

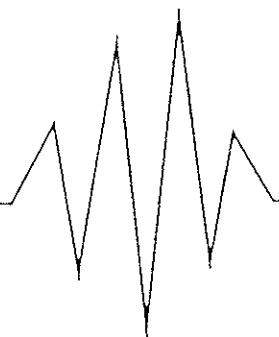
# SICK TO DEATH OF HOMELESSNESS

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An investigation into the links between  
homelessness, health and mortality

By Simon Keyes with Michael Kennedy  
December 1992

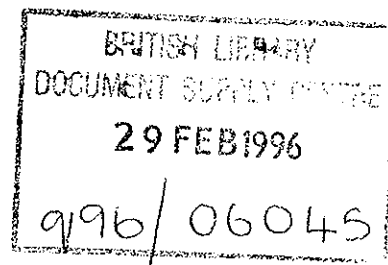
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## CRISIS



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# A PERSONAL FOREWORD

INT

## Homelessness kills people.

You don't have to be a doctor or a social worker to know this is true. Anyone who has walked home on a cold November night and passed someone sleeping rough knows this. The briefest glimpse of "life on the streets" reveals how it ages and damages people. We all know how important our own home is, even if we cannot imagine being without one.

CRISIS invited me to spend three weeks seeking objective evidence that homelessness kills. There has never been thorough study of mortality and homelessness in Britain but information was not hard to find. This report summarises what I learned. It is not an academic or medical treatise, but neither is it just opinion.

I have worked for several years in the homelessness field but I am shocked by what I discovered.

I am left with two strong feelings. The first is anger at the laziness of a society that can tolerate such intense suffering in its midst without attempting to understand it truthfully. Not only are the simple facts about this issue not available; at every step I encountered many prejudices ("They choose to be like that") and stereotypes ("They're just drunks") which are not borne out by the facts.

The second is a powerful sadness. I learned about a world of "parish funerals" (the twentieth century pauper's grave) and anonymous corpses drifting in the Thames. One neatly-written entry in a Coroner's book said "body found in rubbish chute". The loneliness, isolation and despair called to mind words from Ecclesiasticus:

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**"And some there be which have no memorial; who are perished as though they had never been"**

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*Holy Bible: Ecclesiasticus 44:9 (RSV)*

The same text also speaks of:

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**"such as did bear rule in their kingdoms, men renowned for their power".**

---

It is to the women and men in power that I address this report.

*Simon Keyes  
December 1992*



# INTRODUCTION

This report, carried out in the wake of the Government's Health of the Nation White paper<sup>1</sup>, describes the results of a short investigation into the links between homelessness, health and mortality conducted over a period of three weeks during November 1992. The aims of the investigation were:

- ◆ To estimate the number of people who die whilst homeless in England and Wales each year
- ◆ To assess the part that homelessness plays in their deaths.
- ◆ To review the medical evidence of the health risks that attend sleeping rough

We quickly learned that substantial scientific measurements would be impossible because of the difficulty of obtaining reliable statistical data. Many statutory records of mortality, such as Death Certificates, do not record the deceased's housing status, or lack of it. Furthermore, despite the obvious phenomenon of homeless people dying early or in unnatural ways, there is, in this country, an astonishing lack of published research into their mortality.

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**" Good housing is important to good health..."**

---

*Health of the Nation (3.26)*

---

**" Various chronic medical conditions were reported  
and the perceived health state of the population was  
low"**

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*Census of single homeless people in Sheffield 1988; George et al. British Medical Journal (1991) 302:1387*

The scale and urgency of the homelessness problem in Britain means that these questions must be tackled. In the absence of precise information we believe that an educated estimate is justified as a useful starting point. However, we must emphasise that our work is not complete guesswork. We were able to conduct a careful survey of Central London Coroner's records which enables us to base these estimates on a sample of actual cases.

We have been encouraged in this process by many of the medical and other professionals who we interviewed amongst whom there was a common view that the subject is too complicated and poorly documented

1. Health of the Nation: A Strategy for Health in the 1990's July 1992 HMSO

to be approached in any other way in the short-term. Our findings are deeply disturbing.

## Definition of homelessness for this investigation

This report is concerned specifically with people who sleep rough.

We have defined this as people who have "no fixed abode" (NFA) or where their most recent address is either a DSS Resettlement Unit or one of the eight Emergency Nightshelters listed in the London Hostels Directory 1992 (published by Resource Information Service).

This definition is likely to include people who at the time of death were:

- ◆ sleeping rough temporarily
- ◆ living permanently on a street location (e.g. Lincoln's Inn Fields)
- ◆ squatting temporarily
- ◆ Occasional hostel users
- ◆ living regularly in a nightshelter

It does not include people living semi-permanently in the hundreds of voluntary and statutory hostels or any kind of supported accommodation. We use the terms "roofless" and "rough sleeper" as synonymous with this definition.

- ◆ Estimates vary considerably as to how many people this means. the Government's 1991 Census counted 2,703 sleeping rough in 453 sites throughout Britain on the night of 21-22 April<sup>1</sup>. A widely-quoted Surrey University survey concluded that between 2,000 and 3,000 people sleep rough every night in London<sup>2</sup>. Shelter estimates that up to 8,000 people sleep rough through Britain every night, representing about 20,000 individuals who sleep rough from time to time<sup>3</sup>.

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**"The prejudiced find it unnecessary to search for the actual causes of homelessness"**<sup>4</sup>

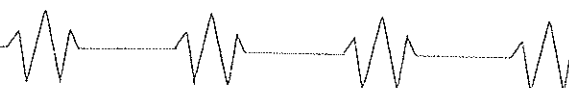
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1 1991 Census: Preliminary Report for England and Wales, Supplementary Monitor of People Sleeping Rough. Office of Population Censuses and Surveys

2 Faces of Homelessness, Jean Moore et al. Housing Research Unit, University of Surrey

3 Left Out: Sleeping Out in Severe Weather (Shelter) 1991

4 Homelessness in Britain: Prof John Greve 1991 Joseph Rowntree Foundation



There are, of course, much larger numbers of people without homes - for instance, in bed and breakfast hotels, living in temporary hostels or unsuitable, overcrowded or unfit conditions. There are major health risks associated with these forms of homelessness but these are outside the scope of this investigation.

## Conduct of this investigation

We used three main sources of information

### 1. Coroners Court Records:

With the kind permission and assistance of H.M. Coroners in the principal courts serving Inner London, we carried out a systematic search of all records of deaths reported to the Coroner between 1st September 1991 and 31st August 1992.

Summaries of each case (including gender, date, age, address, place of death and all comments about cause of death) were entered into a database. Each record was coded with a up to three "cause" of death codes so that, in addition to primary cause of death, statistical information on contributory factors (such as alcohol) could be computed.

