Table IV shows that women, those retaining family contact, and those with a serious medical condition were more likely to be registered with a doctor than were other groups. People reporting alcoholism or drug misuse were less likely to be registered with a general practitioner than were those without these problems.

Sixty five people had either attended or been admitted to a general hospital in the previous month, the largest single reason for attendance being use of accident and emergency services (45 people). In addition, 129 people reported having been admitted to a psychiatric hospital, although 34 of them did not claim to have had psychiatric problems. Table V shows self reported use of general practitioners or accident and emergency services, or both. Although most people used their general practitioner, those reporting either alcohol or drug problems were more likely to have used accident and emergency services (21/65) than were other people who reported using health services (23/132; p=0·018).

Table VI shows mean and median values for the Nottingham health profile dimensions, together with the number scoring zero on each dimension, for the study population and the comparison group derived from the London study.[8] Only 43 homeless people scored zero on all six dimensions. The homeless population scored significantly worse on all dimensions than did the comparison group.

Discussion

The homeless people of today are younger than in previous years. A quarter of our population were aged less than 30, whereas two studies in 1966 found that 10% and 4% of their populations were aged less than 30,[9,10] and a 1981 study gave a figure of 7%.[11] A more

TABLE IV—*Number (percentage) of homeless people registered with a general practitioner according to demographic and social variables*

Group	Registered with general practitioner	Total No in group	χ^2 For difference between groups (df=1)	p Value
Male	173 (63)	275	6·79	<0·01
Female	38 (83)	46		
Epilepsy	11 (92)	12	3·62	<0·05
No epilepsy	206 (65)	316		
Psychiatric illness	89 (83)	107	22·21	<0·01
No psychiatric illness	118 (56)	211		
Alcoholic	47 (52)	90	10·76	<0·01
Not alcoholic	170 (71)	238		
Drug misuse	15 (50)	30	3·79	<0·05
No drug misuse	201 (68)	297		
Family contact	99 (80)	124	14·95	<0·01
No family contact	120 (59)	203		
Registered as unemployed	80 (50)	160	36·84	<0·01
Not registered as unemployed	138 (82)	169		
Admitted to psychiatric hospital	94 (73)	129	4·62	<0·03
Not admitted to psychiatric hospital	124 (61)	202		
Attends psychiatric outpatient department	26 (84)	31	5·71	<0·02
Does not attend psychiatric outpatient department	171 (62)	275		
Sees general practitioner	171 (96)	179	70·73	<0·01
Does not see general practitioner	43 (52)	82		

TABLE V—*Use of general practitioner and accident and emergency services according to social and medical variables. (Numbers in brackets are percentages in each category for each variable)*

	General practitioner only	Accident and emergency department only	General practitioner and accident and emergency services
Been to prison (n=95)	69 (73)	11 (12)	15 (16)
Had epilepsy	10 (100)		
Self reported psychiatric problems (n=80)	66 (83)	4 (5)	10 (13)
Had tuberculosis (n=6)	4 (67)	1 (17)	1 (17)
Self reported alcohol problems (n=54)	35 (65)	9 (17)	10 (19)
Self reported drug problems (n=19)	14 (74)	4 (21)	1 (5)
Chronic medical conditions (n=55)	45 (82)	4 (7)	6 (11)
All respondents (n=197)	153 (78)	18 (9)	26 (13)

TABLE VI—*Mean and median dimension scores for part I of Nottingham health profile for study and comparison populations and significance of difference between populations*

	Homeless population			Comparison population[8]			Two tailed p value (Mann-Whitney U test)
	Mean	Median	% Scoring zero	Mean	Median	% Scoring zero	
Energy	27·2	0	51	8·7	0	83	<0·0001
Pain	11·6	0	63	5·0	0	84	<0·0001
Emotional reaction	32·4	21·8	29	7·6	0	69	<0·0001
Sleep	31·6	16·1	35	10·8	0	70	<0·0001
Social isolation	30·1	20·1	37	4·2	0	87	<0·0001
Physical mobility	8·7	0	62	4·5	0	82	<0·0001
Age	42·5	42·0		42·8	41·1		>0·1

recent study in Bristol found that 35% of the residents in a hostel for the homeless were aged less than 30 and confirms our finding that the young homeless are not confined to London.[12] The proportion of women who are homeless also seems to be increasing. In 1966, 7% of residents in hostels and lodging houses were female compared with 14% in our population.[9]

