

## 'If I die, I die, I don't care about my health'

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1 **'If I die, I die, I don't care about my health': perspectives on self-care of**  
2 **people experiencing homelessness.**

3

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38 **'If I die, I die, I don't care about my health': perspectives on self-care of**  
39 **people experiencing homelessness.**

40

41 **Abstract:**

42 Self-care, which refers to what people do to prevent disease and maintain good  
43 health, can alleviate negative health consequences of people experiencing  
44 homelessness. The aim of the study was to apply a theoretically informed  
45 approach in exploring engagement of people experiencing homelessness in self-  
46 care and to identify factors that can be targeted in future health and social care  
47 interventions. Qualitative semi-structured interviews were conducted with 28  
48 participants opportunistically recruited from a specialist homelessness healthcare  
49 centre (SHHC) of North East Scotland, United Kingdom (UK). An interview  
50 schedule was developed based on the theoretical domains framework (TDF).  
51 Interviews were audio-recorded and transcribed verbatim. Six aspects of self-care  
52 were explored including (i) self-awareness of physical and mental health, (ii)  
53 health literacy including health seeking behaviour, (iii) healthy eating, (iv) risk  
54 avoidance or mitigation, (v) physical activity and sleep, and (vi) maintaining  
55 personal hygiene. Thematic analysis was conducted by two independent  
56 researchers following the Framework Approach. Participants described low  
57 engagement in self-care. Most barriers to engagement in self-care related to TDF  
58 domain 'environmental context and resources'. Participants often resorted to  
59 stealing or begging for food. Many perceived having low health literacy to  
60 interpret health related information. Visits to churches and charities to get a  
61 shower or to obtain free meals were commonplace. Participants expressed  
62 pessimism that there was 'nothing' they could do to improve their health and  
63 described perceived barriers often too big for them to overcome. Alienation, lack  
64 of social support, and the perception that they had done irreversible damage to  
65 their health prevented their involvement in self-care. The theme of 'social circle'  
66 held examples of both enabler and barriers in participants' uptake of risky

67 behaviours. Health and social services should work with persons experiencing  
68 homelessness in designing and delivering targeted interventions that address  
69 contextual barriers, multi-morbidity, health literacy and self-efficacy.

70

71 **Keywords:** Self-care, Homelessness, Health Behaviours

72

### 73 **What is known about this topic?**

- 74 • Ill health is a potential cause and consequence of homelessness but self-care  
75 can prevent and mitigate ill health
- 76 • A need to better understand self-care needs of people experiencing  
77 homelessness has recently been emphasised in health and social care policies  
78 across the UK
- 79 • There is a dearth of research exploring wider aspects of self-care amongst  
80 people experiencing homelessness as previous research has considered nutrition  
81 and diet, and risky behaviours in isolation.

82

### 83 **What this paper adds?**

- 84 • Study participants experiencing homelessness indicated low engagement in self-  
85 care across various domains such as diet, physical and mental health
- 86 • Low engagement in self-care was linked to a lack of resources, multi-morbidity,  
87 low health literacy and social influences
- 88 • Targeted interventions that address contextual barriers, multi-morbidity, health  
89 literacy and self-efficacy can improve participation in self-care

90

91 **Introduction**

92 In the United Kingdom (UK), people are considered homeless if they no longer  
93 have a legal right to occupy their accommodation or if it would no longer be  
94 reasonable (e.g. due to safety concerns) to continue living there (GOV.UK, 2015).  
95 As such, homelessness takes many forms including sleeping rough, living in  
96 derelict buildings, residing in temporary shelters, living in squats or sofa surfing  
97 (Homeless link, 2016). Homelessness is on the rise across urban areas of the  
98 Western World including the home countries of the UK (Scotland, England, Wales  
99 and Northern Ireland) and has been linked to economic austerity. In 2018, nearly  
100 twice as many people slept rough on any given night in England compared to  
101 2010 (Homeless link, 2017; GOV.UK 2018). In Scotland, over 34,000 people  
102 made homelessness applications to their local authority in 2016-17 requesting  
103 accommodation (Scottish Public Health Observatory, 2018).