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**Michael Mock, 48, began to drink heavily after separating from his wife, losing his job and then his home. After sleeping rough for some time he and another rough sleeper, Leslie Wright, made a suicide pact. In August 1991 they took a lethal cocktail of 50 Diazepam tablets (tranquilliser) washed down with alcohol and wild berries. They were found and rushed to Guy's Hospital. Michael soon lost consciousness and never recovered, dying on a ventilator a month later. Leslie Wright recovered, discharged himself and later hanged himself.**

---

*Michael Mock and Leslie Wright*

### 2. Interviews with individuals with a professional interest in the health problems of homeless people:

Ten interviews were conducted with doctors in specialist health projects and hospitals, members of the police, and other people with experience of deaths amongst homeless people.

### 3. Review of medical literature:

Documents and statistics were sought from Health Authorities, from specialist workers and those interviewed. A review of the key relevant medical literature catalogued by the British Library was conducted. Further information came from the Kings Fund Institute.

## Problems of record-searching

Identifying homeless people in official records is more complicated than it seems. We encountered three main problems:

### 1. Nature of Statutory Records:

The official Coroner's Court Registers do not usually record the deceased's address (or lack of one) so it was necessary to examine day books kept by Court officers. Each Court keeps such records in its own way and the amount and format of information available varied from Court to Court (none that we visited held such data on computer). There are therefore likely to be some variations in consistency of description and classification of causes of death and gaps in some of the data.

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"Another memorable early mistake was to ask a new homeless patient for his address. Quick as a flash, he replied "Cloud Cuckoo land...." "

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*Sara Forman, Psychiatric Registrar*

### 2. Retrospective addresses:

Courts, the Police, and to some extent medical services, go to considerable lengths to match a death with an address. "Next of kin" or "known relatives" are important concepts in this world and in some cases the address of a relative may be entered on a record. We also found that even where someone died sleeping rough the address of a hostel where they had stayed might be used. Sometime a hospital address was entered.

Simply searching for "No fixed abode" addresses leads to a substantial under-estimate. In practice searching the records requires careful examination of the place and nature of a death followed by cross-checking against a range of possible addresses and then a further investigation of potential non-NFA cases. This makes the process complicated and time-consuming. Checking large computerised sources, such as the Registrar's records or the Health Authority database, becomes extremely daunting.

### 3. Homeless people disguising their status:

Homeless people frequently do not describe themselves as such when using, for instance, Accident and Emergency Departments.

## OUR FINDINGS

### Results of survey of coroner's courts records

We were able to identify 86 homeless people who had died during the year ending 31st August 1991. Of these 82% were male, 80% were recorded as of "no fixed abode", the others had a nightshelter as the last address. The average age was 47.

81 of these were contained in Coroner's records for the Courts of Westminster, St. Pancras, Hammersmith, Inner South London, Poplar. These cover 10 London Boroughs.

A further 5 records were added from information from the River Police for deaths during the same period in the same London Boroughs which did not appear in Coroner's records.

A summary of the survey results is shown in Table 1. A complete list of causes of death is attached at Appendix A.

Analysis of this information must take into account the following factors;

- ◆ We cannot be sure that we have identified all homeless people in the records as some may have been given addresses.
- ◆ We were not always able to inspect documents with the Coroner's verdict or inquest details so some causes of death are determined by Court Officer's judgements.
- ◆ The cause of death recorded in some of the records we saw may not give a full indication of the nature of the death. For instance, hypothermia was very rarely given although the doctors we spoke to confirmed that this was a common occurrence.
- ◆ Not all deaths are reported to a Coroner's Court. There may be as many as twice the number again who die in hospital and elsewhere. (See Page 14)

These factors mean

- ◆ That our total figures are almost certainly an underestimate
- ◆ That our sample is weighted towards unnatural deaths

An interesting observation is that people we spoke to in the Courts and amongst the police consistently underestimated, from memory, the number of homeless people they had on their records.

**TABLE ONE: Inner London Coroner's records Analysis of cause of death (86 records)**

Cause	Average age	Number in sample	% of sample	National projection	Sample Incidence per 100k	Standard mortality per 100k	Excess Mortality ratio
Accidents	51	16	18.6	42	210	27.1	7.7
Assault murder	38	6	7	16	79	.5	156.3
Pneumonia	54	11	12.8	29	144	50.5	2.9
hypothermia							
Other natural causes	66	15	17.4	39	197	1017.2	n/a
Not known	43	3	3.5	8	39	n/a	n/a
Drug overdose	34	11	12.8	29	144	4.8	30.2
Alcohol poisoning	45	4	4.7	10	52	3.1	16.9
Suicide	37	20	23.3	52	262	7.8	33.6
Coroner's deaths		86	100	225	1127		
Total deaths				617	3085	1,111.0	2.8
<b>Supplementary analysis</b>							
Alcohol-related	44	12	14	31	157		
Drug related	39	22	25.6	58	288		

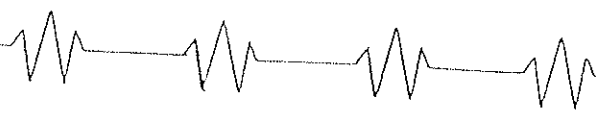
Sample data relates to the period 1 September 1991 to 31st August 1992.

- 1 National Projection:** This figure is extrapolated using the proportion that Inner London homeless represented as a proportion of the national total (38%) in the 1991 Census
- 2 Sample Incidence per 100K:** This assumes a total population of roofless people of 20,000 (Shelter 1991). The total National Projection is therefore multiplied by 5 to obtain the Sample in a theoretical population of 100,000 homeless people
- 3 Standard Mortality per 100K:** expresses the incidence of the same causes as published in the official Mortality Statistics 1990 (OPCS)
- 4 Excess Mortality Ratio:** Expresses the ratio by which the causes in the sample population exceeds the Standard Mortality statistics
- 5 Drownings:** 50% are assumed to be suicides, the other half attributed to accidents
- 6 Drug overdoses:** These are attributed to suicide only where this is suggested by the Coroner's record or where large quantities of drugs and alcohol were mixed.

**TABLE TWO: National projection of Inner London Coroner's Court figures (using 1991 Census data)**

	Census count: Number of homeless people	Homeless deaths in Coroner's records
Inner London total	1031 (actual)	86 (actual)
National total	2703 (actual)	225 (projected)

- 1** Data refers to the London Borough of: Camden, Hackney, Hammersmith, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Westminster.
- 2** Data for the Census was collected on the night of 21/22 April 1991
- 3** Coroner's Court data relates to the period 1 September 1991 to 31 August 1992.



