

Homelessness and the Accessibility of the Health Care System

Brezdomstvo in dostopnost zdravstvenega sistema

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Abstract

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The article describes the results of the first Slovenian research of the health situation of the homeless people, with a special emphasis on the accessibility of the health care system. A field survey was carried out on 122 homeless persons from six Slovenian towns. The analysis has shown that the experience with the accessibility of the health care system by the homeless people is not optimal and that the accessibility of this system is smaller for those with greater risk factors. Particularly threatened in this sense are the individuals with the so-called double diagnoses. On the basis of this analysis recommendations are given for lowering the threshold in health organisations, for a more integral and individualised approach to the homeless persons, and for the development of outreach (health) work.

Key words: homelessness, social exclusion, health, accessibility of the health care system, discrimination, mental health problems, alcohol, drugs, low threshold field work, proactive work.

Povzetek

Članek opisuje rezultate prve slovenske raziskave zdravstvenega stanja brezdomcev s posebnim poudarkom na dostopnosti zdravstvenega sistema. Izvedeno je bilo terensko anketiranje 122 brezdomnih oseb iz šestih slovenskih mest. Analiza je pokazala, da doživljanje dostopnosti zdravstvenega sistema s strani brezdomcev ni optimalno ter da je dostopnost tega sistema manjša za osebe, ki imajo več ogrožajočih dejavnikov. Posebej ogroženi so v tem smislu posamezniki s t. i. dvojnimi diagnozami. Na osnovi analize so podana priporočila za nižanje praga v zdravstvenih organizacijah, za bolj celosten in individualiziran pristop k brezdomcem ter za razvoj terenskega (zdravstvenega) dela.

Ključne besede: *brezdomstvo, socialna izključenost, zdravje, dostopnost zdravstvenega sistema, diskriminacija, težave z duševnim zdravjem, alkohol, droge, nizkopražno delo terensko delo, proaktivno delo.*

Introduction

Homelessness in Slovenia is a relatively new phenomenon, which, as recently as a few years ago, was accompanied by rather astonished reactions of the media and the public, while there had been practically no publications on the topic of homelessness in the Slovenian expert and scientific press until the end of the previous millennium. A turning point occurred mostly in the past five years when homelessness became – within the social issue – one of the more frequent topics, first in mass media and then increasingly also in the professional journals.

In the last 20 years, and particularly intensively in the last five, a network of organisations operating in the field of homelessness has also been developing. With the heterogenising of the phenomenon of homelessness (the representation of an increasing number of different specific populations according to gender, status, age,

origin ...) this network has also expanded and heterogenised itself. Both the expanding and the heterogenisation of the organisational network, in relation to the expanding and heterogenisation of the phenomenon of homelessness itself, are naturally carried out slowly and with a time lag.

The organisational network in the field of homelessness is developed best in the capital Ljubljana, and has also been developing in other Slovenian towns in the past few years: Maribor, Celje, Koper, Slovenj Gradec, Murska Sobota, Kranj ... While the European trend lies mostly in the surpassing of shelters and their replacement with more permanent, stable, and in the long run more promising forms of housing for the individual, such that would enable the individual a starting point for organising other areas of his or her life as well, in the mentioned smaller Slovenian towns, on the other hand, mostly shelters have been set up in the past years.

During the wave of a new interest in homelessness in 2005 and 2006 the first larger and more complex research project was carried out specifically on the topic of homelessness (Dekleva & Razpotnik, 2007; Razpotnik & Dekleva, 2007). In the period after this research more specific topics began to open up, new expert activities and work models developed, and an awareness of new topics still left to be treated began. Among such topics are for instance the model of the housing support to the homeless in their inclusion into a more conventional way of life, the models and approaches of outreach work, the issue of the development of the model or the (internationally comparable) system of counting the homeless (which is becoming topical with Slovenia's inclusion in various European projects) and the topic of the development of the standards of treating homelessness or in general of the development of politics in this area.

