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Medical Problems of the Homeless: Consequences of Lack of Social Policy—A Local Approach*

PEDRO J. GREER, JR., M.D.**

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I. INTRODUCTION

The homeless can no longer be stereotyped as the alcoholic, the deinstitutionalized mentally ill individual, or the "bag lady." Those stereotypes of the homeless now constitute a shrinking minority. Today there is a whole new "streetperson." The minority of the homeless consisting of alcoholics, mentally-ill individuals, and bag women continues to shrink, mostly due to the marked overall increase in other homeless persons, including the women and children who now constitute thirty-six percent of the homeless population, and whose numbers are growing.[1] New York's homeless population alone is estimated at near 36,000.[2] At our own clinic, the Camillus Health Concern for the Homeless,[3] we see more and more pregnant women.[4] Though no comprehensive national study is available, the homeless are clearly represented by every age, gender, race, and ethnic group in

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* Substantial portions of this Article previously appeared in Greer, *America's New Homeless*, 60 MIAMI MEDICINE 19 (1989). These portions are reprinted here with the permission of the publisher.

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1. A report compiled from 29 major cities noted that 39% of the homeless consists of families. U.S. CONFERENCE OF MAYORS, A STATUS REPORT ON HUNGER AND HOMELESSNESS IN AMERICA'S CITIES: 1989, at 2 (1990). None of the 29 cities expected improvement in the immediate future. *Id.* at 72-74.

2. Bricker, *Health Issues in the Care of the Homeless*, in HEALTH CARE OF HOMELESS PEOPLE 1, 4 (1985).

3. The Camillus Health Concern for the Homeless is a health services clinic for the poof located at 708 N.E. First Avenue, in Miami, Florida.

4. We identified 14 pregnant women in shelters in September 1990 alone. A New York study indicated a demographic correlation between out-of-wedlock pregnancy and lower socio-economic class, though there is no clear cause-and-effect relation. *See* McBarnette, *Women and Poverty: The Effects on Reproductive Status*, in TOO LITTLE, TOO LATE: DEALING WITH THE HEALTH NEEDS OF WOMEN IN POVERTY 55, 58-65 (1987).

our society.[5]

There is an interesting regional variation in the racial and ethnic distribution of the homeless population, though generally the homeless population represents a disproportionate percentage of the lower socio-economic sub-groups.[6] In Dade County, 63.5% of our homeless are blacks,[7] yet the most recent statistics available indicate that less than 20% of Miami's population is black;[8] across the nation, blacks comprise 11.7% of the general population, but 40% of the homeless.[9] Nationally, 11% of the homeless are hispanic, yet only 6.4% of Americans are hispanics.[10] Interestingly, in Dade County, hispanics make up 10% to 17% of the homeless population, though more than 35% of the general population is of Spanish origin.[11]

There are also particular classes of the homeless that present special difficulties. For example, over a third of the male homeless population nationally are veterans.[12] Between January 1986 and January 1987, we studied the homeless at the Camillus House who claimed veteran status and found that less than fifty percent had ever utilized the services offered by the Veterans Administration.[13] There was also a twenty-eight percent incidence of mental illness and a fifty-six percent incidence of substance abuse among veterans in our study.

There is no single social policy that embraces the myriad issues of homelessness. We are told that the problem of the homeless arose as a consequence of "deinstitutionalization," a concept that arose in the mid-1960's.[14] The trend towards discharging the mentally ill

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5. *See* J. WRIGHT & E. WEBER, HOMELESSNESS AND HEALTH 45-51 (1987) (presenting demography and noting the lack of other controlled studies). The Wright and Weber study, though exclusively representing the urban segment, is "as close to a national sample of the homeless as anyone has ever gotten." *Id.* at 39. The study utilizes data gathered through the operations of the National Health Care for the Homeless ("HCH"), a privately endowed, community-based health care program consisting of 19 projects in various major cities in the United States. *Id.* at 19. The data are collected from 16 of the projects between start-up in November 1985 through June 1986; the pool consists of 11,797 adult clients with known dates of birth that were seen more than once. *Id.* at 39. This Article uses the HCH study's national statistics unless otherwise noted.