104  
105 People experiencing homelessness face significant disadvantages in attaining and  
106 maintaining a healthy lifestyle (Baggett *et al.* 2013; Aldridge *et al.* 2017;  
107 University of Sheffield, 2012; Fazel *et al.* 2014). They do, therefore, experience  
108 poor health outcomes with a prevalence of mental health illness, alcohol and drug  
109 misuse, and communicable diseases higher than in the general population.  
110 Opioid poisoning, heart failure, infectious diseases, and external causes such as  
111 accidents, often contribute to the higher rate of mortality amongst street dwellers  
112 (Hwang *et al.* 2005).<sup>10</sup> Those occupying homeless shelters are also known to die  
113 at an earlier age than the general population, with the average age of death  
114 being 47 years (Hassanally *et al.* 2018).

115  
116 Amongst multiple forms of homelessness, rough sleeping pre-disposes individuals  
117 to much vulnerability. Government policies in the UK aim to tackle rough sleeping  
118 through devolved administrations allowing England, Scotland, Wales and Northern  
119 Ireland to develop their own legislations and strategies in preventing and

120 managing rough sleeping. In England, rough sleeping strategy was published in  
121 2018 (Gov.UK, 2018) which aims to eliminate homelessness by 2027 by  
122 increasing bed spaces in city council accommodations, increasing access to  
123 substance misuse and mental health treatment and promoting joined-up care  
124 across sectors. 'Housing first' is one of the key interventions to supporting this  
125 strategy. Housing First aims to provide 'a stable, independent home and intensive  
126 personalised support and case management to homeless people with multiple and  
127 complex needs'. It aims to recognise housing as a matter of right than a reward  
128 (Homelessness Link, 2016). Further funding to tackle rough sleeping has been  
129 allocated by targeting areas with high proportion of rough sleeping in England.  
130 Such funding is allocated to offer dedicated support teams and securing additional  
131 bed spaces for people experiencing homelessness (Gov.UK, 2018). Other policy  
132 interventions to prevent rough sleeping includes Scottish Government's abolition  
133 of the priority needs assessment when offering accommodation to persons  
134 experiencing homelessness, entitling anyone finding themselves homelessness to  
135 settled accommodation and not just to families with children as was the case prior  
136 to the Act (The Scottish Government, 2012). Ending homelessness and rough  
137 sleeping: action plan' published by the Scottish government in 2018 aims to also  
138 tackle homelessness by tackling the root causes including additional support to  
139 people with adverse childhood experiences, and developing adversity and trauma  
140 informed workforce (The Scottish Government, 2018).

141

142 Addressing health inequalities requires a specific focus on the disadvantaged  
143 population. In particular, preventative services are known to be effective in  
144 alleviating the health impact of homelessness. Self-care, as defined by the World  
145 Health Organisation, is the ability of individuals, families and communities to  
146 promote health, prevent disease, maintain health, and to cope with illness and  
147 disability with or without the support of a healthcare provider (WHO, 2013), has  
148 been shown to prevent and mitigate ill health including long term illnesses. The

149 principles of self-care which can be applied to prevention and management of ill  
150 health are known to have arisen from a number of theoretical models such as the  
151 theory of self-regulation. Self-regulation models emphasise the importance of  
152 self-efficacy (Bandura, 2005), which relates to an individual's belief in their ability  
153 to learn and perform specific behaviours; and self-management (Lorig and  
154 Holman, 2003) which relates to adoption into practice of such behaviours. Self-  
155 efficacy often reinforces self-management. Self-management strategies, including  
156 patient-led self-care support groups, have also been shown to improve clinical  
157 outcomes amongst patients in a variety of long term illnesses (Minet *et al.* 2010),  
158 including effects on mortality, hospitalisation and quality of life (Ditewig *et al.*  
159 2010). Supporting self-care can increase patient satisfaction of health and social  
160 care services, and enables greater integration of health and social care. In the  
161 UK, self-care features in the National Health Services plan as one of the key  
162 building blocks for a patient-centred health service (Department of Health, 2018).

