

# COMPARING HEALTH CONDITIONS OF HOMELESS CLIENTS IN BUDAPEST DAY-CARE CENTRES

\*Aranka Kovács<sup>1</sup>, Gabriella Csépanyi<sup>2</sup>, Sarolta Kurucz<sup>2</sup>

<sup>1</sup>Semmelweis Egyetem Egészségtudományi Kar Egészségfejlesztési és Klinikai Módszertani Intézet  
Epidemiológiai Tanszék Budapest

Head of the Department: Dr. Domján Gyula CSs

<sup>2</sup>Diótörés Alapítvány, Budapest

Head: Gabriella Csépanyi

## Summary

**Aim.** Diótörés Foundation has carried out a complex health condition study among 100 volunteering homeless people – part of the program supported by The Norwegian Found - which aimed at getting correct diagnosis and proper health care services for the clients. Furthermore, we have targeted at estimating the possibilities for helping clients to integrate into society. Given that most of our clients rely on services of various day-care institutions in Budapest, in this paper we have examined whether clients from different institutions have problems of different kinds.

**Method.** Well-prepared interviewers have questioned the clients on health and social topics, took family anamneses, anthropological data (e.g., BMI, waist circumference), measured blood pressure and took blood samples of clients in order to screen liver enzymes and kidney function, ions, Hepatitis C and HIV infection. The data have been processed with the use of computer.

**Results.** Earlier undiagnosed diseases have been screened among 46% of the examined clients. Clients from different shelters, differ in various aspects such as age, family anamnesis, and health hazardous attitudes. At the same time, well-distinguished differences have been found in the clients' health condition. Unexpectedly, the youngest group of clients – who come from own institute – have not been found the healthiest one. In many cases, dual or triple diagnoses could be found.

**Conclusion.** There may exist differences of clients' lifecycles, diseases and problems found even among institutions with similar services or social profile. Providing these clients with health services in conventional health care institutions has been considered impossible for mutual intolerance. One of the possible solutions is that the involved social institutions could provide or have direct access to specialists of medical fields such as psychiatry and infectology or hepatology so that they could be more easily available to the clients.

---

Key words: homeless shelters, dual diagnosis, Hepatitis C, toxic liver, drug user, health condition of homeless people

---

## INTRODUCTION

Diótörés Foundation, as the leading partner, together with the Chief Medical Office of State and the Hungarian Prison Service Headquarters, formed a consortium which submitted a grant application to the Norwegian Found for the sources of the “EEA and Norwegian Financial Mechanism” in order to provide and finance public health services. One activity of the program, which came to its end in October 2010, was to examine a group of 100 volunteering homeless people for their complex health condition. The fact that over 120 people took part in screenings justifies that initiating the program was right, and the team also plans to continue it due to the immense interest.

The primary goal of Diótörés is to work with the young homeless people. The majority of our young clients have grown up in state orphanages. They often become our clients when passing the age of 18 after leaving the orphanage. There is a great number of drug addicts among them as well as individuals suffer-

ing from mental diseases. Clients have very often been found with dual – psychiatric and addiction – diagnoses with inadequate anamneses, and it is often impossible to prove which problem preceded the other: the psychiatric or the addictive symptoms. The majority of patients also suffer from internal diseases, however they get neither checked up nor looked after due to the intolerance of the health care system and their own behaviour.

Health conditions, special health care and social needs of the patients described above have been examined in our project. These clients often appear in the world of crime, drugs and prostitution, often as victims and due to their appalling social conditions they are exposed to other infectious diseases. That is why enhancing the screening with special screening for a few infectious diseases such as Hepatitis C or HIV was also found important in this project. Our main aim was to provide the clients with accurate diagnosis and proper health care, in other words, to find needs and opportuni-

ties, which help to improve our clients' health conditions and to assist their integration into society. Our clients were considered as being in a special situation from the point of view of homeless services, therefore it was found important to recruit volunteering homeless people from other institutions with similar profile as well.

