

Health surveillance project among single homeless men in Bristol

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SUMMARY. *The establishment of a health surveillance system for the single homeless is described. Health checks were performed in two Salvation Army hostels by a district nurse supported by general practitioners and other workers from one health centre. High levels of morbidity were discovered and the residents were largely treated by the primary health care team. Those residents who were referred to other agencies were shown to have a high attendance rate. An open access clinic was later set up by the district nurse in one of the hostels. This was well received by residents and staff and reduced the call out rate for the general practitioners.*

In some parts of the UK, special medical centres for the single homeless have been established on the premiss that it is unrealistic to expect general practitioners to provide an adequate service. However, this study describes an effective service based on primary care which is acceptable to homeless people while being relatively cheap and easy to administer. We recommend the development of a peripatetic service as outlined in this study, offering health care at hostels, day centres and other places where the homeless are to be found.

Introduction

MONTPELIER health centre is an inner city practice serving St Pauls and surrounding districts in Bristol. The area is lively and cosmopolitan but is also characterized by poverty, unemployment and overcrowded housing. At least 10% of the practice population live in hostels, bedsits or other temporary accommodation and this group are known to be at high risk for health problems.¹⁻³

In 1985 the practice helped in the preparation of a report for central government which requested special funds to improve health care services in the area. In preparing this report, morbidity and mortality statistics were shown to be high on all criteria measured. This was perhaps not surprising, but caused anxiety among the primary health care team. About this time our attention was drawn to the single homeless by a number of cases of tuberculosis among this group over a few months and it was decided to offer a comprehensive health check to residents in the two local Salvation Army hostels.

Method

The two hostels cater for homeless men only. One is a modern purpose-built building but in the other, older hostel men sleep in squalid cubicles, barely large enough for a single bed and locker, and with a kitchen supplied only with bread, margarine, hot water and teabags. Between them, the hostels can house 150 men. Ninety one men had been resident for three months or

more and it was decided to concentrate on this group as they could be registered permanently, allowing their medical records to be obtained. They were also more likely to be available for referral and follow-up. Thirty of these men were already registered with our practice, and neighbouring general practitioners willingly granted us permission to approach the 10 men who were on their practice list. The remaining 51 men were not registered with a local doctor and were invited to join our list.

The protocol included a health questionnaire and basic examination by a district nurse. Laboratory tests included urinalysis, full blood count and serum for urea and electrolytes, and liver and thyroid function tests. A chest X-ray was offered to all residents, but other investigations, such as electrocardiograms and peak flow measurements, were carried out only if indicated.

This health check was found to be acceptable to the residents and the survey booklet took 30–60 minutes to complete. Each completed booklet was independently checked by two doctors and the diagnoses categorized using a modified version of the *International classification of diseases* (9th revision). Where the diagnosis was in doubt the patient was seen for assessment by one of the general practitioners in the practice. The completed booklets were placed in the patients' A4 records, with their consent, and have been a useful source of information for the practice team. Any residents referred for further assessment were followed up to check whether they attended.

There is evidence that data from questioning residents of common lodging houses is more consistent where the men already know the interviewer well as a health professional. In this study the district nursing sister formed a relationship with hostel staff and residents and was a familiar figure.⁴

Results

Of the 91 hostel residents 51 (56%) agreed to have their health checked. The physical illnesses found are shown in Table 1. Significant medical problems included undiagnosed diabetes and hypertension, rapid atrial fibrillation, untreated epilepsy and chronic heart failure. Only 18 (35%) of those checked had no significant medical problem.

The hostel population reported using medical services rarely — only 21 (41%) had had contact with a general practitioner in the previous 12 months while eight (16%) had visited a dentist and 11 (22%) had attended a casualty department. However, these figures were not checked against hospital, dental or general practice records, so they are only a guide. Thirteen men (25%) had need of chiropody services and none of the 12 men with visual acuity below 6/36 had seen an optician in the previous 12 months. The high rate of major dental problems is further evidence that this group is not receiving routine health care.

Of the 51 men 43 (84%) were tobacco smokers and this group included all the cases of chronic bronchitis and emphysema. Twenty five men (49%) were alcoholics although no alcohol was allowed on hostel premises, and drunken behaviour was a reason for exclusion. This group accounted for most of the cases of dyspepsia and accidents. None of the men admitted to using addictive drugs other than alcohol.