6. *See* U.S. CONFERENCE OF MAYORS, *supra* note 1, at 10-11.

7. MIAMI COALITION FOR THE CARE OF THE HOMELESS, TOWARDS AN END TO HOMELESSNESS AND HUNGER IN SOUTH FLORIDA 8 (1989) (figures based upon November 1988 research).

8. NATIONAL DATA CONSULTANTS, FLORIDA COUNTY PERSPECTIVES 83 (1989) (based on 1980 census).

9. J. WRIGHT & E. WEBER, *supra* note 5, at 47-48.

10. *Id.*

11. NATIONAL DATA CONSULTANTS, *supra* note 8, at 83.

12. J. WRIGHT & E. WEBER, *supra* note 5, at 52.

13. The Wright and Weber national study results were even more dismal; only 36% of the veterans showed any evidence of participation in any program. *Id.* at 53.

14. "Deinstitutionalization is a word used to describe the nationwide trend of releasing

from institutions, coupled with the lack of other programs to support the mentally ill, led to their joining the ranks of the homeless.[15] While the problem of the deinstitutionalized, mentally ill homeless does exist, these people represent only a fraction of the eleven to forty-three percent of the homeless who are mentally ill.[16] However, even amongst psychiatrists, there is great difficulty in defining mental illness.[17] There is little standardization in psychiatric studies, which range in their estimates of the mentally ill among homeless persons from as low as fifteen percent to as high as ninety percent.[18]

Whatever the scapegoat, the number of the homeless in the United States is increasing—they could almost be considered a growth industry. Their numbers are increasing at an alarming rate, estimated to be twenty-five percent per year.[19] Estimates of the homeless population in the United States vary from 350,000 to three million persons.[20] In 1985, there were an estimated 8,000 homeless people in Miami alone.[21]

Increasingly, the homeless population is comprised of younger and better-educated persons. In the 1960's and 1970's, the average age of the homeless person was forty-five, and the average educational

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mass numbers of mentally ill individuals from mental hospitals and institutions." NATIONAL COALITION FOR THE HOMELESS, MALIGN NEGLECT: HOMELESS POOR OF MIAMI 24 (1986). Deinstitutionalization resulted from a number of factors, including an increased awareness of atrocious living conditions in mental hospitals and cost cutting efforts by the federal government. *Id.* at 24-25.

15. *Id.* Ironically, the same federal budget cuts that promoted deinstitutionalization stiffened requirements for Social Security benefits. *Id.*

16. J. WRIGHT & E. WEBER, *supra* note 5, at 55, 96 (noting that only three percent of men and five percent of women surveyed had previously lived in institutions). The HCH study considered a client "mentally ill" if the client was diagnosed with a mental or emotional problem by the HCH staff, had a history of psychiatric hospitalization or impairment, or appeared to have a serious mental or emotional problem during at least one contact. *Id.* at 92.

17. *Id.* at 91-92.

18. *Id.* at 91.

19. As noted previously, measurement of homelessness is itself problematic; use of shelters is easiest to enumerate. R. BURT & E. COHEN, AMERICA'S HOMELESS: NUMBERS, CHARACTERISTICS, AND PROGRAMS THAT SERVE THEM 19 (1989). The average increase in requests for emergency shelter among 29 major cities surveyed was 25%. The range of the increase varied from approximately three percent in New York City to 70% in Trenton. U.S. CONFERENCE OF MAYORS, *supra* note 1, at 27.

20. U.S. GENERAL ACCOUNTING OFFICE, HOMELESSNESS: HUD'S AND FEMA'S PROGRESS IN IMPLEMENTING THE MCKINNEY ACT 31 (1989); *see also* NATIONAL COALITION FOR THE HOMELESS, *supra* note 14, at 9 (crediting the Department of Housing and Urban Development and the Community for Creative Non-Violence as the sources for the low and high figures, respectively).

