Audit of work at a medical centre for the homeless over one year

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SUMMARY. An audit of one years' work at a voluntary health care service for the homeless involving doctors, a chiropodist, nurses and social workers was carried out. It was found that although certain health problems are more common among the homeless than in the general population, the range resembles that in any general practice. However, registration with general practitioners was much less common among the homeless than in the general population, and a high proportion of referrals to hospital did not lead to appropriate treatment. The value of a special primary health care service for the homeless is discussed.

Introduction

A NUMBER of studies have looked at various aspects of the health of the single homeless[1-3] and their access to health care services.[4-7] The pattern which emerges from these studies is consistent — despite a higher rate of acute and chronic morbidity than the general population the single homeless have difficulties obtaining adequate health care and problems in using health facilities. Many of the homeless are not registered with a general practitioner and use accident and emergency departments inappropriately to obtain primary medical care.

At an evening centre for the single homeless in the City of London an attempt has been made to provide a limited primary medical care service. This paper reports an audit of the service provided over one year (February 1982 to January 1983).

Health care at St Botolph's Crypt

The evening centre at St Botolph's Aldgate Crypt is staffed by a mixture of paid staff and volunteers. It provides a meeting place in clean and pleasant surroundings, and free food is served to between 80 and 220 people each night. No one is turned away, even if drunk, except for violent behaviour; but alcohol is banned from the Crypt. A social worker is available to give advice and since February 1982 a doctor has attended the centre on one and sometimes two evenings each week. A chiropodist attends the centre each week, and on another night the medical room is staffed by a nurse. At other times the basic medical facilities are available for use by untrained staff. There is no appointment system, but when available a nurse volunteer acts as receptionist and nurse. The scheme operates outside the National Health Service and no prescriptions are issued; instead basic drugs are dispensed in small quantities. As a matter of policy, psychotropic medication and opiate painkillers are not dispensed.

The service is funded entirely by voluntary subscription and does not seek to provide comprehensive primary care. However, it was hoped that easy access to health care facilities in a familiar and informal environment would help to overcome obstacles which may prevent the homeless using normal services.

The audit

Medical service

During the study year the general practitioner conducted 475 consultations with 266 patients in 60 sessions. The patient's address and whether registered with a general practitioner were recorded at the first consultation.

Of the 266 patients 122 (45.9%) could give no fixed address. Ninety-six (36.1%) gave hostel addresses — this was probably an underestimate, as it relied on the addresses being recognized by the doctor. Forty-two (15.8%) gave other addresses which may have been lodging houses or bed and breakfast accommodation. Thus at least 82% of the patients seen could be classified as homeless. Data were not available for six patients (2.3%).

Only 13 of the 266 patients seen were women and of these eight were aged under 35 years. The modal age for the men was 40–45 years with a wide range — 19 were aged under 30 years, and 13 aged over 65 years.

Of the 266 patients 126 (47.3%) were registered with a general practitioner — 106 (39.8%) with a doctor somewhere in London and 20 (7.5%) with a doctor outside London. One hundred patients (37.6%) were not registered with a doctor and data were not available for 40 patients (15.0%). The proportion of patients with reasonable access to general medical services through the National Health Service was, therefore, probably less than 40%.

Figure 1 gives an indication of the principal problems dealt with in 408 consecutive consultations. A general medical history was also taken from all the patients seen by the chiropodist during the study year. Of the 114 patients 36% recorded alcohol problems in the past or present, 15% pulmonary tuberculosis, 31% a psychiatric history, 16% fractures and 11% peptic ulcers. Both these sets of data show the high prevalence of alcohol related problems, including tuberculosis and peptic ulceration. There is also much psychiatric illness. Other illnesses related to the lifestyle of the homeless, such as fractures, burns, infestations and head injuries, are more common than in general practice samples.[8,9]

Hospital referrals. When hospital referrals were made the patient was given a handwritten letter during the consultation. Because of the high rate of morbidity, the limited facilities, and lack of continuity of care, the referral rate was high — in the 475 consultations 70 referrals to hospital (14.7%) were made, and these were followed up by letters to the appropriate medical records officer. Forty-one replies were received (59% response rate). In 29 cases there was no trace of the patient being seen at the hospital after this referral. Of the remaining 12, five at-

