



**WESTERN
MICHIGAN**
UNIVERSITY

The Journal of Sociology & Social Welfare

Volume 17
Issue 1 *March*

Article 7

March 1990

Health Implications of Homelessness: Reports from Three Countries

Gerald Daly
York University

Follow this and additional works at: <https://scholarworks.wmich.edu/jssw>



Part of the International and Area Studies Commons, and the Social Work Commons

Recommended Citation

Daly, Gerald (1990) "Health Implications of Homelessness: Reports from Three Countries," *The Journal of Sociology & Social Welfare*: Vol. 17: Iss. 1, Article 7.

DOI: <https://doi.org/10.15453/0191-5096.1930>

Available at: <https://scholarworks.wmich.edu/jssw/vol17/iss1/7>

This Article is brought to you by the Western Michigan University School of Social Work. For more information, please contact wmu-scholarworks@wmich.edu.



**WESTERN
MICHIGAN**
UNIVERSITY

Health Implications of Homelessness: Reports from Three Countries

GERALD DALY

YORK UNIVERSITY

FACULTY OF ENVIRONMENTAL STUDIES

This paper discusses the health implications of homelessness in the context of problems discovered and remedies proposed in three countries: Britain, Canada, and the United States. The findings, particularly with respect to programmatic responses, are selective. Based upon personal observation over the past four years, they are intended, however, to offer a glimpse at the range of projects which have evolved in the three countries during the eighties.

In 1851 Lord Shaftesbury noted that "as the homes, so the people." Today these relationships, though more complex, are still evident. Among the poorer segments of the population there are direct links among housing, homelessness and health.

The intent of this exercise is to demonstrate that housing, health and homelessness are inextricably related, that a broad range of comprehensive programs are required to deal with the diverse problems of heterogeneous populations, and that locally-devised solutions are most appropriate and likely to succeed.

For purposes of this discussion the most useful definition of homelessness is offered by the United Nations. Included are those without shelter (street people and those who find themselves without a roof as a result of fire or some other emergency), and those whose dwellings are inadequate because they lack protection from the elements, access to safe water and sanitation, secure tenure and personal safety, affordability, and accessibility to employment, education and health care.

Causes and Underlying Trends

In Britain, Canada, and the United States the causes of homelessness are remarkably similar. In all three countries social

changes have been important precipitants of homelessness; much of the problem, however, is at least partially attributable to government policy and to underlying economic conditions. Among the principal causes and underlying trends are: dramatic cuts in public spending on housing and public assistance programs; private sector focus on housing and health programs for middle and upper-income households; decline in the private rental sector and in housing conditions; loss of single room occupancy units and low cost housing as a result of gentrification and demolition; basic economic shifts, accompanied by increasing unemployment and a growing proportion of low paid jobs in the service sector; declining average wage levels relative to housing costs; a widening rift between haves and have-nots; racial discrimination in employment and housing; demographic changes, leading to smaller households, an increase in the number of households, and greater demands on the existing housing stock; the inflexibility of occupancy policies in government-subsidized housing, which can exacerbate domestic difficulties and homelessness; and, a continuing movement toward deinstitutionalization without a corresponding increase in community care facilities to attend to both physical and mental health needs.

The Dimensions of Homelessness in Three Countries

The homeless represent an elusive population. Counts are difficult and suspect. Estimates offered by government are low and self-serving, while figures submitted by voluntary agencies and advocacy groups may be inflated because of a need to secure public funding and private contributions. Population figures may also include double-counting of individuals who frequent several shelters, food banks, medical clinics and drop-in centers. It is important, however, to attempt to quantify the extent of homelessness, at least in order-of-magnitude terms. This is essential so that public policy and programmatic responses may be designed to fit the needs of the variety of individuals who are homeless.

Estimates of the size of homeless need groups in Britain are about 1% of the population (600,000 people), about 0.5-1.0% in

Canada (125,000-250,000 individuals), (Canadian Council on Social Development, 1987), and about 1% of the population in the United States (2.5 million). These figures represent extremely rough estimates which might be found too high by public agencies and too low by advocates for the homeless.

