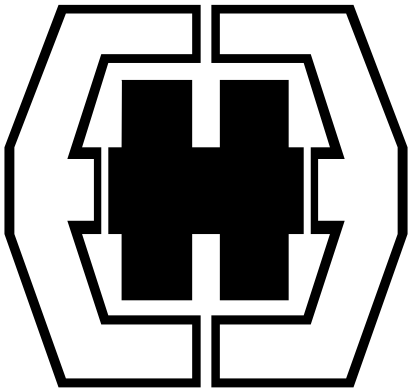

EASTERN HEALTH BOARD

Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin

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Preface

The health of the homeless is an important public health issue. Their adverse health and social circumstances, coupled with the difficulty in meeting their health requirements, ensures that steps to improve their health will be challenging to all those who work with the homeless or as part of the health and social services. There is considerable potential for health and social gain in terms of increased life expectancy, reduced morbidity and enhanced quality of life among those who are homeless.

As a first step, this requires that information be made available for evidence based interventions and decision making in the framing of health policy. This study provides that first step by providing the first empirical information about the health of the homeless population of Dublin. Much of the information that it contains will be of value in the planning of health services but more research will be required to comprehensively investigate specific areas of health and health services.

Chapter One Introduction

Equity is one of the three key principles of the Department of Health strategy document entitled "Shaping a Healthier Future" (Department of Health, 1994). The pursuit of equity, it recommends, should extend to the examination of the health status of certain groups in society. Specifically, it states that disadvantaged groups should be given special attention.

The homeless provide an example of such a disadvantaged group whose health is profoundly affected by their homelessness or by the factors that caused them to become homeless in the first place. Anecdotal and empirical observations from around the world have confirmed this to be the case. What is also known is that the utilisation of health and related services is influenced by being homeless and by the presence of many barriers which limit equality of access to, and outcome from, encounters with these services.

There is a considerable lack of scientific information about the health of the homeless in Dublin and in Ireland. The research that has been carried out on homelessness in this country has mostly been of a sociological nature. This lack of information makes attempts to deal with whatever problems more difficult because there is little or no evidence to inform the health services planning process.

This study aims to bridge the gap between information that is available and information that is required by investigating issues pertaining to the health and health service utilisation of the homeless. Being the first empirical study to do so in Ireland, it is broad and general in nature but it is hoped that it will help to facilitate and prioritise further research into this area.

The information that this study provides, as well as information from some of the future studies that it recommends, will help to inform the development and implementation of health policy in an evidence based way. This will help to produce health and social gain among the homeless in terms of morbidity and mortality prevented, thereby ensuring consistent progress towards the principle of equity as outlined by the Department of Health Strategy.

The objectives of the study are as follows:

1. To describe the size and composition of the adult homeless population of Dublin
2. To describe behaviour related health risk factors among the population
3. To determine the health status of the adult homeless population by enquiring about health and current morbidity
4. To determine the use of health and related services by the homeless
5. To identify barriers that might exist to the use of such services
6. To make recommendations for further research and for the health services based on the findings

Chapter Two Synopsis

The purpose of this study was to provide baseline information about the health of the homeless population of Dublin that would allow planned and prioritised responses to their health problems in terms of service provision and further research. The objectives were to describe the size and composition of the population, to examine behavioural risk factors in the population, to describe the health of the population in terms of self-perceived health and self-reported morbidity, to describe the utilisation of health services and to identify barriers to such utilisation.

The study was a census of homeless people who met the definition of homelessness used here. The data was collected over a five day period of time at hostels, bed and breakfast institutions, food centres and on the streets by trained volunteer interviewers using a specially devised anonymous questionnaire.

The response rate was 64%. The population was heterogeneous but did allow some major sub-groups to be characterised. These are, firstly, older Irish males living in hostels who have been homeless for long time periods; secondly, younger females, often with young children, who live in bed and breakfast accommodation; thirdly, refugees, who also live in bed and breakfast accommodation and, fourthly, young Irish males who sleep rough on the streets. The reasons for homelessness, the health problems, the health risks and the utilisation of services all varied between these groups.

The population had many behavioural risk factors. Most spent much of their time outdoors irrespective of their health status or the fact that they might have young children. Almost 80% of them were smokers, 30% drank alcohol beyond recommended limits and a further 30% of them said that they had used illegal drugs.

Almost half of the respondents perceived themselves to be in poor health. Approximately one quarter of them felt that they were limited by their physical health in the previous month while a similar proportion said that they were limited by their mental health during the same time period. Almost 30% felt that their health had disimproved in the previous year.

Sixty six per cent of people had at least one physical or psychiatric problem. At least one of a number of specific chronic diseases was reported by 41% of people. The reporting of individual health problems was found to vary with age, sex, duration of homelessness and the existence of behavioural risk factors such as cigarette, alcohol and drug consumption.

Close to half of all respondents did not have a personal medical card. Some sub-groups, such as young males and rough sleepers, had particularly low medical card ownership. The possession of such a card was not influenced by the existence of chronic disease. The utilisation of services varied according to age, sex and other demographic factors. Some groups, such as rough sleepers, used all services at low levels. Ancillary services, such as social work and community welfare, were mostly used by young women, often with children, and refugees.

Many barriers to service utilisation, such as the lack of a medical card, language difficulties, cultural differences, information barriers and the unacceptability of many of the existing services to homeless people were identified in the study.

The recommendations emphasise the importance of a co-ordinated and integrated response to the health problems of the homeless. Services are recommended which use an evidence-based multidisciplinary approach, which are acceptable and accessible to users and which reflect the social, as well as purely medical, circumstances in which the homeless find themselves.

Chapter Three Background

The number of homeless people has grown consistently since the 1980s (Lowry, 1996; Jones, Levine & Rosenberg, 1991). Interest in and concern about homelessness has also grown in recent years as evidenced by legislative change, funding for research and services and the emerging literature which has been published on the subject (Toro & Warren, 1991; Toro, Trickett, Wall et al., 1991; Victor, 1992). In Ireland, the majority of the homeless are to be found in the Eastern Health Board region which has experienced a considerable growth in numbers in recent years (O'Sullivan, 1997).

A complex issue such as homelessness defies simple solutions (Jones et al., 1991). The ultimate solution to the problem, for which the most constant precipitating factor is extreme poverty, lies in preventive measures which increase both the economic capacity of those who are vulnerable and the availability of low cost housing (Rosenberg, Solarz & Bailey, 1991). The problem of poverty must be addressed if the root causes of homelessness are to be eradicated (Kondratas, 1991).

Historically, the medical care of the homeless has, at best, been perfunctory and has depended largely on the efforts of sympathetic individuals (Shanks, 1983). In the 1950s, poor physical health was identified as a possible explanation for the existence of skid rows. The homeless had a higher prevalence of chronic physical disease and a lower life expectancy than those of comparable age in the general population (Victor, 1992; Featherstone & Ashmore, 1988; Fisher & Collins, 1993).

Today, homeless people make up a growing vulnerable population that has an unacceptably high risk for preventable disease, progressive morbidity and premature death (Plumb, 1997). Every aspect of a homeless existence compromises physical health to some degree or at least complicates the provision of adequate health services (Wright, 1991).

Any health policy response must begin with an understanding of the nature of the problem (Connelly, Kelleher, Morton et al., 1992). It is important that public health professionals give prominence to explaining the linkage between the structural factors which create the potential for a high prevalence of homelessness and the personal ones which determine who is most susceptible (Sclar, 1990). Physicians have an important role to play in the policy response to homelessness (Hilficker, 1989). Effective disease prevention among homeless people requires effective prevention of homelessness (Plumb, 1997).

The first official report on homelessness in Ireland was produced in 1927 but it was not until the 1960s, when concern grew about rough sleeping, that the problem came to the fore again. The ensuing campaigns and advocacy of many voluntary agencies and individuals resulted in the Housing Act[1] of 1988 (O'Sullivan, 1996).

[1] Housing Act, 1988. Dublin: Stationery Office.

Chapter Four Methods

Given the lack of research that has been carried out in Ireland on the health of homeless people, little data has been collected which would be of use in helping to inform service provision or to prioritise research in the area of homelessness and health. The objectives of this study are consequently general in nature. Therefore, an approach had to be chosen which would best allow these objectives to be met.

The first stages of this study were concerned with the establishment of the feasibility of the study, the support that would exist for it and the existence or otherwise of barriers that would prevent it from taking place. The selection of an appropriate design for this study began, therefore, with a period of consultation with those who work with and on behalf of the homeless. The organisations involved in this consultation process included the following: The Homeless Section, Eastern Health Board; Dublin Corporation Housing Section; the Homeless Initiative; Dublin Simon; Trust; Focus Ireland; the Diocesan Social Justice Group; St Vincent De Paul and the Salvation Army.