One of these more specific topics also concerns the health care issue or the question of the health situation of the homeless population, the question of their health care treatments, the question of how the homeless experience the health care system, what they think of its accessibility and what its attitude is towards them. The health care's attention was turned in this direction, in the broadest sense of the word, when we began to contemplate which the particularly vulnerable and threatened groups within healthcare are, and connect this concept with the notion of social

exclusion. In connection with this topic the Slovenian Ministry of Health ordered the elaboration of an analysis on the topic of Homelessness and Health. This article discusses a part of the results of this analysis¹.

Homelessness and the Health Care Issue

One of the most pressing problem themes, connected with homelessness, is the health care issue. It also presents one of the key challenges in the forming of a policy in the field of homelessness. Numerous research in this field (for example, Riley et al., 2003; Masson & Lester, 2003) reports on the relation between homelessness and the poor medical condition or on the worse medical condition of the homeless in comparison with the general population. At the same time, this research also testifies of the more serious disease patterns within the homeless group. The medical problems of the homeless are said to be, according to the findings of much of the foreign research (for example Carter et al., 1994, and Grumbach et al., 1993; both quoted by Savage et al., 2006), mostly of a chronic nature and not as urgent, which is why long-term care and nursing is more suitable for them than an urgent one.

According to the findings of numerous surveys there are three key medical problems that can be understood as causally connected with homelessness or with extreme social exclusion: mental illnesses (or in a broader sense, mental health problems), addiction to alcohol and addiction to illegal drugs. Various surveys thus find among the homeless, in addition to worse physical health, also a high level of mental health problems. Certain surveys records as much as 80 to 95 % of the homeless with mental health problems (Riley et al., 2003). Other authors report that mental health problems (often measured with a prevalence of former psychiatric hospitalisations or treatments in general) are present in 10 to 60 % of the entire homeless population and that 70 % of the homeless or more are addicted to different psychoactive substances (Scott, 1993; Savage

¹ More complete information on this analysis is available in the publication »Brezdomstvo, zdravje in dostopnost zdravstvenih storitev« (Razpotnik and Dekleva, 2009), where certain segments of this article are also published.

et al., 2006). All of the problems listed, of course, condition the creation of new ones and enable the deepening of the vicious circle of social exclusion, which in turn conditions also the exclusion from health care systems and the deepening of an unhealthy life style, thus only increasing the medical problems listed, as well as others. In addition to the three areas mentioned, within the field of homelessness/health care, infectious diseases (tuberculosis, certain liver diseases, sexually transmitted diseases) are also often discussed in professional articles, mostly from an epidemiological perspective, the risk of which increases in poor living conditions, such as that of the homeless.

Research on other threatening factors frequently connected with homelessness has shown that the issue of homelessness is often connected with childhood abuse (Mounier & Andujo, 2004) and with disfunctional families (Tyler, Cauce & Whitbeck, 2004). In Scotland, for instance, among the homeless youth there is a third of those who had spent their childhood living outside the family, in an institution or a foster family (Jones, 2003). Very often the issue of homelessness and the use of various substances and addiction is connected with increased medical risks and a risky sexual behaviour (especially among the young), which increases the risk for this population to become infected with the HIV virus (Bell et al., 2003). With the latter, prostitution is also connected (Gwadz et al., 2004).

Likewise, the issue of homelessness is also frequently specifically connected with the affiliation to subcultures (ethnic, cultural, regarding sexual orientation, or others) and disability (Whitbeck et al., 2004). The differences are naturally derived from the unequal position of different social groups within different societies, are connected with obstacles in the accessibility of important social sources and with the discrimination which one or the other subcultural group experiences in the (non)treatment within the health care system. The consequences of the above-mentioned characteristics are manifestly often shown as psychological peculiarities of individuals, which hinder them from establishing permanent and satisfying social relationships with others and indirectly also affect their life style, which brings health risks and worsens the accessibility of health care services.

