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# **Homelessness and Health: What do we know? What should be done?**

by Anne-Marie Barry, Roy Carr-Hill  
and Julie Glanville

## **DISCUSSION PAPER 84**



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**WHAT SHOULD BE DONE?**

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## Abstract

This paper first reviews the range of health problems faced by different groups of the 'homeless', and second, the use of health services by the homeless and, in particular, their first contact with the service. The current patterns of provision have been widely criticised and the various attempts and proposals to improve provisions are examined. The paper concludes by discussing the types of research which are required to develop adequate and appropriate policies.

## INTRODUCTION

There is a considerable body of knowledge on homelessness but much less is known about the implications of homelessness for health and for the appropriate provision of health care. The purpose of this paper is twofold. First to review what is known about the issue of homelessness and health and, in particular, to identify gaps in the existing knowledge base; and second, to assess existing or proposed policy 'solutions' to the health problems of the homeless taking into account the reforms of community care following the Griffiths Report as well as the new contract for General Practitioners.

The range of health problems faced by different groups of the 'homeless' are considered in the first section. The use of health services by the homeless and in particular their first contact with the service is the subject of the second section. The current pattern of provision is widely criticised and there have been various attempts and proposals to improve provision which are examined in section three. This leads on in the final section to the discussion of the types of research which are required to develop adequate and appropriate policies.

## I THE HEALTH PROBLEMS OF THE HOMELESS

There is a close relationship between homelessness and poor health. Homelessness has been found to be associated with excess morbidity and mortality (Webster and Rawson 1977; Asander 1980; Brickner et al 1986) and with an increased risk of communicable diseases, injuries, hypothermia and malnutrition (Robertson and Cousineau 1986). Chronic health problems are described in a variety of studies with respiratory complaints being the commonest, but including malnutrition, pulmonary TB, physical handicaps, mental illness, personality disorders, alcohol abuse, drug abuse and epilepsy (Webster and Rawson 1977; Hewetson 1975; Blower 1978; Borg 1978; Baxter and Hopper 1984; Kroll et al 1986). Indeed, it has been argued that poor health is one of the defining characteristics of the single homeless (Greve and Currie 1990).

But a stereotypical image of the homeless as uniformly destitute, male and alcoholic is inadequate (Brickner et al 1986). Much of the recent literature emphasises the diverse character of the homeless and, in particular, the growth of the 'new homeless', that is families, women, children and young people.

Since the Second World War, housing policy makers have aimed at providing a home for every family who wanted one and, indeed, by the mid 1960s with the growth of the stock of council housing, the numbers of persons living in temporary accommodation had dropped to a very low level (see Table 1). However, numbers started to increase again especially when new building was curtailed after 1979 at the same time as the right to buy was introduced; the majority of these 'new' homeless families are in Bed and Breakfast accommodation.

Table 1      New Council Housing Starts and Numbers of Families Registered as Homeless since the Second World War, England and Wales (1)

	Homeless Households (2)		Council Housing		
	Numbers of persons in temp. accom. (thousands)	Applications accepted by local council Thousands of households      Proportion with Dependent Children	Completions (thousands)	Sales(3) (thousands)	
1966	13				
1970	24				
1973	21		72	34	
1975		34	89	5	
1977		32	108	13	
1980	(half year only)	33	67	71	81 (4)
1981		75	65	47	103
1982		78	65	30	202
1983		83	62	30	146 (5)
1984		94	61	29	103
1985		102	67	23	92
1986		109	66	19	88
1987		118	65	16	102 (6)
1988		123	65	16	147

Notes:

- 1      Counting rules changed completely at least three times during this period: from 1966 to 1973 numbers of persons were counted; from 1974 applications accepted by the local authority from households were counted. Further, after the introduction of the Housing (Homeless Persons) Act 1977, the coverage changed. According to Social Trends the results for 1983 and 1984 are not fully comparable with earlier years.
- 2      If a household, after the authority has accepted responsibility, leaves without contacting the authority and no further contact is made during the following six months, it is assumed that they are no longer homeless.
- 3      Including leases, disposals to housing associations and disposals of property previously municipalised.
- 4      The 'right to buy' established by the Housing Act 1980 came into force in October 1980.
- 5      Includes the sales of some 3,000 dwellings on Council Farm Estate, Knowsley to Stockbridge Village Trust.
- 6      Including sale of 5480 dwellings by the London Residuary Body to Thamesmead Town Ltd.

Sources:      Columns (1-3) Social Trends various years  
                  Columns (4-5) Housing and Construction States various years.