Each hostel, bed and breakfast, guesthouse, food centre and "soup run" catering for the homeless in the Dublin area was contacted initially by post and subsequently by telephone to seek their support. A proposal was developed which was submitted to the Eastern Health Board Programme Manager for AIDS, Drugs and Homelessness[2] for support and funding.

4.1 Study Design

The study was carried out using an interviewer administered questionnaire. The structured questionnaire allowed information to be gathered from homeless people about their health and related matters. It was considered imperative that a clear definition of homelessness be used here so that findings could be interpreted more easily and also to make recommendations concerning the appropriate population.

A homeless person[3] for the purposes of this study was as follows:

> **A person over the age of 18 who, at the time of the study, is a resident of a homeless hostel or homeless bed and breakfast or other such institution or who is sleeping rough and who is not a resident of a psychiatric institution or "houseless" by reason of ethnicity (i.e. travellers)**

This definition is not intended to cover every adult in Dublin who might meet a conceptual definition of homelessness. Furthermore, it includes those who are literally homeless rather than at risk of homelessness and, in this respect, differs from definitions used elsewhere. It could be criticised by those who conceptualise homelessness in a different way. It emerged, however, following the literature review and consultation process described above, as a practical definition in attempting to identify those whose health is poorest and who are at greatest risk by virtue of their accommodation status. It was considered appropriate to target those in greatest potential need as the initial step in the overall process of developing services for this vulnerable group.

4.2 Estimation of Population Size

The Department of the Environment provides official statistics based upon a biannual census of the homeless carried out using legal definitions of homelessness. In 1996, the estimated number in the Eastern Health Board was 1767. However, no one figure for the

[2] Following structural changes to the Programmes within the Eastern Health Board, the homeless are now included under the Mental Health and Social Exclusion Programme.

[3] The terms "homeless person", "the homeless" and "homeless people" for the purpose of this study, indicate those who meet this definition.

point prevalence of homelessness can adequately describe the problem of homelessness or begin to convey enough information for the purpose of health service planning.

Institutions that accommodate homeless people in the Dublin area consist of purpose-run hostels, bed and breakfasts and sheltered housing. The great majority of homeless people are accommodated in hostels around the city with the next biggest proportion using bed and breakfasts establishments. The remainder use sheltered housing or sleep rough in the streets.

The working estimate of homeless people for this study comes from combining the total number of hostel beds and the numbers in bed and breakfasts, sheltered housing accommodation and those who sleep rough on the streets. This gives a total working estimate for the purpose of the study of 938. The actual number of homeless people who meet the definition to be used as a denominator for the response rate is derived from the numbers registered at these institutions at the time of the study.

4.3 The Questionnaire

The questionnaire was anonymous and confidential and this was stressed to all potential interviewees. An initial draft questionnaire was discussed with people who work with and on behalf of the homeless during the consultation stage of the study. This allowed it to be developed in a way which would maximise its relevance and acceptability to the homeless population.

The questionnaire was necessarily general since no specific issue could be explored in detail, given the general objectives of the study. The questionnaire was divided into four sections: demography, homelessness, health and use of health services. A final question asked respondents for recommendations on how services could be improved.

4.4 Interviewers

Thirty three interviewers were recruited to carry out the interviews on a voluntary basis over a one week period. The interviewers came from Focuspoint, a voluntary agency which works with the homeless, the Department of Social Policy in UCD and the Medical Student's Voluntary Society, which is a University College Dublin society engaging in various voluntary activities with the underprivileged, the elderly and the handicapped. Trained medical students have been used successfully to collect data in a similar study (Gelberg & Linn, 1989) and it was felt that a such an approach would be feasible in this study. An initial meeting between the author and society members was arranged at which the nature of the project and the interviewer's role was explained.

Each of the interviewers attended one of two training sessions. Firstly, the nature of the study, including both methods and objectives, was explained to the interviewers. The questionnaire was then examined question by question. Issues requiring clarification which arose during the course of these sessions were addressed by the author.

The final part of each training session involved the assigning of individuals to particular institutions on particular days. This was done on the basis of individual preference, where possible. There were enough people to ensure that each interviewing location had enough interviewers to match the potential number of interviewees.

4.5 Pilot Phase

A pilot study was carried out six weeks in advance of the study date. Thirty homeless people were interviewed in one hostel on one evening. This led to some changes in the questionnaire to aid understanding by the interviewees and allowed a detailed time plan to be drawn up for the study based on the time taken to complete the questionnaire (15 minutes). This was necessary in order to allocate the correct number of interviewers to each institution based on the number of potential interviewees in each institution.

4.6 Study Phase

The data collection began in March 1997. The hostels were visited in the early evenings in most cases but, in the case of larger institutions, interviewing began in the afternoon. Most of the bed and breakfasts were visited during the daytime and evening times, while the food centres were visited at lunchtimes throughout the week. Interviewers accompanied soup runs on two nights of the week between 9pm and 1am.

Chapter Five Results

5.1 Response Rate

510 completed questionnaires were returned at the end of the five days of the survey. Eight of the people interviewed did not meet the definition of homelessness used. The total denominator that was used for the purposes of this study was 780 giving a response rate of 64.4% (502/780).

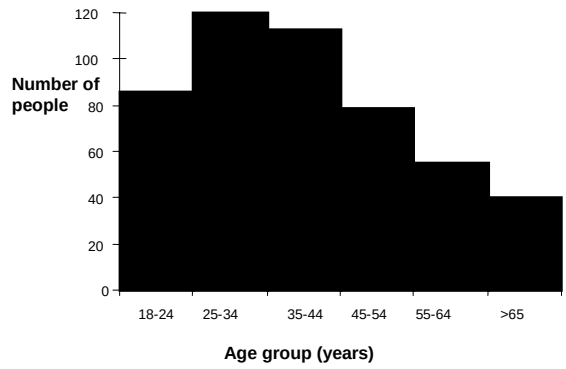
The response rates for each of the hostels varied between 27% and 100% with an average response rate of 53.2%. Fifty nine (15.3%, n=385) of those who were living in hostels were actually interviewed in other locations such as on the streets and in food centres bringing the response rate up to over 63% for people registered in hostels at the time of the interview. Response rates for the bed and breakfasts in the survey varied between 40% and 100% with an average of 58.7%. The response rate for those sleeping rough was 86.5% (32/37) using the average soup run number as a denominator.

5.2 Demography

5.2.1 Age and Sex

The distribution of age in the population of homeless that were interviewed is shown in figure 1. Almost two-thirds of the group (319/493; 64.7%) were under the age of 45 while only 8.1% (40/493) were over the age of 65. More than 85% (428/502) of the population of homeless were male and the age distribution of this group was similar to the total homeless population. Three-quarters of the female homeless population were under the age of 45 (54/70; 77.1%) while 14.3% (10/70) of them were over the age of 65. Nine respondents (1.8%, n=502) did not specify their age.

Figure 1 Age distribution of adult homeless people of Dublin (n=493)



5.2.2 Marital Status and Children

The marital status of the respondents is laid out in table 5.1. The female homeless population most frequently said that they were single, married, separated or widowed. The male population mostly said that they were single, separated or divorced. However, comparison of these proportions within and between the sexes did not reach statistical significance.

Those who were ever married were more likely to have children and also to have a greater number of children. Younger women were more likely to have had children than older women. The age of these children was sought in order to determine whether or not the homeless people had dependants or had children on whom they could depend. Children were categorised into the under 18 age group, defined as children in the Child Care Act of 1991, and the over 18 age group on whom a homeless person might depend for social or

financial support.

Table 5.1 Marital status among male and female homeless

Marital Status	*Male*		*Female*		*Total*	
	Number	%	Number	%	Number	%
Single	284	67.2	41	58.6	325	65.9
Married	35	8.3	14	20.0	49	9.9
Separated	69	16.3	6	8.6	75	15.2
Divorced	19	4.5	1	1.4	20	4.1
Widowed	12	2.8	5	7.1	17	3.5
Cohabiting	4	0.9	3	4.3	7	1.4
Total	423	100	70	100	493	100

There was a total of 395 children in the dependent category (under 18) whereas there were 293 over the age of 18 years. The proportion of females with dependants was greater than the corresponding proportion for males. Furthermore, the average number of dependent children was greater among females than males. Homeless parents with dependent children were also more likely to be less than 45 years old and to be married or ever married.

5.2.3 Nationality and Political Status

Seventy eight percent of respondents were Irish and 12% were non-Europeans. Of the remainder, 5% were British nationals and a further 5% were from other European countries. The non-Irish were younger than their Irish counterparts with only 5% over the age of 45. Seventy seven respondents (15.3%) described themselves as refugees or asylum seekers while 14 (2.8%) described themselves as members of the Irish Travelling community.