163 It is important however to understand that within the spectrum of patient care,  
164 most care is shared care involving primary, secondary or tertiary health care and  
165 social care, and can involve a small or large components of self-care  
166 (Department of Health, 2005). In chronic and debilitating health conditions,  
167 people's participation in self-care is often minimal, whereas self-care occupies  
168 greater share in management of acute and non-debilitating conditions. Self-care  
169 practice is also dependent on context-specific factors including available resources  
170 and individuals hence should not be blamed for non-participation in self-care.

171

172 The seven pillars of self-care provide a framework to consider a wide range of  
173 activities relevant from the self-carer perspectives (International Self Care  
174 Foundation, 2018) (table 1). These include awareness of physical and mental  
175 health, health literacy and health seeking behaviour, healthy eating, hygiene,  
176 physical activity and sleep, and risk avoidance. The seven pillars of self-care  
177 framework, proposed by the International Self Care Foundations postulates that

178 unhealthy behaviours such as smoking, excess consumption of alcohol, poor diet  
179 and insufficient exercise often tend to cluster together (International Self Care  
180 Foundations, 2018). Similarly, healthy behaviours in the seven pillars also cluster  
181 together. **Therefore, promoting one healthy behaviour may motivate individuals**  
182 **to uptake other healthy behaviours.** We have previously used the seven pillars  
183 framework to identify appropriate interventions to promote self-care in offshore  
184 workers (Smith *et al.* 2018, Gibson Smith *et al.* 2018a).

185

186 Table 1 to appear here

187

188 Ill health is a potential cause and consequence of homelessness. A need to better  
189 understand supporting self-care and self-management for people experiencing  
190 homelessness, have recently been emphasised (The Queen's Nursing Institute,  
191 2016). There is a dearth of research exploring wider aspects of self-care amongst  
192 people experiencing homelessness as previous research has looked at aspects  
193 such as nutrition and diet (Seale *et al.* 2016), risky behaviours (Roerecke *et al.*  
194 2013), and health information seeking (McInnes *et al.* 2013) in isolation.

195

196 The aim of this study was to apply a theoretically informed approach in exploring  
197 engagement of people experiencing homelessness in undertaking self-care and to  
198 identify associated barriers that can be targeted in future health and social care  
199 interventions to promote self-care.

200

## 201 **Method**

202 Qualitative semi-structured, face-to-face, interviews were conducted with patients  
203 registered with an SHHC in North East of Scotland, UK between October 2015 and  
204 January 2016. This facility provides services to a patient population of  
205 approximately 400, of whom approximately 50% are on methadone therapy.

206 Patients aged 18 years and over, presenting for the consultation during the data



207 collection days and those referred by the SHHC staff, were invited to participate.  
208 An effort was made to achieve variation in age and sex of the study participants.  
209 Researchers on site, who operated in pairs, provided further information about  
210 the research. Signed, informed consent was obtained by the researchers prior to  
211 interview commencement.

212

213 An interview schedule was developed based on the research aim, experience of  
214 the research team, available literature, and the Theoretical Domains Framework  
215 (TDF) (Cane *et al.* 2012; Francis *et al.* 2012). TDF is a framework consisting of 33  
216 behavioural theories incorporated into 14 domains which allows researchers to  
217 identify barriers, facilitators or determinants of a particular behaviour. These  
218 include environmental context and resources, knowledge, skills, intentions, goals  
219 and behavioural regulations (table 2). TDF has been used extensively in  
220 qualitative studies to identify target behaviours for future interventions and to  
221 characterise implementation problems (Cane *et al.* 2012; Atkins *et al.* 2017). The  
222 researchers have previously used TDF in qualitative studies in identifying barriers  
223 of: access to primary healthcare by persons experiencing homeless (Gunner *et al.*  
224 2019) and effective transition of care of such persons across services (Gibson-  
225 Smith *et al.* 2018b). When using TDF, it is imperative that the framework is used  
226 from the outset, including the development of an interview schedule, as the use  
227 of TDF at later stages of the research provides challenges in mapping the data  
228 against TDF domains (Cane *et al.* 2012; Atkins *et al.* 2017).