This phenomenon is not specific to the UK. Whilst homelessness was thought to be decreasing by the late 1960s (Caplow 1970), increases were noted during the 1970s and 1980s in several major cities of the industrialised world (Darnton-Hill et al 1990). In the United States, the increase between 1982-83 was estimated to be thirty eight per cent (Marwick 1985). The composition of the homeless population in the US is also shifting from the classic skidrow image to include more women, young drug abusers, younger unemployed men and those with a past history of severe psychiatric disturbance (Fischer et al 1986; Levett 1986).

Different groups have different health care needs as their health problems vary widely. Three groups are considered here: homeless families, the destitute and the single homeless.

a) Homeless Families

The health problems of homeless families temporarily housed in bed and breakfast accommodation are a product of social and environmental deficiencies. A report jointly produced by the Health Visitors Association and the British Medical Association (1988), states that most accommodation of this sort is insanitary and lacking in the most basic amenities. Diseases spread quickly and infestation in the form of scabies, lice, fleas, bedbugs and mice are common. The physical condition of the buildings adds to potential health problems since over a third of multi-occupied dwellings lack adequate fire escapes and are in need of major repairs and 15% are overcrowded (ibid, p12).

The connection between this 'new' homelessness and poor health was first demonstrated by an assessment of the experience of homelessness, based

on a sample of 521 homeless families in London (Randall et al, 1982). This revealed that the majority of the respondents had experienced some deterioration in their health. The most common complaint was that of 'mental strain', '... which ranged from 'nerves' and tension to nervous breakdowns. Forty two per cent of all families said that one or both adults in the family had suffered such strain' (Randall et al, 1982; p 29). Later, Watson and Austerberry (1986), also discussed the mental illness, anxiety and depression experienced by homeless women concluding that '... mental illness, anxiety and depression appear to be a result of homelessness in as many cases as they appear to be the cause'.

The most detailed examination of health and homelessness, however, is to be found in *Prescription for Poor Health - The Crisis for Homeless Families*, produced jointly by the London Food Commission, the Maternity Alliance, SHAC and Shelter (Conway, 1988). The particular focus of that study was the health of mothers and children under five based on 57 women and their children in London, Manchester and Southend and interviews with relevant professionals. The health records of other women and children in the same geographical area were also examined in order to compare the health status of those living in hotels and similar people in the general population.

*Prescription for Poor Health*, begins by appraising the links between poverty, poor housing and poor health.

Housing acts as a crucial link between poverty and health because, as shown by successive housing condition surveys, poor people tend to live in the worst housing. Those who have failed to secure any form of permanent housing - the homeless are in the worst position of all, and are amongst the poorest and most vulnerable in society (Conway, 1988; p5).

The poor health of those families housed temporarily in hotels is examined in terms of problems of hygiene, housing conditions, diet, resources and safety. In particular the authors point to three factors which present particular risks to those living in hotels. (i) Conditions for storing, preparing and cooking food are generally poor, as are washing facilities and the general condition of the buildings. (ii) People housed in hotels tend to be unemployed or on low wages and have large families; three groups of people who are generally vulnerable to poor health. (iii) Living conditions are stressful and depressing which results in a general tendency to poor health (Conway, 1988; p 10).

Analysis of the interviews of the 57 women reveals that depression and tension are very common, as are minor illness such as headaches, migraines, vomiting, diarrhoea and chest infections. Similar conclusions are also made by the authors of *Homeless Families and Their Health*. They report high rates of mental illness and strain.

Marital and emotional problems, behavioural problems and developmental delay in children have been found. Depression and post-natal depression are common. Homelessness causes stress and anxiety which in turn cause deteriorating family relationships (Health Visitors Association and the General Medical Services Committee of the BMA, 1988; p 12).

Of the 57 women interviewed by the authors of *Prescription for Poor Health*, 34 reported that they had suffered from headaches and migraine. Twenty had suffered vomiting and diarrhoea and 16 had had some sort of chest infection. One GP interviewed said that the homeless experienced '... more psychiatric problems, depression, anxiety and sleeplessness, and more homeless children suffer from more respiratory tract infections ... There is a higher consultation rate amongst the homeless than other patients.'

(Conway, 1988; p 43).

The authors also examined the health of children under five and pregnant women and conclude that all these problems occur in an exaggerated form for these two groups. Women housed in hotels tended to have more post-natal complications and smaller babies than the general population. Five of the 19 babies included in this survey were premature and 2 had low birth weights. The health of children is said to be poor because of inadequate diet and poor safety conditions in the hotels. The research carried out for this book indicates that 'Hotel children are often late walkers, late talkers and slow in keeping themselves clean. You often see children still walking around in nappies at three years old', (Conway, 1988; p 82; see also Health Visitors Association and the General Medical Service Committee of the BMA, 1988).