The refugee group was younger than the remainder of the homeless population with nobody over the age of 45 interviewed. Refugees were more likely to be female (RR 1.6, p=0.048) than the non-refugee population but neither refugees nor non-Irish homeless were more likely to be married. Thirty two refugees had a total of 60 dependent children which was an average of 1.9 each.

5.3 Homelessness

5.3.1 Frequency and Duration

Forty five per cent of homeless respondents had been homeless for more than one year (long-term homeless) at the time of interview while a further 34% had been homeless for between one and twelve months. Twenty one per cent of people had been homeless at interview for less than one month (short-term homeless). Those who had been homeless for more than one year were more likely to be male and Irish and over 45 years old. Table 5.2 shows the duration of homelessness among the main nationalities and political or ethnic groups.

Table 5.2 Duration of homelessness in selected political and ethnic groups

Category	*Refugees*		*Non-Irish*		*British*		*Travellers*		*Irish*	
	n	%	n	%	n	%	n	%	n	%
Less than 1 month	18	26.5	28	28.3	7	30.4	2	14.3	73	18.9
1 to 12 months	48	70.6	59	59.6	8	34.8	5	35.7	106	27.5
>Twelve months	2	2.9	12	12.1	8	34.8	7	50.0	207	53.6
Total number	68	100	99	100	23	100	14	100	386	100

Table 5.3 shows the number of episodes of homelessness and the mean number of years

since first becoming homeless in those who have been homeless in the past. Two hundred and one (40%) respondents had been homeless on one or more occasions in the past with a mean number of episodes of 3.9. Those who had been homeless before were more likely to smoke, to use drugs and to suffer from depression, anxiety and foot problems.

Table 5.3 Number of episodes of homelessness and years since first becoming homeless in those who have been homeless before*

Category		*Number in group*	*Mean number of episodes*	*Mean number of years since first homeless*
Sex	*Males*	172	3.9	10.5
	Females	29	3.6	10.5
Age group	*Under 45*	136	4.0	8.5
	Over 45	62	3.6	13.3
Nationality	*Irish*	177	4.0	10.5
	Non-Irish[°]	24	3.1	9.8
Duration	*Long-term*	90	3.9	14.2
	Short-term	51	4.3	6.6
Total		201	3.9	10.5

[*] This table has not been totalled because the groups that it shows are overlapping; [°]Refugees not included

5.3.2 Childhood Experience of Residential or Foster Care

Seventy one people (16.5%) had been in care for various lengths of time during their childhood. Forty one (52.6%) of these people had been in care for a total of more than 5 years while 68 (87.2%) of them were long-term homeless. Although no more likely to have been in care, the long-term homeless were more likely to have spent more than 5 years in care than others who had also been in care. There was no association seen between age, sex, marital status, parenthood or nationality and the length of time spent in care.

Table 5.4 Residential status of selected homeless groups[*]

Group	*Hostel (n=385)*		*B&B (n=85)*		*Sleeping rough (n=32)*		*Total (n=502)*	
	No.	%	No.	%	No.	%	No.	%
Male	339	88.1	58	68.2	31	96.9	428	85.3
Female	46	11.9	27	31.8	1	3.1	74	14.7
Under 45 years	216	56.1	81	95.3	22	68.8	319	64.7
Over 45 years	164	42.5	0		10	31.3	174	35.3
Irish	356	92.5	10	11.8	28	87.5	394	78.5
British	21	5.6	0		2	6.3	23	4.6
Refugees	3	0.8	74	87.1	0		77	15.3
Travellers	12)	3.1	1	1.2	0		13	2.6
Long term	204	53.0	3	3.5	12	37.5	219	43.6

[*] This table has not been totalled because the groups that it shows are overlapping

5.3.3 Current Residence

Table 5.4 shows the number of people from different sub-groups of the homeless in each of the residential categories. Three hundred and eighty five (76.7%) of the respondents were living in one of the hostels surveyed at the time of interview. A further 85 (16.9%) were living in bed and breakfast accommodation. Thirty two (6.4%) were sleeping rough when interviewed. Those who were living in hostels were more likely to be male, over the

age of 45 and long-term homeless. They were also more likely to be Irish than non-Irish while refugees were less likely than non-refugees to reside in hostels.

5.3.4 Reason for Homelessness

More than one quarter (149; 29.3%) of those surveyed did not provide a response to the question enquiring about the principal reason for homelessness. The three main reasons cited by the respondents to the question accounted for almost two-thirds of the responses (231; 64.9%) while the top five reasons accounted for over 80% of reasons given. Table 5.5 shows these top five causes among the age-sex groups of homeless people for whom the reasons for homelessness could be expected to differ.

Table 5.5 Reason for homelessness among selected homeless groups

Group		*Drug/Alcohol Abuse*		*Relationship Problems*		*Financial Problems*		*Child/Parent Problem*		*Eviction*	
		No.	%	No.	%	No.	%	No.	%	No.	%
Males n=185	*<45*	57	30.8	33	17.8	28	15.1	29	15.7	8	4.3
Females n=35	*<45*	7	20.0	6	17.1	4	11.4	3	8.6	1	2.9
Males n=120	*>45*	19	15.8	35	29.2	35	29.2	4	3.3	11	9.2
Females n=13	*>45*	0		2	15.4	3	23.1	1	7.7	4	30.8
Total n=353		84	23.8	76	21.5	71	20.1	37	10.5	24	6.8

5.4 Lifestyle and Behavioural Risk Factors

Two hundred and seventy two (56.8%) respondents said that they usually spent the day outdoors and walking around the streets while a further 70 (14.6%) said that they usually spent the day indoors in a hostel or day centre. Of the former group, 54% were males under the age of 45 while 34% were males over the age of 45. A further 9% were females under the age of 45 while 3% were older females. These young women had 47 children between them, 44 of whom were under the age of 18.

Seventy eight per cent of respondents were currently smoking and a further 6% were ex-smokers. When comparing those who never smoked to those who were current or ex-smokers it was found that the latter were more likely to be over the age of 45, Irish, long term homeless, heavy drinkers and to have been in care during childhood.

Among those who consumed alcohol the overall average number of units of alcohol consumed per week was 49.8. Consumption of alcohol was significantly more likely among males and Irish people. Twenty nine percent of all respondents were found to drink beyond recommended limits, (21 units per week for males or 14 units per week for females (Department of Health, 1995)). Heavy drinkers, defined in this way, were more likely to be male and Irish. The prevalence of alcohol abuse among those who said that they did drink alcohol was 48% and their mean weekly alcohol consumption, in units, was 93.5.

Twenty nine percent of respondents said that they had used illegal drugs. They were significantly more likely to be under the age of 45, single, Irish and to have dependent children. They were also more likely to have been in care during childhood. They were all smokers but were no more likely to drink or to drink to excess than those who had never used drugs.

5.5 Perceived Health Status

Slightly more than half (57%) of the respondents who rated their health, categorised it as good to excellent while the remainder rated it as either fair or poor. Males were significantly more likely then females to rate their health as good. Self-rated health was also assessed in those who had reported themselves to be suffering from one or more of a list of 13 individual physical or psychiatric conditions. Those reporting at least one chronic disease were 1.9 times more likely to perceive their health as poor while those reporting a psychiatric problem were 1.8 times more likely to perceive their health as poor. Table 5.7 outlines these 13 problems and diseases and the effect they have on the perception of health among those who suffer with them.

Table 5.7 Chronic disease and its effect on perceived health status

Condition	*n*	*Good perceived health*		*Poor perceived health*		*Relative Risk**
		No.	%	No.	%	
Chronic Physical Disease						
Diabetes Mellitus	12	6	50.0	6	50.0	1.1
Hypertension	59	28	47.5	31	52.5	1.6
Arthritis	65	26	40.0	39	60.0	1.5
Heart Disease	24	14	58.3	10	41.7	1.0
Epilepsy	25	4	16.0	21	84.0	3.7
Tuberculosis	13	1	7.7	12	92.3	7.7
Respiratory Disease	75	23	30.7	52	69.3	2.0
Peptic Ulcer Disease	65	26	40.0	39	60.0	1.5
Psychiatric Problems						
Depression	153	66	43.1	87	56.9	1.5
Anxiety Disorder	130	45	34.6	85	65.4	1.9
Other Problems						
Dental Problems	176	87	49.4	89	50.6	1.3
Skin Problems	76	36	47.4	40	52.6	1.3
Foot Problems	100	41	41.0	59	59.0	1.5

*A relative risk of 2.0 indicates that one is twice as likely to rate their health as poor

Those with poor perceived health were no more likely to make use of any of the health services which were enquired about. These included services that were based in hospital, general practice and community care. Current users of prescription only medication were more likely to rate their health as poor compared to those who were not on prescribed drugs. However, those who rated their health as poor were no more likely to be in possession of a current medical card.