## METHOD

We have addressed a number of institutions providing services for the homeless in Budapest, mainly day care centres, and finally the following three of them decided to take part in our program:

1. Day and Warming Shelter (7 Szabolcs Str., 1134 Budapest);
2. Protection Caritative Association (9 Dankó Str. 1086 Bp.);
3. Clean Spring Foundation (373 Üllői Str. 1181 Bp.).

We interviewed the clients on venue and/or we invited them to Diótörés ambulance service centre and offered them an abundant breakfast. We took clients' blood pressure and blood samples and registered anthropological data before breakfast. When taking blood samples, we screened the samples for Hepatitis C and HIV as well, besides the normal routine laboratory tests (consisting of blood count and liver enzymes, kidney function and ions). During the interview, we asked the patients about their personal and family health history and anamnesis in different ways. During the first interview and also when evaluating the results (second meeting), we offered the patients in need to find the most suitable health care services for them upon request.

The data were processed with the use of Excel software. The number of examined individuals amounted for 120, the youngest person was 17 and the oldest one was 64 years old among them. Age distribution was almost thoroughly even, while the sex ratio shifted significantly towards male patients; i.e. only 10 women participated in the program. It also has to be noted, that more than the half of the patients were born in Budapest.

Besides the regular diseases to be screened such as common cardiovascular diseases, were also screened for hepatitis C and HIV. Apart from these, after having looked at the findings we found a certain group of dis-

eases to be notable. For instance, these were the cases when the number of red blood cells and SeFe significantly differ, so manifested iron deficiency anaemia could be detected among the clients. In other cases the number of white blood cells indicated the infection in progress. Thirdly, the rise of the liver enzymes indicates liver diseases. We considered all diseases, which patients had not mentioned earlier or had been unaware of, even when asked as the result of screening.

Table 1 shows the diseases found in this a way in 46% of the clients screened by the method described above:

Social workers accompanied clients (both with newly diagnosed and previously known diseases) to obtain proper health services not available at Diótörés, but only at other institutions. Another way of assistance was to book appointments on the phone for the clients.

Our experience can be summed up as follows: 80% of the participants had problem finding a physician when becoming aware of their illnesses. Our screening program needed at least two meetings and the high number of patients returning for the findings (67%) proves that they do request care from the curative health care system, or need someone to look after their health condition. At the same time, in cases when special therapy was needed to proceed with the examination or to provide treatment for our clients, we had to face serious obstacles on the contrary of our assistance. Conflicts occurred between the health care institutions and the clients with hepatitis C (we didn't have HIV patients) when the institutions were not specialised in providing their services also for the homeless. Only the continuous presence of the social worker could alleviate the conflict, which is not an easy thing when a time consuming (months long) treatment has to be carried out.

In this paper, we aim to highlight the differences among the institutions with the noticing also that the differences proved to be harsher than expected.

## RESULTS

The age of the surveyed clients was not considered typical, as the youngest person was 17 the oldest one was 64 years old. The age distribution was even be-

Table 1. Newly found diseases and their proportion.

| Disease (group)        | Nr. of clients with newly found disease | % of clients with newly found disease | % of all the screened clients |
|------------------------|---|---------------------------------------|-------------------------------|
| Anaemia                | 10                                      | 18                                    | 8                             |
| Inflammatory focus     | 12                                      | 22                                    | 10                            |
| Cardiovascular disease | 12                                      | 22                                    | 10                            |
| Toxic liver disease    | 9                                       | 16                                    | 7.5                           |
| Hepatitis C            | 9                                       | 16                                    | 7.5                           |
| Other                  | 3                                       | 5                                     | 2.5                           |

tween the two age limits. The average age of clients was 41 (dispersion = 13), which is insignificantly different from an imaginary case when one person might belong to each year between 16 and 64 years (average age would be 40.5 years and the dispersion would be 14). As for the recruiting institution, a significant difference was found in age, as well. The youngest age group was represented at Diótörés, and the two older relatively homogenous age groups, were no. 1 and 2. No. 3 client group could not be defined by age so clearly, as both the average age and the distribution come near to the summed data. It can be stated that the various institutions take care of different age groups of clients, and the clients belonging to a certain age group can be considered as typical of an institution (table 2).

