# Health, health promotion, and homelessness

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Contemporary health promotion emphasises the concepts of lifestyle, risk, and preventive health behaviour alongside the broader societal concerns of the environment, public policy, and culture.[1] The recent green paper *Our Healthier Nation* stresses a more coordinated approach to health promotion for people who are socially excluded, emphasising behavioural change through targeted interventions at the level of the community.[2] There have been extensive reviews of homelessness and health,[3 4] along with calls for urgent action,[5–7] but little attention has been paid to the health promotion needs of homeless people, and there is no firm evidence base for practice. One challenge for health promotion is to develop and deliver appropriate initiatives to a heterogeneous population that is not always easy to categorise but has a wide range of needs. The healthcare priorities of a young man sleeping on the streets differ from those of a single mother in temporary accommodation. To be homeless means more than just the absence of secure accommodation. Homelessness has as much to do with social exclusion as with bricks and mortar, and demands a range of health promotion strategies.

## Summary points

- Homeless people are a heterogeneous population whose diverse health promotion needs are poorly met
- Needs assessment and qualitative research are required to identify the specific health promotion needs of subgroups of homeless people
- Action research followed by rigorous process and outcome evaluation are needed to provide an evidence base that can inform good practice
- A multisectoral approach to health promotion would capitalise on help seeking patterns of homeless people
- Health promotion among homeless people should be practical and educative, taking into account their hierarchy of needs and specific housing environments

## Health and housing

At one level, the health condition of homeless people is a product of housing policy.[3] Over the past two decades in Britain, the shift from subsidised public renting to subsidised owner occupation has reduced the social role of housing and has pushed health issues down the housing agenda. Furthermore, evidence suggests that people with health problems are losing their accommodation and becoming homeless.[3 8] Although rehousing can secure considerable improvements in mental health,[9] the selective sale of public housing and the decline in quality of the remaining housing stock have meant that any benefits of priority access to public housing are being counterbalanced by its contribution to the development of illness and disease.[10] Additionally, poor health now competes with a range of other priorities and no longer guarantees access to public rented housing.[11]

Homeless people find themselves in a range of inadequate housing, characterised by poor location, condition, and quality—all of which are correlates of mental and physical health problems.[10 11] In crude terms, the health status of homeless people is extremely poor when compared with that of the general population.[4] This is true for diet and malnutrition[12]; substance misuse, mental illness, and sexual health problems[4 13–15]; infectious diseases (such as tuberculosis and hepatitis)[3 4 16]; and other physical problems related to living conditions and lifestyles, ranging from cardiovascular disease to accident and hypothermia.[3 4 16]

However, the link between health problems and homelessness is neither unidirectional nor one dimensional, as evidenced in the case of mental illness.[17 18] High levels of stress among homeless people, for example, have been connected with stigmatisation and stereotyping.[19]

## Accessing health care

Homeless people are more likely than others to present with a disease rather than at prevention or screening stages, and often use accident and emergency departments for their healthcare needs.[4 20] As a consequence, they are often missed by primary care health promotion initiatives.[21 22]

Health provision targeted at homeless people includes health visitors, link workers, health advocates, and sessional workers such as general practitioners and community nurses, who have provided outreach care in hostels and day centres. One review examined

35 targeted schemes, all of which had a dual aim of providing direct services to homeless people and promoting integration into mainstream health services. The research concluded that while managers commonly felt they had been very successful in the former, few could claim equal success in the latter.[23]

Given these findings, health promotion should be developed in the context of the ways in which homeless people seek health care. This may involve considerable adaptation of, or indeed a move away from, traditional patterns of provision such as primary care services based in the general practice.

## Health promotion

Most interventions aimed at homeless people have focused on disease prevention and are largely unpublished. These include vaccination programmes, mobile screening clinics, and the distribution of condoms. Interventions have also tended to concentrate on young homeless people living on the streets or in hostels. Groups such as elderly people and families living in temporary accommodation have largely been ignored. Agencies for homeless people are often preoccupied with crisis management, so the long term health of their clients is not always a priority. Indeed, health may not be a priority for homeless people themselves—basic survival needs such as food, drink, and warmth may concern them more than the possibility of future illness.[15] One useful intervention might simply be to tell a homeless person where the nearest shelter or soup kitchen is.

Health promotion should also provide practical help such as sunhats, sunblock, clean socks, and washing facilities. At the same time, information can be given about how to avoid sunstroke (and hypothermia) and how to care for feet and general hygiene.