Britain

In 1948, as decreed in the National Assistance Act, local authorities took on the legal responsibility to provide temporary accommodation for "persons who are in urgent need thereof." This law proved inadequate, however, in dealing with the growing numbers of homeless people who were displaced by slum clearance and highway building projects during the fifties and sixties. Many resorted to squatting. Advocacy groups, like Shelter and CHAR, responded to the growing crisis and lobbied relentlessly at Westminster to bring this problem to public attention.

The extent of homelessness and the responsiveness of local authorities varied widely. The system was whimsical. One's right to housing often seemed to hinge on the political will of the local authority as well as one's relationship with the social worker assigned to the case. Welfare and housing departments continually passed the buck back and forth because no definitive policy had been developed. As early as 1971 certain boroughs used travel vouchers to induce people to leave their jurisdictions. Other authorities started to use bed-and-breakfast hotels for temporary accommodation of homeless families. By 1976 this practice was costing one million pounds annually for a total of 1500 households.

Advocacy groups began pressuring government to take action in the face of a rapidly growing problem. In 1977 legislation was passed. The Housing (Homeless Persons) Act defined people in need as "those without accommodation they were entitled to occupy." Specifically included were those, like battered women, who were threatened with homelessness. Priority groups included families with dependant children, pregnant women, those made homeless by fire or other emergencies, and those who were vulnerable as a result of old age or mental or physical disabilities. Local authorities were obliged, under the

Act, to provide temporary housing to priority households while their cases were examined. If found to be homeless they were entitled to permanent council housing.

Following passage of the 1977 Act the number of households certified as being homeless rose from 33,000 (in 1976) to over 53,000 (in 1978). By the late 1980s the total had doubled again, to more than 130,000 (Department of the Environment).

While local authorities now accept their obligation to deal with homelessness, central government has made little progress since the late 1970s. Public interest groups are again mobilizing to exert pressure on government because council housing stocks have been reduced, the private rental market has dwindled to less than ten percent of total stock, and local officials have resorted to shabby bed and breakfast accommodations to house those waiting for permanent housing.

Reformers have been frustrated because of hostile or apathetic responses from government. Buck-passing has occurred at both the national and local levels. The Department of Environment attributes the rise in homelessness to "profound changes in the nature of our society," including dramatic increases in divorces and illegitimate births, as well as youth mobility:

Young people are leaving home earlier and with higher, if not always more realistic, expectations about what they might expect by way of housing...Because of these long term social problems and the fact that homelessness is to a very large extent a symptom rather than a cause, the scope for Government action is limited. (Department of Environment, 1987)

Despite this *laissez-faire* attitude, a variety of innovative programs and projects have evolved in Britain. While many are publicly-funded most have been developed by voluntary organizations. A host of agencies have emerged to deal with a number of different aspects of homelessness. Their responses are based upon an understanding of the need for a diversity of housing, health, education and employment programs and support services to deal with a heterogeneous array of homeless people.

The United States

American cities in the 1980s have been characterized by public squalor in the midst of private affluence. Homeless street people huddle on heating grates outside luxury condominiums and sparkling office towers. In New York the municipal government now has to place over 30,000 people (including more than 12,500 children) in shelters. Many more remain on the street, preferring to avoid the squalid, violent emergency shelters. About 90% of the homeless families in New York City are black or Hispanic. The city has been described as "like the wedding cake in a bakery window: an exquisite excess of spun sugar covering a cardboard core...where the megarich in stretch limousines look away from the 1.8 million living in poverty" (*Time*, November 30, 1987).

The local government now spends over \$250 million annually on shelters like the 1200-bed armory which is used by an assortment of drug addicts, mentally ill adults, runaway youths, and families with young children. Each year, despite dramatic increases in expenditures on emergency shelter and on obscenely expensive welfare hotels, the queue becomes longer. The supply of affordable housing has virtually disappeared. With government acquiescence, 90% of the single room occupancy units have been lost to conversion or the wrecker's ball. Meanwhile, the waiting time for public housing units in 17 years.