It is not surprising that the number of homeless women is much lower than that of homeless men, for some reason; however, their number is significantly higher in Diótörés and number 1 institution. As it could be expected, being raised in a foster family occurred more often among homeless people than in the average population,

since the family plays a significant role in establishing a home. This is consistent with the fact that the representation of clients with anamneses of mental illnesses, suicidal attempt or drug use has been found rather high among the clients of Diótörés, while the traditional legal abuse - drinking alcohol - was typical of the no. 1 and no. 3 recruiting institutions and in the institution no. 1 it was significantly higher than drug abuse.

As for the clients' birthplace, the vast majority were born in the capital - as expected; because only institutions in Budapest were only involved in the program. Moving from one settlement to another is rather untypical in the Hungarian society, and it is even more untypical among disadvantaged groups. A greater number of clients were born in the country at the Diótörés comparing to the average and clients born in Budapest were overrepresented in no. 3 institution. Behind attitudes deviating from conventional lifestyles (homelessness), data referring to mental disturbances can often be found in the anamneses, and their number was found remarkably high among the clients of Diótörés.

Table 2. Comparison by recruiting institutions.

| Aspects   | Diótörés | No. 1 Szabolcs Str. | No. 2 Dankó Str. | No. 3 Üllői Str. | Total    |
|---|----------|---------------------|------------------|------------------|----------|
| Average age/dispersion (year)                                       | 26/6.2   | 48/7.6              | 50/8.2           | 46/12            | 41/13    |
| Female/male distribution (%)  | 14/86    | 15/85               | 3/97             | 0/100            | 8/92     |
| Venue of childhood institution/<br>/foster parents/own family (%)   | 51/29/20 | 4/31/65             | 13/23/64         | 13/0/87          | 23/21/56 |
| Places of birth capital/country (%)                                 | 43/57    | 50/50               | 42/58            | 67/34            | 48/52    |
| Health/illness awareness (%)  | 26/74    | 34/67               | 55/45            | 71/29            | 38/62    |
| Mental disease and/or suicidal<br>attempt in anamnesis (yes/no) (%) | 69/31    | 19/81               | 35/65            | 21/79            | 38/62    |
| Consumption of alcohol on regular<br>basis (%)                      | 41/59    | 46/54               | 66/34            | 83/17            | 58/42    |
| Consumption of drugs (%)  | 50/50    | 12/88               | 6/94             | 13/87            | 21/79    |

Table 3. Comparison of recruiting institutions by newly found diseases.

| Screened diseases<br>(groups of diseases) | Diótörés | No. 1 Szabolcs Str. | No. 2 Dankó Str. | No. 3 Üllői Str. | Total  |
|---|----------|---------------------|------------------|------------------|--------|
| Hepatitis C (person/%)                    | 2/22     | 4/44                | 3/33             | 0/0              | 9/100  |
| Toxic liver disease (person/%)            | 3/33     | 5/56                | 1/11             | 0/0              | 9/100  |
| Anaemia (person/%)                        | 1/11     | 5/56                | 3/33             | 0/0              | 9/100  |
| Inflammatory focus (person/%)             | 2/17     | 2/17                | 4/25             | 4/25             | 12/100 |
| Cardiovascular disease (person/%)         | 2/17     | 3                   | 5/42             | 2/17             | 12/100 |
| other (person/%)                          | 1/33     | 1/33                | 1/33             | 0/0              | 3/100  |
| Sum (person/%)                            | 11/21    | 19/35               | 16/30            | 6/11             | 54/100 |

Basing on the data presented above it can be stated that the no.1 group is the most vulnerable to diseases and the group no. 3 is the least vulnerable one. The occurrence of toxic liver diseases could be most expected among the members of the group no. 3, still the members of the group no. 2 suffer from it the most. At the same time – contrary to their young age – this type of disease can be observed among the clients of Diótörés as well. As summed up in Table 2, the number of psychiatric diseases with accompanying addictive symptoms is rather high among the clients at Diótörés, and it can also be observed that there are many patients suffering from internal illnesses at the same time. Summing up, dual or even triple diagnoses may as well occur in this group (table 3).