Twenty nine per cent of the people who responded to the question felt that their health status had disimproved in the previous year. These people were more likely to be under 45 years old, female and to have children, especially children under the age of 18. The long term homeless were also more likely to state that their health had declined over the previous year.

Deterioration in health status was associated with greater utilisation of services. When those whose health had deteriorated were examined, they were found to have a higher average consultation rate with a GP in the previous six months and to have a higher average attendance rate at out-patients departments over a similar time period.

Twenty seven per cent of respondents said that they had been limited in their daily activities in the previous 4 week period by their physical health. This was more likely to occur in those who were Irish and those who had a history of illicit drug use. Twenty four

per cent of respondents said that they were similarly affected during the same period of time by their mental health. The factors that were significantly associated with this were young age, female sex, illicit drug use and cigarette smoking. Those who drank alcohol were no more likely to declare themselves limited as a result of mental or physical problems over the previous four `weeks.

5.6 Health Problems

General Health Problems

The questionnaire enquired about chronic diseases (table 5.8), both physical and psychiatric, and other chronic problems such as skin, foot or dental problems. Sixty eight per cent of people complained of at least one physical or psychiatric problem, including skin, foot and dental problems. Forty one per cent reported a previous diagnosis of one of the chronic physical diseases shown in table 5.8 while 37% of people complained of psychiatric problems.

Table 5.8 Estimated prevalence of physical and psychiatric problems

Condition	*Number with condition*	*Prevalence %*
Chronic Physical Disease		
Diabetes mellitus	*12*	*2.5*
Hypertension	*60*	*12.7*
Arthritis	*65*	*13.7*
Heart disease	*24*	*5.1*
Epilepsy	*25*	*5.3*
Tuberculosis	*13*	*2.7*
Respiratory disease	*75*	*15.8*
Peptic ulcer disease	*65*	*13.7*
Chronic Psychiatric Problems		
Depression	*154*	*32.5*
Anxiety disorder	*131*	*27.6*
Other Problems		
Dental problems	*176*	*37.1*
Skin problems	*76*	*16.0*
Foot problems	*101*	*21.3*

There was no sex difference in the prevalence of chronic disease but older respondents were more likely to report at least one chronic disease. The long-term homeless were also more likely to report a chronic disease. Females were more likely to report psychiatric disease. No difference, however, was noted in the prevalence of psychiatric disease between younger and older respondents. The long term homeless and hostel dwellers were more likely to report psychiatric disease. However, when age was accounted for, these effects were confined to the under 45s.

Smokers and ex-smokers were more likely to report chronic disease, psychiatric disease and skin problems. Although chronic disease was no more prevalent among those taking illicit drugs, psychiatric disease was more likely.

Alcohol consumption was greater in those with chronic disease and psychiatric disease. The role of alcohol in these problems was further evidenced by the increased risk of chronic disease and psychiatric problems among those consuming excessive amounts of alcohol. The specific problems which were associated with excess alcohol consumption were hypertension, arthritis, anxiety and peptic ulcer disease.

The average number of GP visits in the last 6 months was higher among those with chronic disease. Similarly, the average number of visits to accident and emergency and

hospital outpatients was higher among those with chronic disease. Among those with psychiatric disease, similar differences in GP visits and hospital visits were found. These people were also more likely to have used health board social work services in the last six months.

Individual Health Problems

When each of the problems was examined individually, it was found that diabetes mellitus, hypertension and dental problems were no commoner in any one sub-group of the homeless population. Irish people were more likely then non-Irish people to have a diagnosis of arthritis, respiratory disease, peptic ulcer disease, depression, anxiety disorder, skin problems and foot problems. These foot problems were more likely to be seen in those who said that they spend the day outdoors walking the streets.

The long-term homeless were more likely to suffer from arthritis, heart disease, tuberculosis, depression and anxiety disorder. They have a greater prevalence of heart disease than people who have been homeless for shorter durations under the age of 45 but not above this age. Similarly, the effect of long-term homelessness on the prevalence of depression is only seen in younger respondents.

Thirty four per cent of respondents were taking prescription medications at the time of interview. Those doing so were more likely to be older, Irish and those who were either homeless for longer than one year or had become homeless within the last month. There was no difference detected, however, between males and females. People reporting at least one chronic disease or psychiatric problem were significantly more likely to be taking prescription medication.

5.7 Service Utilisation

Fifty five per cent of respondents stated that they had a current medical card, while 45% said that they did not. Table 5.9 shows the number of people with a medical card in selected groups. Older people were more likely than younger people to have a medical card. Irish people were also more likely to be in possession of a medical card as were those who were long-term homeless. Refugees, however, were significantly less likely to have a current medical card.

Respondents who said that they had at least one health problem were no more likely to have a medical card. Similarly, those who said that they suffered from at least one chronic disease were also no more likely to have one. Those who reported a psychiatric disorder, however, were more likely to have a medical card. People with a history of drug misuse were significantly less likely to have a medical card.

Table 5.9 Number of medical card holders in selected groups*

Category	*Total number in group*	*Number of cardholders in group*	*Percentage of cardholders in group*
Males under 45	251	112	44.6
Females under 45	50	32	64.0
Males over 45	148	102	68.9
Females over 45	15	8	53.5
Sleeping Rough	26	5	19.2
Hostel Dwellers	376	222	59.0
Refugees	58	18	31.0
Irish	373	229	61.4
Non-Irish	94	28	29.8

* This table has not been totalled because the groups that it shows are overlapping

Possession of a medical card was found to have an effect on GP consultation rates in the

previous 6 months. Those who had a medical card had a mean of 3.6 visits to a GP in that time period compared to 1.8 visits among those without a card but medical card status had no effect on visitation rates to accident and emergency departments or to hospital out-patient facilities even when chronic disease status was considered. When those reporting psychiatric problems were considered, those with medical cards had a significantly greater mean GP attendance rate in the previous 6 months.

Under the age of 45, females were more likely to have visited a GP in the last 6 months than males but no difference between the sexes was seen in the older age groups. The refugee population were significantly less likely to use GP services than others. Those who rated their health as poor were no more likely to have attended the GP in the last 6 months. However, those who suffered from hypertension, epilepsy, depression or anxiety were all more likely to have made use of GP services.

The numbers using the services surveyed and the proportion that these numbers represent of the total population are shown in table 5.10. The lower portion of the table shows some special services which would only be used by some of the population.

Table 5.10 Number of visits to health and social services in last 6 months (n=502 unless otherwise specified)

Service	*No visit*		*1 visit*		*2-6 visits*		*More than 6 visits*	
	No.	%	No.	%	No.	%	No.	%
General practitioner	241	48.0	94	18.7	121	24.1	47	9.4
Public health nurse	463	92.2	12	2.4	16	3.2	11	2.2
Social worker	417	83.1	27	5.4	31	6.2	27	5.4
Community welfare	294	58.6	58	11.6	70	13.9	80	15.9
General hospital clinic	400	79.7	52	10.4	35	7.0	15	3.0
Accident and Emergency	390	77.7	83	16.5	27	5.4	2	0.4
Drug addiction services (n=136)*	92	67.6	4	2.9	11	8.1	29	21.3
Psychiatric clinic[%] (n=185)	123	66.5	14	7.6	32	17.3	16	8.6
Community psychiatric nurse[%] (n=185)	133	71.9	8	4.3	27	14.6	17	9.2
Child health clinic[%] (n=176)	162	92.0	5	2.8	6	3.4	2	1.1

*users of illegal drugs only; [%] those with depression or anxiety only; [%] Those with dependent children only

Those who were long-term homeless were more likely to have seen a public health nurse or a visiting nurse in the previous 6 month period. Those who availed of social work services in the previous 6 months were more likely to be young, female, to have dependent children and to be Irish. Those who used the community welfare services were more likely to be young, homeless for less than one year or to be refugees.

The users of general hospital out-patient facilities were more likely to be long-term homeless and resident in hostels. Those who used such facilities in the previous 6 month period were also more likely to be Irish. Those who rated their own health as poor were more likely to have used hospital services in the previous 6 months as were those with heart disease, respiratory disease, peptic ulcer disease and skin disorders. Appendix 1 shows the numbers and proportions in different groups using the various services.

Respondents who had visited hospital accident and emergency departments were more likely to be young people with greater behavioural risk factors such as smoking, alcohol consumption beyond recommended limits and illegal drug use.

Use of the casualty departments was also more likely among those with hypertension,

arthritis, epilepsy, respiratory disease, peptic ulcer disease, depression, anxiety, skin disorders and foot disorders.

