The “Literally” (and Not So Literally) Homeless

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Homelessness as a topic for public debate could be said not to have existed in the U.K. until November 16th, 1966, when BBC Television aired the play ***Cathy Come Home***, which charted a young couple’s decline into homelessness and hopelessness when the breadwinner was injured at work. The charity Shelter began in the same year, and both were to prove powerful influences on public policy. The executive director of the U.S. Interagency Council on Homelessness is impressed by the fall in numbers of those sleeping rough (from 1,850 a night in England in 1998 to 500 now¹). In claiming that “for the first time in 20 years” U.S. cities are also seeing a fall in persons sleeping on the streets or long-term in shelters and that “we are ending the disgrace of homelessness,” Mr. Philip Mangano cheerfully admits to stealing British ideas.² Via legislation, which places a duty on local authorities to find shelter whatever the cause of the homelessness, and by initiatives such as the Rough Sleepers Unit (now part of the Homelessness Directorate in the Department of Communities), things have improved in Britain. Inevitably, there is debate about the true numbers and the problem has not yet gone away. Between 2000 and 2004 only 5 of London’s 33 boroughs recorded a fall in homelessness, and two-thirds of England’s 94,000 families in temporary accommodation were in the capital. The Government’s target is to halve the number in temporary accommodation by the year 2010.

Medical publications on homelessness tend to focus on drug abuse and alcoholism, other mental health problems, and infections such as HIV/AIDS and tuberculosis, all conditions more likely to be found at the extreme end of homelessness, among those sleeping in shop doorways and under cardboard boxes, for instance. Another focus is access to health services;³ the University of Oxford has recently launched a postgraduate course on the provision of health care to this vulnerable group. However, there is a wider problem with housing shortages, and confusion can arise between those sleeping rough and individuals or whole families who find it difficult to buy or even rent a home. Both groups are in a sense “homeless”. The former are what a Californian study refers to helpfully as the “literally homeless”,⁴ but the struggles of the larger second group are not being ignored. In the U.K., where “getting on the property ladder” is most people’s dream, help with first homes is provided by hundreds of local housing associations and the parent body, the Housing Corporation. The Corporation’s strategy does now cover the literally homeless,⁵ but its main activity is the investment in 2006–2008 of £3.9 billion (US \$1.97 billion) in 84,000 new homes, 58% for rent. The planning process also assists as, increasingly, approval of housing developments becomes easier when there is “affordable” or “social” housing in the project, and such provision is a focus of the Thames Gateway renovation project east of London.

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Preventing literal homelessness and its medical consequences requires knowledge of the underlying cause, or rather, causes. Some recent German research hints that simply providing a permanent home is not the whole answer.⁶ The roots of homelessness and the answers to it may not be purely economic. Cause and cure may also depend on where you are and on age, as illustrated by a few recent publications. In California, the average age of the elderly homeless surveyed was increasing by 8 months a year;⁴ in New York City, age and arrest history were predictors on longer-term homelessness;⁷ in Australia, at the other end of the age spectrum, it appears that family conflicts are a more important reason for running away from home than abuse, physical or other.⁸ The distinction between the literally and not so literally homeless is helpful but a bit artificial; a spectrum of causation and suffering is far more likely. The statistics for homelessness may be showing encouraging signs, but housing remains an important issue that requires cross-sectoral communication between medicine and public health, on the one hand, and politics and economics on the other.

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