The poor medical condition of the homeless is most often contributed by authors (for example Riley et al., 2003) to the

following factors:

- ◆ less suitable medical care,
- ◆ financial obstacles in the use of health care services,
- ◆ nonfinancial obstacles in the use of health care services, such as problems (psychological, relationship, social ...) deriving from mental health problems and/or addictions to psychoactive substances.

Masson and Lester (2003) add that much of the research confirms that the attitude of the medical staff towards the homeless creates important obstacles in the accessibility of the health care system to these people. It would be reasonable to add to this list at least one more item, namely, the health threatening life style of the homeless, which is represented by the absence of a safe residence or living in an unstable, insecure and dangerous environment, exposed to unpredictable weather and social influences. This is therefore more of a secondary consequence of the way of life itself than an independent factor.

The authors Turnbull, Muckle and Masters (2007) find that despite a higher level of different illnesses and diseases the homeless, often due to different reasons, do not use medical services or feel there is a lack of effective medical services for them. The lack of medical care which the population in discussion would feel and label as suitable is evident in the fact that the homeless visit medical institution less often than needed, resulting in their medical problems becoming accumulated, remaining untreated, often becoming old and consequently harder to solve. The lack of accessible medical care is also shown in an often mentioned phenomenon (for example Savage et al., 2006), that is, in the use of urgent help (emergency unit) as the source of basic or any kind of medical care. In other words, this means that from various reasons the homeless acquire medical care only when their medical condition is so poor that they are brought there by others or when in distress they come there themselves looking for urgent help. Many articles include contributions expressing the need for adapting the health care system, which is in many places directed towards stratification, to the most vulnerable part of the population, to which health care is the least accessible. This need is being realised across the world in the formation of proactive services accessible to the homeless and

incorporated into the community, whose workers do not wait for the homeless to start looking for their services themselves, but make the first step and come to the environment of those that need help. Such services ought to be founded on forms of work that are based on individualised, non-discriminatory paradigms, integrated in the living space. In Slovenia as well the appearance of dispensaries intended for citizens without health insurance has taken this path, however, the problem is that these dispensaries are not included in the public health care system.

When contemplating the attitude of the medical staff towards the homeless the results of the study by Masson and Lester (2003) from Great Britain deserve mention. The authors researched the attitude of medical students towards the homeless at the beginning of their study and at the end. The results have shown that within the five-year period of study the attitude of the students towards the homeless becomes worse, which mostly points to a need for programmes that educate medical workers to also include in their curriculum the issues of social exclusion, the equal treatment of all patients and the understanding of their peculiarities. Melvin (2004) reports that the homeless feel unwelcome in general medical practices, while many have also felt an unwanted, patronising attitude of the medical staff towards them.

Within the already threatened group of the homeless there can also be identified the particularly threatened groups and their specifics contemplated and discussed. As has already been said, many authors report on a high degree of mental illnesses among the homeless. Many believe that such widespread mental health problems among the homeless are a result of the disintegration of a system of institutions that were decades ago still intended for the long-term stay of people with mental health problems. Craig and Timms (1992) believe that the roots of the problem are much more complex than the mere deinstitutionalisation or breakdown of asylums. They are of the opinion that the increased extent of mental health problems among the homeless has been contributed to by the tendency towards the shortest and most intense treatments as possible, also in the events of serious, protracted and complex mental health problems. The need for medium-term and long-term care of such mental health problems and for (social) rehabilitation remains unsatisfied. And the homeless patients with mental health problems who would require a more lasting rehabilitation, and above

all continuous social care, are often designated as those that only "occupy the beds in today's often crowded health care system". The same authors (Ibid.) identify the main cause of the problems with the accessibility of suitable medical services for homeless people (with mental health problems) also in the lack of assertive field services. Melvin (2004) similarly finds that effective outreach work is recognised by many authors in the discipline today as the most successful form of engaging and including an otherwise hidden segment of users.