Despite the dearth of published reports, there are examples of what health promoters deem good practice. These include national campaigns tailored to local needs, health fairs and other community based health promotion events, and outreach initiatives targeting homeless people. Approaches through peer intervention, focusing on counselling and befriending, have also been adopted.[24] Several specialist posts have been established to provide expertise in health care and homelessness, and have been successful in reaching people who are not usually in contact with established services, such as young homeless people and commercial sex workers.[25] Voluntary organisations have worked on building partnerships with business and in funding specialist alcohol and drugs workers to work directly with homeless people.[26] Education materials, particularly those focusing on HIV and AIDS information for young people, have been aimed at homeless groups.[27] Health promoters have also stressed the importance of practical assistance. Educating people about dental health may be pointless if they do not have a toothbrush, and attention to hygiene may not always be possible for those sleeping rough. Simple, practical assistance may sometimes be the most appropriate form of health promotion.[28] Health promotion initiatives need to dovetail with immediate and practical aid. For example, homeless heroin users may be more amenable to general health promotion initiatives once they are in receipt of a methadone prescription.

**Barriers to health promotion among homeless people**

- Workers with homeless people are often isolated—there is little coordination or collaboration between health promotion agencies
- Health promotion departments rarely set up initiatives aimed specifically at homelessness and housing
- Homeless people can feel alienated from health promotion materials,[25] as these often require high levels of literacy[28]
- Although homeless people are concerned about health related problems, low self esteem and low expectations prevent them from engaging with health promotion activities[21 30]

Published reports of health promotion aimed at homeless people record only limited success.[29] Rigorous evaluation studies are needed urgently. The literature, largely unpublished, points to a number of barriers to successful health promotion among homeless people, and these are shown in the box.

## Delivering health promotion

Any health promotion activity should be preceded by an assessment of health needs describing the target population and setting.[31] This will not only help identify need but will assist in planning and developing the intervention according to the profile of the target group and its social networks and venues.

The diversity of subgroups of homeless people is apparent. In parallel with general health promotion campaigns, targeted interventions can focus on the particular needs of homeless groups such as those sleeping rough, single mothers, and young people. Qualitative research should be conducted to identify the key health promotion needs of different homeless groups. Mapping of social networks and the involvement of homeless people in formative evaluations will identify the venues and best means of delivering health promotion. RP is currently conducting a study into the feasibility of using vendors of the *Big Issue* newspaper as health promoting peer educators. Other fruitful lines of inquiry might include using some canteen workers in hostels and day centres as health advocates in relation to nutrition. Any innovative approaches

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need careful monitoring and evaluation. However, they have the potential to empower the peer educators, add to the social capital of marginalised homeless people, and build on existing informal strategies for coping.

The multiple needs of homeless people drive them into contact with a wide range of agencies. The response of individual agencies is often focused narrowly, driven by crisis, and short term. Yet the diversity of this multiagency contact presents a real opportunity for intersectoral health promotion. These agencies could coordinate health promotion activities with assistance from local health promotion specialists. New primary care groups may provide an ideal forum for developing strategies, backed by resources from local health improvement plans. Housing services may well be willing to participate, given the current enthusiasm for emphasising the added value to be provided over and beyond the provision of accommodation.

The white paper *The New NHS* develops the patient partnership strategy by encouraging patient, carer, and public involvement in making healthcare decisions.[32] A nationwide pilot scheme, recently established by the National Homeless Alliance, aims to create a sustainable network of self help initiatives to help homeless people set their own agendas. Alongside this setting of priorities, we need action research projects that are developed in close collaboration with homeless people, their advocacy groups, and health professionals working in the area to improve and focus targeted health promotion activities. Only then will we be in a position to conduct evaluative research and build up an evidence based approach to health promotion for homeless people.

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*A memorable patient*

## Unerring trust

Mine is a rural practice in north Yorkshire, spanning over 20 villages. Needless to say, we have several branch surgeries, each of which has a different social grouping and a character of its own. Close to one distant surgery was a piece of common land, much favoured by the travelling people, most of them genuine Romany.

When in residence, they would turn up at the surgery in hordes, very demanding, but always respectful and polite. You had the feeling that complaints and illnesses had been "stored up," for a good sorting out. They always attended surgery and never called me out, although I had once been escorted with great dignity to a stream, in order to wash after delivering a baby.

I was, therefore, surprised to be asked to call at the caravans in order to see a man who was "very sick." It was a summer evening and a chair was produced for me to sit in the open. A cyanosed and breathless man of about 65 was helped from a caravan in obvious cor pulmonale. Accustomed to a different audience, I was horrified and began to talk about hospital admission, but this was firmly and politely declined.

At the end of a long day I became irritated and asked if they had brought me seven miles to refuse my advice. With patience they explained that they had received my advice. If I thought he was going to die then they were sure I was correct. Politely they added, "What you don't realise is, we have brought him from 200 miles away to see you."

Humbled I returned to my comfortable home. I never saw him again.

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