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PERSPECTIVE: PART III

BEHAVIORAL HEALTH AND NEEDS ASSESSMENT AT A HOMELESS SHELTER

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What does a homeless person need? A home.

Chronically sheltered homeless individuals, a vulnerable and marginalized population, disproportionately suffer from preventable diseases such as metabolic syndrome. They experience high rates of psychiatric illnesses, such as mood disorders, psychotic disorders, PTSD and drug addiction, and high-risk sexual behaviors. Interventions have historically been limited in this complex population, who deserve our attention. There are further complexities when a homeless person is marginalized by race, which may pose additional biases and barriers to care. For instance, the vast majority of inner city and homeless individuals in Rochester, NY, are African-American men—a symptom of a history of racial imbalance.[1] In other cities, the distribution may be different, with veterans, undocumented and uninsured immigrants, or Puerto Ricans (post-Hurricane Maria) constituting the majority of the homeless population. The unique needs of any group ought to be considered when designing an intervention.

In 2018, as a fourth-year medical student at the University of Rochester (home of the biopsychosocial model), I conducted a needs assessment at the House of Mercy (HOM), a recently upgraded 82-cubicle facility that became the largest homeless shelter in Rochester.

The assessment was performed to guide future interventions for dietary change and social engagement—two important determinants of health. It required me to become acquainted with residents, prepare lunch with volunteers and staff (many of whom are former residents) to understand their nutrition challenges, and survey current and former residents (many of whom stop by for meals and socialization) on the topics of perceived social engagement and dietary habits. I led an intervention—a weekly focus group for women, a subminority at HOM—using motivational interviewing to discuss past traumas, body image, and nutrition (including diabetes education). The group discussions were held in a quiet staff conference room, safely tucked away from the hustle and bustle of the common area of HOM. These ladies trusted me and spoke up when prompted, but they seemed less eager to connect with their peers. I empathized when a few women suggested that they wished HOM were segregated by gender, stating they felt uncomfortable sleeping near men at night.

Many beneficiaries of HOM were willing to engage in discussion—I spoke with roughly half of them regarding their health needs and barriers. I was surprised to learn that some of them had been living at HOM for multiple years, the majority felt strongly supported by staff, and all were isolated from family or had none to speak of. A number of them expressed difficulty attending doctors' visits—largely secondary to few options for transportation and lack of a smart phone. Many whom I queried reported high consumption of meat and sugar, compounded by largely sedentary lifestyles. Resoundingly, they agreed that sugar addiction was a reality. Some expressed interest in access to healthier food, while others were more skeptical—many cited the development of diabetes as a factor that would motivate dietary improvement.

Evoking the "Stages of Change" model, some of these individuals may be in the pre-contemplative stage for dietary change. Their presumed stage must be understood in the context of recurrent trauma. Therefore, it is the role of healthcare providers and social workers to foster change. While motivational interviewing is the therapeutic modality most linked with sustained behavior change, the success of this intervention has been limited in a study of homeless young adults.[2] Additionally, a systematic review demonstrated that application of the Knowledge-Attitude-Behavior model for understanding

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sugar intake is likewise limited,[3] suggesting that there are other factors to consider.

This begs the question—would efforts at dietary behavior change be futile in the context of chronic stressors? Could unlimited funding to provide options for a healthier diet improve the health of this complex population, without addressing their homelessness? HOM relies largely on food donations from grocery stores, which poses nutritional limitations—these donations mostly consist of pastries and fruit, and these were placed as snacks whenever available (in addition to three full meals). I was surprised to see a soda vending machine on site; staff anecdotally mentioned that this improved beneficiaries' moods, and when soda was previously unavailable, they would leave the building in search of it.

Rather than a reactionary approach, a different paradigm, the Housing First model,[4] can theoretically be applied to the issue of poor dietary habits in the homeless population. The initiative provides short- or long-term rental assistance via two programs, respectively, rapid re-housing or permanent supportive housing.[4] This model proves that providing individuals with stable housing without pre-requisites, serves as a platform for autonomy, remaining housed, improving quality of life, participating in job training programs, attending school, discontinuing substance abuse, decreasing domestic violence, and spending fewer days hospitalized.[4] However, there are some individuals whose physical or mental health circumstances may prevent them from successfully living independently, even when provided with long-term rental assistance. Therefore, I propose that long-term community housing should be considered as an alternative to chronic sheltered homelessness.

To foster a healthier and more socially engaged community in this unique population, future interventions should pursue housing models which are conducive to a wellness-focused community living structure, such as apartment communities with improved communal spaces, or tiny house communities. Some wellness features may include plants, sunlight, access to exercise, and cooking classes. In addition, focused dietary knowledge assessment and education should be considered, including regarding portion size, the role of meat consumption in the development of diabetes, and serious complications of diabetes. Lastly, interventions to improve access to primary care and psychiatry, utilizing telehealth modalities when appropriate, could improve the health of this complex population.

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