## Summary of findings

### On the basis of our investigation we estimate that:

- ◆ Coroner's Courts in England and Wales recorded approximately 225 deaths of homeless people (in the year to 31st August 1992)
- ◆ Not all deaths are reported to the Coroner. We estimate that approximately 617 people are likely to have died in total in England and Wales whilst homeless (in the same period)
- ◆ The average age of death of homeless people recorded in Coroner's records is 47. Average life expectancy in Britain is 73 for males and 79 for females <sup>1</sup>
- ◆ The excess mortality rate amongst homeless people is 3 times higher than the population as a whole
- ◆ People sleeping rough run much greater health risks than others. In our survey they are:
  - 150 times more likely to be fatally assaulted
  - 34 times more likely to kill themselves
  - 8 times more likely to die in an accident
  - 3 times more likely to die of pneumonia or hypothermia than the population average.
- ◆ Alcohol was noted as a contributory factor in the deaths of 14% homeless people but was rarely the main cause (5% cases).
- ◆ 65% premature deaths recorded were probably preventable given proper housing and good health care for those concerned.

<sup>1</sup> Source: Health of the Nation (1:2)

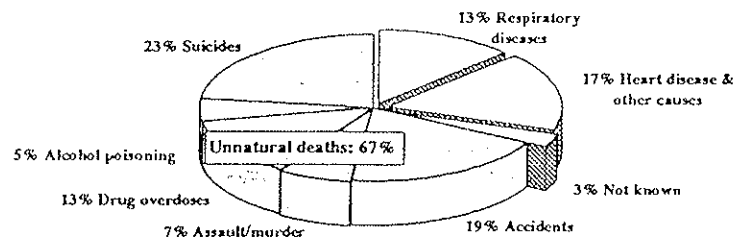
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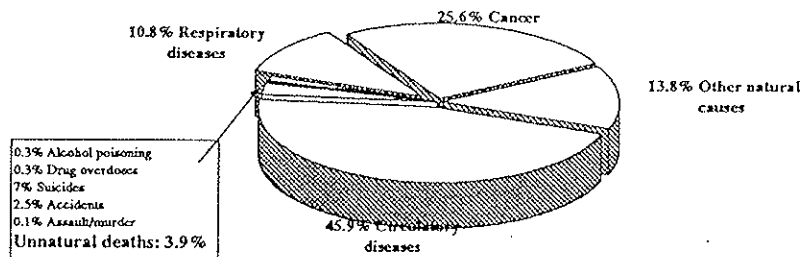
<sup>1</sup> Source: Health of the Nation (1.2)

### Cause of death - homeless people



From a sample of 86 homeless people in Central London 1991/2. Source: Inner London Coroners Court records

### Cause of death - total population



Source: OPCS Mortality Statistics 1990

## DISCUSSION

Bearing in mind the above distortions, the characteristics of the cause of death of this sample are striking and extraordinary, casting into sharp perspective the bleak reality of living on the streets.

The diagrams in Figure 1 illustrate graphically how different the deaths of homeless people are to those of the rest of the population.

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**Maurice Clark, 46, had spent many months homeless in Oxford, in and out of the Nightshelter and sometimes sleeping rough. Eventually he was helped to find a bedsit of his own. Some weeks later he was discovered dead. The Coroner's verdict was that he had died of septicaemia due to lice bites resulting from malnutrition. He had a roof over his head but had lost the ability to care for himself.**

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*Maurice Clarke*

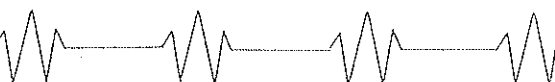
Our main observations are:

- ◆ Suicide is the biggest single cause of death (23%) amongst these homeless people
- ◆ Overwhelmingly the people in this sample met premature and unnatural deaths. Excluding those who died from "Other natural causes (mainly heart disease) from the sample means that the average age at the time of death was 44, less than 60% of the average British life expectancy.
- ◆ The dangers of living on the streets are dramatically illustrated by the very high level of fatal assaults (murders) and accidental deaths. The astonishing level of fatal assaults compared with the population as a whole reflects both the high level of violence within some homeless "communities" and the grim phenomenon of opportunist attacks.
- ◆ The notion that "they all die of drink" is not supported by these statistics. Only 5% were recorded as dying as a direct result of alcohol misuse. It was noted as a contributory factor in 14% cases - related, for instance to accidental deaths. However, we would expect a substantially larger proportion to have been involved in alcohol abuse as part of their lifestyle.

### Age and cause of death

Correlating cause of death with age suggests several further observations:

- ◆ Homeless people who died of natural causes (primarily heart disease) had an average age of 66. This compares with a population average of



76. However, they lived significantly longer than those who died of unnatural causes (44).

- ◆ Those who died of pneumonia and/or hypothermia died on average 12 years younger than of other natural causes
- ◆ Those who died of drug overdoses had the lowest average age (34) .
- ◆ The average age of those who killed themselves (37), the largest single group, was significantly less than the overall average and less than half the normal population life-expectancy. The sample area included Kings Cross where there is a very high concentration of drug users, we would not expect the national incidence of drug-related deaths to be as high.

These findings reflect the heterogeneous characteristics of people sleeping rough. There are long-term homeless people who have adapted to life on the street whose lives are shortened by the harsh environment and lack of health care on the streets but otherwise live to a reasonable age. Alcohol may increase the risk of disease or of a fatal accident in this group and they also run the risk of contracting pneumonia or failing to find adequate shelter in a cold spell.

There is also a younger group for whom excessive drug and alcohol abuse is a symptom of a chaotic and disenfranchised lifestyle that is extremely hazardous. The high level of deaths of this type amongst homeless people contrasts with a marked decline in drug-related deaths in the population as a whole as the overall use of barbiturates and opiates diminishes.

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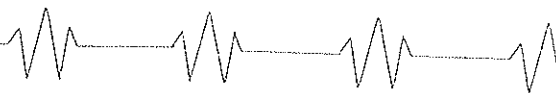
**In the exceptionally cold spell in February 1991 several homeless people died. One morning the Police were called to a public toilet in Rochdale, Lancashire. Inside was the charred body of a man who had set fire to himself in an attempt to keep warm. Next day, forty miles way in Blackpool, another burnt corpse was discovered in a derelict brewery.**

---

*Anon*

The high suicide rate perhaps reflects the presence of a significant number of people with severe mental health problems, although the low average age associated with this group suggests that they are unlikely to be long-term ex-residents of mental institutions who are homeless as the result of the closure of institutions.

We do not believe that all suicides result from a pre-existing mental illness. There is evidence to show that prolonged homelessness induces mental health problems such as depression or anxiety. It is difficult to avoid concluding that some people must be brought "to the end of their tether" by being homeless and kill themselves in bleak despair.



There can be little doubt that homelessness itself exacerbates the problems of the latter two groups and should be considered a contributory factor in their deaths.

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# ESTIMATING THE NATIONAL TOTAL OF DEATHS OF HOMELESS PEOPLE

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Our brief includes making an estimate of the national total of deaths of people who are homeless. This section explains how we approached this task.

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## Relationship of Coroner's Records to total deaths:

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Coroner's records give only part of the total picture.

In 1990 77% all deaths in England and Wales were certified by a medical practitioner and do not appear in Coroner's Records <sup>1</sup>.

