Homelessness & Health

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The Causes and Conditions of Homelessness

The Extent of Homelessness

Approximately 3.5 million people, 1.35 million of them children, are likely to experience homelessness in a given year.

National Law Center on Homelessness and Poverty, 2007

Serious personal health problems and flaws in health care systems are major contributors to contemporary homelessness. Some health problems—addictions, schizophrenia, major depression, physical disabilities—are distressingly obvious, particularly in persons living in public spaces, while others are less visible but equally insidious, undermining the capacity to maintain stable housing and function independently. In far too many cases, a fragmented health care system responded inadequately to the multiple needs of persons experiencing homelessness, who are indigent and typically uninsured.

Homelessness and poor health

In 1988, the Institute of Medicine of the National Academy of Sciences found that homelessness and poor health strongly correlated in three ways:

- **Health problems cause (contribute to) homelessness.** Half of all personal bankruptcies in the United States result from health problems, and there is a short downhill slide from bankruptcy to eviction to homelessness. Moreover, some health problems more prevalent among people experiencing homelessness than in the general population—such as addictions, mental illnesses, and HIV/AIDS—undermine the family and social supports that provide a bulwark against homelessness for many vulnerable people.

- **Homelessness causes health problems.** People without homes experience merciless exposure to violence, communicable diseases, the elements, and parasitic infestations. Circulatory, dermatological, and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand in hand, increasing vulnerability to acute and chronic illnesses. Stresses associated with homelessness also reduce resistance to disease, account for the emergence of some mental illnesses, and enhance the false promises of relief offered by alcohol and drugs. Individuals and families with no housing suffer illnesses at three to six times the rates experienced by housed people.

- **Homelessness complicates efforts to treat health problems.** The realities of living without stable housing do not attune well with the health care delivery system. The locations of health care facilities are often far from where people experiencing homelessness stay, public transportation systems are insufficient or nonexistent in many places, and most people who are homeless are without cars. It is not easy for people

> without telephones to negotiate clinic appointment systems, and other survival needs (finding food and shelter) may take priority. Standard treatment plans often require resources not available to persons who are homeless, such as places to obtain bed rest, refrigeration for medications, proper nutrition, or clean bandages.

These three correlations, noted by the Institute of Medicine nearly two decades ago, still pertain today. The mainstream health care system often is not prepared to contend with multiple co-morbidities commonly seen in people experiencing homelessness, and is unwelcoming toward those with behavioral health issues who may appear unclean or threatening, cannot pay for services, and typically lack health insurance. Consequently, many individuals who are homeless had negative experiences with the health care delivery system in the past and thus avoid mainstream providers.

Homelessness and Health Care: Fundamental Issues

Health problems cause homelessness. Homelessness causes health problems. And homelessness complicates efforts to treat health problems. A list of some of the multiple facets of this intersection between homelessness and health is below:

Unstable housing

- Increases risk for serious health problems
- Complicates treatment adherence and recovery

Limited access to nutritious food and water

- Irregular meals with little dietary choice
- Higher risk for dehydration

Higher rates of communicable disease

- Respiratory/sexually transmitted infections including HIV and tuberculosis
- Skin diseases and infestations

Serious and complex medical conditions

- Increased risk for acute/chronic diseases with multiple co-morbidities
- More acute, life threatening conditions due to delayed care

Lack of health insurance/resources

- Limits access to specialty care and prescription drugs
- Over half of people experiencing homelessness nationwide are uninsured

Lack of transportation

- Limits access to health care
- Presents obstacle to employment, especially in rural areas

Discontinuous/inaccessible health care

- Due to lack of health insurance, high mobility, and fragmented health services that are ill-prepared to deal with complex psychosocial problems

Chronic stress

- Anxiety associated with homelessness, struggle to meet basic needs
- Has negative effects on health, development, and learning

Developmental discrepancies

- Developmental regression/neuropsychological dysfunction common regardless of age, gender, diagnosis, or medical/psychiatric history

Higher rates of abuse

- Over 80% of women experiencing homelessness are victims of severe physical/sexual assault
- Children who are homeless are two to three times more likely than others to experience abuse

Behavioral health problems

- Higher incidence of mental illness, substance use disorders
- Increase risk for disease; can interfere with treatment adherence

Physical/cognitive impairments

- Secondary to trauma, mental illness, chronic substance use, infection, stroke, tumor, poisoning, developmental disabilities

Barriers to disability assistance

- Insufficient documentation of impairments for disability claims
- Restricted access to housing and health care, especially for persons who are mentally ill

Cultural/linguistic barriers

- Minorities over-represented; health disparities apparent
- Limited English proficiency, cultural insensitivity of providers—obstacles to care

Limited education/literacy

- Completion of education beyond high school is less likely
- Many are not able to read English well or to read at all

Lack of social supports

- Far from place of origin; seeking jobs, services, or respite from abuse
- Alienated from family and friends, stigmatized, isolated

Criminalization of homelessness

- Arrests for activities that are permissible within the privacy of a home
- Medications often confiscated during arrest, not returned
- Criminal record an obstacle to employment, housing, services

Bonin, E., Brehove, T., Kline, S., Misgen, M., Post, P., Strehlow, A. J., & Yungman, J. (2004). *Adapting your practice: General recommendations for the care of homeless patients.* Health Care for the Homeless Clinicians' Network. Retrieved from www.nhchc.org/Publications/6.1.04GenHomelessRecsFINAL.pdf

Serving People with Disabilities

What is disability?