229

230 The interview schedule was reviewed for credibility by the research team,  
231 including a general practitioner (GP) and a nurse practitioner based at SHHC, a  
232 GP practice support pharmacist, a community pharmacist and academic health  
233 services researchers. Six pillars of self-care were explored (table 1). The seventh  
234 pillar of self-care 'rational and responsible use of medicines and products' was  
235 explored in another study (Paudyal *et al.* 2017).

236

237 Table 2 to appear here

238 The interview schedule was piloted amongst four participants. No change in the  
239 interview schedule was needed hence the pilot transcripts were analysed together  
240 with the main study transcripts. Interviews lasted a maximum of 30 minutes, with  
241 trained researchers, were audio-recorded and transcribed verbatim. Participants  
242 were recruited until data saturation was achieved, when no new themes emerge,  
243 as realised by the researchers during transcription and preliminary analysis of the  
244 data. Saturation was assumed based on the repetition of the themes from the  
245 subsequent interviews in the context of available data (Saunders *et al.* 2018).

246

247 The Framework Analysis technique (Ritchie *et al.* 2003) was used to guide the  
248 analytical process. The data pertaining to each pillar of self-care were coded into  
249 a matrix design based on the TDF (table 2). A framework was developed for each  
250 of the six pillars of self-care behaviours. Data relevant to these behaviours were  
251 mapped to the TDF domains and relevant themes under each domain were listed.

252

253 Researchers (VP, KM and DS) met to discuss initial coding after analysing the first  
254 four transcripts. Duplicate, independent checking of the transcripts and analysis  
255 was undertaken. Six undergraduate pharmacy students, including two visiting  
256 students, conducted duplicate independent analysis of the transcripts based on  
257 the coding.

258

259 Ethical and governance (R&D) approval for the study was granted by NHS East  
260 Midlands Committee (15/EM/0404) and NHS Grampian (2015RG005)  
261 respectively.

262

263 **Results**

264 Twenty-eight patients were interviewed, the majority of whom were male (n=21)  
265 with drug misuse being the key reason leading to homelessness (n=17) (table 3).  
266 The mean age was 42 years (range: 25-67 years). Most participants had faced  
267 homelessness for between six months and four years (n=17) (table 3).

268  
269 Table 3 to appear here

270  
271 Results from the thematic analysis are described below under each pillar of self-  
272 care. Narratives are presented alongside illustrative quotes in this section. The  
273 results are then mapped against TDF domains to relate the factors and barriers in  
274 relation to participant engagement with each pillar of self-care (table 4).

275

### 276 **Self-awareness of physical and mental health**

277 Most participants demonstrated knowledge and awareness of their health  
278 conditions and the impact of homelessness had on the onset and severity of their  
279 illnesses. Health conditions such as mental illness including drug and alcohol  
280 misuse, infections, ulcers, asthma, back pain and fatigue were commonly  
281 experienced as expressed by participants during the interviews. Participants  
282 described their capabilities and motivation to adopt better physical and mental  
283 health were compromised due to a lack of stable accommodation. Participants  
284 described feeling 'useless' and having suicidal ideation.

285

286 'I tried to kill myself about 5 times. It [homelessness] kicked your self-esteem to  
287 death.' 40 year old male

288

289 **Most participants mentioned that they didn't attempt to change anything about**  
290 **their health while facing homelessness as health was not high amongst the list of**  
291 **priorities given the adversities they were facing.**

292

293 'You care about your drugs, and at the time you think if you (I) die, you (I) die,...  
294 you (I) don't care about your health...it doesn't matter, that's what you thought.  
295 It's a dark place to be.' 34 year old male

296

297 Participants also mentioned having experienced a lot of stigma and discrimination  
298 in society which negatively impacted their physical and mental well-being.