The incidence of inadequate diets is greater when people are homeless or housed in a hotel. Forty eight of the 57 interviewed in the survey whose diets were analysed were eating poor diets, with a tendency to depend on take-aways, cafes, snacks and pre-packaged convenience foods. The authors report that '... the consumption of fruit and vegetables was generally lower than for other low income groups in the general population' (Conway 1988, p 58). This is linked to the families' access to adequate cooking facilities. Where families had regular access to a kitchen they ate more fresh fruit and vegetables than those without such access. A third of the women who did not use a kitchen rarely ate vegetables or salad (Conway 1988; p 65).

There is no doubt that restrictions on council housing have led to the growth in the numbers of homeless families. Moreover, the evidence

conclusively demonstrates the association between homelessness and poor health and the difficult living conditions experienced by those in bed and breakfast accommodation. But, whilst there is every reason to argue, independently of any health implications, that everyone has a right to adequate housing, it is less clear that homelessness per se is the cause of poor health. Thus, Ward (1979) and Drake et al (1981) have both argued that those who become homeless were in poor health before they became homeless.

b) The Health of the Destitute and Homeless

The term 'destitute' implies a dependence on hostel or night shelter accommodation and a different range of health problems to those discussed in the preceding section. Such people are prone to mental illness and alcoholism as well as specific diseases such as TB and epilepsy. The evidence cited in most instances is based on case studies of admissions to hospitals or samples taken in hostels or night shelters; a comparison by Priest (1971) of those in common lodging houses and those seen in a clinic showed a high incidence of schizophrenia even among those in common lodging houses. Many of the discussions are placed in the wider context of changing patterns of caring for the mentally ill; for example Brickner et al (1986) argue that greater importance attached recently to the care of the mentally ill in the community in America has resulted in larger numbers of mentally ill people being homeless (see also Darnton-Hill et al 1990 for Australia and Joseph et al, 1990, p.270 for the UK). The latter also suggest that there is a connection between the closure of long-stay psychiatric hospitals and the increasing number of mentally ill homeless people.

Nevertheless, vagrancy is not 'new' in the same way as was suggested

for homeless families; neither are their health problems. For example, two studies in the mid 1970s suggested there was a typical disease pattern amongst vagrants. Stewart (1975) concluded that the most common diseases amongst the homeless are bronchitis, cardiac diseases, TB, arthritis, diseases of the central nervous system, mental deficiency, alcoholism, epilepsy and psychiatric illness. Similar conclusions were drawn by Hewetson (1975) based on the author's own experience of working at reception centres. He reported malnutrition, pulmonary TB, physical handicap, loss of limbs, mental illness and mental defects and alcohol and drug abuse as the main forms of illness among the destitute.

Findings based on more recent surveys show the same pattern. Thus, Jones (1987) examined the social and medical problems of 171 residents of three hostels and found that the most common problems were related to alcohol, disability and psychiatric problems. Fifty seven of the sample of 171 had alcohol related problems and 41 had psychiatric problems, while a further 26 had some form of physical disability (*ibid*, p 27).

It appears that there are three main health problems for the destitute and homeless. Firstly, a broad range of physical illnesses related to the condition of homelessness; secondly, alcohol and drug related problems; and thirdly, psychiatric conditions. The three categories are not mutually exclusive but are closely connected, especially the second and third.

#### i) Physical Illnesses

Destitute people are susceptible to infectious diseases especially pulmonary tuberculosis (Barry et al, 1986; Capewell et al, 1986; Gross and Rosenberg 1987; Nardell et al 1986; Schieffelbein and Snider 1988; Shanks and

Carroll 1982, 1984); they are vulnerable to dermatological and muscular skeletal diseases (Ramsden et al 1989; Shanks, 1988; Toon et al 1987); and homeless women are more likely to experience difficulty during pregnancy (Conway, 1988).

Recent statistics provided by Crisis on those people using their medical facilities between 22-27 December 1989, indicate that many of the illnesses of homeless people can be directly related to their life on the streets. Typical of such complaints were respiratory ailments, including bronchitis and asthma. Analysis of the data on the types and numbers of requests to the medical team (based on presenting problems rather than related problems such as alcohol and drugs) reveals a wide range of illnesses, including nose and throat problems, skin complaints, 'flu', colds and angina. The Crisis information also provides a breakdown of the type and range of illnesses experienced by homeless women (55 of the total 491 in the sample). For example, two of the ten women who had recently been in hospital had been there to give birth. The remainder had been there for treatment of hepatitis, hernia, sterilisation, miscarriage, abortion and minor operations (Crisis, 1990). Herzeberg (1987) also discusses the range of physical illnesses experienced by homeless women in his study of homeless men and women admitted to an East London psychiatric hospital during the period 1971-1980. These included carcinoma of the breast, pyrexia and epilepsy.