The Americans with Disabilities Act of 1990 defines disability as "a physical or mental impairment that substantially limits one or more of the major life activities." Many people with disabilities use the term "impairment" to refer to their individual limitations. These limitations may include blindness, deafness, conditions that make it difficult or impossible to walk or to speak, conditions that make it harder to understand or learn, and conditions that can cause seizures.

A person with a disability may move, see, hear, or learn and understand differently from a person without a disability. Whatever the disability, all people have a right to good health care, and good health depends on enough nutritious food to eat, regular physical activity, and access to information and services to prevent and treat health problems.

Some causes of disabilities

- Congenital disorders
- Poverty and malnutrition
- War
- Accidents or trauma
- Poor access to health care
- Illness
- Dangerous work conditions
- Poisons and pesticides

Attitudes create barriers

Attitudes and wrong ideas about what persons with disabilities can or cannot do may prevent them from living a full and healthy life. Many people see only the disability that someone may have. They do not see a person with a disability as a total person, or they think people with "impairments" have something "wrong" with them that require a cure, rehabilitation, or protection. People may experience disadvantages because of impairment, but they are hurt more by the limitations imposed by other's attitudes and by social, cultural, economic, and environmental barriers to full participation in society. The physical and mental health of people with disabilities will improve when communities improve access, challenge prejudice, and create equal opportunities.

How workers can help

- Recognize the challenges faced by people with disabilities
- Improve access to health care
- Offer to accompany people to medical appointments
- Provide transportation to appointments
- Help individuals apply for federal disability assistance, SSI-related Medicaid and other entitlements

- Help to obtain and store assistive devices
- Work with your community to assist people with disabilities to find appropriate housing, while ensuring they have access to adequate shelter in the meantime
- Nurture confidence

Tips for Serving People with Physical Disabilities

- **Speak at eye level** to create rapport with people in wheelchairs.
- **Talk directly to people** and look at them when addressing their needs.
- **Encourage the use of care partners.** If a care partner is available and the person agrees, invite the care partner to accompany the individual to access services and go to appointments.
- **Do not turn disabilities into handicaps.** Redesign entrances for wheelchair ramps; add devices to raise toilet seats; use "sling" scales to weigh clients with disabilities.
- **Allow extra time to care for people with impaired mobility.** Let individuals move and perform tasks at their own speed.
- **Evaluate the whole person.** Individuals also have other concerns that are unrelated to their disabilities.
- **Care, even if you cannot cure.** Address concerns and improve people's quality of life by understanding the barriers they face and helping them to overcome them.

Adapted from: Conill, A. (2002). Tips for serving people with physical disabilities. *Healing Hands*, 6(6).

Addressing the Connections between Poor Health and Homelessness

The Housing Shortage

Harvard University's Joint Center for Housing Studies reports that one in seven American households pay more than 50% of its income for housing.
In no community in the U.S. today can someone who gets a full-time job at the minimum wage reasonably expect to find a modest rental unit he or she can afford.

Out of Reach 2007–2008. National Low Income Housing Coalition. Retrieved from http://www.nlihc.org/oor/oor2008/

Life Expectancy

U.S. Population:	77 years
Homeless in Boston:	47 years
Homeless in Atlanta:	44 years
Homeless in San Francisco:	41 years

O'Connell, J. J. (2005). *Premature mortality in homeless populations: A review of the literature*. National Health Care for the Homeless Council, Inc.

In communities nationwide, projects providing primary care to people experiencing homelessness seek to disrupt the terrible nexus between poor health and homelessness. As of September 2008, the 207 Health Care for the Homeless (HCH) program grantees of the Health Resources and Services Administration (HRSA) and related Community Health Centers provided health and social services to 1,000,000 clients per year. These projects typically operate as part of Community and Migrant Health Centers, hospitals, Departments of Public Health, or as freestanding agencies. Most combine HRSA funding with other revenue and grants to provide a broad range of services.

At a minimum, each project provides a prescribed set of required services, including primary health care and substance use disorders, emergency care and referrals, outreach, and assistance in qualifying for entitlement programs and housing. Many HCH projects go well beyond these basic services, offering dental care, mental health treatment, sub-acute recuperative care, supportive housing, and other services needed to resolve their clients' homelessness.