With the change of social circumstances the structure of the population, threatened with homelessness, changes as well, including its characteristics and needs. An always interesting and important view within this is, among other things, the age structure of the homeless population, since the group of younger homeless people has different needs than the group of older ones, while the needs of both are connected with the physical health of the individual and the sociological characteristics of an individual generation. A survey performed in the USA (Garibaldi, Conde-Martel & O'Toole, 2005) dealt precisely with the comparison of the medical condition and the unsatisfied medical needs between the groups of younger and older homeless persons. The researchers included persons aged from 18 to 49 in the younger group, and persons aged 50 and above in the older group. They discussed the researched topics with the homeless in interviews. The need for medical care ranked second among the most urgent needs within the older group, right after the need for housing support. The older group reported 3.6-times more often chronic diseases, the older ones had arranged health insurance 2.8-times more often than the younger group and were addicted to heroin 2.4-times more often than the group under the age of 50 (this finding is unusual from the Slovenian viewpoint and is probably connected with the fact that the tradition of the use of heroin is much longer in the USA than in Slovenia). Those over 50 also used medical care intended especially for the homeless more often than the younger group, for instance shelter-based clinics and street outreach work. However, the older homeless persons reported rarely on the need for treating addiction with different substances (despite a greater degree of substance abuse among them).

The study by Crane and Warnes (2001) has confirmed that people with combined problems, double diagnoses or the coexistence

of problems with alcohol abuse and other drugs are particularly problematic from the point of view of the accessibility of health care services. This study has also determined that services which would fully take care of this segment of the users, that is, people with combined problems, or that would assume responsibility for them are either nonexistent or too few. Providing the users with combined problems integral care in one place would, due to their way of life, marked precisely by their lack of looking for various clinics or using their services, be of key importance.

Purpose of the Research and the Methodology Used

The purpose of the aforementioned analysis was to study the basic area of the medical needs of the homeless, their experiences with the health care system and their impression of the system, including the accessibility of the system, the level of their trust in this system and the experience of the attitude of the system towards them. This contribution reports only on the experiences of the accessibility of the health care system among the Slovenian homeless and on which – as regards the accessibility of the health care system – the especially threatened groups of the homeless are.

The data has been obtained with individual field surveys of 122 homeless persons from six Slovenian towns. In Ljubljana the search for respondents was carried out in different locations, among which often on the streets, while in the five smaller towns only in the local homeless shelters. Our definition of homelessness which was read in the beginning to the persons surveyed goes as follows:

You are homeless if you sleep outside, in basements, vestibules, bases, temporary sanctuaries, shelters or other temporary housings intended for the homeless, in housing groups for the homeless; if day to day you do not have a guaranteed roof over your head or a home of your own and have nowhere to go even if you are facing eviction.

The interviewers were specially trained persons with plenty of past experience in field work with the homeless.

In addition to demographic questions and many questions on the various aspects of the medical condition, the survey also included

another 40 questions on the experience with the accessibility of the health care system.

Results of the Analysis

The experiences with the health care system and its own treatment within it was determined with the use of two scales or item groups. The first (Table 1) was comprised of eight statements on the topic of the accessibility of medical help, information, the possibilities of participation and respectful treatment. This set was named in short »integral evaluation of the quality of medical treatment«. The respondents could choose within every item among five answers ranging from »not true at all« to »very true«. Table 1 shows the percentage of answers expressing disagreement with the claims and therefore an explicitly negative experience of the health care system. The respondents with such an experience of the system ranged from 11.6 to 26.9 %. It could be concluded in a simplified way that approximately a fifth of the respondents evaluates the possibilities of the accessibility of medical help, the possibilities of participation and of respectful treatment within it as poor.