Information provided by the Great Chapel Street Medical Centre and Wytham Hall residential medical centre further describes the range and types of illnesses of homeless people. Analysis of the data concerning 1482 new patients treated by the Great Chapel Street Medical Centre (their Annual

Report for 1988-89) between 1 March 1988 and 28 February 1989 indicates that the most common complaints were psychiatric (19%), respiratory (17%) and dermatological (12%). Amongst the other presenting problems were neurological illnesses (8%) and problems related to the digestive system (4%). The data from Wytham Hall also gives information about the second and third diagnosis of the patient. Primary diagnosis confirms the pattern of health problems discussed above. The second and third diagnoses show the high rate of problems related to mental illness, alcohol and drug abuse (Wytham Hall Annual Report 1988-89).

ii) Mental Illness, Alcohol and Drug Related Problems

An early study in London by Wood (1979) examined the incidences of schizophrenia and personality disorder amongst all those who stayed at the Camberwell Reception Centre during 1972. Her research indicates the particularly high prevalence of mental illness, alcoholism, personality disorder and general ill health amongst those passing through the Centre. For example, of the c.4000 attending as new cases at the Centre, 890 had some form of mental illness, 550 had alcohol and addiction related problems and 770 had some form of personality disorder (Wood 1979; p 207).

Current data show a similar pattern. Thus among patients seen by the Crisis medical team over the Christmas period of 1989, alcohol and drug withdrawal accounted for 26 requests for medical treatment. The same problems were given as reasons for recent admissions to hospital in 10 out of 70 cases (Crisis, 1990). Crisis also reports that psychiatric problems were given as reasons for recent admissions to hospital in 16 out of 70 cases and the primary diagnosis of those admitted to Wytham Hall in one year was



psychiatric related in 26% of the cases (Wytham Hall Annual Report, 1988-89).

The study carried out by Joseph et al (1990) describes a drop-in psychiatric clinic in Great Chapel Street Medical Centre, involving 260 new patients seen between June 1984 and May 1987. The patients were mainly male (89%), single (79%) and aged between 25 and 34 (50%). Schizophrenia was the most common diagnosis (24%), followed by personality disorder (20%) and alcohol related problems (17%). The remainder were characterised by neurotic disorders and drug dependence.

In the American context, it has been suggested that an increasingly large part of the homeless population are mentally ill (Fischer 1985). The single homeless are said to be particularly vulnerable to psychiatric and physical ill health since their lifestyle makes it difficult for them to be integrated into the existing health system. Indeed, Joseph et al (1990) argue that there is '... evidence that these people are mentally ill before becoming homeless and that their illness may be the cause of their homelessness' (p.270). On the other hand, the growing incidence of psychiatric and alcohol-related disorders in the population of homeless people (Drennan and Stearn 1986; Featherstone and Ashmore 1988; Gelberg et al 1988; Koegel and Burnham, 1988; Shanks 1988; Weller 1989) might more adequately be explained with reference to a process of de-institutionalisation which is poorly coordinated with the provision of shelter (Lowry 1990; Marshall 1989).

c) The health problems of the single (young) homeless

Recent public debate has focussed on the growth of the numbers of young

homeless appearing in city centres. But, in the literature available, their health problems are not usually distinguished from the general health problems of the single homeless. It is far more common for these two groups of homeless people to be discussed in relation to the provision of health care, rather than specifying the varying range of health problems they experience.

The CHAR (1983) study, *Single Homeless - The Facts*, is based on a sample of 521 homeless people in Bedford, Brighton, Camden, Haringey, Manchester, Stoke on Trent, and Tower Hamlets in 1982. This study indicates that at the time of the interviews, 49% of people had some sort of social or medical problem and 30% were suffering from a physical illness or handicap. Jones (1987) found that 20% of young people interviewed in Leeds were vulnerable due to ill-health, handicap, drug addiction or alcohol abuse. Once again, these figures are not unusual. In Australia, Darnton-Hill et al (1990) found that the percentage of men reporting symptoms or past histories of ill-health were approximately double the proportion of industrial workers. Moreover, the effects of these as well as other minor disorders may be exacerbated by the under-availability and under-use of primary medical care (Beecham 1988; Boyer 1986; Health Visitors Association and General Medical Services Committee of the BMA, 1988; Lovell 1986; Lowry 1989; Powell 1987; Stearn 1987; Williams and Allen 1989).

Recent data available from such organisations as Crisis and the Great Chapel Street Medical Centre do not provide specific information of the nature and range of health problems of young people. Figures from both sources do, however, indicate that young people form an increasingly important section of the homeless population. Great Chapel Street Medical

centre in particular was set up to provide open access to health care for young people and the clinic reports that the majority of its new patients continue to be under 35. The mean age for people treated in the year 1988-89 was 30.5. Statistics on new patients for the same years show that 37% were between the ages of 17-24 and 28% were between 25 and 34 (Great Chapel Street Medical Centre 1989). In comparison, Crisis seems to deal with an older range of people. Figures for the Christmas 1989 period show that only 19% of those treated were under 25, although 77% were under 45. This fact, says Crisis, helps in '... dispelling the widely held belief that those afflicted by homelessness are grey' (Crisis 1989).