21. NATIONAL COALITION FOR THE HOMELESS, *supra* note 14, at 9. However, as with all homelessness demography, reports vary widely; a February 1989 study by Barry University estimated that there were 4,858 homeless persons throughout Dade County, Florida. *See* MIAMI COALITION FOR CARE OF THE HOMELESS, *supra* note 7, at 8.

level was that of a ninth grader, yet today the average age is about thirty-six and the average educational level is the eleventh grade.[22] National statistics show that nearly one-fifth of the homeless have some college experience and almost four percent are college graduates.[23]

The average age of female homeless persons is younger than that of males, even when including lone, mentally impaired women, typically older than forty, from whom the "bag lady" stereotype has arisen.[24] In Miami, at the Camillus Health Concern, the average homeless woman was 23.4 years old. Nationally, women comprise approximately thirty-one percent of the homeless population.[25] Homeless women encountered in the National Health Care for the Homeless program[26] were broken into five groups. In the first group were lone mentally impaired women; their median age was forty, and they comprised nearly a third of the female homeless population.[27] The second group consisted of single mothers, who made up approximately twenty-five percent of the women in study.[28] Their median age was twenty-seven, and they had a low incidence of mental illness or substance abuse.[29] The third group, homeless teenage girls between the ages of sixteen and twenty, constituted seven percent.[30] Many fleeing abusive families, the members of this group had an astoundingly high twenty-four percent rate of pregnancy.[31] The fourth group, representing nineteen percent of all homeless women, were women in homeless families without dependent children.[32] Finally, the residual group contained lone adult women without children, partners, or mental illness; their distinctive feature was a significantly greater incidence of alcohol abuse than the other women.[33]

The gravest consequence of homelessness is the fate of the children. Nationally, an estimated ten percent of the homeless are chil-

22. J. WRIGHT & E. WEBER, *supra* note 5, at 1.

23. *Id.* at 49. Nearly 40% of the population as a whole and 17.5% of adults over 25 years of age and below the poverty line have some college experience. *Id.*

24. *Id.* at 47-50.

25. *Id.* at 46. The population of female homeless among the cities with HCH programs ranges from 22% to 49% of the total homeless population; however, the proportion is exaggerated because HCH targets shelters for women. *Id.*

26. *See supra* note 5 (describing the HCH program).

27. *See* J. WRIGHT & E. WEBER, *supra* note 5, at 47.

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

dren, fifty-four percent of whom are under five years of age.[34] An estimated sixteen percent already have chronic illnesses.[35] These children, growing up in grossly inappropriate environments, are exposed to tuberculosis, drugs and their consequences.[36] Handicapped by such illnesses from youth, the homeless children's infirmities limit their hopes of working and re-integrating into society as they grow older.[37]

II. DISEASE AMONG THE HOMELESS

A survey of disease in the homeless population reveals potential disaster. The homeless in the United States have a higher incidence of all acute diseases with the exception of obesity;[38] of course, it is ludicrous to consider obesity a problem in a malnourished population. In our studies at the Camillus Health Concern, infectious diseases were the most common diagnoses. The single most common diagnosis at discharge was upper respiratory infection, typically viral. Sexually transmitted diseases (exclusive of AIDS) were the second most common diagnoses. Most alarming was the high incidence of pulmonary tuberculosis.

The decline of pulmonary tuberculosis appears to be ending after forty years of steady progress.[39] The previous decline resulted not merely from the use of the antituberculosis drugs, but mainly from improved living conditions.[40] Living on benches, under bridges, in alleyways, and other makeshift shelters, the homeless have not benefited from the national trend toward improved living conditions.