Many in government have been paralyzed by entrenched opinions of the homeless as drug addicts and freeloaders. The position of the Reagan administration was set out by David Stockman who asserted that "I don't think people are entitled to services...I don't accept that equality is a moral principle" (*New York Times*, March 24, 1981. A second federal official, Philip Abrams of the Department of Housing and Urban Development, explained away the problem of severe overcrowding by glibly noting that doubling up "is characteristic of Hispanic communities, irrelevant to their social and economic conditions ...It is a cultural preference, I am told." Others in the administration, notably Attorney General Edwin Meese, accused homeless people of cadging free meals at missions and food banks. The federal response was to pass the buck to state and local governments.

Rather than produce housing, the Reagan administration argued that free market mechanisms would ensure that all boats rose with the incoming tide. Meanwhile, the share of federal dollars allocated to education, training, employment, social services, health, income security, and housing fell from 25.5% in 1980 to 18.3% in 1987. During the same period the federal budget for defense increased from 22.7% to 28.4%. It was not until mid-1987 that substantial authorizations were made in Congress for programs dealing with homelessness. It is still uncertain how long this aid will be available and how effectively it will be applied.

At the local level responses have varied from innovative programs to blatant attempts to run the homeless out of town. A gradual awareness of the scope of homelessness has been evolving. It is now recognized by many as a nationwide concern in rural as well as urban areas. For several years the U.S. Conference of Mayors' Task Force on Hunger and Homelessness has surveyed major cities. In December 1986 they reported:

By far, the most significant change in the cities' homeless population has been in the number of families with children...In 72 per cent of the cities, families comprise the largest group for whom emergency shelter and other needed services are particularly lacking...Well over two-thirds of the homeless families are headed by a single parent. (U.S. Conference of Mayors, December 1986)

The most promising trend in the United States has been the ability of local agencies, both public and private, to obtain funding from foundations and private sources for the development of creative local programs. In the health field, for instance, a number of cities have devised innovative outreach projects which have been successful in assisting street people who were ignored by conventional welfare programs.

Canada

Because of its climate and the existence of a reasonably effective safety net of health and welfare services, Canada has relatively few people who are forced to exist on the streets. The Canadian Council on Social Development estimates, based upon

a snapshot survey of shelter users, that the extent of homelessness is only about half, in percentage terms, of Britain and the United States. Toronto's shelter population, the highest in Canada, is only one-fourth of the rate in New York City.

When problems are not visible, however, government often does not feel compelled to react. The national housing agency (Canada Mortgage and Housing Corporation) has attempted to devolve responsibility for homelessness to the local level. Provincial and city authorities, however, are just now beginning to realize the serious implications of homelessness for public policy in terms of housing, health, employment training, and community services.

Perhaps the most salient characteristic of homelessness in Canada is the significant variation among cities. Both depressed and booming areas of the country have a high incidence of homelessness. Economically dormant regions like Newfoundland have very high rates of unemployment and have witnessed significant out-migration to areas like southern Ontario. In the Toronto region, which receives many of these newcomers, the economy is vibrant but few can afford the excessively high cost of housing. Average home prices now exceed \$250,000. As a result, overcrowding and homelessness are on the increase. Toronto's vacancy rate is nil and most single room occupancy units have already been lost to gentrification. Meanwhile, the city's 2400 hostel beds were occupied last year by more than 25,000 different individuals. On any given night throughout the year virtually all of these beds — some of which consist only of a mat on the floor — are occupied.

The Health Implications of Homelessness

It is often difficult to ascertain which came first, homelessness or poor health. Homelessness frequently is the result, as well as the cause, of poor health. An obvious characteristic of homeless people is the fact that many suffer from ill health and from injuries. Life on the street is violent for some, and unhealthy for all. Homelessness contributes to poor health through such factors as hypothermia, physical and psychological stress, exposure to viruses, and lack of access to proper

health care. When one lives on the street, or is forced to move frequently from one insecure environment to another, the inevitable result is stress and poor health. Among the health problems encountered are the following.

Sleep Deprivation

Life in shelters and many insecure accommodations is noisy, chaotic, anxiety-producing, and often violent. It is still common for residents to be required to leave the premises each morning so that facilities can be cleaned. As a result, most simply roam the streets or find temporary shelter in alleyways and bus stations or under bridges. Many suffer from sleep disorders which result in apathy or behavioral impairment. Children, in particular, are likely to experience emotional difficulty and an inability to function effectively in school.

