Medical provision for the homeless in Manchester

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SUMMARY. The events leading up to the establishment of a separate primary care service for the homeless and rootless population in Manchester are described.

The organization, funding and commitment of the project are outlined and an insight into the life-style of this population is provided.

During the first quarter of 1981, 2,049 consultations were given. The most common causes for consultation were psychiatric, alcoholic and respiratory conditions.

Introduction

THE problems of medical services for inner city areas are now attracting serious and increasing interest, with particular concern being directed to the single homeless. The plight of this group, who seem to be drawn to large towns and cities, is not a new phenomenon (Mayhew, 1861; Booth, 1890; London, 1903) and public attention has been focussed upon it by several authors in the last few years (Timms, 1968; Stewart, 1974; Cook, 1975; Shanks and Owen, 1981; Shanks, 1981a, b, c).

Historically, the medical care of the homeless has been at best perfunctory and has depended largely on the efforts of sympathetic individuals. As long ago as 1954 Sargaison reported that:

> "the main gap in the welfare legislation is found in the lack of facilities for dealing with illnesses in elderly lodging house men."

Even today, large numbers of homeless people experience difficulty in obtaining medical care (Davies, 1974) and, because they have no fixed address, they are often not registered with a general practitioner. Hewetson (1975) found that 13 per cent of the inmates of this country's largest reception centre had never been on a doctor's list; 24 per cent had once been on one but were no longer registered. Sixty-three per cent were nominally on a doctor's list, but the majority of these were registered with doctors in distant practices so that, for all practical purposes, they did not have a family doctor. A census carried out in Edinburgh revealed that only 32 per cent of hostel residents were registered with a general practitioner (MacLean and Naumann, 1979), whereas the number of registrations in Scotland as a whole was 6 per cent greater than the total population—the 'inflation' effect. Thus homeless people are heavily dependent for medical care on an already overburdened hospital casualty service. Jeffrey (1979) reported on the hostile attitude towards deviant patients shown by some staff in casualty departments. Such patients pose a problem with which the NHS is at present ill-equipped to deal *(British Medical Journal,* 1976), so that the DHSS (1975) has felt it necessary to draw the attention of area health authorities to their responsibilities.

The homeless, because of their life-style, form a subgroup of people with particular patterns of morbidity which require more than average medical care. For example, Scott and his colleagues (1966) revealed that less than half were free from chronic disease, 17 per cent had chronic bronchitis, 10 per cent had pulmonary tuberculosis and 28 per cent suffered from a psychiatric disorder or epilepsy. Alstrom and colleagues (1975) reported a significant excess mortality for all age groups among those living in common lodging houses, compared with the general population.

Aims

The aim of the present paper is to describe a primary care medical service set up for the homeless population of Manchester.

The practice

In 1977 the Medical Practices Committee agreed that the Manchester Family Practitioner Committee could establish a limited-list practice to deal solely with the

homeless, who then numbered some 2,500. By agreement with the Manchester Area Health Committee I was granted a full-time Research Fellowship for two years and was attached to the staff of the Area Medical Officer, with the remit to study both the medical problems of the homeless and the organization of primary care. The arrangement agreed with the Medical Practices Committee was for the general practitioner (the author) to operate a limited-list practice, the earnings from which were to be assigned to the Area Health Authority. My salary was related to the Senior Clinical Medical Officer grade and paid by the Area Health Authority.

I was appointed in 1978 and soon discovered the size and complexity of the problem. Initially, I provided medical care for one night shelter with a registered maximum capacity of 80 but which, in practice, housed some 300 people a night. In the early stages it was difficult to provide any sort of medical care because I had practically none of the basic facilities which are normally taken for granted in general practice. There was no electricity, no adequate sanitation, no running water and no privacy. At the time of my appointment there were not enough beds to go round and the majority of the inmates slept on chairs, on the bare concrete floor or on urine-soaked mattresses placed thereon. This situation has improved now that the shelter is required by the Environmental Health Department to restrict its admissions to the registered maximum (108), but conditions still remain primitive and grossly inadequate.