Table 1: Percentages of the respondents in disagreement with individual claims of the scale of experiences with the health care system

Claim referring to the experiences with the health care system	% of those who replied »not true at all« or »not true«
Medical help is accessible enough when I need it.	11.6
The questions that I had posed to the medical staff were answered in an understandable way.	15.0
Before the beginning of treatment, the process of the treatment and the risks connected with the treatment were clearly explained to me.	23.1
I always participated in the decisions regarding my treatment whenever I wanted to.	26.7
I was treated with dignity and respect.	26.9
I was ensured privacy during talks and the performing of procedures.	15.1
I was acquainted with the rights and obligations as a patient.	16.7
I evaluate the treatment I received as good.	25.8

The second scale was comprised of 23 claims, with a two-level option of answering, YES or NO. This scale (Table 2) contains more specific and concrete views of (mostly) negative characteristics of the operation of the health care system, again from the point of view of the persons treated within it, the accessibility, adaptation and attitude of the medical staff. It has been named »obstacles in the accessibility of medical services«. This term, of course, includes both the objective and the subjective aspects, in addition to the awareness of the fact that this is a process which is realised with the cooperation between users and individual segments of the health care system. The percentages of the critical respondents vary in the case of individual items from 15 to 70 %, with approximately 45 % on average. Some of the items may not have much to do with the health care system directly (for example *I have problems with transportation to the place of help* or *The location of the institution is unsuitable for me*); others are of a sort of subjective nature (for example *I do not know how to seek help*); the third could be called systematic (for example *The entry waiting line is too long*); while the fourth allegedly reflect both the conduct of the staff as well as the experiences of the users, most likely precisely in connection with the special characteristics of the homeless (for example *I feel discriminated in the medical institution*). Three of the claims express a positive evaluation, while the remaining 19 express a negative one (if the respondents agree with them). Viewed on the whole, a majority of the viewpoints that the scale inquires about is perceived negatively by between 30 and 50 % of the users, which is most certainly worrisome.

Table 2: Percentage of the respondents in disagreement with individual claims of the scale of experiences with the health care system

Claim referring to the experiences with the health care system	% of those who agree with this claim
The health care workers are not kind or friendly.	37.8
The health care workers do not properly understand my needs, problems ...	50.8
The health care workers assess and judge me too much.	37.8
I have problems with transportation to the place of help	32.5
I do not have the necessary documents to enter a programme (for example health insurance).	31.1
The location of the institution is unsuitable for me (hard to access ...).	16.8
I do not know how to seek help.	15.3
I feel discriminated in the medical institution.	33.3
I have bad experiences with experts/I do not trust them.	34.5
The entry waiting line is too long	69.7
The time for a checkup/conversation is limited.	65.5
Medical institutions cannot help me.	21.3
Medical services are too expensive.	63.6
The atmosphere in medical institutions is too chaotic.	55.5
The employees do not possess enough knowledge to work with the homeless.	58.5
The expectations and demands of the medical institutions are too great (for example abstinence).	55.1
No confidentiality.	42.0
The programmes are not adapted enough to special groups (for example the homeless, users of illicit drugs ...).	61.9
Limited working hours of the services.	65.5
I have the option of filing a complaint against the medical services I have received.	66.1
The preparation period for the inclusion into a treatment programme that I need is too long.	56.4
I am satisfied with the attitude of the doctors towards me.	63.2
I am satisfied with the attitude of other health care workers (nurses, technicians ...) towards me	67.8

A few separate questions also inquired about the specific (critical) aspects of treatment within health care. Two of these questions explicitly inquired about the experience of discrimination, namely, one question asked about an experience regarding the homeless status, and the other regarding the status of a drug user. Answers

in Table 3 show that both statuses are largely connected with discrimination in the experiences of the users, and in a far greater degree with the status of the drug user than with the homeless one. A certain not negligible portion of the respondents was of the opinion that they had been discriminated positively, however, there were approximately four times less of them than of those who had experienced negative discrimination.

Table 3: Answers of respondents (in percents) to two questions on discrimination, connected with two stigmatised statuses (the answers to both similarly set questions shown separately in two columns).