Deaths are reported to the Coroner according to rules laid down by the Registrar General. These include all cases where the cause of death is not immediately known, or where a person dies who has not been seen by a G.P. in the last 14 days. Usually anyone who dies within twenty four hours of admission to hospital is referred as is any death where there is a suspicion of self harm or violence. All "unnatural" deaths are supposed to be reported and the Police refer any cases in which they are not happy with the circumstances. Most sudden deaths are reported, unless a G.P. is satisfied that the cause is natural. Deaths reported to Coroners were usually described to us as "unnatural".

We think it likely that a larger proportion of deaths of homeless people are reported to the Coroner than of the population as a whole, although we have been unable to obtain authoritative figures.

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**Of 47 bodies recovered from the River Thames in one year 9 were homeless people. Of 60 deaths on the London Underground 5 were homeless people.**

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Many deaths are not reported to the Coroner however. A homeless person admitted to hospital with pneumonia who dies after several days would be unlikely to appear in the coroner's records if they were registered with a G.P. or known to the hospital. The opinion of a Consultant at the Westminster Hospital, which deals with more homeless people than any other hospital, was that at least twice as many homeless people die there than are recorded by the local Coroner (although he thought it would be an enormous job to prove this from their records).

We tested this idea informally by asking a number of hostels for information about deaths of homeless people known to them during the period of our Coroner's sample. One Resettlement Unit reported, for instance, that 7 people had died there during the year in question although

<sup>1</sup> Source: OPCS Mortality Statistics 1990

only one of these was found on the appropriate Coroner's records. Other hostels and nightshelters gave similar information.

In theory comparing Coroner's Records against those of the relevant Health Authority(s) might provide a way of determining the proportion of non-Coroner deaths Health Authorities are supposed to use a special postcode (ZZ992VZ) to record no fixed abode addresses. It was outside the means of this investigation to carry out such an exercise although we strongly recommend this be done. National data on hospital admissions and deaths is in principle available from the Office of Population Censuses and Surveys, but could not be supplied for this investigation.

However, a rough test calculation using data from N.W. Thames Regional Health authority yielded meaningless results, (where the number of NFA hospital deaths was smaller than the number recorded in just one of the Coroner's courts) so we suspect that the problems of identifying homelessness cases in hospital records (See page 5) creates major statistical distortions.

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### **Estimating the total number of homeless Coroner's cases**

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We estimate that the total of 86 homeless Coroner's cases in Central London is equivalent to a national total of 225 for the year 1st September 1991 to 31st August 1992.

This is based on a simple straight line projection based on data from the 1991 Census. This is shown in Table 2.

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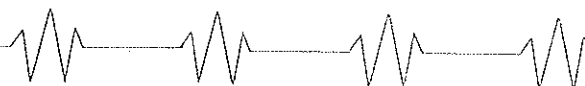
### **Estimating the total number of all homeless deaths**

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This is a much more difficult exercise because there is no firm basis for relating homeless Coroner's cases to overall homelessness mortality rates. It can only be achieved by making a number of assumptions.

Our estimate is that **617 people** are likely to have died in the period 1st September 1991 to 31st August 1992

We have assumed that the ratio of Coroner's cases to total deaths is approximately 1:2. It is certainly likely to be greater than the 1:4.3 ratio for the population as a whole because the circumstances of such deaths makes them more likely to be reported to a Coroner. This estimate is made by an experienced consultant at Westminster hospital. We therefore taken a total of 150 as the number of non-coroner deaths for Central London (compared with 86 Coroner's cases). Projecting this on the same basis as above suggests a figure of 392 non-coroner deaths. This number is added to the figure in b) to produce the total.



## Calculating the Excess Mortality ratio for homeless people.

To test the validity of these assumptions and to compare mortality rates for specific causes of death against the population as a whole we have calculated the excess mortality rate using the same method as the Swedish study. For this we have assumed that the total population of homeless people is that estimated by Shelter i.e. 20,000 individuals each year fall within the definition of homelessness used in this investigation. (Remember, few of these are homeless all the time so the number at any one time is likely to be in the region of 7,000 to 8,000).

The proportion of deaths in this "homeless population" is compared with the overall number of deaths per annum in the English/Welsh population as a whole. By this measure the proportion of homelessness deaths is 2.8 times greater than the population average. If the "homeless population" is smaller than 20,000 then the rate is, of course, higher.

## Discussion

The estimates are speculative, involving a number of assumptions that we were not able to test scientifically. They are therefore able to be challenged and we hope that others may be able to provide more data for this.

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**Barney, 35, had slept rough in Bristol for a number of years. He seemed to cope with the rigours of living on the street and didn't take too much notice when he began to feel off-colour. Friends, who had slept rough with him but were now housed, were concerned at his rapid deterioration. They took him in and took him to hospital. Within a few days he was dead. He had contracted Hepatitis B whilst sleeping rough but the treatment came too late.**

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*Barney Kirkpatrick*

However, there are some indicators that the scale of this estimate is correct. The Black Report 1980 (published by Penguin in "Inequalities in Health" 1988) demonstrated that mortality rates are related to social class (as defined by the Registrar General) and quality of housing. Demonstrating that the people in Class V (unskilled and largely low paid workers) has 2.5 greater chance of dying before retirement age than Class I (Professional class) and over 1.5 times the population average, the report concluded that "social inequalities in health can be understood in terms of specific features of the socio-economic environment; features such as accidents at work, overcrowding and smoking". Black observed that lower social classes had particularly high mortality rates in connection with accidents and respiratory disease, two of the major health risks for homeless people. By this measure it is to be expected that homeless people would have a higher mortality rate.

The excess mortality ratio produced by these assumptions is actually lower than Alstrom's Swedish Study <sup>1</sup> which calculated an excess mortality rate of 3.8 although there are many differences between the two studies.

Anecdotal support comes from the fact that number of homeless people who died in Oxford (which has a very large homeless population) during 1991/2 was double that expected using the mortality rate we have calculated.

The only significant British study of homelessness and mortality was carried out by Shanks <sup>2</sup>, who conducted a retrospective study of 78 homeless men who had at one time been resident in a single large municipal lodgings house in Manchester and who had died between January 1977 and June 1981. This concluded that the cause of death differed considerably from the general population, pointing particularly to marked increase in the incidence of tuberculosis, malignant disease, bronchitis and other respiratory diseases. He concluded that "the pattern of mortality exhibited is probably related to the poor social conditions under which these men lived".

We believe these conclusions lend weight to our findings and, if anything, suggest that they are slightly less than the true order of magnitude. This is, of course, a long way short of scientific proof but we feel we have made a case that warrants proper investigation.