Initially I held consulting sessions at 07.30 and 19.30, these being the times when the majority of the homeless were likely to be in residence. I considered it vital to ensure that my services were not only available but seen to be available, so that necessary medical care could be provided and some form of rapport developed.

The service has now expanded to cover other parts of Manchester, including visits to eight hostels or lodging houses and to two day centres. There is no central surgery and all consultations are conducted in the hostels themselves, to ensure easy accessibility for residents. The consultations are held at the times when a large number of the residents can be expected to be present. There is no appointment system. Any warden, police officer or probation officer who is concerned about a particular individual may bring him or her to see me without prior arrangement.

The consulting-room facilities are still very inadequate and consist only of the bare necessities. At one day centre only a formica-topped table and a chair are provided, situated in the middle of a large day-room where, at other times, activities such as table-tennis, snooker and darts take place. Despite this, there may be 30 or more people to be seen, some of whom have travelled from across Manchester and beyond seeking medical attention but who, because of their nomadic life-style, will not accept conventional medical care.

Out-of-hours problems are normally dealt with by myself, although there is provision for occasional support and holiday relief from the medical emergency deputizing services. A previous arrangement with a local single-handed practitioner was unsuccessful.

There is the same access to hospital diagnostic facilities as for other general practitioners. By personal contact it has been possible to develop special links with some hospital consultants whose services are frequently called upon (psychiatrists, chest physicians and surgeons). Thus patients coming into these categories may, at times, enjoy preferential treatment.

There are no ancillary staff, and some consultations may be hurried and cursory. Nonetheless, routine treatments such as chiropody, minor surgery, counselling, dressings, disinfestation, conventional nursing tasks and antenatal and post-natal services are provided, these being carried out by the author.

In addition, the harrowing task of routine paperwork as well as the completion of medical record cards and E.C.1 forms has to be undertaken. Recently, however, a secretary has been appointed to help with standard office procedures, and until recently I enjoyed the help of a voluntary chiropodist who accompanied me to a large municipal common lodging house once a week. Although no nursing care was provided initially, the district nursing services have lately begun to show an interest.

The patients

Most cities have their share of middle-aged and elderly men who drowse away alcoholic afternoons on the common or, purple-faced and oblivious, wander through glass-littered alleys in the inner city areas. These cities act as unwilling repositories for the unwashed and unwanted escapees from conventional life, who spend their time among a scattering of like-minded companions, whose loneliness and depression is punctuated by outbursts of aggression. These are the homeless and rootless in the true sense, belonging to nobody and to nowhere. They usually have no family ties, eat poorly, neglect medical care and are the products of various forms of deprivation in the lower social strata. They are dependent on official or voluntary charity and, through self-neglect, appear to be destined to ill-health (Shanks, 1981a). My limited-list practice is drawn solely from this group; it is restricted to inmates of hostels and common lodging houses, vagrants sleeping rough and people recently discharged from prison.

The common lodging house developed in the nineteenth century and the description of its habitués has changed little over the years:

> "No description can give an adequate idea of these receptacles of poverty and vice."

wrote the Reverend Sym in 1848. More recently, in 1956, *The Times* described the inhabitants of common lodging houses as:

Conditions seen in Manchester common lodging houses during the first quarter of 1981.

Diagnostic category	Number	Percentage
Communicable diseases	68	3.3
Neoplastic	15	0.7
Metabolic	23	1.1
Haematological	26	1.3
Psychiatric	407	19.9
Alcoholism	369	18.0
Cardiovascular	78	3.8
Respiratory	281	13.7
Gastro-intestinal	149	7.3
Obstetric or gynaecological	31	1.5
Genito-urinary	17	0.8
Dermatological	126	6.1
Musculoskeletal	84	4.1
Trauma	132	6.4
Chiropody	83	4.1
Social	91	4.4
Others	69	3.4
Total	2049	100.0

> "men who have had a row with their wife, youths who have drifted from casual employment into permanent unemployment, newly arrived labourers from Ireland, old lags, alcoholics, criminals on the run, mental defectives."