Have you ever had the feeling of being treated differently in medical institutions because you are homeless/a drug user?	To whom or what does the question refer?	Refers to the homeless status	Refers to the status of drug user (N = 44)
Yes, in a negative sense (stigmatisation, isolation, avoidance, insults ...).		33.9	50.0
Yes, in a positive sense (special privileges, extra attention of the medical staff and social service ...).		8.3	11.4
I did not have a feeling of being treated differently because I am homeless/a drug user.		36.4	13.6
In my opinion the medical staff did not know I was homeless/a drug user.		14.0	9.1

After reviewing the distribution of answers to the questions on the accessibility of the health care system we tackled the question of whether there are any systematic differences in the perception of the health care system between individual groups of homeless persons.

Two key indicators of the experiencing of the health care system have been chosen, namely:

- on the basis of the set of questions shown in Table 1 a composite variable has been formed, called »integral evaluation of the quality of medical treatment«. The scale has proved to be very reliable (Cronbach alfa amounted to 0.91), which is why this indicator was formed by adding up the values of the answers to all eight questions:
- on the basis of the set of questions shown in Table 2 a second composite variable has been formed, called »obstacles in the accessibility of medical services«. In the case of this scale as

well a high Cronbach alfa (0.87) was reached, which is why we have added up the values of the answers to all the 23 questions in the scale.

Table 4 shows the correlations between 18 independent variables (characteristics of the subgroups of the homeless persons) and between these two criterion indicators. In the cells of the table the degree of statistical importance has been entered (where the difference between groups was statistically important on the level of at least 0.100) and a description of the relation between the independent and criterion variable. If this relation was not statistically important the appropriate cell only contains the dash mark (–). Seen on an example: in the cell defined by the fourth row and second column, the value of 0,000 is written, which indicates that the groups of homeless persons, which differ according to the age at which they had experienced their first period of homelessness, differ greatly as regards their average integral evaluation of the quality of medical treatment, namely so that the higher age of the first homelessness is connected with a higher evaluation of the integral evaluation of the quality of medical treatment.

Table 4: Relation between 18 independent variables and two criterion indicators of the experiences with the health care system. Each cells contains the statistical probability of error (if smaller than 0.10; ANOVA) and a description of the direction of the correlation (if it is statistically significant).

Characteristics of subgroups of the homeless	Integral evaluation of the quality of medical treatment	Obstacles in the accessibility of medical services
Gender	–	–
Age	–	–
Higher education	0.096 A higher evaluation of quality.	–
Higher age of first homelessness	0.000 A higher evaluation of quality.	0.003 Experiences less obstacles.
Total duration/state of homelessness	–	–
Visited a doctor in the past year.	–	–
Resided in a youth home.	0.031 A lower evaluation of quality.	0.031 Experiences greater obstacles.
Spent time in prison.	–	0.009 Experiences greater obstacles.

Continuation of table 4:

Higher social support	0.027 A higher evaluation of quality.	0.013 Experiences less obstacles.
Addiction to alcohol (by their own evaluation)	0.001 A lower evaluation of quality.	0.002 Experiences greater obstacles.
Higher result on the AUDIT scale (harmful drinking of alcohol)	0.000 A lower evaluation of quality.	0.000 Experiences greater obstacles.
addiction to drugs (by their own evaluation)	0.003 A lower evaluation of quality.	0.075 Experiences greater obstacles.
Has tried heroin.	0.009 A lower evaluation of quality.	0.041 Experiences greater obstacles.
Resided in a unit for treating addiction.	0.075 A lower evaluation of quality.	0.086 Experiences greater obstacles.
Higher number of signs of mental problems/psychiatric treatment	0.000 A lower evaluation of quality.	0.001 Experiences greater obstacles.
Resided in a psychiatric hospital.	0.003 A lower evaluation of quality.	0.020 Experiences greater obstacles.
Has in addition to mental problems (at least one sign of four) at least one more diagnosed addiction (either to alcohol or to illegal drugs).	0.000 A lower evaluation of quality.	0.000 Experiences greater obstacles.

The results in Table 4 can be briefly (and in a simplified manner) summed up as follows: the more of the different threatening factors a subgroup of homeless persons has, the worse it evaluates the quality of the health care system, the more obstacles it experiences in the use of it and the harder accessible it seems.