Nutritional Problems

A study of homeless men at a Birmingham, Alabama soup kitchen found that 94% suffered from lack of nutrients, resulting in weakness, fatigue, depression and other emotional problems. Facilities of this sort usually lack proper refrigeration, are unable to supply fresh fruits and vegetables, and thus cannot provide the nutrients which are most important for a transient population. Malnourishment is a fact of life for these people, which places them at risk of intestinal disorders and infectious diseases.

Skin Diseases

Most homeless people have great difficulty washing their bodies and their clothes. Shelters and other temporary accommodations generally lack showers. These individuals are prone to skin diseases, not only from the habitual use of dirty clothing, but also from ill-fitting shoes, from cuts and abrasions, from malnourishment and bacterial infections.

Respiratory Ailments

Respiratory illnesses are now commonly referred to as the shelter syndrome. In such close quarters adults and children are

susceptible to these ailments. Recent studies in both Canada and the United States have found a high incidence of tuberculosis among homeless people (City of Toronto, 1987; Brickner et al., 1985).

Physical Illnesses

As many as 40% of the homeless suffer from such chronic physical problems as heart disease, emphysema, diabetes and high blood pressure. A substantial proportion have multiple problems, which are compounded by lack of proper medical attention on a regular basis.

Mental Illnesses

The links between homelessness and mental illness have been the subject of numerous research studies, but the results are not clear (Arce & Vergare, 1984; Bassuk, 1984; Lamb, 1984; New York Office of Mental Health, 1982). Part of the problem is differentiating among substance abusers, those who are mentally ill, those who have been deinstitutionalized, and those who exaggerate their aberrant behavior in order to secure a place in a treatment center. (City of Toronto, 1987)

Bean, Stefl, & Howe (1987) concluded that the overlap between homelessness and mental illness remains a tangled web of confusion, mental disorders and social conditions. Mental illness may either cause or result from homelessness. Many of the characteristics of the mentally ill are also common in homeless people — namely, they are poor, often members of minority groups, disenfranchised and without social support. The picture, then, is unclear; but it appears that about one third of the homeless require psychiatric help.

AIDS

The litany of ills besetting the homeless now includes the dreaded acquired immune deficiency syndrome. Many street people are drug users and a large proportion engage in homosexual sex to earn money for survival. Not surprisingly, they are a high risk group for AIDS. The spread of this disease among homeless people has some health professionals concerned about

the possibility of an epidemic. As with many diseases, public education is a major problem. In the case of AIDS, however, hysteria frequently replaces reason. "With almost every individual who has AIDS," a specialist in Toronto noted recently, "there is a horror story about being shunned by friends, families and lovers, about losing jobs, about being evicted from an apartment." With the caseload doubling every four months, there are now more than 40,000 known AIDS patients in North America; virtually all will die within two years.

Innovative Programs in the Three Countries

Creative programs and projects have been developed to address some of the concerns noted above. A few exemplary projects are described below.

Information and Advocacy Centers

The notions of information, access to social benefits and health care, and power are interrelated. It is essential that homeless people know whom to deal with and how to gain entrance to the complex maze of service agencies in order to secure their entitlements. In Britain, most cities now have a citizen's advice bureau and housing aid centers which provide essential information on the availability of health, welfare and housing benefits. Among a host of small group Shelter is probably the best known. It has been operating effectively as a lobbying and public information body since the mid-1960s.

An exemplary advocacy group is SHAC (The London Housing Aid Centre), which takes on cases of people who have been refused help by local authorities. It has been notably successful in fighting for the rights of elderly persons, about half of whom are ultimately accepted by the boroughs following SHAC appeals (Conway and Kemp, 1985).

Some groups act as advocates for those homeless people who are mentally ill. This assistance is especially important for the large numbers about to be deinstitutionalized. MIND, the National Institute of Mental Health Housing Unit based in London, provides assistance and training programs to agencies managing or developing accommodation for this population.

MIND's training package covers finance, legislation, support services, resident selection, space layout, and residents' rights. MIND has also lobbied extensively for improved community services to assist those who have been released from institutions. Its aims include fostering public awareness that mental illness should not be a barrier to the enjoyment of the full rights and responsibilities of citizenship (MIND, 1987).