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34. *Id.* at 48-50. The HCH study defined homeless children as those 15 years of age or less. *Id.*

35. *Id.* at 112. The HCH study considered any one of the following a chronic disease: tuberculosis, prophylactic TB therapy, AIDS, cancer, diabetes mellitus, anemia, seizure disorders, seriously impaired vision or hearing, cardiovascular disease, hypertension, chronic obstructive pulmonary disease, liver disease, arterial disease, all colostomies, kidney disease, chronic peripheral vascular disease, all tracheotomies, amputations other than fingers and toes, and paraplegia. *Id.* at 31 n.17. Thirty-one percent of adult HCH clients had one or more chronic illnesses. *Id.*

36. *See* Schieffelbein & Snider, *Tuberculosis Control Among Homeless Populations*, 148 ARCHIVES INTERNAL MED. 1843, 1843 (1988) (noting the high incidence of tuberculosis infection arising from "crowded and poorly ventilated" areas in which the homeless take shelter); *see also* J. WRIGHT & E. WEBER, *supra* note 5, at 74 (observing that significant numbers of drug problems arise among homeless children as young as 11 years old).

37. J. WRIGHT & E. WEBER, *supra* note 5, at 112.

38. *Id.* at 114.

39. *Id.* at 109 (noting the decreasing rate of decline in tuberculosis cases).

40. *See* Iseman, *Tuberculosis: An Overview*, in HEALTH CARE OF HOMELESS PEOPLE, *supra* note 2, at 152 (crediting "Darwinian selection, improved nutrition, more hygienic housing, the sanitorium movement with patient isolation, and chemotherapy" for the reduction in tuberculosis).

This, coupled with malnourishment and substance abuse,[41] as well as an increase in tuberculosis related to HIV infections,[42] has caused the resurgence of pulmonary tuberculosis. There are approximately 500 cases of pulmonary tuberculosis per every 100,000 homeless persons, contrasted with only 9.6 cases per 100,000 in the United States population overall.[43] The homeless thus have an incidence of tuberculosis fifty times that of the overall population. In light of these statistics, the goal of the Secretary of Health and Human Services to completely eliminate tuberculosis seems idealistic,[44] unless the problems of the homeless are substantially addressed. As AIDS becomes a disease of the lower socio-economic classes, HIV infection will increase in the homeless population. Although the true incidence of AIDS or HIV infection in the homeless has not yet been studied, reports suggest an increase of homeless AIDS patients.[45] In Miami, considering only those patients previously diagnosed elsewhere, three percent of our patients come into the clinic pre-diagnosed with AIDS. Preventive measures such as the "safe sex" and "clean needles" campaigns are illusory "where the simple act of washing one's face and hands, not to mention one's 'works,' is clearly problematic."[46] Thus, if kept unchecked, AIDS should steadily increase in the homeless population over time.

Screening for HIV in our clinic, we have consistently found an HIV seropositivity[47] of greater than twelve percent among the adult homeless. In a study we presented at the Fifth International AIDS meeting in Montreal in 1989, we showed no difference statistically for HIV infection in the homeless, regardless of race, ethnicity, risk groups (intravenous drug abuse, prostitutes, and homosexuals), or lack of risk groups.[48] Poverty was the only common denominator and, if not a risk factor, it was a very strong co-factor for the risk of HIV.[49] We are currently studying co-infection with hepatitis and HTLV-1 with HIV viruses.

Other important diseases which impact on morbidity and mortal-

41. Schieffelbein & Snider, *supra* note 36, at 1843.

42. *See* P. Greer, J. Dickinson & R. Holmes, HIV Infections Among Homeless in Miami 1 (June 5, 1989) (study presented to International Conference on AIDS) (available from author).

43. J. WRIGHT & E. WEBER, *supra* note 5, at 108-09.

44. *HHS Secretary Sullivan Endorses Goal to Eliminate Tuberculosis in U.S.*, 104 PUB. HEALTH REP. 407 (1989).

45. *See, e.g.*, P. Greer, J. Dickinson & R. Holmes, *supra* note 42 at 4.

46. J. WRIGHT & E. WEBER, *supra* note 5, at 108.

47. Seropositivity is used to indicate presence of immunological evidence of a specific infection. *See* STEDMAN'S MEDICAL DICTIONARY 1192 (25th ed. 1990).