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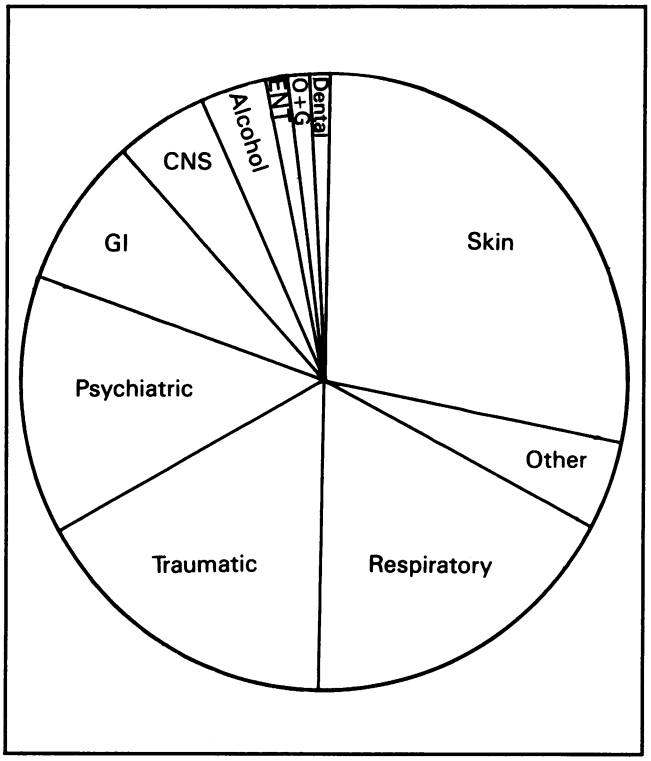

Figure 1. *Problems dealt with in the 408 consecutive consultations with the doctor. GI = gastrointestinal, CNS = central nervous system, ENT = ear, nose and throat, O + G = obstetrics and gynaecology.*

tended once and then did not attend for follow-up, two were admitted but defaulted subsequently from follow-up, and only five completed the course of hospital treatment as advised, two of these making one hospital visit only.

These results should be interpreted with caution, since the overall response rate was only 59% and the absence of a record of a referral does not mean that a consultation has not taken place; files may be misplaced or unavailable when required. Nevertheless the picture suggested by these data is bleak. Even allowing for possible inaccuracies, it seems that a high proportion of referrals did not lead to appropriate treatment. At least eight patients returned for a second letter saying that they had lost the first, and presumably other patients lost their letters but did not return. Appointments once made may not be kept, or follow-up visits missed. It appears that successful referral to secondary care is exceptional among this population.

Chiropody service

The homeless commonly walk miles for food, shelter, social security payments and so on; often in poor footwear and in all weathers. They have difficulty in gaining access to washing facilities and clean hosiery, and have a high prevalence of diseases affecting the feet such as alcoholism, malnutrition and burns.

To try to assess and meet the chiropody needs of the homeless a clinic was set up at the evening centre. After a simple foot bath a brief medical history was taken, the patient's chiropody problems assessed, treatment and footcare advice given, and a return appointment arranged if required.

During the study year 114 patients were treated (108 men and 6 women) and 161 treatments given in 39 sessions. The age structure of the population seen resembles that of the medical patients.

Foot hygiene was rated on a three point scale by the chiropodist. Good foot hygiene was taken to be feet that were clean without bathing (58% of patients), average those which were clean after a simple foot bath (38%), and poor those whose feet were ingrained with grime (4%). This distribution did not appear to differ markedly from that of the general population.

As expected, many of the patients' chiropody problems were due to poor footwear which was often ill-fitting, worn and not waterproof. Plastic shoes with no ventilation and cheap nylon socks, together with constant walking and hyperhidrosis led to gross maceration and blistering, the most common severe problem. Ulcers resulted from a variety of causes — pressure from thickened nails, breakdowns underlying hard corns, neglected burns or injuries to the feet.

Among the 114 patients 16 cases of foot deformities were seen. Of these, five were congenital, nine caused by injury and two by other illness.

Twenty-four patients (21.1%) had foot problems which were severe enough to require review within one week. Ulceration (nine patients) and blistering (11) were the most common reasons for arranging early review. Ten of the 24 patients complied with the request for early review.