## II USE OF THE HEALTH SERVICE BY THE HOMELESS

In this section, the way in which the various groups of the homeless use the existing health services is described. This discussion highlights some of the problems with the structure and administration of the health service. It also acts as an introduction to the discussion in the next section on the provision of primary health care for the homeless, since the majority of such projects were established to overcome difficulties experienced by the homeless in gaining access to primary health care.

Many of the problems of inadequate health care provision for the homeless stem from their low rate of registration with GPs. Thus, in the mid 1970s, Hewetson emphasised the difficulties this presented for the administration of the health services because the homeless do not '... fit into NHS clerical arrangements being of no fixed abode, usually lacking a medical card, and having no medical records ...' (Hewetson 1975; p 12). The significance of this failure to register with a GP has been underlined

recently by Powell: '... lack of registration does imply that the person is not willing or is unable to obtain the services provided through the normal primary care mechanism' (Powell 1988a).

This is not a problem confined to those staying in hostels or those of no fixed abode. In *Homeless Families and Their Health*, the authors state that registering with a doctor is not always the first priority of homeless families, given the many other problems they are likely to face. In addition, homeless families tend to be unfamiliar with the local GPs and their surgery arrangements. This leads to the homeless having a lower rate of registration than the general population. The report also draws attention to the problems of those families whose first language is not English and therefore have an additional barrier to establishing contact with a GP (Health Visitors Association and the General Medical Service Committee of the BMA, 1988). The extent of this problem is highlighted by Davies (1987) in his study of homeless families in the Finsbury Park area: 60% of the families were Asian, principally from Bangladesh (the remainder were English, West Indian and Irish).

The 57 families discussed in *Prescription for Poor Health* (Conway, 1988), also had a lower permanent registration rate than the general population. In this study, 23 of the 57 women interviewed were still attending a GP in an area other than the one where they were living; 13 were permanently registered with their local doctor; 19 had temporary registration and 2 had not registered at all. Temporary registration is considered by the author to be inadequate because medical records are not transferred. Half the children under five only had temporary registration.

The authors of *Homeless Families and Their Health* conclude that families in temporary accommodation have a distinctive pattern of health service use.

In such circumstances, homeless families often resort to accident and emergency departments of local hospitals or child health centres. But this is no substitute for the continuing care of the GP (Health Visitors Association and the General Medical Services Committee of the BMA, 1988, p 14).

Where the families do not make the first move, *Prescription for Poor Health* indicates that for homeless families the first point of contact with the health service is often through a health visitor, who is concerned principally with the health of the children (Conway, 1988).

The first point of contact for the destitute and single homeless is likely to be of a different order to homeless families with small children. Hewetson (1975), for example, remarks that the homeless and destitute usually only seek advice in the later stages of their illness whereas, according to the authors of *Prescription for Poor Health*, the homeless staying in hostels seem to have a higher consultancy rate than the general population, once they are registered with a GP. Stewart (1975) maintains that the first point of contact with the health service for the destitute is not with their GP but when they are taken to hospital, generally as an out-patient or to the Accident and Emergency Department.

Information provided by Crisis (1990) indicates that of the 491 people seen over the Christmas period 1989/90, 239 (51% of those for whom the information was available) were registered with a GP. Although the figure for registration is high, 49% still remain unregistered. Crisis also

suggests that the real figures may be worse, since the research reported in *Primary Care for Homeless People* revealed that only 11% of the homeless were registered with a local doctor.

Crisis concludes that such people are denied access to primary health care and are forced to rely on other means of treatment, the most common of which was treatment in Accident and Emergency departments. Other means of access to health care were through mobile doctors visiting hostels, health centres, Day Centres and specific centres such as Great Chapel Street. Dr Angela Burnnett, Medical Co-ordinator of Crisis, says that Accident and Emergency departments are not suitable for homeless people because '... they can do little of the essential preventative and monitoring work which is carried out by GPs' (Crisis, 1990).

This discussion identifies a number of problem areas, in relation to the use of the health service by the homeless, both for individuals and families and for the providers of the service. Firstly, the homeless experience difficulties in gaining access to health care, registering with local GPs and in obtaining information about services in their area. Secondly, the providers of health care experience problems in dealing with a mobile population and one which has a specific range of health problems which have a higher incidence amongst the homeless compared to the population generally.