Outreach Projects

The discouragement effect is prevalent among homeless people who must contend with endless delays and a bewildering array of forms to be completed at housing, employment, health, and welfare agencies. Many become frustrated after several encounters with hostile receptionists and apathetic bureaucrats. Because of their appearance some are turned away from health care facilities. Others are rejected because they lack a fixed address.

Outreach programs are essential to deal with such people who are unable to gain access to the system. One effective model is mobile health teams, funded by foundation grants, which operate in 20 American cities. Teams consisting of a physician, a clinical nurse, a social worker and an outreach worker, along with psychiatrists in some cases, operate vans in the evening to provide first aid and referrals for street people (Levine & Stockdill, 1986).

In Britain several efforts, like the East London Homeless Health Project, have begun to develop links between medical practitioners and homeless families placed in temporary lodgings by local councils (Daly, 1988).

Toronto's Street Health organization is an interesting example of a grass roots effort to provide front-line aid to homeless individuals. A group of nurses volunteer their time during off-duty hours to operate an informal clinic at several locations in the downtown core where there are substantial numbers of shelters, missions, food banks, and community service facilities serving the homeless. Started on a shoestring, the group's existence has been tenuous because they refused public funding which required that the board relinquish control. Finally, public support has been secured with few strings attached and the

services of Street Health (which looks after homeless men) have been expanded to include the Street Haven clinic for women (Daly, 1989).

Education Programs

For some homeless people, permanent housing will solve their problems. For others, like those who are leaving prisons or mental hospitals, housing alone will be insufficient. Organizations in Britain offer a combination of housing and education and training schemes for these people. One, the North London Education Project, has formal links to permanent housing (through the Hackney council) and well as with local colleges (through the Inner London Education Authority). Participants, who are selected after interviews, are provided with private rooms in a hostel and are enrolled in job training schemes or in college degree courses. Organizers believe that, for the particularly vulnerable young people who have recently been deinstitutionalized, a combination of training, housing, and support are essential to restore the individual's mental health and sense of self worth (NACRO, 1987).

Other models, like that used by the Housing Support Team in south London, offer short courses for homeless people who are waiting to be rehoused. About 300 people are trained annually in three-day courses which cover social security procedures and benefits, budgeting and banking, housekeeping and establishing links with a new community (Housing Support Team, 1987).

Several different approaches have been attempted in American cities. Most, like the Employment and Training program in Massachusetts, emphasize job training, while providing participants child care, transportation and other benefits aimed at enabling them to break out of the cycle of welfare dependency (Kaufman, 1987).

Programs for Youth

A variety of programs, including Covenant House — which operates in New York, Fort Lauderdale, Toronto, and Houston — provide shelter, food and counselling for people under the age of 21 who are on the streets. Services include mobile teams in

vans operating nightly to help youngsters gain access to health and community service networks (Ritter, 1987). Most of these young people are on the street because they have no alternative. Virtually all suffer from some health problem. They are subjected to constant stress and are frequently exposed to life-threatening situations. A substantial percentage are the victims of sexual abuse and many are involved with drugs.

Several innovative projects in England have been developed by the voluntary sector to deal with homeless young people. These include the Hungerford Drug Project, a street-based agency conducting outreach work and counselling with young drug users. A similar undertaking in Kaleidoscope, the drug dependency unit for southwest London; it operates an all-night youth club, a hostel, and medical and educational facilities (Saunders, 1986).

Programs for Women

Many women are homeless or, if in abusive domestic situations, are potentially homeless. Often referred to as the hidden homeless, they suffer from stress and other health problems as a result of being forced to live in violent homes or from having to move frequently from one tenuous arrangement to another. Given low incomes and child care responsibilities, their housing choices are severely limited. Many in England, for example, even though they represent a priority need, have been temporarily accommodated for several years in unhealthy, chaotic, even dangerous bed-and-breakfast establishments. In the United States the principal users of welfare hotels are single mothers with very young children.

A number of women's groups have developed alternatives to these shabby hotels which induce anxiety and a host of associated health problems. Among the solutions are refuges for battered women, transitional housing, and a few cooperatives and other forms of permanent housing specifically designed for women and their children. Some women's organizations also offer counselling and referrals for physical and mental health problems.