Discussion

This audit gives some indication of the health problems and needs of the single homeless, and is broadly in agreement with the findings of other studies.[1,3,10] The morbidity in this group of people has changed little over the past two decades or even since Orwell[11] wrote about the homeless life. The major chronic problems seen are those traditionally associated with homelessness — mental illness, tuberculosis, chronic bronchitis, trauma and problem drinking.[1] Some homeless people have conditions such as epilepsy, physical handicap, and even Huntingdon's chorea, where the usual pattern of care has broken down.[2]

Minor, acute illnesses, which form a large proportion of the problems seen in primary care, present particular problems for the homeless. They lack the facilities to look after themselves when unwell and are at risk of particular infections and infestations because of their circumstances.

Perhaps one of the most valuable lessons of this project for the authors was the destruction of stereotypes and preconceptions about the homeless. Though certain problems are more common, the patients are as varied as those seen in any general practice.

As a society we accept that everyone has the right to health care. How best can that care be delivered to this group? Some have argued[5,7] that no special provision should be made, suggesting that if general practitioners and hospital staff were educated to be more sympathetic to the homeless, and homeless patients taught how to use the health service, the present system would be quite adequate. Technically, temporary resident and emergency treatment procedures do enable the homeless to have access to general medical services, and subsequent hospital referral is then possible. It is further argued that a special service would stigmatize the homeless, and discourage other areas of the health service from taking any responsibility.

However, these arguments are unrealistic. Many of the single homeless are not registered with a general practitioner, and many find it difficult to deal with health service bureaucracy. Suspicion of authority and a disorganized approach to life militate against using normal care facilities and against complying with treatment when offered, as demonstrated by the follow-up of hospital referrals reported here.

There are advantages in having health professionals who are trained in primary health care skills — general practice, community nursing, chiropody and so on — but who also have specialist knowledge of the homeless. That this would increase the stigma of this group is irrelevant — the homeless are already sitgmatized by society. Growth of expertise and knowledge among those providing health care for the homeless may be an important way of changing attitudes, just as the hospice movement has changed attitudes to the terminally ill.

It may be that the best way to provide health care for the homeless is a multipurpose day or evening centre. Other options are a surgery in the area which makes this group especially welcome, or a peripatetic service offering health care at hostels, day centres, and other places where the homeless are to be found. The Department of Health and Social Security in conjunction with the City and East London Family Practitioner Committee and the Department of General Practice at St Bartholomew's and the London Hospital Medical Colleges, is currently piloting such a project in east London.

If special facilities are provided, it is essential that they be of a similar standard to the primary health care provided to the rest of the population. Those which exist are mainly privately funded and staffed by volunteers and although they have done valuable pioneering work, this is no way to provide primary health care to the poorest section of our population. What is required is a comprehensive primary health care team working from adequate premises with access to pathology and other services such as chiropody and physiotherapy. A major aim should be to encourage the re-integration of patients into the conventional care system, while accepting that this will not always be possible. These are not second class people, and they deserve better than second class service.

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Quality of life on antihypertensive drugs

A multicentre randomized double-blind clinical trial was conducted among 626 men with mild to moderate hypertension to determine the effects of captopril, methyldopa and propranolol on their quality of life. Hydrochlorothiazide was added if needed to control blood pressure. After a 24-week treatment period, all three groups had similar blood pressure control, although fewer patients taking propranolol required hydrochlorothiazide. Patients taking captopril alone or in combination with a diuretic were least likely to withdraw from treatment because of adverse effects (8% vs. 20% for methyldopa and 13% for propranolol). The treatment groups were similar in scores for sleep dysfunction, visual memory, and social participation. However, patients taking captopril, as compared with patients taking methyldopa, scored significantly higher ($P<0.05$ to <0.01) on measures of general well-being, had fewer side effects, and had better scores for work performance, visual–motor functioning, and measures of life satisfaction. Patients taking propranolol also reported better work performance than patients taking methyldopa. Patients taking captopril reported fewer side effects and less sexual dysfunction than those taking propranolol and had greater improvement ($P<0.05$ to <0.01) on measures of general well-being.

The findings show that antihypertensive agents have different effects on the quality of life and that these can be meaningfully assessed with available psychosocial measures.

Source: Croog SH, Levine S, Testa MA, *et al.* The effects of antihypertensive therapy on the quality of life. *N Engl J Med* 1986; **314:** 1657-1664.