### III THE PROVISION OF HEALTH CARE FOR THE HOMELESS

There is a small body of literature discussing the provision of primary health care for the homeless. In the 1970s, Wood (1979) had already pointed

out that services to meet the needs of homeless single men were inadequate. Stewart (1975) remarked that not only are the homeless characterised by their poor health but '... their overriding inability to seek out sources of medical help, and by the service's failure to provide treatment in appropriate circumstances ...'. There have been recent initiatives in the provision of health care services for homeless people, including:

- the use of salaried GPs (Golding 1987; Shanks 1982, 1983; Williams and Allen 1989);
- the appointment of house doctors (Holden 1975; Powell 1987, 1988a, 1988b); and/or
- peripatetic nurse practitioners (Drennan and Stearn 1986; Alley and McConnell 1988; Cumberledge 1986);
- setting up of mobile surgeries (Ramsden et al 1989; Conway 1988).

However, these developments are uncoordinated. Two themes recur in the literature. The first relates to the desirability of separating or integrating the provision of health care for the homeless from that provided generally. The second theme is that of the need to provide health care which is acceptable to the homeless.

(a) Homeless families

The authors of *Prescription for Poor Health*, stress the need for a 'strategic' approach to the provision of health care for the homeless; one

which does not segregate them from the community as a whole. The authors discuss a number of schemes in the London area aimed at providing for the health needs of those in temporary accommodation. For example, an initiative set up by the North Kensington Health Authority in 1987 is discussed. This involved establishing a 'Special Health Care Team' which combined greater social work support with the collation of information about local facilities such as GPs, hospitals and schools. The Finsbury Park 'health mobile' was another attempt to bring health care to the homeless. Other ideas described by the authors are based around developing playgroups into centres for health care, welfare and benefit advice.

The authors also underline the dangers inherent in such schemes. Principally they see these in terms of specialist centres for the homeless creating a situation where GPs feel that they are absolved from all responsibility. The authors are also concerned that by

'... channelling all the homeless to one source of general medical care, specialist centres are effectively denying the right of patients to choose their GP. If the relationship between patients and specialist practitioner breaks down, it is the patient who is left stranded' (Conway, 1988; p 100).

Instead they suggest that the homeless should be integrated into general primary health care services. Specifically they suggest that what is needed is greater employment of health development workers, a designated health liaison worker to work with the Family Practitioner Committee (now the Family Health Services Authority) and the homeless, and greater research and monitoring of the co-ordination of health care issues (Conway, 1988; p 102).

Similarly, Parsons (1987) looks at the provision of primary health care



for homeless families in the City and Hackney districts of London where health visitors are specifically allocated to homeless families. She argues that this, together with the provision of a nursing auxiliary specifically to look after the records of the homeless, has proved successful in bringing healthcare to families. Parsons (1987) also stresses the need to provide services specifically for women and children and the necessity of providing a Bengali speaking health advocate.

(b) The destitute and single homeless

One of the most detailed discussions of the provision of health care for the single homeless can be found in the report by Bayliss and Logan, *Primary Health Care for Homeless Single People in London*. Bayliss and Logan (1987) argue that the NHS is historically and structurally geared towards meeting the needs of people with a home base, particularly families, and it is assumed that there is no possibility for change (*ibid*, p 10). They review three main options and critically assess the worth of each. The criteria for their assessment is based on the degree to which services for the homeless are fully integrated into the services provided for the population as a whole. On this basis they are particularly critical of 'Walk in' clinics which they say do not adequately cater for the needs of all the single homeless and which do nothing, in the words of the authors, to help 'people escape from the subculture of homelessness...' (Bayliss and Logan, 1987). The authors are, however, careful to distinguish between different types of 'Walk in' clinics, principally those which are designed exclusively for the use of single homeless people and those which are open more generally whether to homeless people, to local people not registered with their doctor and to those who do not wish to see their own GP. It is the former type only which

is the object of criticism. The second option reviewed is that of the 'Medical input into Common Lodging Houses and Hostels'. The principal problem highlighted is that the type of service again tends to segregate the homeless from the general population. Further, the authors emphasise that inputs into hostels can only cater for a section of the homeless population.

In their report, they therefore conclude that solutions to this problem will have to be sought outside the existing framework of health care and they call for a fully integrated service which would allow for a flexible response to the health needs of the homeless based on a 'multi-service, teamwork approach'.

'The situation homeless people are in can then be best understood, and they can be given support in dealing with environmental factors which are affecting their health.' (Bayliss and Logan, 1987, p 14).

The implications of such an approach will be drawn out in the following section which addresses policy implications.

Experiments and practical suggestions are discussed by Powell and by the authors of *Prescription for Poor Health*. Powell's work is based on a qualitative assessment of an Edinburgh scheme to provide for the needs of single homeless hostel dwellers. Contrary to arguments in other literature, Powell suggests that '... there was little evidence of the single homeless having difficulties in gaining access to Primary Health Care Services in Edinburgh, or of the demand for a change in the service from them...' (Powell 1988b, p 185). The Edinburgh scheme involved setting up a central surgery to provide primary health care for the homeless. This operated from rented premises close to the hostel and involved work undertaken by a team of

doctor, nurse and health visitor. Powell reports that this scheme proved more acceptable to the residents and more successful than an earlier 'house doctor' scheme, where a local GP took patients from the hostel.