Eighteen men (35%) had a history of admission to psychiatric hospital while 10 (20%) were currently being treated for psychiatric illness or had been referred to the community

Table 1. Physical illnesses found among the 51 hostel residents.

	No. (%) of residents
Chronic bronchitis/emphysema	22 (43)
Significant dyspepsia	16 (31)
Accident needing medical treatment in previous 12 months	15 (29)
Skin disease	15 (29)
Eczema	10 (20)
Major dental problems	13 (25)
Eyesight < 6/36 (corrected with glasses)	12 (24)
Congestive heart failure	7 (14)
Significant deafness	7 (14)
Angina	6 (12)
Prostatism	4 (8)
Epilepsy	3 (6)
Undiagnosed diabetes	2 (4)
Untreated hypertension	2 (4)
No significant illness	18 (35)

psychiatric nurse for assessment. This confirms the suspicion that such hostels care for men with active or 'burnt out' mental illness.

The social problems experienced by the 51 men are shown in Table 2. Despite high rates of illness only one sixth of the men were claiming sickness benefit. One in 10 requested a social worker to help sort out family or financial problems, and only one in three were actively seeking alternative accommodation.

Referrals

Most of the medical and social problems of these men were referred to members of the primary health care team, who included general practitioners, district nurses, community psychiatric nurses and a practice-attached social worker. Sixteen men were referred to other agencies for hearing or vision assessment, hospital consultant advice and so on, and 13 (81%) attended these referrals.

Wider effects of the study

In the newer hostel, the staff were enthusiastic about the project and canvassed support from the residents but in the older hostel, the staff were negative and initially portrayed the survey to the residents as a compulsory check by the health authority. At the end of the health survey, the district nursing sister continued to visit the hostels for two hours once a week at their request. Extra cover was provided by the health authority to allow the district nurse time to carry out the survey, and later to run a clinic in the newer hostel. This open access clinic was well attended, and requests for visits by general practitioners in the practice were reduced. The officer in charge of the newer hostel was agreeably surprised by the response to the project and the improvement in morale among both staff and residents.

The survey highlighted various deficiencies in the service offered by our practice, and provided hard data on which to base requests for additional resources. As a result, the community psychiatric nursing service offered to provide a regular weekly

Table 2. Social problems found among the 51 hostel residents.

	No. (%) of residents
Unemployed	41 (80)
Financial difficulties	21 (41)
Looking for alternative accommodation	16 (31)
Claiming sickness benefit	8 (16)
Family problems	6 (12)

session at the two hostels; a local dentist agreed to start a clinic at the newer hostel; Alcoholics Anonymous now hold a weekly meeting there; and a decision on a request for a chiropody session is expected soon. In addition, the audiology department of Bristol Royal Infirmary is screening and following up pensioners for hearing problems.

The survey also had some unexpected results. For example, we approached the kitchen at the newer hostel to request a more appropriate diet for a newly diagnosed diabetic. This led to a discussion of the nutritional content of the basic fare provided for other residents and improvements were subsequently made. As the nurse became proficient in performing the health checks it was found that her skills could be directed at other high risk individuals, such as elderly people living alone.

Discussion

Vagrancy is not a new phenomenon. In the fourteenth century peasants, formerly tied to a manorial system, acquired the freedom to move and by Elizabethan times there were an estimated 200 000 'masterless persons' at a time when the able-bodied poor were supposed to have masters.⁵ These vagabonds were usually regarded as lazy, criminal or rebellious by the ruling classes and at different times were incarcerated, impressed, transported, conscripted for compulsory labour or hanged. Hardly less unfortunate were those subjected to hair-pulling, the pillory, ear cropping or the ducking stool.⁵

Studies of morbidity among those living in doss houses and those sleeping rough have shown a changing pattern over the past 100 years. Mental illness and alcoholism have increased while major infection is waning, although throughout history this group has provided a nucleus for serious outbreaks of diseases, such as cholera, smallpox and enteric fever.⁶ As recently as 1966 pulmonary tuberculosis accounted for 10% of the morbidity among those living in common lodging houses.⁷ No new cases of tuberculosis were found in our survey, but there had been five cases over the previous 20 months in the two hostels.