5.8 The Views of Homeless People

Homeless people were asked for their views on homeless services and how they might be improved. Many felt that the services in general were unsatisfactory but they varied in their degree of dissatisfaction and the elements of the services with which they were most dissatisfied. The services that were available to those on the streets were particularly criticised as were the casualty departments of specific hospitals for the way in which the staff "looked down upon" those people who were homeless. One respondent replied, "You go to receive something you are entitled to and it's hassle, unhelpful and uninformative staff."

This also applied to the general perception of the hostels which were declared to vary greatly in their standards and general acceptability by the homeless people who were using them. Other respondents said that they were satisfied with the services or felt that they could not be improved upon, while some respondents said that they did not know enough to be able to make recommendations for service improvements.

The comments of some people were reserved for specific services. Many people felt that the services for homeless drug addicts were insufficient while others felt that more visits by doctors to hostels, greater availability of counselling, day centres in hostels and facilities for children in the hostels were necessary. The issue of personal and property security in hostels was raised by some of the respondents who said that they had nowhere to safely store personal belongings. One person recommended that there should be a system of automatic clinic referral put in place for homeless people at their first point of contact with the services.

Barriers of access to some of the services that are provided by the health board and other agencies were identified by some of the respondents. They include such things as financial barriers, particularly in respect of dental services and information barriers which some respondents said arise because of an unwillingness on the part of the authorities to make information available to homeless people on their entitlements. Some respondents felt fear and intimidation when they attempted to use some services or visit some centres. A small number of Irish respondents expressed resentment at what they perceived as preferential treatment of refugees in the allocation of resources and the provision of support.

General recommendations for potential improvements in the services were made by some respondents. Many identified the need for more and better standards of accommodation and pointed out the requirement for support and supervision of those homeless people who were moving back into home or housing following a period of homelessness. Others felt that the facilities for drug addicts and alcoholics should be separate from those provided for other homeless people, particularly where they have children.

Chapter Six Discussion

6.1 Introduction

This is the first study that has examined the health of the adult homeless population of Dublin or which has had the general health of this vulnerable group as its central theme and focus. Given this fact, it was essential that it be broad in nature so as to provide general baseline data on health, behavioural risk factors and health service utilisation for the homeless people.

This may help to define the most pressing health issues among the homeless and to integrate the activities of those who provide health services for the homeless. It may also help to prioritise areas for further research which could then be more focused and specific than this study. There is a role to be played in this research by all those who work with the homeless, as evidenced by the dearth of published material on the health of the homeless population of Ireland.

6.2 Response Rate and Methodological Issues

The response rate of 64.4% achieved in this study, while not as high as might be desired, is in keeping with or better than response rates that have been achieved in other studies among homeless people (Wright & Devine, 1995; Link et al., 1994; Victor, 1992). One previous study of the adult homeless in Dublin bed and breakfast establishments, which was not looking at health issues, achieved a response rate of 34% of the 120 people estimated to be staying in bed and breakfast accommodation during the three month period of the study (Moore, 1994). Many studies avoid the difficulties relating to definition of homelessness or population denominator estimation and, therefore, do not quote response rates (George et al., 1991; Gelberg & Linn, 1989).

The response rate obtained was mainly affected by the absence of potential interviewees from the interview sites at the time of interview. Although it was not expressly measured, the number of refusals which occurred was small. It would appear, therefore, that inducements, which have been employed in other studies (Gelberg & Linn, 1989), would not have made a considerable difference to the overall response rate in this study.

It was noted, however, that people in food centres were less willing to be interviewed which may have been related to the relative lack of privacy and the interference of such questioning with the necessity of eating. Language difficulties were experienced when interviewing the refugee homeless which prevented completion of the interview in some cases. Future studies should consider these findings at their planning stage.

6.3 Demography

The homeless population is heterogeneous and very few would fit the demographic stereotype of a homeless person which is commonly perceived or expressed. This is evidenced by the complex age, sex, nationality and ethnic composition of the homeless population which was found in this survey.

The demographic characteristics of the homeless population interviewed are in keeping with those of homeless populations from similar surveys carried out elsewhere. A similar census of homeless people carried out in Sheffield found that 85.9% were male, 44.1% were under the age of 45 and 10.6% were over the age of 65 (George et al., 1991). The sex structure of the Dublin homeless population is almost identical to this and the age breakdown of both populations is similar, although the Sheffield population appears to be somewhat older. In comparison to the overall Irish population, the homeless population contains a smaller proportion of people over the age of 65 (11.5% vs. 8.1%) (Central Statistics Office, 1997).

The age and sex profile of the population in this study is broadly in keeping with the

profile from the 1991 census of population in Great Britain. This provides information on the age and sex breakdown of hostel residents and rough sleepers who were enumerated in England, Scotland and Wales. In England, 70.7% were male compared to 81.4% in Scotland and 68.4% in Wales. Sixty seven per cent of those enumerated in England were under the age of 45 compared to 59.7% for Scotland and 37.0% for Wales (Office of Population Census and Surveys, 1991).

The Dublin homeless population appears to be younger than the corresponding populations in Wales and Scotland but similar in age to the English homeless population. It also contains more males than might be predicted from the British figures. These British figures do not include those who live in bed and breakfast accommodation who could be expected to contain more females than a hostel or street population of homeless people (Connelly & Crown, 1994).

The finding that greater proportions of homeless women than men were married agrees with the findings of a literature review which covered marital status among the homeless. This review also agrees with the finding in this study that the majority of homeless men were either married or separated (Scott, 1993).

The nationalities and ethnic groups within the population present special challenges to the health services in overcoming the barriers to health care that might exist and in ensuring that all homeless people have health care that is appropriate to their needs. Almost four out of every five homeless persons in Dublin are of Irish origin while the remainder come from Britain, Europe, Asia and Africa. The African/Asian group together with some eastern Europeans are asylum seeking refugees in this country and recent anecdotal and official figures indicate that this category is increasing in size (Balazs, 1993; O'Sullivan, 1997).

6.4 Reasons for Homelessness

Many of the factors that emerged as important determinants of homelessness, such as substance and alcohol abuse, financial problems and relationship difficulties, could have an important role to play in the causation of disease or in the individual's ability to cope with disease or infirmity.

In recent years, attempts to address the homelessness crisis have increasingly focused on prevention which requires an understanding of the causes of homelessness. The role that the reduction of homelessness could play in the prevention of disease, at all levels of prevention, is clear. A study of health and homelessness should, therefore, attempt to define the reasons for homelessness among the population.

This study recorded one reason which, in the opinion of each interviewee, was the main reason for his or her current period of homelessness. An assumption was made that this would provide a good measure of the relative importance of various factors in the causation of homelessness.

More than one quarter of people interviewed did not wish to provide a reason for their homelessness. This may indicate that such reasons could be difficult for those who are homeless to discuss, particularly in the context of a study such as this. The determinants of homelessness are complex and multi-factorial and a more detailed investigation of these factors would require a specific study of the issue with the use of a more appropriate method.

The five most common reasons for homelessness that were expressed by the interviewees accounted for more than 80% of responses. Substance/alcohol abuse was the commonest reason given and was particularly common among young people. This could indicate that drug abuse, in particular, which was much commoner among young people, is playing an increasing role in the causation of homelessness. Such a conclusion is in keeping with findings from other studies (Susser et al., 1993; Johnson et al., 1997).

Relationship difficulties and financial problems were important reasons in all groups but particularly in the older homeless group. These financial problems can result from a combination of individual and structural factors. The importance of relationship difficulties in the origins of homelessness has been stressed by other commentators (Connelly et al., 1992). The absence of the social support of family and friends, as evidenced by the number of people reporting relationship difficulties or child/parent problems in this study, is an important determinant of homelessness (Shinn et al., 1991).

Psychiatric illness has received much attention in the literature as a possible cause and consequence of homelessness. It was not reported by the interviewees in this study to be an important determinant of their homelessness. Nevertheless, the prevalence of those psychiatric illnesses included here was in keeping with other published studies, indicating that it may well be operating as an underlying cause but not as a direct precipitant of homelessness (Scott, 1993; Fischer & Breakey, 1991; Koegel et al., 1988).

Seventeen per cent of respondents had been placed in care at some stage before the age of 18, which is close to that reported elsewhere for a census of homeless adults using self reports of care placement in childhood (Susser et al., 1987) and that found in a sample of homeless adults (Mangine et al., 1990). This may indicate that institutionalisation in childhood is an important underlying risk factor for homelessness in later life. Nevertheless, those who had been in care did not cite it as an important reason for their homelessness.

Other potential reasons for homelessness such as release from prison did not emerge as common reasons in this study. It is possible that they may act as underlying causes rather than direct precipitating reasons and were, therefore, underestimated. It is also possible that people may have chosen not to reveal such factors as reasons for their homelessness.