1. Mortality amongst homeless men C.H. Alstrom et al. Br. J. Addict 1975 70:245

2. Mortality amongst the inmates of a common lodgings house: Shanks (1984). Jour. Roy. Coll. Gen Pract. 34:38



TABLE THREE: Comparison of mortality data from different studies				
	% of sample			
	Stockholm 1975	Atlanta 1985/91	San Francisco 1991	London 1992
Natural deaths	75	39	39	34
Accidental injury	20	48	34	36
Homicide	n/a	10	13	7
Suicide	6	3	6	23
Undetermined	0	0	8	0
Alcohol factor	high	60	33	14

1. Accidental injury includes drug and alcohol deaths.
2. Alcohol factor refers to the number of cases in which alcohol was mentioned in records but not necessarily the direct cause of death. The same applies to drug factor.
3. Comparison between these figures must be made with great caution since the studies are not directly comparable. For instance the London figures refer only to coroner's deaths which are bound to exaggerate the proportion of unnatural deaths. The high incidence of suicide in London is however, a very striking factor.

# THE HEALTH RISKS OF HOMELESSNESS

Deaths of homeless people are obviously related to the health problems they encounter and the effect of the "street" environment. This Section reviews the medical evidence of increased morbidity rates for specific health risks. There is a large body of material from the U.S., Europe, and to a lesser extent from Britain, although much of it deals with specific problems in specific localities and settings.

## Summarising the literature

The most sophisticated and extensive study of the morbidity of homeless people in Britain was published by Shanks in 1988, based on a three year study of 2,500 homeless people in Manchester. We have identified almost 20 other smaller, local studies and Table 4 in Appendix B summarises data from 10 other English sources<sup>1</sup>. Each employs a different method and system of classification of symptom, and they deal with different segments of the homeless population. Results are therefore very difficult to compare. We have therefore reanalysed the published data and attempted to represent it in a form that is crudely comparable. Individual symptoms are shown as a proportion of the total number of symptoms observed in the group studied and expressed as a percentage. This method is a simple (if limited) yardstick to enable different studies to be viewed from the same perspective but conclusions must be drawn with caution. There would be obvious benefits from a more scientific comparison of the researchers' original data.

In his study Nigel Shanks calculated a profile of the same symptoms in the population as a whole expressed in the same way as his homelessness data<sup>2</sup> and this is included as a benchmark.

The main conclusions of our literature review and the compilation of Table 4 are:

- a) The pattern of health problems amongst homeless people differs substantially from that of the general population.
- b) There is considerable variation of the pattern of health problems within the homelessness population itself.
- c) Our impression overall is that the most common health problems which appear to be specifically associated with homelessness include:
  - ◆ respiratory disease (including bronchitis, pneumonia and TB)
  - ◆ musculo-skeletal problems, such as arthritis

1 References are given in TABLE 4 Appendix B.

2 We have used his data for the whole population, not the set adjusted for social class.



- ◆ Trauma - external injuries caused accidentally or otherwise
- ◆ Gastrointestinal diseases
- ◆ Epilepsy and diabetes
- ◆ Mental illness

d) There is a high level of self-harm amongst homeless people, manifesting itself in suicide attempts, excessive drinking and drug abuse and disregard for a health lifestyle.

We must emphasise that the considerable variation of method and findings of different studies make it difficult to generalise about the health problems of homeless people as a whole. This is not surprising since this "group" is in reality extremely heterogeneous, with considerable diversity of background, age, lifestyle and health. The only thing these people have in common is the misfortune to live in a very difficult environment. In one sense there is no such thing as a "homeless person", only ordinary people who are homeless.

### Health risks of the homeless lifestyle

We will not attempt to summarise all the medial information we have seen - some of it is contradictory anyway. We will therefore present our own general observations on the health risks that face people who are homeless.

Homeless people, almost by definition, tend to lead an unhealthy lifestyle which, in addition to the direct environmental pressures on their health, will tend to weaken their resistance to health risks. There is some evidence to suggest that prolonged homelessness may actually lead to the immunosuppression, weakening of the bodies immune system, and it is possible to speculate about connections between this and the same phenomenon observed in people with high stress levels.

Smoking, drinking and poor diet are prevalent features of the homeless lifestyle, although malnutrition as such appears to be rare.

Living outside also brings with it increased risks of accidents and assault. Proximity to traffic and finding shelter in derelict or unsafe buildings are reflected in high rates of trauma in the medical evidence from Accident and Emergency Departments.

The survey of users of DSS Resettlement Units revealed that many homeless people face multiple health problems, and its evidence showed strikingly that homeless women show more frequent and severe problems than men.

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Bridget, spent the last two years of her life in a tent. Her boyfriend regularly beat her up and she drank heavily. The local police found her "always charming" but to passers-by she appeared to age twenty years in that period. She died, aged 36, of alcohol poisoning but the inquest noted that she was heavily bruised. Closing the case the Coroner commented "I'll have to report this to the proper authorities so that such deaths can be prevented; but I doubt that such an authority exists"

---

*Bridget Enwright*

For various reasons, homeless people may be unable or unwilling to seek medical attention. There is a wide debate about the problems of homeless people registering with G.P.'s and the most effective ways of targeting health services to homeless people (the London Health Authorities, for instance, have developed elaborate weightings systems)<sup>1</sup> and considerable evidence to show that homeless people tend to use accident and hospital emergency departments for primary health care needs. However, seeking medical attention requires a homeless person to make contact with the social structure from which they may feel distant and this may inhibit their motivation to seek treatment.

Finally, even when a health problem has been diagnosed, a homeless person may find problems with treatment. Following a prescribed course of medication may not be simple whilst sleeping rough and poor. Losing possessions, either through neglect or theft, is a common experience for a homeless person. This lifestyle is not organised around the clocks and calendars required for regular medication. It is also clear that for some homeless people medications become a commodity to be traded in exchange for other desirables (cigarettes, drink, a patch to sleep on) at the expense of their function as treatment.

#### The three week rule:

One interesting idea we encountered was that when an individual becomes homeless their behaviour and status changes rapidly over the first few weeks of homelessness. Illustrated by people sleeping rough in Central London for example, this means that in the first few days a person who is comparatively unprepared for sleeping rough can probably be seen just with a blanket in a shop-door. The next stage may be to find to join up with other homeless people and be huddled in a small group. After a week or so they have probably acquired some form of shelter ("bash"), like a cardboard box and moved out of the main highways where they are both continually disturbed and the obvious subject of other people's (dis)interest. Eventually they will tend to gravitate towards one of the soup run venues or more organised sites. Alternatively, they may use such

<sup>1</sup> Contact Access to Health, 32 Chapter St, London SW1 Tel 071 233 6599.

facilities but hide themselves away in a remote location such as an empty building or car-park.

This idea is pragmatic but it does point to two important aspects of how people cope with homelessness. Firstly, the longer it proceeds the more damaged an individual is likely to become and, in particular, the more a person retreats into an alternative social structure.

Secondly, whilst some people are able to adapt to homelessness, there is a considerable cost to this in medical terms. However, this process of adaptation is profoundly "deskilling" in terms of the individuals ability to reintegrate successfully into mainstream housing and social life.

