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Setting up new medical services

The homeless

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Summary

The medical literature on homeless people tends to concentrate on their biographic characteristics or clinical problems without enough attention being given to the social and environmental contexts which they have to survive. This article summarises the literature on the role of social factors in the causation and outcome of health problems of the homeless and emphasises the importance of addressing the social context in effecting intervention. Services that deal with the social needs of the homeless will be more successful in meeting their needs and reducing their distress.

Keywords: homelessness, healthcare

Homeless people: definition
People who lack a stable home and the personal resources, such as work, family and friends to acquire such a home

Box 1

Homeless people: classification
• homeless families in temporary accommodation like bed and breakfast hotels • single homeless people in hostels • single homeless people who sleep rough and use temporary shelters occasionally

Box 2

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Urbanisation and poverty are associated with high physical and mental morbidity.[1,2] The health problems of the urban poor are different to those of the better off because of poor personal and environmental hygiene. Housing is an important part of their environment and plays a significant role in physical and mental health.[3,4] Factors like humidity and temperature,[5] indoor air quality,[6] sanitation,[7] noise,[8] lack of space and domestic lighting are factors in housing conditions that influence both physical and mental health.[4] Curtis has studied the link between individual morbidity and living in a deprived area in three London Health Districts. She found that people in deprived areas had a higher prevalence of health problems and were more likely to consult their doctors than those living in affluent areas.[1]

Faris and Dunham, in 1935, in a classic study of mental hospital admissions for schizophrenia and depression, studied the distribution of admissions according to the social geography of Chicago. They found that there was a 10-fold higher admission rate in the inner city areas compared with the higher class suburbs.[9] Studies which compared urban populations with those of rural areas have found an excess of psychiatric morbidity in the urban areas.[2,11–13]

Hollingshead and Redlich in 1958 studied people in contact with psychiatric services in New Haven, US, and compared them with a sample from the general population. They found that the lower social classes had a much higher proportion of mental disorders especially psychoses. The authors suggested that the difference could be explained by the different diagnostic and therapeutic practices toward the lower classes.[14] More recent sociological investigations have supported this view.[15]

Defining homelessness

There is no generally accepted definition of 'homelessness'. Two universal features of homelessness have been identified. The first is a lack of adequate shelter that could be called home, and the second is absence of affiliative bonds to the social structure.[16,17] From these characteristics, a definition can be formed (box 1).

Under the terms of the 1948 National Assistance Act, the National Assistance Board had a duty to make provision for persons 'without a settled way of life'. Both the 1966 National Assistance Board survey *Homeless single persons* and the OPCS 1972 survey *Hostels and lodging houses for single people* adopted such a definition of homeless people.[18] The National Assistance Board defined homeless people as the people who use hostels, bed and breakfast hotels and other forms of temporary accommodation. Applying this definition broadly to the accommodation and situations of homeless people, they can be classified into three separate groups (box 2).

The health problems of homeless people

Homelessness is one aspect of severe urban deprivation. Homeless people are more vulnerable to the multiple health risks associated with urbanisation and poverty. Both the physical and mental health problems of the homeless could be explained in part by their poverty and being disadvantaged.

The loss of home is a life event that may precipitate mental or physical illness[12]; 46% of the women and 38% of the men who were displaced from the slums of West End of Boston, US, were found to have a long-term grief reaction to the loss of home.[19] A recent survey of the health status of single homeless people in Sheffield suggested that psychiatric symptoms in these people were the result rather than the cause of their homelessness.[20] Furthermore, both the life-style and the environmental conditions associated with homelessness are causes of health problems. The homeless are vulnerable to the effect of extreme climatic conditions and the difficulties of maintaining their body temperature

expose them to health problems ranging from hypothermia to heat stroke.[21] The higher prevalence of drinking problems among homeless people (compared with the general population) make them vulnerable to accidents,[22] while physical and mental problems associated with alcoholism can cause them to neglect their health and not to seek help in time.[23]

Those who sleep rough face adverse factors which predispose them to ill health. They are deprived of warmth, privacy, food, cleanliness, and healthcare.[24,25] The remaining homeless live in hostels or bed and breakfast hotels. These usually experience similar difficulties contributed to by crowding and lack of privacy, washing or cooking facilities.[26,27]

The constant mobility of the homeless, together with inadequate personal care[21] and poor diet,[28] make them vulnerable to a wide variety of health problems from leg ulceration to infectious diseases.[29] Tuberculosis is increasing in deprived urban areas, particularly among the homeless and other disadvantaged groups.[30,31]

The mortality of homeless people has been found to be four times higher than the mortality of the general population.[32] There is also an excessive mortality rate recorded in the winter months.[33] The commonest cause of death was found to be accidents,[32,34] while alcohol abuse had been a significant contributing factor in a large proportion of cases (70%).[34] Other common causes of death were tuberculosis and other respiratory diseases,[33] cirrhosis of the liver[32] and malignant diseases.[33] Although there may be a pre-existing vulnerability, the excessive early mortality could be explained by the stresses of poverty and the lack of economic security[35] which lead the homeless to neglect their health.[36]

Socio-economic factors have also been shown to affect health. For instance, Roper and Boyer, in a study of perceived health in 201 homeless men and women in Los Angeles, found that the length of unemployment, education, gender, and number of nights spent in the shelter were the best predictors of poor health.[37] In addition, Shanks noted that the excess consultation rate of homeless people to his general practice compared to that of the general population, disappeared when he adjusted for the difference in social class.[23] These studies indicate that the health problems of homeless people are closely related to their poverty and being disadvantaged.