The aetiology of homelessness should be examined by further research which would look at the role of both structural and individual factors in more detail. Particular attention should be paid to mental health and physical infirmity as individual factors that may increase the risk of homelessness. This may help to identify those people who would benefit from early intervention to prevent their homelessness.

6.5 Residence Patterns of Homeless Adults

No attempt was made in the interview to determine the recent or past patterns of residence among the homeless population on the assumption that current residence would be a reasonable measure of overall patterns.

Using the results of this study, homeless people in particular residential settings can be loosely characterised and grouped. Hostel dwellers were long-term homeless, older Irish men, while those in bed and breakfasts were younger females and refugees. Those living rough on the streets were mainly young Irish males.

The health behaviour and health status of the groups in each of these settings are determined, not alone by the location in which they live, but also by their demographic composition. The type of accommodation in which they live may influence their health as well as their ability to deal with ill-health. Evidence for this in terms of variations in disease patterns and service utilisation is discussed below.

Policies vary between hostels that cater for different sexes with the result that many men spend the day out of their place of residence, often on the streets or in other exposed places. This may have an effect on the causation of or exacerbation of certain illnesses. Health needs may also be determined by the same factors that were responsible for homelessness in the first place and these were found to vary between the age and sex groupings.

6.6 Patterns of Homelessness

The patterns of homelessness that were revealed by this survey give some cause for concern. Almost half of interviewees were long-term homeless and 40% of them had been homeless before. Those who had been homeless in the past had, on average, 3.9 episodes of homelessness with a average period since first becoming homeless of over 10 years. Similar patterns were seen in all age and sex groups.

What can be concluded from this is that a sizeable proportion of the population experiences repeated periods of homelessness going on over long time periods. Other studies have indicated that such groups are at highest risk of health problems (Bines, 1994; Balazs, 1993).

The high proportion of people who have been homeless for long periods of time is also a cause of concern since their increasing duration of homelessness puts them at an ever increasing risk of ill-health. Older Irish males residing in hostels are over-represented in the long-term homeless group. Their fewer episodes of homelessness would seem to suggest that they may have accommodated to homelessness and institutionalisation more than others.

The short-term homeless represent a particular problem as many of them could possibly benefit from prompt and appropriate social intervention. They constitute one in five of the homeless population surveyed and have often become homeless as a result of an acute crisis. The longer their period of homelessness, the greater their risk of becoming homeless on a more permanent basis and the greater the risk to their health.

6.7 Behavioural and Lifestyle Related Risk Factors

Over half the homeless people surveyed spend the day “walking the streets”. This includes a number of younger women with young dependent children for whom such activities are inappropriate. Older people and those with chronic disease were no less likely to spend the day in this way, again indicating the inappropriate nature of this form of activity. Furthermore, those who did spend their time in this way were more likely to report foot problems which could possibly be a consequence of this form of lifestyle.

Many of these people come from male hostels, some of which operate a policy of compulsory evacuation between certain daylight hours. This may lead to weather exposure problems and consequent causation or exacerbation of disease or other infirmity (Usatine et al., 1994; Balazs, 1993).

Seventy eight per cent of the homeless people in this study smoked cigarettes and this high prevalence of cigarette smoking is identical to a prevalence of 78% found in another comparable study (Gelberg & Linn, 1989). It is a much higher prevalence of cigarette smoking than the 29% of people aged 15 and over in the general Irish population (Department of Health, 1995). This exposure to the health effects of cigarette smoking, that almost all of the homeless population experiences, can be assumed to have considerable deleterious health effects.

This study also found a high prevalence of 29% for alcohol abuse (defined as consumption of more than 14 units of alcohol per week for women and 21 units per week for men) among homeless people. The prevalence of alcohol abuse reported in the literature among homeless people has varied considerably according to the methods of measurement employed (Fischer & Breakey, 1991). Another study, using a similar approach to this one, found a prevalence of alcoholism of 28% (George et al., 1991). Nevertheless, the prevalence of alcohol abuse found in this study would appear to be somewhat lower than reported figures from the US of 30% to 40% of all homeless people (McCarty et al., 1991).

The prevalence of drug use in different studies has also varied according to the method of

measurement (Fischer & Breakey, 1991). Lifetime prevalence estimates between 10% (McCarty et al., 1991) and 52% (Robertson et al., 1997) have been reported. The latter figure indicates that the prevalence found in this study of 28% could be an underestimate of the true lifetime prevalence.

It appears, therefore, that the prevalences of both alcohol and drug use were lower than might be expected. This could be explained by the often expressed fear on the part of the interviewees that use of drugs or alcohol intoxication could result in expulsion from certain institutions.

Those who have other lifestyle risk factors such as drug and alcohol abuse are almost all smokers. These lifestyle risk factors act with other risk factors such as living environment, weather and diet to increase the risk of many common diseases and complicate the management of chronic diseases (Gelberg, 1992; Balazs, 1993; Usatine et al., 1994).

The risks to health experienced by the homeless from the conditions in which they live and from the risk behaviours that they exhibit indicate that there is considerable potential for environmental change, health promotion and disease prevention to reduce their morbidity and mortality from preventable diseases.

6.8 Self-Perceived Health

For the purposes of simplicity, the respondents were divided into two groups based on their response to the question about how they would rate their own health. Nearly half (44%) of all homeless people rated their health as either fair or poor. This compares to estimates of between 33% and 48% from other studies which have also used perceived health status to measure health among the homeless (Jahiel, 1991).

According to self-reports, no difference was seen in perceived health status between most demographic groups, with the exception of sex. It is possible that this sex difference could reflect a true difference in health between males and females or a greater tendency for females to perceive their health as poor for a given level of health. Some evidence for the former interpretation is provided by the fact that no sex difference in the physical diseases included was found while evidence for the latter comes from the fact that females report more psychiatric problems which are in turn associated with a poorer perception of health status.

Perceived health status did not show significant differences between current and non-smokers. Furthermore, those who rated their health as poor had a similar intake of alcohol to those who rated their health as good. Users of illicit drugs, however, were more likely to perceive their health as poor. This indicates that those who smoke and those who drink or abuse alcohol do not appear to assess their health as poor in spite of the health risks associated with these forms of behaviour.

The limitation in activity experienced as a result of physical health provides some insight into why homeless people with poor health behaviour do not perceive their health as poor. They do not feel physically limited by their smoking or alcohol intake. The increase in smoking seen in those with limited activities as a result of mental problems is likely to result from the distress associated with mental illness.

The chronic diseases that were found to be associated with poor perceived health status were those that would be associated with more disabling and more distressing symptoms such as epilepsy, tuberculosis, arthritis, depression and foot problems. Those chronic conditions that are not often associated with distressing or disabling symptoms such as heart disease, hypertension and diabetes mellitus do not appear to result in a poorer assessment of health by homeless people who report them. The fact that those who use prescription medications are more likely to report poor health indicates further that it is when reminders of disease are overt that one is likely to perceive one’s health as poor.

Those who rate their health as poor among the homeless population are no more likely to use any of the health services, perhaps indicating that something beyond simply the recognition of health need is required for services to be used. It may be that barriers to service utilisation prevent homeless people from accessing health services when they feel in poor health.

Deterioration in health status compared to one year before, however, was found more commonly in some groups than in others and was found to be associated with greater use of GP and out-patient services. This indicates that, among the homeless people, while current health perception does not necessarily increase service utilisation, a relative deterioration in perception of health does.

6.9 Physical and Mental Health Problems

The prevalence of many chronic diseases and chronic problems was higher than would be expected from a sample of similar demographic composition drawn from the general population. One previous study that was carried out in Dublin allows for comparison (Lyons, Carroll, Doherty et al., 1992). It provides some estimates of chronic disease prevalence in a population using GP services as well as in the community at large. The estimated prevalences of diabetes mellitus, hypertension, peptic ulcer disease, respiratory disease, depression and anxiety disorder were greater in the homeless population than would be expected from their estimates of community prevalence of these conditions.

Long-term homelessness was associated with a greater likelihood of chronic disease and this effect was independent of age. This may point to the role of homelessness in the causation of disease. Furthermore, the association between chronic disease and behavioural risk factors such as cigarette smoking, alcohol abuse and drug taking points to the role that these risk factors play in the causation of disease in the homeless.

The prevalences that have been found here for some of the chronic diseases and conditions are consistent with those found in other studies of the homeless. These studies, however, were either specifically designed to look at a given condition, or used more in depth interviewing, physical examination and investigations in order to satisfy case definitions (Kinchen & Wright, 1991; Darbyshire, 1995; Citron et al., 1995; Balazs, 1993; Weller, 1989).

When the specific chronic physical diseases included in this study were examined together (table 5.8) their combined prevalence was 41%. This compares to prevalences reported by other commentators for chronic disease in homeless populations of 40.0% (Plumb, 1997), 38% (Robinson & Cousineau, 1986) and 30% to 40% (Fleischman & Farnham, 1992).