Powell concludes by calling for more schemes of this type to encourage single homeless people to register with a GP and recommends that a female GP be included for women. He goes on to assess a number of other potential schemes for the provision of health care for the homeless, including 'house doctors' and salaried GPs, but concludes that the Edinburgh scheme proved the most acceptable to both the providers and the recipients. In addition Powell suggests that '... efforts be made to incorporate psychiatric services together with those of the primary health team for this population...' (Powell, 1988b, p 195).

In another report, Powell describes the homeless as having above average need for health services, although they were less frequent users. Generally the single homeless only consult their GPs at an advanced stage of illness. He examines a scheme in Manchester and the Edinburgh scheme discussed above, both of which aimed to increase individual registration with GPs. Powell reports that the systems of 'single handed doctor' in Manchester and the Edinburgh scheme were successful. In Edinburgh, in particular, registration with GPs increased from 32% of hostel dwellers in 1974 to 88-90% in 1986. He concludes by remarking that these services need to be extended to the growing population of single homeless in bed and breakfast accommodation and to those sleeping rough (Powell, 1988a, p 84).

Other initiatives in the health care of homeless people include the Great Chapel Street Medical Centre and Wytham Hall. The health care provided

by the Great Chapel Street Medical Centre is supplemented by weekly psychiatric sessions at the day centre at St-Martin-in-the-Fields and residential care in Wytham Hall (Great Chapel Street Medical Centre 1989). The psychiatric service provided is discussed by Joseph et al (1990) who suggest that such a scheme has a number of advantages over other forms of care since the patients are familiar with the centre staff, the atmosphere is an informal one and referrals are made to a psychiatrist known personally to the staff of the centre.

'A drop-in psychiatric clinic, based on a pragmatic, flexible and responsive approach can significantly enhance the quality of medical service offered to the single homeless in a primary care setting. Schizophrenic patients in particular seem to benefit. The model may be replicable in other centres' (Joseph et al, 1990, p 271).

#### IV DEVELOPING APPROPRIATE POLICIES

Currently, the homeless have a high profile. The extent to which this reflects, in part, the 'discovery' of an already existing phenomenon is unclear because the available data are incomplete over time or across authorities. Nevertheless, it seems that there has been some real growth of homeless families (see Table 1 above) and the experience of London based agencies (see above) would suggest that there has also been an increase in the numbers of the young homeless during the 1980s.

In terms of their health, it is clearly important to distinguish between the different sub-groups of the homeless. The stereotypical picture of the destitute old male alcoholic provides an inadequate description of the range and severity of health problems facing the homeless families and

the, mainly younger, single homeless. Families in temporary accommodation are under strain and also suffer from poor living conditions, the (young) single homeless suffer from respiratory ailments because they live on the streets.

Moreover, the contact each group has with the primary health care services is different. In the case of families, this might be with health visitors in relation to children, whilst for those using hostels, this might be in the form of Outpatients or Accident and Emergency services.

Several authors have, of course, stressed the importance of identifying the specific needs of each of the different groups of homeless people with a view to designing appropriate and targetted services. At the same time, most also stress the importance of providing a service which is acceptable to those receiving the service and which the homeless can continue to use once they are rehoused. Hence the importance of integrating any service provision with the overall structure of health care provision so as not to stigmatise the users of a particular service. For example, Bayliss and Logan (1987) and Fischer (1985) draw attention to the need to include the homeless in the 'community', on two levels. Firstly, to integrate primary health care for the homeless into the provision of health care generally. Secondly, to accept the homeless as part of the 'community' even though they are a particularly mobile section of the population.

The problem is that the homeless do not 'fit' into the administrative structure of the NHS because they do not always have medical records (Hewetson, 1975). Fischer (1985) argues for a new approach based on the availability of social support. For the mentally ill homeless he suggests,

as in the Griffith Report (Griffiths, 1988), the provision of Case Managers to help them deal with other agencies and organisations. Like Bayliss and Logan (1987), he hints at the inadequacy and inappropriateness of much of the existing health service in relation to the needs of the homeless.

Developing a treatment program for the homeless mentally ill requires a conceptual shift away from traditional models. This may include shedding professional traditions and going to the homeless people in the street or in the shelters rather than expecting them to come to conventional clinics (Fischer, 1985, p 29).