A minority of the homeless people in our study reported a history of alcoholism, dispelling the myth that homelessness is the inevitable end result of a misspent life. It is worrying, however, that 9% of the population admitted to a history of drug misuse, a major cause of homelessness in America.[13]

Most of our study population were registered with a general practitioner. This contrasts with the results of studies of the use of health services by homeless people in London,[14] but agrees with findings in other parts of the country.[12] Those registered with a general practitioner had more social stability, as evidenced by their degree of family contact, and it is unsurprising that those in need of regular drugs were more likely to be registered with a general practitioner than were other people. Conversely those with a history of alcoholism or drug abuse were more likely to use an accident and emergency department than were other homeless people using health services. These people fit the stereotype of homeless people and, being easily recognised, create the impression of large numbers.

There was a high prevalence of self reported mental illness in this population, and its perceived health state was poor. Many women claimed to have been admitted to a psychiatric hospital or to have a history of psychiatric illness, which contrasts with the small number of women admitting to a prison history. The police, when confronted by a woman behaving strangely, may initiate a hospital admission in circumstances in which a man would be charged and remanded in custody. On the other hand, homeless women have been shown to cooperate poorly with psychiatric treatment,[15] and their male counterparts may remain in hospital care.

With the introduction of community care the number of long stay patients in psychiatric hospitals in England and Wales is being reduced. The community services necessary to support patients discharged from hospital are in many cases lacking, and despite statutory obligations under the Health and Public Services Act 1968 few homeless people have been housed by local authorities.[16] The rest live in the limited number of reception centres, in substandard rented accommodation, or on the street.

This study was funded by a grant from the Clair Wand trust of the BMA. We thank Mr J P Nicholl for help with the design of this study; Dr S E Garbett and Mr P Conway for help in data collection; and members of the Sheffield Salvation Army and staff of Sheffield probation centre, reception centre, and Sheffield City Council for their help during the census. We also thank Drs Sarah Curtis and Denis Bucquet for help in providing a comparison group and Dr Sonja Hunt for advice. Finally, we thank Miss Jacqueline Chaplin for typing the manuscript.

1 Roe M. Parliamentary written answer. *House of Commons Official Report (Hansard)* 1988 May 18;**133**:cols 480-1. (No 153.)
2 Lowry S. Caring for the homeless. *BMJ* 1989;**298**:210.
3 Canter D, Drake M, Littler T, Moore J, Stockley D, Ball J. *The faces of homelessness in London: interim report to the Salvation Army.* Guildford: University of Surrey Department of Psychology, 1989.
4 Shanks NJ. Consistency of data collected from inmates of a common lodging house. *J Epidemiol Community Health* 1981;**35**:133-5.
5 Shandler I. *Philadelphia's Skid Row: a demonstration in human renewal.* Philadelphia: The Redevelopment Authority, 1966.
6 Hunt SM, McEwen J, McKenna SP. *Measuring health status.* London: Croom Helm, 1986.
7 Hunt SM, McKenna SP, Williams J. Reliability of a population survey tool for measuring perceived health problems: a study of patients with osteoarthritis. *J Epidemiol Community Health* 1981;**35**:297-300.
8 Curtis S. *Intra-urban variations in health care. The comparative need for health care survey of Tower Hamlets and Redbridge.* Vol 1. *Adult morbidity and service use.* London: Queen Mary College Department of Geography and Earth Sciences, 1985.
9 National Assistance Board. *Homeless single persons.* London: HMSO, 1966.
10 Lodge Patch IC. Homeless men, a London survey. *Proc R Soc Med* 1970;**63**:437-41.
11 Shanks NJ. Demographic features of inmates of common lodging houses (MSc thesis). Manchester: University of Manchester, 1981.
12 Vassilas C, Male P, Mitchell T, Cook D. Registration amongst the homeless in an inner city general practice. *Health Trends* 1990;**22**:89-90.
13 Breakey WR, Fischer PJ, Kramer M, *et al.* Health and mental health problems of homeless men and women in Baltimore. *JAMA* 1989;**262**:1352-7.
14 Ramsden SS, Nyiri P, Bridgewater J, EL-Kabir DJ. A mobile surgery for single homeless people in London. *BMJ* 1989;**298**:372-4.
15 Herzberg JL. No fixed abode: a comparison of men and women admitted to an east London psychiatric hospital. *Br J Psychiatry* 1987;**150**:621-7.
16 Weller MPI. Does the community care? *Public Health* 1986;**100**:76-83.

(Accepted 22 March 1991)