Access of the homeless to healthcare

Homelessness increases the need for healthcare. However, the homeless under-utilise traditional health services.[23,38] They are less likely to be registered with a general practitioner[23,39] and more likely to use Accident and Emergency departments as an alternative.[40-42] They also tend to neglect their health problems until an advanced stage.[43,44]

In 1983 Shanks described the establishment of separate primary care services for the homeless population in Manchester. He reviewed the cases seen in the first quarter of 1981 and found that there was a high prevalence of chronic alcoholism and medical morbidity. Shanks concluded that the mode of delivery of care to this population is crucial as they did not use the mainstream medical services because they were suspicious of normal social mechanisms and conventional channels of care. In addition, the lack of co-operation between various health and social services diminished the impact of any healthcare intervention. His recommendations included encouragement of doctors trained in the relevant specialities to work with homeless people, the appointment of a salaried doctor to deal with this special group, and full co-operation between relevant agencies in order to implement a co-ordinated and comprehensive approach to dealing with their health and social problems.[23]

In 1987 Powell described a study to evaluate a primary healthcare scheme which was operated by house doctors working with single homeless hostel dwellers in Edinburgh. The scheme was acceptable to both hostel dwellers and staff and highlighted the high healthcare burden of this population. Female hostel residents requested a female practitioner within the scheme to work with them. The author discussed ways of improving the service through integrating it with mainstream healthcare provision with more involvement from other services, particularly psychiatric and social work.[44]

Shanks in 1988 carried out a three-year prospective study to assess the morbidity of homeless people in Manchester. Compared with the general population, adjusted for social class, homeless people had a similar overall consultation rate, although they showed a very different morbidity pattern. They had a higher number of consultations for psychiatric and dermatological conditions balanced by low consultation rates for cardiovascular and musculoskeletal disorders. He suggested that information collected by cross-sectional studies does not give the full picture of the levels of chronicity and

Homeless people: contacts with health services

Characterised by:
- less use of primary care mainstream services
- more use of A&E and hospital services
- presentation at a later stage of their illness

Box 3

Services that work with homeless people should:

- incorporate outreach community services
- address the complicated social problems of these people
- adopt a multidisciplinary approach

unmet needs that are due to homeless people's restricted access to healthcare. Shanks recorded only one diagnosis per consultation, although he noted that these patients usually presented with a multiplicity of problems.[43]

The consultations of 73 single homeless patients to the Accident and Emergency department in Newcastle were compared with an age-matched control group of 75 home-based patients by Maitra.[40] He suggested that hospital Accident and Emergency departments, which are used frequently by the homeless, are inappropriate to meet the special and complex health and social needs of these people.[40] He concluded that coordinated, comprehensive and coherent management of the health problems of the single homeless should address substance abuse and unemployment, and meet their need for psychological, social and medical support in the community. It is important to comment that the rising prevalence of drug and alcohol abuse among the homeless and home-based people is outstripping resources. The homeless tend to be left with unmet needs. The way forward is to commit adequate and ring-fenced resources for the treatment of substance-abuse problems in the homeless.

In the US, Robertson and Cousineau studied the health status and access to care reported by 238 homeless adults sampled from three 'lunch lines' and two shelters.[45] Only a third reported their health as fair or poor and women reported more health problems. Most of them were without health insurance (81%) because they could not afford it and because they had no permanent address. The authors concluded that homeless people have many health problems; face many barriers to necessary medical care and exhibit more costly utilisation patterns because of greater use of in-patient care. The large numbers of homeless people are a challenge to public health which has not yet been met.[45]

Homeless people exhibit patterns of health service utilisation that differ sharply from those of home-based people. Homeless people had higher rates of hospitalisation for physical and mental disorders but lower ambulatory care. They had fewer social contacts and a higher rate of imprisonment.[46] On the other hand, homelessness was found to influence physician decisions to admit patients. This was found to be related to the severity of social adversities rather than the severity of the illness.[47] It has been found recently that catering for the social needs of patients by a social worker in an emergency department had reduced the need for admission.[48]

Conclusion

The health problems of homeless people are closely associated with their poverty and with being disadvantaged. Epidemiological studies of these health problems have found that the most impressive association is with socio-economic variables related to poverty.[20,23,37]

Studies on the utilisation of health services by homeless people have shown that they are less likely to use mainstream health services, using Accident and Emergency Departments at later stages of their illnesses instead.[23,40,42] Specialist services that work with the homeless in their hostels, hotels and day centres, significantly increase utilisation. Catering for the social needs of the homeless is an important component of services to the homeless.[48]

Services that work with homeless people should deliver a holistic approach that takes into account their expressed needs to be able to meet their professionally assessed needs. This has a resource implication that should be considered within the needs assessment undertaken by health and social services joint commissioners in purchasing services. Pro-active multidisciplinary out-reach services that target their resources and expertise towards meeting the needs of homeless people are needed.[49]

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Medical Anniversary

FREDERICK BANTING, 4 NOVEMBER 1891

(Sir) Frederick Banting (1891–1941) was born in Ontario, Canada, and was educated at Toronto University where he qualified (1916) and soon joined the Royal Canadian Army Medical Corps. He earned the MC for gallantry in France. He was co-discoverer of insulin with JR Macleod, Charles Best and JB Collip. He became head of the Central Research Committee of the National Research Council of Canada. He was sadly killed in an air crash on 21 February, 1941. He is commemorated by the Banting Institute, the Banting Foundation and the Banting memorial lectureship of the University of Toronto.

— *DG James*