Bayliss and Logan argue that what is needed to deal with the health needs of the homeless is a locally based, interdisciplinary team approach. They claim that this would not only have the advantage of 'going out' to people (what the authors refer to as a pro-active approach) but would also provide the opportunity for homeless people to make their views and needs known through a structure which encouraged their participation.

General community health workers should be engaged to go out into the local area to make contact with people who need assisted entry into the health service: a backup resource should be established, where specific information on issues around homelessness can be made accessible. The key words here are choice and responsiveness of the service to the needs of the homeless (Bayliss and Logan 1987; p 7).

There is an articulated demand for co-ordinated health provision for the homeless in which their social and health needs are taken into account. There is also an emphasis on the need for locally based services which respond to the needs of the homeless and to which they are able to contribute. The emphasis on co-ordination and co-operation of the different agencies looking after the homeless has led to demands for interdisciplinary teams (including doctors, nurses and social workers) to provide health care.

It is further argued that health authorities should pursue a multi-service approach, based on '... a holistic perception of a person's needs....' (Bayliss and Logan 1987; p 14). The difficulty is in knowing exactly what this means and in finding evidence that it is cost effective.

The authors of *Homeless families and their health* state their aim as the identification of a number of practical solutions to ensure better access to primary health care for the homeless. Principally they suggest that FPCs (now FHSAs) should respond to the special requirements of practices looking after the homeless; for example, in the form of appointing GP facilitators and reimbursing practices for extra ancillary staff who may have been taken on. The report calls for co-ordination and co-operation between District Health Authorities, Local Authorities and Homeless Persons Units to ensure that information about access to health care in their area is given to the homeless. The report also emphasises the importance of attaching responsibility for health care to the local authority receiving the homeless into their area (Health Visitors Association and the General Medical Services Committee of the BMA, 1988).

There have, of course, been considerable changes in the organisation of primary care. In principle many of the services discussed here, for example institutional care for the mentally ill, should be provided by the Local Authorities in the wake of the Griffiths report. But, even assuming that 'adequate' funding were available, it will be very difficult to design appropriate styles of care, let alone individual care packages without considering more information about the homeless.

The new GP contract also has several implications, in principle, vis-

a-vis the homeless. For example, the capitation payments are only to be augmented for patients whose residence is in a deprived Enumeration District; the homeless, who may be presumed to generate extra workload because of the pattern of morbidity described above, do not have a residence. On the one hand, the contract requires a medical for new registrations which would clearly be useful for the homeless, but on the other hand, it may also frighten them away! Whether or not these lead to an overall benefit or disadvantage for the homeless is unclear.

#### V CONCLUSIONS: DEVELOPING A KNOWLEDGE BASE FOR POLICY

The review of evidence has shown that there are many different factors to take into account when discussing the provision of health care for the homeless. There are different sub-groups to consider with differing health problems and different points of contact with the primary health care services.

The statutory health and local government agencies have responded to these problems with a variety of initiatives focussed on improving access to primary health care, providing community based care and providing a service which did not segregate the homeless from the general population. The review of the relevant literature identified a number of important issues. Firstly, there was great emphasis on the need for primary health care provision for the homeless to be integrated with provision of health care for the general population. Secondly, the importance of co-ordination, liaison and co-operation between housing and health authorities in providing information and services for the homeless. Thirdly, the need to increase the registration of homeless people with GPs and finally to provide a service which meets the



needs of the homeless in a way which is acceptable to them.

But there is little evidence to assess whether or not these will be effective. Indeed, this is a basic problem with all the studies reviewed here; there is a lack of reliable data about the health problems of the homeless and about their use of health care services.

Nearly all the studies have been small scale or based on the clientele of a particular unit with the inevitable biases of that type of design. The lack of reliable data is particularly acute for the young single homeless. What is needed is a large-scale in-depth study of the health problems of the (young) single homeless.

The lack of data also makes it very difficult to assess the variety of initiatives undertaken by the statutory health and local government agencies in response to the problem. For example, the apparent tension between the need to target specific (sub-)groups with a specific kind of service provision and the desire to provide locally based integrated health services for the homeless that are characterised by co-operation, liaison and information sharing amongst the professionals and agencies involved may be a non-issue. However, it is difficult to make any pronouncements without basic information on the effectiveness of different alternative policy options. Moreover, the framework for assessing policy options has changed given the reform of community care following the Griffiths report and the implications of the new GP contract. What is needed here is a thorough evaluation of new schemes, where possible following up groups of (young) single homeless who have been in contact with particular schemes compared to those who have not.

Without basic data of these kinds, the debate about the health of the homeless will continue to be based mostly on guesstimates and rhetoric. With the possible increase in the size of the problem and competing pressures on resources, there is an urgent need to develop an adequate knowledge base so that NHS purchasers fulfil their remit of identifying the local health care needs of the population (even if some of them are homeless) and meeting these needs cost-effectively.

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