Comparable prevalences for diabetes mellitus and hypertension in another study using self-reported morbidity were 2.7% and 20.5% compared to 2.5% and 12.7% in this study (Gelberg & Linn, 1989). A Sheffield study, using similar methods of measurement, found very similar prevalences of epilepsy (4% vs. 5.3%) and tuberculosis (3% vs. 2.7%) (George et al., 1991).

The Sheffield study also found a similar prevalence of psychiatric illness to this study (34% vs. 36.9%) (George et al., 1991). The prevalence of depression found in this study was 32.5% which compares closely to an estimate of 29.5% found in an American study which looked at the prevalence of psychiatric disease in the urban homeless. However, the American study would indicate that this study may have overestimated the prevalence of anxiety disorder (27.6% vs. 17.6%) (Koegel et al., 1988). This may have occurred because less strict diagnostic criteria were used in this study.

The combined prevalence of all physical and psychiatric complaints was 65.7%. Previous studies reported a prevalence of 82% (Heffron et al., 1997). Another study of single homeless people found that 72% complained of at least one health problem (Bines, 1994).

The most prevalent self-reported health problem in this study was dental disease, which is consistent with another study which found that dental disease was the commonest problem noted on physical examination (Breakey et al., 1989).

It appears, therefore, that the estimates of prevalence of physical and psychiatric problems in this study are in keeping with other studies which have provided prevalence estimates. The problems that have been identified are all common problems in the population at large but many appear to be particularly prevalent among the homeless population. Further studies, which include physical examination, history taking and investigations should be conducted to examine the physical and psychiatric problems of the homeless in more detail and to allow comparison with non-homeless groups.

6.10 Utilisation of Services

Estimates of utilisation of the various health and social services were made using a crude question about the number of visits made to a given service in the previous six months. While figures from the literature which allow meaningful comparison with this study are difficult to obtain, interpretation of the variation in utilisation rates between sub-groups of the homeless population in this study is possible.

Utilisation of GP services was higher in younger females and lower in refugees than in other demographic groups. The former group could be expected to use GP services more for obstetrical and gynaecological reasons and for child health problems. Refugees may be poor attenders due to lack of familiarity with the Irish health care system and because they might receive their medical care elsewhere, although no evidence for this exists in this study. Furthermore, their under-utilisation of GP services could also be explained by cultural factors.

The fact that accident and emergency attendants are younger while outpatient attenders are mainly Irish long-term hostel dwellers may reflect differences in the problems they experience, differences in their help-seeking behaviour or differences in their access to the various health services.

While no comparable mean outpatient consultation number or risk of outpatient consultation could be found in the literature, an odds ratio of 3.7 for the odd of using outpatient services among those reporting at least one chronic medical problem has been reported (Wenzel et al., 1995). This compares closely to the odds ratio of 3.1 found in this study for similar consultations over a similar time period.

Those who make most use of the social work services are young Irish females with dependent children which may indicate that these services are used for the child care services that they provide. It is those who reside in the bed and breakfast sector who make most use of the community welfare services. These are also the residential facilities which the community welfare services use most when making referrals for refugees, younger people and those homeless for shorter time periods.

Services for drug addicts and those with psychiatric illness appear to be underused by those for whom they are intended. Over two thirds of them have made no use of these specialist services which may indicate that other barriers to their use may exist. Almost one in five of those who said that they have used illicit drugs use addiction services more than once a month indicating that some of these people may be involved in on-going programmes to deal with addiction, but that other homeless people who have used drugs may not have sufficient access to them.

When homeless people report a deterioration in their health status over the previous year, they report greater use of health services such as GP and out-patient facilities. It is not possible to say with certainty whether the change in perceived health results in increased services use or increased services use results in changes in perceived health. Nevertheless, it is likely that greater use of GP facilities would result in greater utilisation of out-patient

facilities by reason of increased referrals from general practice. It, therefore, appears that perceived deterioration in health results in self-referral to general practice which results in referral on to out-patients.

Those who said that they had been limited in their daily activities over the previous four weeks as a result of their physical or mental health were no more likely to visit any of the services. This may indicate that this limitation does not act as a cue to action or that limitation in activity only results in help-seeking when it has been present for periods longer than four weeks.

The only health service that was used to a greater degree by those with behavioural risk factors such as tobacco, alcohol and drug abuse was the accident and emergency department which may imply that this is the most accessible element of the health services to those who suffer the consequences of such lifestyles.

The pattern of health problems associated with greater utilisation of different health services gives some insight into help-seeking behaviour among homeless people, the sources of medical care for homeless people who are unwell and the possible barriers that may limit access to health services. The broader array of physical and mental problems that increase the use of the accident and emergency department compared to the GP or out-patient services indicates that many homeless people receive their medical care in accident and emergency even for chronic disease. The reasons for this require further research to be adequately characterised but are probably a combination of factors which relate not only to the health services but also to the homeless themselves.

The use of each of the health services was associated with a greater use of prescription medications. When the conditions for which these medications were more likely to be used were examined it was found that hypertension, diabetes mellitus, peptic ulcer disease and tuberculosis were not associated with greater medication use. It is possible that this could result from lack of access to health services for these problems or from poor compliance among the sufferers. The latter seems a likely explanation when it is seen that, in the main, these are conditions without disabling or distressing symptoms. The exception here would be tuberculosis, but considerable evidence exists for poor compliance in the management of this disease among the homeless (Citron et al., 1995). The diseases which are associated with disabling and distressing symptoms do, however, show greater use of medications among their sufferers.

6.11 Barriers to Utilisation of Services

People who make greater use of the services may encounter fewer barriers such as lack of information and financial disincentives. The differences in utilisation that are seen between the sexes were only seen at younger ages and probably reflect the differences in medical card ownership, child dependency and illness patterns between the various demographic groups.

The existence of barriers is further evidenced by the lower utilisation of GP services among refugee homeless, also independent of age. The refugee homeless were also lower users of accident and emergency departments and general hospital clinics than other demographic groups. They may find it difficult to access some services, either through inability to get and understand information, ineffective communication in both directions with health care providers or lack of familiarity with the Irish health services and general inexperience with bureaucracy.

Cultural barriers, in terms of beliefs and ideas about health, illness and help-seeking behaviour, may also exist, which may limit the access of refugees, as well as native Travelling people, to health services and homeless services. Literacy difficulties, while not addressed in this study, could create a further information barrier of access to health services among the general homeless population.

The barrier to service utilisation that results from the lack of a medical card is considerable. Almost half of the homeless population have no personal medical card. Very few among certain sub-groups, such as those sleeping rough, have a medical card. The lack of a medical card means that the only way to access GP services is by paying cash at the point of consumption. Some hostels have special arrangements with local GPs to provide free GP services for their residents. This does not address the low coverage of medical cards among the population in general and makes the continuity of care that should be received at primary care level almost impossible for some homeless people who move in and out of, or between, hostels.

Those reporting at least one problem and those with one of the chronic diseases were no more likely to have a medical card indicating that a large financial barrier may exist to service utilisation among those with on-going health needs. Further evidence of this barrier is provided by the fact that those who say that they have used illegal drugs are actually less likely to have a medical card for reasons beyond simply the fact that they are younger than the remainder of the population. Only those reporting a psychiatric problem were more likely, among those reporting health problems, to have a medical card.

In spite of the barrier provided by lack of a medical card, those with chronic disease were more likely to use GP services in the previous six months. However, the fact that they were also more likely to use accident and emergency departments may indicate that the lack of a medical card forces some homeless people to meet their on-going health requirements through accident and emergency departments.

The health problems which were found to be associated with greater use of accident and emergency departments, such as hypertension, skin problems, peptic ulcer disease, arthritis and depression, would seem to provide further evidence of this inappropriate use of health services among homeless people. It is the primary care services which would be the most appropriate for the care of these chronic and non-emergency problems. Without access to these services, there is no continuity of care for the homeless person within the health services.

This “inappropriate” use of the accident and emergency department may give rise to some resentment and ill-will on the part of the staff of these departments. Evidence from views of homeless people on the health services in this survey indicates that this creates a “vicious cycle” of barriers and decreased utilisation of services which ensures that the homeless person is further isolated from the health services.

Less than one in five of the people sleeping rough on the streets had medical cards in spite of their often greater medical needs. Reasons such as the lack of a permanent address, fear of bureaucracy on the part of the homeless person, ignorance of entitlements or competing priorities as discussed above may explain this. The socio-economic status of the homeless population is such that no homeless person should be without a medial card so that this financial barrier of access to appropriate health care is removed.

The contributions through open questions of the study respondents indicate that the type and location of a service influences its accessibility. Some people felt that services should be provided in the homeless hostels and other institutions by GPs and other medical staff. Many of the barriers to service utilisation that are described above would thereby be removed and this would ensure greater acceptability and appropriateness of the service and would, therefore, enhance utilisation.