48. P. Greer, J. Dickinson & R. Holmes, *supra* note 42.

49. *Id.* at 4.

ity occur in an alarming frequency among homeless individuals. The incidence of hypertension is two to four times higher than in the general population.[50] Gastro-intestinal disorders, ranging from ulcers and colitis to diarrhea and gastritis, are nearly double the ordinary rate.[51] Peripheral vascular disease, manifested by disorders such as gout, varicosities, and gangrene, is ten to fifteen times more common among the homeless than the rest of the population.[52] Characterized by venous or arterial deficiencies in the extremities, the high rate of peripheral vascular disease among the homeless arises from constant forced walking or sleeping with the legs in a dependent position, rather than from alcohol abuse.[53] Poor dentition arises three times more often, and neurological disorders arise five times more often among the homeless than among the general population.[54] In effect, a third-world country of disease is superimposed over first-world country diseases. What we don't pay for today, we will pay for tomorrow, not only economically but in the future of this country.

III. THE CAMILLUS HEALTH CONCERN

As one can see, there is a problem with homelessness and its attendant medical consequences. The Camillus Health Concern was established to satisfy a need—to fill a void in the health care delivery system. The health care system was not designed to serve the extended homeless population, a population which was not properly anticipated or addressed by the government.[55]

Alina Perez-Stable[56] and I met about six years ago to design and develop a system to care for the homeless in Miami. We began by seeing patients in the shelter's dormitory area, at first in a haphazard schedule, but later regularly, twice a week. Throughout this time, our only tools were our hands, eyes and ears. Our pharmacy could barely fill a small drawer, while the patients easily filled the office. We approached the Veterans Administration Medical Center in Miami, and with the complete support of the Chief of Staff, we were given five medical examination tables, four desks, thirty waiting room chairs, two dental chairs, and a dental x-ray machine. Private practitioners

50. J. WRIGHT & E. WEBER, *supra* note 5, at 105.

51. *Id.*

52. *Id.* at 105-06.

53. *Id.*

54. *Id.* at 106.

55. NATIONAL COALITION FOR THE HOMELESS, *supra* note 14, at 11-13 (surveying state and federal reports).

56. Alina Perez-Stable is Education Coordinator for the Health and Human Values Program at the University of Miami School of Medicine.

and other hospitals in the county followed, donating the remaining pieces of equipment, and pharmaceutical companies gave medications.

Presently the clinic is located at 708 NE First Avenue, in Miami, Florida, adjacent to the Camillus House and one block south of the new Miami Arena; it is the only homelessness clinic south of Birmingham, Alabama. After Brother Paul Johnson, the Director of the Camillus House, saw our dedication, he acquired our present building, currently valued at greater than $300,000. With the help of the local H.B.O. Comic Relief Benefit at Uncle Funnies Comedy Club, which collected $11,000, the clinic was completed for about $40,000. This, combined with the value of equipment, the in-kind services of volunteer doctors, nurses, social workers, and the malpractice coverage program, reaches almost $500,000 in private money and labor generously given by our community to help the poor.

Through the Stewart B. McKinney Homeless Assistance Act,[57] we received a grant to continue our efforts to provide health care to the Dade County homeless, following the philosophy established at the clinic. This grant offers social and mental health services, and supplements existing services with a full-time doctor, a full-time nurse, and two nurse practitioner students, showing dedication in educating future health care workers.

Students from the University of Miami Medical School greatly supplement the program. Through Alina Perez-Stable's efforts to produce a curriculum, the medical school approved work at the clinic as a two-week credited elective for fourth-year medical students. This system of health care thus not only helps the homeless, but it trains our future doctors to realize social-economic impacts on health care. Our nurses come from the private sector, the Veterans' Administration Medical Center, and Jackson Memorial Hospital.[58] Nursing students represent a wide variety of schools, including the University of Miami School of Nursing, Barry University's School of Nursing and Nurse Practitioners and School of Podiatry, Miami Dade Community College's School of Nursing, and Florida International University's

57. 42 U.S.C. § 11301 (1988). Under the McKinney Act, the Health Resources and Services Administration of the Public Health Service administers the "Health Care for the Homeless" program. The program grants funds to local, nonprofit health services organizations to provide care for the homeless. U.S. GENERAL ACCOUNTING OFFICE, HOMELESSNESS: MCKINNEY ACT PROGRAMS AND FUNDING FOR FISCAL YEAR 1989, at 50 (1990).