Programs for AIDS Patients

Despite the antipathy of residents' groups and the apathy of bureaucrats, a few groups have managed to create innovative programs for people with AIDS. In Toronto, for instance, one of the most interesting projects is Casey House, a hospice for AIDS sufferers. Other programs include an AIDS drop-in center and outreach programs in the schools to acquaint youngsters with the reality of AIDS and related health problems.

Conclusions

In order to address the problems noted in this paper, a comprehensive range of programs, including permanent housing and long-term commitments to health care, is required to adequately deal with an array of ills encountered by increasingly heterogeneous populations. It is especially important that these programs be locally devised and operated on-site where homeless people congregate and where they can obtain related community services (Dear & Wolch, 1987). While small private or voluntary agencies may be the most appropriate providers of these services, government must be involved as both a funding source and a provider of certain medical, social and community services. While the problems of homeless people should not be pigeon-holed as those peculiar to "special need groups," it will be necessary to focus on certain populations which have been hidden or neglected — these include battered women and runaway youths. Moreover, it is essential that funds be directed to such outreach programs as mobile health services in order to provide front-line assistance for the hard-to-reach homeless. Finally, the programs and projects developed should emphasize information, advocacy and access in order to ensure that homeless people are informed, empowered, and visible.

References

- Arce, A. A. & Vergare, M. J. (1984). Identifying and characterizing the mentally ill among the homeless. In H. R. Lamb, (Ed.), *The Homeless Mentally Ill* (pp. 75-899), Washington, DC: American Psychiatric Association.
- Bassuk, E. L. (1984). The homelessness problem. *Scientific American*, 251, 40-45.
- Bean, G. J., Stefl, M. E., and Howe, S. R. (1987). Mental health and homelessness. *Social Work*, 32, 411-416.

- Brickner, P. W. et al. (Eds.). (1985). *Health care of homeless people*. N Y: Springer.
- Canadian Council on Social Development (1987). Homelessness in Canada: the report of the national inquiry. *Social Development Overview*, 5 (1), Autumn.
- Conway, J. and Kemp, P. (1985). *Bed and breakfast: slum housing of the eighties*. London: SHAC.
- Daly, G. (1988). *A comparative assessment of programs dealing with the homeless population in the United States, Canada, and Britain*. Ottawa: Canada Mortgage & Housing Corporation.
- Daly, G. (1989). Homelessness and health: a comparison of British, Canadian and U.S. cities. *Cities*. February: 22-38.
- Dear, M. and Wolch, J. (1987) *Landscapes of Despair: From deinstitutionalization to homelessness*. Princeton: Princeton University Press.
- Department of Environment (1987). *Homelessness information pack*. London: HMSO.
- Housing Support Team (1987). *Briefing papers*. London.
- Kaufman, N. (1987). the Massachusetts approach to homelessness: Innovations in legislation and regulations. Paper presented to IYSH conference, Ottawa.
- Lamb, H. R. (Ed.) (1984). *The homeless mentally ill: A task force report of the American Psychiatric Association*. Washington: American Psychiatric Association Press.
- Levine, I. S. and Stockdill, J. W. (1986). Mentally ill and the homeless: A national problem. In B. Jones (Ed.), *Treating the homeless: Urban psychiatry's challenge*. Washington: American Psychiatric Association Press.
- MIND (1987). *Homelessness and the plight of mentally ill people*. London: MIND.
- NACRO (National Association for the Care and Resettlement of Offenders) (1987). *Briefing papers*. London.
- New York Office of Mental Health (1982). *Who are the homeless? A study of randomly selected men who use the New York shelters*. Albany, NY: Office of Mental Health.
- Ritter, B. (1987). *Covenant House: Lifeline to the streets*. NY: Doubleday.
- Saunders, B. (1986). *Homeless young people in Britain: The contribution of the voluntary sector*. London: Bedford Square Press.
- Toronto, City of (1987). *Report of the inquiry into the effects of homelessness on health*. Toronto: Department of the City Clerk.
- U.S. Conference of Mayors (1987). *A status report on homeless families in American cities*. Washington, DC.