Chapter Seven Conclusions

The adult homeless population of Dublin is a heterogeneous group made up of many people of different ages, sexes, nationalities, cultures and races. A single characterisation of homeless people that represents all of them cannot be made. In spite of the limitations of any attempts to broadly generalise, some identifiable sub-populations do exist. One group could be characterised as older Irish males living in hostels who have been homeless for long time periods. Another group would consist of younger females, often with dependent children, homeless for short time periods and living in bed and breakfast accommodation. The refugees, also living in bed and breakfast institutions, make up a third group while a final group could be identified as younger Irish males living on the streets.

The reasons for homelessness among each of these groups vary. Some of the common reasons given for homelessness result directly or indirectly from factors that often relate to the health of the individual. The indirect effect of other factors which are more structural in nature and their interaction with individual factors relating to health can be inferred.

The patterns of homelessness experienced by the homeless also vary. For many homeless people a cycle of recurrent homelessness or homelessness going on for many years appears to be common. People with such patterns of homelessness suffer from many different health problems and experience barriers to utilisation of some services which limits their utilisation of appropriate health care facilities.

Homeless people with unhealthy lifestyles do not necessarily regard themselves as being in poor health as a consequence and seem to seek medical care only when they notice a relative deterioration in their health. This may limit the value of health education and opportunistic health screening among them.

The main differences in health between homeless and non-homeless people appears not to be the actual health problems that they suffer from, but their greater health risks, the higher prevalence of their health problems and their limited access to appropriate intervention when they are ill. The health problems consist of a variety of common chronic physical diseases, psychiatric problems, drug abuse and other health problems for which they do not receive or use appropriate medical services.

There is evidence that when they do receive services for some of these problems, appropriate management does not always occur, possibly because of poor compliance. Without on-going appropriate and acceptable care, the resultant morbidity, mortality and reduced quality of life from these health problems can be considerable.

Many barriers exist to the utilisation of services and particularly to the appropriate utilisation of services. The financial barrier created by lack of medical cards may result in homeless people having to bypass the more appropriate primary care services and use the services of accident and emergency departments. Services are often perceived to be of poor or variable quality and homeless people have low expectations of them.

A simple response to these health issues is not possible. The first step is that they are characterised as has been done in this study. Recommendations for further action are made in the following chapter.

Chapter Eight Recommendations

1. Consideration should be given to the development of a fixed term strategy for health services for the homeless. It should be reviewed and extended as appropriate after this period of time. It should be based upon a comprehensive needs assessment of the health of the homeless which should include a clear definition of homelessness and a comprehensive count of those who meet that definition. The development of the strategy should be a joint project between the hospitals, health boards, GPs, local authorities and voluntary groups involved in the care of the homeless with a fixed time period for its report and implementation.
2. Consideration should be given to the establishment of health services linked to the community welfare services so that homeless people could have access to health services in a form of a "one stop shop" with the welfare and social which are currently provided for homeless people. This would help to bring health services to those with minimal access. It would also improve integration between health and other services.
3. All those who are being admitted to homeless institutions or who otherwise come to the attention of the agencies caring for the homeless should have easy access to health facilities to ensure that any potential problems are identified and dealt with. For this reason, closer liaison, collaboration and greater communication should take place between the health boards, local authorities, education bodies and voluntary agencies.
4. Outreach services should be put in place to engage those homeless people, especially street dwellers, whose access to medical services is limited and link them to available services. These outreach services could be linked to the other health services for the homeless. Planning of services which are sensitive to cultural differences and language difficulties will allow the social and medical services to be tailored appropriately, resulting in more effective interventions.
5. In order to overcome the poor coverage with medical cards, special medical cards should be used for homeless people which do not require complex application procedures and which do not require that an address be used. Easy registration should be the underlying principle.
6. The chronic diseases (such as tuberculosis, diabetes mellitus, epilepsy and hypertension) which were found to have increased prevalence using the questionnaire in this study should be further investigated to determine their prevalence using clinical examination and investigations as appropriate. This should lead to the establishment of routine screening for tuberculosis, if prevalence criteria are satisfied.
7. When homeless people receive treatment for illness from health professionals, the problem of poor compliance should be considered when arranging a treatment regime and follow-up schedule.
8. The policies of homeless institutions should be reviewed by the homeless health strategy group to ensure that people are not forced outdoors each day, that families are not separated from one another and that mixing of older women with alcohol problems with younger women and children does not occur.
9. The questionnaire that was used in this project should be developed and validated in order to ensure that a useful monitoring tool for the health of the homeless is available. Brief questionnaires, such as this one, using self ratings of current health status provide a feasible way of screening large numbers of homeless individuals for health problems.

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Appendix 1

Numbers and proprtions using services in last six months in different groups

Group	*n*	*GP*[*]		*PHN*		*SW*		*CW*		*OPD*		*A&E*	
		No.	**%**	No.	**%**	No.	**%**	No.	**%**	No.	**%**	No.	**%**
Demography													
Young males	265	124	**46.8**	16	**6.0**	38	**14.3**	129	**48.7**	49	**18.5**	73	**27.5**
Young females	54	35	**64.8**	9	**16.7**	28	**51.9**	32	**59.3**	15	**27.8**	16	**29.6**
Older males	158	89	**56.3**	13	**8.2**	17	**10.8**	42	**26.6**	35	**22.2**	21	**13.3**
Older females	16	10	**62.5**	1	**6.3**	1	**6.3**	4	**25.0**	0	**0**	2	**12.5**
Refugees	77	26	**33.8**	5	**6.5**	5	**6.5**	38	**49.4**	10	**13.0**	6	**7.8**
Irish	394	224	**56.9**	33	**8.4**	75	**19.0**	152	**38.6**	88	**22.3**	95	**24.1**
Long-term homeless	219	123	**56.2**	25	**11.4**	41	**18.7**	69	**31.5**	56	**25.6**	49	**22.4**
Residence													
Hostel	385	214	**55.6**	33	**8.6**	68	**17.7**	160	**41.6**	88	**22.9**	93	**24.2**
Sleeping rough	32	8	**25.0**	2	**6.3**	4	**12.5**	6	**18.8**	1	**3.1**	7	**21.9**
Bed and breakfast	85	36	**42.4**	6	**7.1**	11	**12.9**	49	**57.6**	14	**16.5**	10	**11.8**
Lifestyle													
Heavy drinkers	127	74	**58.3**	13	**10.2**	21	**16.5**	54	**42.5**	25	**19.7**	42	**33.1**
Drug users	136	73	**53.7**	13	**9.6**	29	**21.3**	60	**44.1**	26	**19.1**	41	**30.1**
Chronic disease													
Diabetes mellitus	12	9	**75.0**	2	**16.7**	2	**16.7**	5	**41.7**	5	**41.7**	3	**25.0**
Hypertension	60	43	**71.7**	11	**18.3**	19	**31.7**	22	**36.7**	15	**25.0**	22	**36.7**
Arthritis	65	41	**63.1**	9	**13.8**	10	**15.4**	27	**41.5**	20	**30.8**	23	**35.4**
Heart disease	24	16	**66.7**	5	**20.8**	6	**25.0**	8	**33.3**	14	**58.3**	5	**20.8**
Epilepsy	25	20	**80.0**	3	**12**	8	**32**	9	**36.0**	9	**36.0**	11	**44.0**
Tuberculosis	13	7	**53.8**	2	**15.4**	2	**15.4**	2	**15.4**	5	**38.5**	2	**15.4**
Respiratory disease	75	46	**61.3**	9	**12.0**	18	**24.0**	34	**45.3**	24	**32.0**	26	**34.7**
Peptic ulcer	65	39	**60.0**	7	**10.8**	9	**13.8**	29	**44.6**	23	**35.4**	26	**40.0**
Depression	154	102	**66.2**	16	**10.4**	40	**26.0**	70	**45.5**	39	**25.3**	50	**32.5**
Anxiety disorder	131	92	**70.2**	18	**13.7**	32	**24.4**	56	**42.7**	35	**26.7**	42	**32.1**
Dental problems	176	99	**56.3**	18	**10.2**	30	**17.0**	82	**46.6**	43	**24.4**	50	**28.4**
Skin disorder	76	48	**63.2**	11	**14.5**	17	**22.4**	30	**39.5**	24	**31.6**	30	**39.5**
Foot problems	101	69	**62.4**	11	**10.9**	17	**16.8**	45	**44.6**	26	**25.7**	38	**37.6**

*GP = General Practitioner; PHN = Public Health Nurse; SW = Social Worker; CW = Community welfare; OPD = Out-patients clinic; A&E = Accident and emergency;