As a class, the homeless provide an unusually heterogeneous sample. I have reported elsewhere the difficulties encountered in obtaining reliable information from this section of society (Shanks, 1981c), and certain local factors, such as the discharge policy of the nearby psychiatric unit, will affect the composition of this population as well as its source (from lodging houses, reception centre or those sleeping rough). However, whatever their diversity, the homeless may have personality factors in common.

In Manchester this population appears to be composed mainly of people of Celtic or Northern origin who are usually male, single, homeless, and suffering from personality disorders and social ostracism. Further, there is a high incidence of chronic alcoholism and medical morbidity (Shanks, 1981b).

Consultations

Eight hundred and seventy-three different homeless patients were examined in the first quarter of 1981; 826 (94.6 per cent) were male and 47 (5.4 per cent) were female. An analysis of the diagnoses is shown in the Table and gives an average of 2.3 diagnoses per patient.

Discussion

The general standard of health among the homeless is poor and is aggravated by the squalid and dirty conditions in which they often live. Sometimes they are quite unwilling to seek help, even though they may be suffering from chronic disabling conditions such as tuberculosis which, in the 1950s, was the fourth most common cause of death among the inhabitants of the common lodging houses in Glasgow (Laidlaw, 1955). Severe under-use of conventional health-care facilities by the homeless is endemic. It is difficult to take preventive health measures among such a population, and throughout history they have provided a nucleus for serious outbreaks of disease such as cholera, smallpox and enteric fever (Laidlaw, 1955).

The single homeless clearly require medical care, and they should have the same right of access to general medical services as all other members of the community. No one would disagree with this desire. Yet my experience suggests that the problem in caring for the group lies not so much in the availability of care as in its delivery. Many of the single homeless are suspicious of normal social mechanisms and conventional channels of access to medical care, and because of this they fail to use the mainstream medical services. Equally, some general practitioners may resist (or, at least, not encourage) requests from the homeless for medical care. Other patients may be unwilling to use the same surgery premises for fear of infestation and contracting a communicable disease and may be disturbed by the unkempt appearance and bizarre behaviour of some of the homeless.

Certain individuals working in this field have managed to overcome some of these barriers to delivery of health care to the homeless and achieve some success. However, their impact is often diminished by a lack of any co-ordinated approach by the authorities and by the isolation in which they are usually working.

This lack of co-operation between the various statutory bodies providing health and social care does not allow the best use of existing resources. It is not so much a question of there being no one available able to offer assistance as a need to make existing resources available. One solution would be to encourage doctors undergoing higher training in the relevant specialties (general practice, psychiatry and chest medicine) to become involved in delivering medical care to the homeless. In the long term, however, the only solution is full co-operation between the agencies concerned, so that a common approach may be defined and the experience of the homeless becomes known. But, unfortunately, as there is no effective, central organizing body which controls and supervises the delivery of medical care, the DHSS may in the future have to consider an alternative system of primary medical care for the homeless. Under this system, salaried doctors could be appointed to deal with this special group. Ideally, full-time posts, with suitable incentives, should be created to attract people to work with the homeless, and essential financial provision should be made available for premises and supporting staff.

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Acknowledgements

I am grateful to Dr. H. W. K. Acheson, Senior Lecturer, Department of General Practice, Manchester University, for his help and encouragement over the submission of this paper, to the Endowment Panel of the Manchester Area Health Authority for their support of the Research Fellowship, and to Dr Peter Povey for his guidance and permission to publish.

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Clinical trials

The problems posed for the clinician who has patients in randomized clinical trials are reviewed.

Source: Schafer, A. (1982). The ethics of the randomized clinical trial. *New England Journal of Medicine,* **307,** 719-724.