### Respiratory diseases:

Respiratory diseases, such as bronchopneumonia, are common in the population but our statistics show that they are more likely to kill homeless people than others. In addition other respiratory diseases such as TB show an alarmingly high level of occurrence in the homeless population. A recent four year study<sup>1</sup> demonstrated this and discovered that only about a third could be cured within one year. Ramsden, the author, commented " The prevalence of tuberculosis and the difficulty of treating patients seems surprising in a highly developed nation".

Such respiratory diseases are associated with smoking and drinking, and other aspects of the homeless lifestyle may exacerbate an individual's vulnerability. For instance, a French study has shown that pneumococcal pneumonia is prevalent amongst users of lodgings houses in Paris, suggesting that it is possible for some nightshelters to transmit contagious diseases.

### Hypothermia

It is not difficult to understand why sleeping rough may cause the body temperature to drop. Hypothermia is the only topic on which Government sources were able to provide statistics, probably related to the fact that it is a subject of political sensitivity. According to the OPCS answer to a Parliamentary Question<sup>2</sup> only 6 people in the whole of England and Wales died of hypothermia who were recorded as being of no fixed abode. This figure is treated as a joke in medical circles and says far more about the nature of statutory records than about the problem. In our own survey we found on two hypothermia cases, but this reflects the fact that hypothermia is a condition that can be fatal although the actual cause of death may be a more specific event (heart failure, pneumonia etc.)

1 Tuberculosis among the Central London Single Homeless. Ramsden et al: Journ. Roy. Coll. Physicians 22:1 (1988).

2 Hansard: 15 March 1991.

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**"To reduce the prevalence of cigarette smoking in men and women aged 16 and over to no more than 20% by the year 2000"**

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*Health of the Nation Target (p72)*

---

**"Of 51 men 43 (84%) were tobacco smokers"**

---

*Health surveillance project amongst single homeless men in Bristol 1988.*

## Alcohol

Alcohol is a common feature of the lifestyle of some homeless people, but they are by no means a unique social group in this respect.

On balance we think that less than half of homeless people have a "drink problem", perhaps 30%. In only 14% our Coroner's sample did records show that this was linked to their cause of death. It is clear that different groups of homeless people exhibit different levels of drinking. Studies in Manchester<sup>1</sup> and East London illustrate this. In the former, 49% of a sample of 410 homeless men (predominantly) in Manchester were considered to be "alcoholic". In East London<sup>2</sup> compared with a matched sample of housed people, a greater proportion of homeless men and women did not drink at all, although when they did it was in more harmful quantities. The Charing Cross Casualty Department survey suggested 21% patients had a "secondary care issue of alcohol abuse". Studies are sometime distorted by the fact that many agencies ban drunk clients from using their services.

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**"To reduce the proportion of men drinking more than 21 units of alcohol a week from 28% to 18% by 2005"**

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*Health of the Nation target (p57)*

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**"The most striking feature of the Alcohol Worker's data is the sheer numbers of clients and consultations..."**

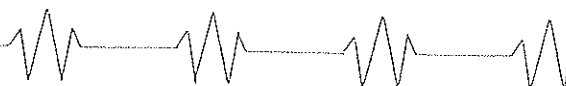
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*East London Homeless Health Primary Care Team 1990*

In addition to the direct damage caused, for instance, to the liver, alcohol can be a contributory factor in other health problems. Its dilatory effect on

1 Alcoholism and Homelessness: Shanks. The Practitioner 233:1364 (1989).

2 Out in the Cold: Routledge 1992. Chapter by John Balazs.



blood vessels, for example, increases bodily heat loss rendering people more vulnerable to hypothermia.

Our view is that the widely-held assumption that homelessness is simply "due to" drink is one of those enduring myths that seriously obstructs balanced consideration of the homelessness issue. It is similar to the absurd idea that being homeless is just a question of "Choice". Both might be described as "saloon bar" thinking.

Alcohol was described to us as "the greatest self-medication" of all time. It is widely used as such in the general population and this may explain its appeal to people undergoing the horror of homelessness is both social and anaesthetic. Like smoking, it is one of the few pleasures available to homeless people, it can be shared and it relieves temporarily the mental and physical pain of homelessness.

Combined with a poor diet and taken earlier in the day than is socially acceptable, drunkenness amongst homeless people is more visible than, say, in the City of London where the amount of money an individual spends on drink is likely to be far greater than on the streets (where the most common beverage by far seems to be Tennents Extra).

### Suicide/self-inflicted injuries

The most shocking of our Findings is that suicide is the most common form of death in the sample we studied.

Methods included drowning, throwing themselves under trains, hanging, and alcohol and drug overdoses. In one case a man simply lay down in the road in front of an approaching lorry.

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**"To reduce the overall suicide rate by at least 15% by the year 2000 (from 11.1 per 100,000 population to no more than 9.4%)"**

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*Health of the Nation target (p84)*

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**"One of the key areas for concern ... was the significant number (13%) presenting with a primary care issue of self-harm or overdose"**

---

*Charing Cross Hospital Accident and Emergency Department report on use by homeless people .*

We suggest that these deaths may be the result of mental disturbances but also the conscious decision of people who are unable to solve their housing problems and cannot tolerate the rigours of being homeless. This area has been little explored in the literature we read, and is ripe with confusing and imprecise terminology. For instance, several text referred

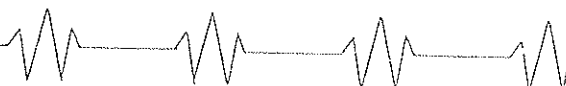
simply to "personality disorders", a term of no precise or agreed clinical meaning.

The high incidence of mental health problems, particularly schizophrenia, ranging from 10% to 40% in different studies of people actually sleeping rough requires careful attention. In our experience it is unlikely that this results from people from closing mental institutions being discharged onto the streets. However, it may well be that existing "Care in the Community" models meet such patients needs for a limited period before breaking down. In addition, with fewer acute psychiatric beds available it may be that there is a lack of provision for acutely ill people who would previously have been admitted to an institution.

Undoubtedly the experience of homelessness causes mental illness. Studies based on self-reporting all show homeless people themselves concerned about "depression", "anxiety", problems with memory" Much work has centred on identifying environmental "stress" factors in professional life<sup>1</sup>, recognising that stress can be physical and mentally very damaging. By any standard the degree of personal and environmental stress to which homeless people are exposed is enormous and this would be expected to be reflected in physical and mental health symptoms.

Our view is that one of the largest missing pieces of the homelessness jig-saw is our ignorance of the psychological changes that happen to someone who is homeless. It is easy to envisage, in simple human terms, how failing to solve the problems must lead to disillusionment and a feeling of powerlessness followed increasingly by a sense of alienation and anger towards the society which walks by on the other side of the road, and which appears increasingly to disown homeless people as their own position and appearance deteriorates. What is needed is a proper psychological study of these processes.

<sup>1</sup> See, for instance, *Stress & Health*: Phillip L Rice; Brooks/Cole Publishing Co. 2nd Edition (1992).