Previous studies have shown high levels of alcohol and smoking related diseases among the homeless, and a prevalence of psychosis and organic mental illness up to 20 times higher than in the general community.⁸⁻¹⁰ Physical illness has been shown to be common and inadequately treated.^{1-3,7,11} This study demonstrates that almost 40 years after the inception of a National Health Service, at a time of increasing homelessness, there has been little change in the health of this group who are mostly unable or unwilling to use health services. The high morbidity levels reported here are partly explained by this being a prospective study, whereas almost all other studies have retrospectively analysed consultations in primary care or special centres. In Booth's study in 1899⁹ only nine out of 288 cases were aged over 60 years. In contrast, more than 40% of our group were over 60 years old and illnesses of the elderly were well represented. Many of these old men were obviously failing both mentally and physically, and were in a quite pitiable state. In fact, on first entering the older hostel our response was similar to that described by Henry Mayhew in 1861 'as we entered the men stared, and never was so ragged an assemblage seen ... their squalor and wretchedness produced a feeling approaching to awe...'¹²

The single homeless

Many of the single homeless are pleasant and easy to deal with, and are simply people who for various reasons have fallen on hard times. However, a proportion present a real problem for primary care, because other patients may be put off by their unkempt appearance or frightened by their unpredictable and

antisocial behaviour. The homeless lead itinerant disorganized lives, are alienated from authority and institutions, and are frequently physically or mentally infirm or the worse for drink.

Consequently many general practitioners refuse to accept homeless people on their lists or to visit hostels for the homeless; and these social outcasts often receive only a grudging emergency service from casualty departments and general practice deputizing services.¹³ This is a classic example of the 'inverse care law', where those who have the greatest medical needs receive the worst standard of care.¹⁴

Possible solutions

In parts of the UK, where primary care has proved too inflexible to provide an adequate service for the homeless, special medical centres have been set up.^{2,15,16} Some of these have been criticized on the grounds that they are too clinical, expensive to set up and difficult to integrate with primary care services.¹³ More importantly, they may discourage other parts of the health service from taking any responsibility for the care of the homeless.

We believe that a peripatetic service, offering health care at hostels, day centres and other places where the homeless are to be found,^{2,13,16} can be based on the system described here. The service is based on primary care and develops the role of the nurse practitioner. The treatable medical conditions discovered in this study justify the effort involved and there are rewards for general practitioners in that less visits are required and their information is increased without their having to perform all the checks themselves. Most importantly, this service is acceptable to the homeless and is cheap and easy to administer.

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AIDS update

Cumulative totals of UK reports of acquired immune deficiency syndrome cases, by transmission characteristics, to 30 June 1988.

Transmission categories	No. of cases			No. of deaths		
	Male	Female	Total	Male	Female	Total
Homosexual/bisexual	1315	—	1315	738	—	738
Intravenous drug abuser (IVDA)	20	7	27	14	3	17
Homosexual and IVDA	27	—	27	12	—	12
Haemophilic	107	1	108	67	1	68
Recipient of blood						
Abroad	10	9	19	7	5	12
UK	9	3	12	7	3	10
Heterosexual, presumed infected						
Abroad	36	14	50	11	6	17
UK	4	6	10	3	4	7
Child of HIV-antibody positive parent	6	10	16	2	6	8
Other/undetermined	12	2	14	6	2	8
Total	1546	52	1598	867	30	897

Cumulative totals of UK reports of human immunodeficiency virus antibody positive persons, by transmission characteristics, to 30 June 1988.

Transmission category	No. of HIV cases			
	Male	Female	Unknown	Total
Homosexual/bisexual	4101	—	—	4101
Intravenous drug abuser (IVDA)	894	477	28	1399
Homo/bisexual male and IVDA	65	—	—	65
Haemophilic	1065	3	1	1069
Blood/components recipient	43	36	1	80
Heterosexual contact	200	225	7	432
Child of at risk/infected parent	34	31	30	95
Multiple risks	8	—	—	8
Other/undetermined	1297	117	131	1515
Total	7707	889	198	8794

Source: Communicable Disease Surveillance Centre, London and Communicable Diseases (Scotland) Unit, Glasgow.