The occurrence of Hepatitis C, toxic liver diseases (of unknown origin, iron deficiency, bleeding, etc.), and anaemia is rather high in the first group. It has also to be stated that drug abuse, prostitution or at least relationship with prostitution can be found in the background of the exploration of Hepatitis C infections.

## CONCLUSIONS

Homeless population cannot be considered as homogenous and various institutions have to provide different social and healthcare services for homeless people struggling with different problems on different levels.

People with similar life circumstances seem to be drawn to the same institution when choosing and getting admitted to an institution. However the severity of their problems deriving from their age, previous medico-social background and their present health condition, cause their burden of disease to be of different scale even in the institutions of de same profile.

Homeless people also have needs such as taking care of their health and receiving suitable treatment, however institutions take care of needs in different ways, both quantitatively and qualitatively. Homeless people whose diseases cannot be treated by the GP and would need further medical competencies to get better, will probably not be able to rely on institutions providing health services for the average population. A solution to their problem could be to connect the healthcare services more intensively to social institutions, or to give a direct access to the healthcare services to the workers of the social net. Providing home-

less with suitable services needs to be structured in various levels: the client who is able to lead their own lives should be leaded for the social institutions but those who are unable to do so should be first offered human circumstances of life. Providing them with complex services is of utmost importance, though. Psychiatric, hepatologic (primarily hepatitis) and infectologic strengthening of the health care background in social institutions would also be very important. Society can defend itself against the infectious diseases and deviant behaviour of the homeless by providing them with care which would serve not only their own but the society's interest as well.

We must be aware that although homeless care falls into a given – not medical but social – institutional category, the routes leading to it are different, depending strongly on different kinds severity. The institutions taking part in their care attract people with fates of different categories so their needs for healthcare will be different as well. The patterns of financing either social or health care constitute a problem for our Norwegian partner (Tyrili Fundation) as well, since their clients are also young, coming in most cases from orphanages and often struggling with addiction or other psychiatric diseases.

They would also need health and social services, but treating a person's troubles is financed through a particular institution, which is obviously not equipped with such complex resources. As a conclusion, consensus on dividing tasks between the social and health professions in order to improve the service profiles of the institutions will serve the interest of both the clients and the institutions. □

## References

1. <http://wellnesstipp.fw.hu>: A Népszabadság számára végzett omnibusz felmérés eredményei MASMI Hungary Piackutató Intézet, 2007. január 4. – Results of the Omnibus survey made for the Népszabadság, MASMI Hungary Market Research Institution. 4 Jan. 2007.
2. <http://www.szinapszis.hu/hirek/49>: Gyerekcipőben jár a magyar egészség tudatosság – Hungarian Health Awareness still in its infancy, Synopsys Ltd.
3. <http://egeszsegertek.blog.hu/api/trackback/id/1983789>: A magyar egészség tudat számokban 2010.05.08 – Health Awareness in Hungary in numbers.
4. Buda B: A lélek egészsége A mentálhigiéna alapkérdései Nemzeti Tankönyvkiadó 2003; Buda B, The soul's health, the basic questions of mental hygiene, national Textbook Publisher, 2003.
5. Buda B, Kopp M: Magatartástudományok, Medicina 2001; Buda B, Kopp M, Sciences For Behaviour, Medicina, 2001.

Received: 18.07.2011  
Accepted: 22.08.2011

Correspondence to:  
\*Aranka Kovács

Semmelweis University Faculty of Health Sciences  
Institute of Health Promotion and Clinical Methodology  
Department of Epidemiology Budapest  
tel.: 0036-30-318-57-60, fax:(0036-1-210-9831)  
e-mail: goldie19@t-online.hu