If we analyse Table 4 in greater detail, we see that:

- persons who had experienced the first period of homelessness earlier in life evaluate the health care system as worse and experience it as less accessible. This result can be interpreted in at least three ways. The first being that perhaps those who had first become homeless in a lower age are more often users of illicit drugs, while those who had first become homeless when older are users of licit drugs or nonusers. The obtained result can be explained with the supposition that the health care system is less inclined towards the users of illicit drugs or is not adapted enough to them. The other possible explanation is that the

homeless who had become such later in life have a longer period of experience with conventional life and were socialised in a way that also implies a greater acceptance of a (conventional) health care system. The third explanation could be that in the case of the homeless who had become such earlier in life there are several types of the threatening and disadvantageous bio- and psychosocial factors present and more of them, giving them more characteristics today, which means that the health care system accepts them with greater difficulty, and is at the same time harder to access;

- persons who had already resided in a youth home, an treatment establishment or prison evaluate the health care system as worse and experience it as less accessible. Residing in one of the mentioned institutions also indicates the existence of several types of the threatening and disadvantageous bio- and psychosocial factors present and more of them, which are obviously connected with worser accessibility of the health care system;
- persons with worse social support networks evaluate the health care system as worse and experience it as less accessible. The problem here is that the formal networks (among which belongs the health care one) could – ideally – compensate for the worse developed and active informal social networks, however, our data does not point to such an effect;
- persons who are addicted to alcohol and use it in more harmful ways evaluate the health care system as worse and experience it as less accessible;
- persons who are addicted to illicit drugs and use them in more harmful ways evaluate the health care system as worse and experience it as less accessible;
- persons who show several signs of mental health problems or have already been psychiatrically hospitalised evaluate the health care system as worse and experience it as less accessible;
- persons with the so-called double diagnoses, comorbidity or a simultaneous presence of addiction and certain other mental problems/illnesses particularly obviously (statistically significantly) evaluate the health care system as worse and experience it as less accessible.

Conclusions

The basic finding of the analysis is that the health care system is less accessible and of lesser quality for those homeless persons who are by themselves more at risk, more burdened with disadvantageous factors, with a worse medical condition (here mostly mental problems and addictions were checked), with an otherwise worse psychosocial support and less (positive) experiences with conventional life and would therefore need a better, increased and easier accessibility of the system. Such a result is in accordance with most of the research in this field.

For the successful use and operation of the health care system there is hence a multitude of social and individual suppositions for which we assume are realised for all users, however, it has turned out that in the case of the homeless this is often (or even as a rule) not valid. The reflection on the medical treatment (or on the handling of the health care issue) of the homeless people must therefore include more than just a reflection on the »treatment« in the narrow sense of the word, that is, more than just offering relatively narrowly defined health care services. Thus it is not enough to offer professionally suitable procedures of diagnosis and treatment, but it must be actively (actually »proactively«) reflected on how the homeless will understand and use the medical options and offers, and then, naturally, take action in accordance with the actual living situation of the homeless. Our survey has shown (as had much of the other quoted surveys) that in this case the persons particularly at risk are the ones with the so-called double diagnoses or combined problems or that these persons should be offered special care.

In literature several models of proactive and special, specific health care for the homeless are often mentioned. In Slovenia a model of a »social dispensary« has been developed, which on its own already sets certain eliminating entry criteria (the use of illicit drugs!). The key recommendations deriving from our analysis show the need for:

- lowering the threshold for entry into the health and dental care system;
- integral treatment or at least the integral acceptance of an

individual within a single (medical) organisation (nonstigmatising and nondiscriminatory treatment);

- a more individualised help and one adapted to the individual; in particular the specific groups of the homeless ought to be emphasised (the young homeless, users of illicit drugs, individuals with double diagnoses, the elderly, the infirm and invalid homeless);
- developing models of outreach work with the purpose of reaching the hidden subgroups of the homeless and placing such work within the public health and social security.

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