## CONCLUSIONS

This investigation deals with an area of enormous complexity, which is poorly documented, in which professional opinion is far from consistent, and in which the real-life details are extremely distressing. We do not feel able, in these circumstances to draw firm conclusions about the nature of the links between Homelessness, Health and mortality. But we do have some views.

- ◆ Broadly the people in this report fall into two categories: those who die without a home and those whose deaths are causally connected with their homelessness. In future work it will be necessary to separate these two carefully. In our view it is no less tragic that someone dies without a home than that their death results from homelessness.
- ◆ We are astonished by the numbers of people that appear to die prematurely or without a roof. Before commencing the study we guessed that the total might be perhaps 100 deaths. This issue is much greater and more serious than any agency has previously recognised.
- ◆ Many of the areas of health needs discussed correspond to those the Government has targeted for action in its Health of the Nation strategy. There is a strong case for giving priority to homeless people within this strategy.
- ◆ Until records in courts, doctor's surgeries, hospitals and elsewhere (e.g. police) record homelessness in a consistent and retrievable form it will be difficult to measure and monitor this pressing problem.
- ◆ There are many different definitions of "homelessness" amongst the agencies we consulted. Without a common practical definitions neither can information be aggregated nor stereotypes and prejudices eliminated.
- ◆ The people whose deaths are documented in this report represent the pinnacle of the colossal iceberg of housing need. Although numerically a small part of the total picture their needs are so great that they deserve to be recognised by all concerned with health and housing issues.

We wish to conclude this report with some practical suggestions for future work.

## A WAY FORWARD

The Government has made major commitments both to tackling the problem of Sleeping Rough<sup>1</sup> in Central London (though not elsewhere) and to improving the nation's health.

Neither will succeed in meeting the needs of many people sleeping rough unless there is a clear and concerted effort to understand the relationship between homelessness and health, particularly the severe damage that people suffer who sleep rough for more than a few weeks.

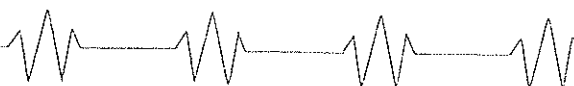
Whatever the professional and political disagreements about how the issue of homelessness is most effectively to be addressed, and paid for, the facts deserve to be established. It is unacceptable in our sophisticated, and comparatively wealthy society that we should be ignorant of a major killer in our midst.

We hope that the evidence and suggestions in this report can serve as the stimulus, and perhaps starting point, for a properly resourced scientific study.

This is what we think needs to be done:

- ◆ A longitudinal study of the hospital admissions and deaths to establish how many homeless people die in hospital (or are certified by a G.P.) and analysis of the major causes of death.
- ◆ A national study of Coroner's Court records to identify accurately the number of homeless people whose deaths are recorded. Such a study would need to be based on a clear knowledge of the nature of homelessness in each area and should be conducted by researchers independent of the Court system, taking into account the problems of searching records that we highlight on page 5. All Death Certificates and inquest records should be examined.
- ◆ The establishment of a system of reporting all deaths of homeless people, including those in hospitals, hostels, public places and elsewhere, to a single point, for instance, the appropriate Coroner's Court. As long as the definition of homelessness is clear this could be easily achieved by the Registrar General in his instructions to Coroners and others.
- ◆ Conduct a detailed psychological study of the effect of rooflessness on homeless individuals. The behavioural and mental changes that occur as people adapt to life on the streets are a potent source of opinion and judgement but are almost undocumented. This could examine our

<sup>1</sup> In 1990 the successive Ministers for Housing, Michael Spicer and Sir George Young, announced the Rough Sleepers Initiative in Central London, backed by a budget of £96 million. A further £85 million has been committed up to 1996.



notion of the "three week rule" (page 21) and needs to examine in depth the possible role of drink as "self-medication"

- ◆ Publish the results of this work as soon as possible and invite comments from health, housing and voluntary sector agencies on ways of reducing mortality rates amongst homeless people.

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**"... there is a commitment (in Health of the Nation) to the pursuit of "health" in its widest sense..."**

---

*Virginia Bottomley, Secretary of State for Health, July 1992*

As a small charity, CRISIS has used its resources to commission this report as a means of drawing attention to a problems that is almost completely ignored. It is also far beyond the capacity of a charity to begin to solve.

We consider that it must now be a Government responsibility to take the next steps by commissioning an immediate professional examination of the horrific situation we have described.

If our estimates prove to be incorrect then at least we will know the facts. If, as our investigation has led us to fear, mortality and morbidity rates amongst homeless people much higher than in the rest of the population, then there will be a clear agenda for action since these deaths are preventable.

**There can be no reason not to know the truth.**



# APPENDIX A

## Inner London Coroner's Court records

### Summary of principal causes of death

	Sex	Age	Details
<u>ACCIDENTS</u>			
	F	36	Accidental: Car while under Infl. Alc
	M	?	Bronchopneumonia/severe head & chest injuries
	M	61	Coronary thrombosis, atheroma, fractured skull
		?	Inhalation of fire fumes and burns
		71	Fell into basement
		21	Impaled on pole on building site
	M	62	Died in Fire
	M	51	Died in Fire
	M	?	Cerebral Haemorrhage
	M	51	Smoke inhalation and body surface burns
	M	55	Road Traffic accident
<u>ALCOHOL</u>			
	M	31	Alcohol & Methadone intoxication
	M	54	Cirrhosis
	M	24	Alcohol poisoning
	M	58	Alcohol (poisoning)
	M	42	Alcohol (poisoning)
	F	44	Diazepam (tranq.) & alcohol
	M	52	Alcohol & Diazepam poisoning
	M	54	Occlusion of airways/alc & diazepam poisoning
	M	39	Alc & mixed drug overdose
<u>ASSAULT</u>			
	F	28	Unlawfully killed
	M	20	Stab wound to heart
	M	53	Stab wound to chest/ involved in scuffle
	M	43	Strangulation
	F	43	Stabbed in a fight.
	M	43	Fracas at railway station/battered
<u>DRUGS</u>			
	M	32	Acute opiate Intox
	M	32	Acute morphine poisoning
	M	63	Methadone overdose
	M	31	(Drug overdose?)
		27	Drug Overdose
	M	?	Heroin overdose
	F	34	Mixed Drug poisoning
	M	32	Morphine poisoning
	M	29	Opiate Overdose

F	34	Mixed Drug poisoning
M	26	Morphine overdose/inhalation of vomit

DROWNED

M	40	Drowning
M	31	Immersion
M	?	Drowning in Regent's Canal
M	23	Drowning
M	?	Drowning
F	35	Drowning
M	22	Drowning
M	?	Drowning
	?	Drowning
	?	Drowning