To engage persons who are homeless and to provide effective care, HCH projects utilize a number of approaches that accommodate the realities of homelessness. These include:

- **Outreach.** The HCH physicians, nurses, social workers, and others skilled at making connections with people who are homeless (often including persons who experienced homelessness themselves) seek out and bring care to people who are homeless wherever they are—in encampments, under bridges, on the streets, in jails, at soup kitchens and other service sites.

- **Service locations.** The HCH clinic locations are in or near shelters and other places where people who are homeless congregate.
- **Service hours.** Many HCH projects operate during extended hours to accommodate the schedules of clients who work or must be elsewhere at certain times to secure food or shelter.
- **Transportation.** The HCH projects frequently provide transportation to and from clinics, specialty providers, Social Security or Food Stamp offices, and shelters.
- **Elimination of financial barriers.** The HCH projects assure that inability to pay even a small fee does not become a barrier to receiving health services.
- **Sensitivity.** The HCH staff endeavors to understand the unique circumstances and stresses associated with homelessness. They understand that the process of engaging individuals who are homeless often involves overcoming significant fear and suspicion, and that a patient, nonjudgmental, persistent approach is often necessary.
- **Comprehensive services.** The HCH providers understand that health care and other basic needs are interrelated, and strive to address each client's needs holistically using multidisciplinary clinical teams. Integration of primary care with the treatment of mental health and substance use disorders is a hallmark of HCH practice, and efforts to secure housing, entitlements, and jobs are intrinsic to this approach.
- **Case management.** Coordination of a wide range of on-site and referral resources receives particular attention in the HCH approach to care.
- **Clinical adaptations**. To promote favorable clinical outcomes, HCH providers developed techniques such as prescribing simple medical regimens with few side effects, or screening for common problems during the first encounter with a client.
- **Advocacy.** The HCH staff engages in advocacy to secure client services, to protect clients' rights, to affect the local service-delivery systems so that they meet the needs of their clients more effectively, and to change policies that cause, exacerbate, or create obstacles to resolving homelessness.
- **Client involvement.** The HCH projects are careful to involve their clients in developing realistic treatment plans, in the governance of their agencies, in evaluating the efficacy of homeless services, and in advocating for service improvements and policy change.

The HCH Program employs a model of care that is appropriate for everyone, but adapts particularly well to the circumstances of those most in need. By creating numerous new service-delivery sites and modalities, the HCH Program contributed significantly to the development of the health care infrastructure in the United States. In that respect, HCH is far more than a safety net.

Yet for those whose personal circumstances reduced them to homelessness and for whom all other systems failed, HCH remains the final safety net. The quality of care available through HCH improves the health and well-being of displaced people and models a high standard of care for all service providers.

A variety of community service providers can adopt or modify the HCH approach to care described above—disaster shelters, long-term homeless shelters, public health departments—to meet the health needs of displaced persons.

Human Rights, Shelter, and Health Care

The Universal Declaration of Human Rights, adopted by the United Nations in 1948, proclaims, "everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing, and medical care."

The United States urged the adoption of the Universal Declaration of Human Rights, and it extends to the world the promises of our nation's founding documents. Yet the United States still struggles to implement basic human rights, as evidenced by widespread homelessness and the lack of health care for millions of Americans. Indeed, our nation is one of only five United Nations member States to fail to ratify the International Covenant on Economic, Cultural, and Social Rights, a legally enforceable treaty that protects rights to living wages, food, clothing, housing, and "the highest attainable standard of physical and mental health." Emergency shelters do not satisfy these rights—indeed, they are shocking evidence of their violation.

Given the current necessity of emergency shelters, however, it is important to recognize the rights of shelter residents. At the most basic level, shelter residents have the right to respectful treatment, whether their homelessness results from a sudden disaster or from long-term social, economic, and personal problems. The opportunity to have a voice that others listen to is an essential component of respect; shelter operators should establish procedures for redressing grievances and appealing decisions that affect the residents, and should make the procedures known to residents.

Likewise, in health care patients have rights that providers of care must respect. Chief among these are the rights to be informed about one's health status, to participate in decisions regarding treatment, and to have one's privacy and the confidentiality of treatment relationships protected. Economic and housing status does not abridge these rights.

Care providers, including volunteers and paid staff, also have rights that shelter operators and residents must recognize and protect. Among these are the rights: to respectful treatment; to work in a safe and healthy environment; to have the tools and resources necessary to accomplish their jobs; to earn a living wage; to appeal adverse decisions; and to form labor unions.

It is incumbent upon all involved in our work to help assure human rights. Unlike the Economic, Cultural, and Social Rights discussed above, civil rights to free expression and participation in the political process are well-established in the United States, and their exercise in the struggle for everyone's full human rights is their greatest fulfillment.