299

300 '...it (homelessness) affects you. People think you are a flaming drug addict,  
301 scumbag, all they think ken [sic *know*], look at this mink, ken, sitting begging, get  
302 a job, ken. It's nae good, you feel like snapping, and punching the \*\*\* out of folk,  
303 but you cannae can you. You have got to hold yourself back. Especially on a  
304 Saturday night...: '...I've been asked, like by a couple of guys, gay men for sex,  
305 ken. Its nae good, they think you're homeless, they think you will do anything for  
306 money, ken cause you are begging, ken.' 36 year old male

307

### 308 **Healthy eating**

309 Most participants described having adequate knowledge on the importance of  
310 healthy meals to maintain good health. However, most reported poor access to  
311 healthy meals due to lack of resources. One participant described experiences of  
312 surviving on chocolates for several weeks. For a few participants, drugs or alcohol  
313 would take precedence over food. Lack of appropriate space to prepare and cook  
314 meals was commonly mentioned as a barrier. Visits to churches and charities for  
315 free meals and accessing cheaper food sources, such as fast food chains, were  
316 commonplace behaviours. Participants often had to rely on food given by those  
317 passing by when sleeping rough.

318

319 'When you're sitting on the street folk would give you a coke and a sandwich or  
320 something, sometimes I would have four, or five or six sandwiches that I would go  
321 through but the nutritional (value) is low, so you, you lose a lot, your weight just

322 falls off you... Just nae eating right and taking drugs and alcohol it's just, the  
323 weight just falls off you.' 34 year old male

324

325 One participant described the extreme experience of hunger lasting several days  
326 where he had no other option than to steal food from a retailer.

327

328 'Ehm, basically I never ate for days, and then it would get to the point that I would  
329 get so hungry that I would need to steal a sandwich or something out a shop.'39  
330 year old male

331

332 Table 4 to appear here

333

#### 334 **Health literacy and seeking health information**

335 Some participants described experiences of actively seeking health information  
336 from their health and social care professionals for a diverse range of health issues  
337 including substance misuse. Participants demonstrated awareness of where to  
338 seek health information, with the preferred source of information being GPs and  
339 nurses at the SHHC and social service counsellors. Participants who had very  
340 recently moved to temporary accommodation also mentioned use of the internet  
341 to seek health information. However, most participants identified themselves as  
342 having low literacy skills and often not being able to interpret health information.

343

344 'I've looked up the internet [about health condition] a couple of times but I don't  
345 understand it.' 43 year old Male

346

347 Some participants expressed feeling emotional in relation to discussing their  
348 health with their healthcare professionals. This was due to their health being  
349 closely linked to the life circumstances they were facing and being uncomfortable  
350 discussing such issues with other people.

351

352 'I just don't like new people [healthcare professionals]. I just don't like having to  
353 kinda having to repeat everything. I get myself in a muddle and I get all stressed  
354 out.' 33 year old female

### 355 **Personal Hygiene**

356 Maintaining good personal hygiene was a priority for some participants. Those  
357 who demonstrated motivation and intentions to remain free from substance  
358 misuse mentioned that there was no excuse for not maintaining personal hygiene  
359 even when sleeping rough. Some mentioned being advised by charities regarding  
360 where to go on a daily basis for a shower. Others would pop in to friends' houses,  
361 railway stations, and fast food restaurants to get a 'wash'. Some participants  
362 described experiencing insecurity in public clean up facilities which prevented  
363 them from using them on a regular basis.

364

365 'We've had to go to McDonalds to have a wash and stuff like that, there is, you will  
366 find places, ken fit [sic *know what*] I mean. There is no excuse to be sitting in  
367 some state some people are in. OK, your clothes are getting ripped cause you are  
368 sitting on pavements all day and stuff like that, ken, you are going to look a mess,  
369 doesn't mean that you have got to be stinking, a stinking mess, you know. But it is  
370 hard.' 47 year old female

371

372 Other participants described that maintaining good hygiene was challenging due  
373 to other life priorities and getting housed in stable accommodation was the only  
374 way to maintain good personal hygiene. Therefore some participants were not  
375 being personally motivated to wash or dress themselves properly even when they  
376 had options and facilities available. Participants expressed emotions when  
377 mentioning accounts of being stigmatised because of their poor personal hygiene.