58. Jackson Memorial Hospital is the core of the University of Miami School of Medicine's Jackson Memorial Medical Center, one of the top medical treatment and research facilities in the country according to a survey of the nation's leading specialists. H. DIETRICH & V. BIDDLE, THE BEST IN MEDICINE 16 (1986).

Department of Nutrition. With local universities working together to help our homeless, our college students realize what can neither be taught nor learned within the "ivory tower."

A system of health care has arisen that cuts all barriers by *not* having restrictive paperwork or appointments. The clinic dispenses medication and caters to the needs and hours of the homeless. Health problems are a consequence of social ills, and both must be addressed. So we also offer legal services, case workers, psychologists for children, a podiatrist, and a drop-in AIDS counseling service. The services must go to the needy, and adapt to their culture of homelessness, ethnicity, or otherwise. We are currently in the process applying for a health care van for outreach services. A van proves to be a valuable part of providing the homeless with medicine, as demonstrated by the program at the New York Children's Health Project, which recently acquired two vans for homeless children.[59] Unfortunately, limitations such as a lack of shelters to park vans will hinder implementation of the van program in Miami. Nonetheless, we are optimistic.

The clinic at the Camillus Health Concern delivers more than health care. Because often the homeless themselves do not utilize the established clinics or hospitals, we go to them. With the trust the homeless have had in the Camillus House and now have with us, we are often their only point of entry into society: our primary philosophy is "*We Are Their Wedge into Society*." If we are to function as a wedge into society, we cannot be just a clinic, treating episodic illness and serving as a conduit to primary care centers. If the patient becomes dependent on us for health care, the chances of getting him back into the mainstream are greatly curtailed.

IV. CONCLUSION

The history of our clinic reveals that it is the result of reaction, rather than anticipation. We have begun to approach this population in a reaction to a problem. Now let us anticipate the consequences and prevent them. Until recently, Miami failed to offer any services for the homeless.[60] Yet Miami's health care delivery system for the

59. The New York Children's Health Project, run by the Montefiore Medical Center in New York City, has had a van program since November 1987. Telephone interview with Dr. Irwin Redlener, Director of the New York Children's Health Project (February 13, 1991).

60. *See* NATIONAL COALITION FOR THE HOMELESS, *supra* note 14, at 12 (noting that "Miami has no program that provides care for the city's homeless"). In late 1988, the City of Miami opened a temporary shelter at the Bobby Maduro Miami Stadium, which was operated until the end of January 1989. Since then, Miami joined with Dade County in opening a shelter known as Beckham Hall. MIAMI COALITION FOR CARE OF THE HOMELESS, *supra* note 7, at 7.

homeless is now among the most comprehensive anywhere in the country.[61] Despite our success, the problem continues to outpace our resources. We do not plan to create a permanent bureaucracy. We only wish to temporarily fill the void left by our current public health care system. In the overall picture of the homeless, we cannot have them dependent on us. Thus our responsibility is to form a bridge back into the system that should be available to them. Medical needs are a consequence of more fundamental problems; unless the housing, economic, employment, and social issues are confronted, the homeless will pass through a revolving door of illnesses. By the same token, we must be as comprehensive as possible with our own services to address those problems. The longer we wait, the longer the homeless are on the streets, and the more difficult and expensive our society's problem becomes.[62]

61. The author is affiliated with the National Health Care for the Homeless Council, a group of directors of health services centers from across the nation. The consensus of opinion held by the members of the council is that the services provided at the Camillus Health Clinic were more comprehensive than any other represented by members of the council.

62. Let us show our compassion. If you wish to help, please call the Camillus Health Concern at (305) 577-4840.