NATURAL CAUSES

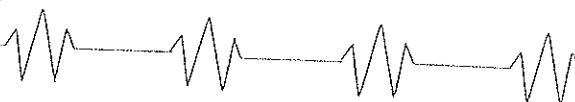
	72	Heart (failure?)
M	64	Unspecified natural causes
M	70	Coronary Heart Disease
M	55	Ischaemic Heart disease
F	58	Acute enterocolitis/mitral valve disease
M	74	Coronary Heart disease
M	74	Coronary Thrombosis
F	79	Pulmonary embolism
	69	Asbestosis
F	50	Cerebral infection/cerebral atheroma
	69	Acute peritonitis
M	?	Sudden Death/Natural Cause
M	?	Sudden Death/Natural Cause
M	59	Left ventricular failure/rheumatic fever
M	67	Infarction of brain

UNKNOWN CAUSE

M	56	Unascertainable
M	?	(not specified)
	29	N/K

PNEUMONIA/HYPOTHERMIA

M	49	Bronchopneumonia Misadventure
	69	Septicaemia/pneumonia
M	?	Hypothermia
	66	Bronchopneumonia
M	?	pneumonia
M	64	Bronchopneumonia/Emphysema
M	71	Bronchopneumonia
M	53	Hypothermia/Alc intoxication
M	59	Bronchopneumonia
	22	Pneumonia/Natural Causes
M	32	Hypothermia



## SUICIDE

M	38	Acute Propoxyphene & dihydrocene poisoning
F	25	Morphine poisoning/non-dependant abuse
F	29	Sub- massive liver necrosis/paracetamol o/d
M	77	Acute morphine poisoning
M	38	Multiple injuries
M	45	Mixed drug poisoning
M	?	Hanging
M	?	Hit by train/multiple injuries
M	?	Hit by train/multiple injuries
M	?	Hit by train/multiple injuries

Total number of Records:86

## Notes

1. **Classification of cause of death** by authors
2. **Description** is transcribed from Coroner's day books amplified only to make abbreviations clear. In some cases the authors had access to further information about cases. The descriptions given are not necessarily the official recorded cause of death.
3. **Gaps in information** primarily reflect gaps in records rather than details unascertainable.



# APPENDIX B

TABLE 4: Relative incidence of disease (morbidity) amongst homeless people

Source	% symptoms shown as a proportion of all symptoms shown											
	Total population	Hospitals (casualty)	Hostels	Hostels	Streets	G.P.	Resettlement	Units	Crisis (Open Christmas)	Past history		
Location and date		Charing Cross X 1991	Lewisham 1990/1	Bristol 1985	London 1991	Manchester 1979/82	Sheffield 1991	Oxford 1985/90	London 1991	Provincial 1988	London 1991	London 1991
Sample size	293	105	91	48	2500	719	2500	719	2839	546	546	546
Method	Expected	Retrospec	Diagnosed	Diagnosed	Diagnosed	Self	Diagnosed	Self	Self	Diagnosed	Past history	
Av age (estimated)	32	39	(50)	40	45	43	(45)	(35)	(45)	(45)	(45)	(45)
% male	75	100	100	100	96	89	89	86	89	88	88	88
Note	e	a	b	c	d	e	f	g	h	i	j	k
Symptoms treated												
Cardiovascular	15	10	9	6	4		1	2	2	2	1	6
Dermatological	6		22	11	11		1	5	6	7		
Gastrointestinal	9	20	11	16	14	8	6	4	2	2	19	2
Genito-urinary	2		3		5		2	2	2	2	1	11
Neurological	7		9	3	6	4	4	5	5	6	2	24
Respiratory	19		6	19	22	13	3	7	9	11	14	
Muscular/skeletal	11	6		11	4		2	18	8	18		
Trauma	7	23	48	13	6	8						
Other	13	12	11	16	6	8	22		21	17	4	
Infection/wounds	2	2		6	5							
Alcohol related	0	17		100			28	41	12	23	5	33
Psychiatric	9	16	5	6	10	34	12	20	22	4	14	
Drug related	0	4		8	20	9	22	2	2	9	10	

Notes

- 1 Published data from each study has been manipulated to show the % each symptom represents as a proportion of all symptoms.
- 2 Reclassification of original data is the responsibility of the current authors
- 3 Under method "Self" means self-assessment by patients using a questionnaire or interview. "Retro" means retrospective analysis of patients records.
- 4 Gynaecological symptoms have been omitted due to the very small female sample.

References to sources in TABLE 4

- a Primary Care, Homelessness and the A & E Department; Charing Cross Hospital, Martyn Penfold (July 1992)
- b Use of accident and emergency Dept. by homeless people:Lewisham Hospital, London. Stark (1991)
- c Health Surveillance Project amongst single homeless men in Bristol; Featherstone & Ashmore; Journ. Roy. Coll. Gen. Pract. 38:353 (1988)
- d Cold Weather Shelter, January 1991, Paddington Children's Hospital: Gt. Chapel Street Medical Team
- e Medical morbidity of the homeless: N. Shanks; Journ. Epidem. Comm. Health; 42:183 (1988)
- f Census of single homeless people in Sheffield; Shanks et al.BMJ 302:1387 (1991)
- g Health and Homelessness in Oxford: Dave Collett; Oxford Homeless Medical Fund (July 1992)
- h Survey of Admissions to London Resettlement Units:Gillian Elam; DSS Research Report No. 12 HMSO (1992)
- i Users of Resettlement Units: Maureen O'Neill; Resettlement Agency (1989)
- j Open Christmas 1991, Medical Room Preliminary statistics; CRISIS
- k As j; Patients were asked to give details of their medical history.

# ACKNOWLEDGEMENTS

## THE AUTHORS

**SIMON KEYES** wrote this report and planned the research work. He has worked with organisations concerned with homelessness for 10 years in a voluntary and professional capacity. He was the first Chair of Homes for Homeless People and more recently Director of Housing Services for Shelter. Future projects include working with homelessness organisations in Hungary and creating a new project to assist mentally vulnerable homeless people caught up in the criminal justice system.

**MICHAEL KENNEDY** carried out much of the Coroner's Court survey, several interviews and part of the literature review. He is a barrister with a particular interest in crime and employment issues.

**ADAM WOOLF** is Information and Policy Officer for CRISIS. He commissioned and supervised this project. The authors would like to record their thanks to him for his creative and constructive support.

We would like to thank the following people for their co-operation and assistance with this investigation:

**Dr. John Burton**  
**Dr. Douglas Chambers**  
**Dr. Paul Knapman**  
**Dr. Sir Montague Levine**  
**Dr. Jeremy Booth**  
**Carolyn Clark**  
**P.C. Clements**  
**Dr. John Collins**  
**Brian Lloyd**  
**Martin Penfold**  
**Dr. Simon Ramsden**  
**Inspector Bill Ranson**  
**Father Barry Carpenter**

We would also like to thank the many other people who gave us ideas, figures, anecdotes and written materials.

Desktop published using Xerox Ventura V3, Coreldraw V2, Microsoft Excel V3, Wordperfect V5.1, Windows V3.1 TrueType font Times New Roman  
by Sophie Talbot

£5.00



Registered as Crisis at Christmas charity number 266533  
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