378

379 '...you don't care about long hair, if it's greasy, you don't care if you walk onto a  
380 bus and everybody walks off the bus 'cause you smell.' 34 year old male

381

382 **Risk avoidance or mitigation**

383 Most participants admitted to their current or past use of illicit drugs, hazardous  
384 drinking of alcohol, and smoking habits. Most participants who admitted  
385 substance misuse also mentioned being on opioid replacement therapy (ORT).  
386 Social influences were described as key to participants choosing to adopt or give  
387 up risky behaviours. However, some participants described lack of self-regulation  
388 and behavioural control in helping them to come off the substances. Some also  
389 described alcohol and substance misuse as a coping mechanism.

390

391 'Never succeeded, I've tried to give it [alcohol and drug misuse] up but think it's  
392 the only thing that keeps my nerves tied together just now so, but just, I think I've  
393 done too much damage to repair it anyway so If I'm going to die now, I'm gonna  
394 die. I've made my choices, so I've made my bed I'll have to lie in it, sorta thing.  
395 That's about it.' 39 year old male

396

397 Participants described going to extremes to obtain money for illicit substances  
398 including robbery and prostitution. Some participants described accounts of  
399 successfully giving up risky behaviours such as substance and alcohol misuse.

400

401 'When I was on drugs and [I felt] that...if I died one day, I died and then well my  
402 life was... when you're on drugs, you see [drugs] making these people die around  
403 you. I've been lying in a bed and the boy next to me was dead. It's just, oh well,  
404 I'd go into his pockets and take his money and drugs and walk out the house. Aye,  
405 that's the way you are. It's a weird, it's a horrible thing drugs. It does it to you,  
406 ken [sic *know*], heroin.' 54 year old male

407

408 'I've been totally clean off everything for just over a year in April.. I ended up  
409 being in mental health hospital for almost three months. That was like an extended  
410 rehab sorta thing, so I like stayed away from everything for 3 months which gave

411 me a fighting chance and I've been clean ever since then. Think I've had one drink  
412 in last New Year since then.' 39 year old male

413

#### 414 **Physical activity and sleep**

415 Most participants mentioned engagement in physical activity was beyond their list  
416 of priorities. Morbidity, disability or lack of accommodation preventing them  
417 taking up physical activities. A few participants expressed disinterest and lack of  
418 motivation in engaging in the discussion about aspects of physical activity during  
419 the interviews and such lack of self-efficacy was linked to adverse life  
420 circumstances.

421

422 'No I've no done nothing (physical exercise) – just nothing at all. Just can't get  
423 motivated. That's how I'm waiting to see the psychiatrist and to get on my anxiety.  
424 'Cause I couldn't even come down here. Couldn't leave the house or and that's  
425 what made us depressed 'cause I like just going right out, ken getting up and  
426 going out. I couldn't get out on my own. 34 year old female

427

428 Some participants living in temporary, council offered accommodation described  
429 the use of a gym or walking to maintain health. Many described having very little  
430 or no sleep while facing homelessness. Lack of stable accommodation was a key  
431 barrier to attaining quality sleep. Some mentioned using illicit substances to  
432 enable better sleep. Participants described stigma, theft and violence while  
433 sleeping rough.

434

435 '... you're sleeping in car parks and everything, freezing cold, ...so you don't get to  
436 sleep ken [sic *know*] and folk say, "oh you should come to mines if you're ever  
437 stuck", but you never bother, ken, because you knock on somebody's door in the  
438 middle of the night they're hardly happy to see you but, eh aye, it was an absolute  
439 nightmare because there was no churches letting people in or anything.' 49 year  
440 old female



441

442 **Discussion and conclusion**

443 This study has explored homeless from the participants' perspectives on wider  
444 aspects of self-care through the use of theory. Engagement in self-care was  
445 perceived to be low across several pillars of self-care theory including healthy  
446 eating, health information seeking, maintenance of personal hygiene, risk  
447 avoidance and mitigation, and maintenance of personal hygiene mainly due to  
448 context, resource specific barriers and lack of self-efficacy due to poor perceived  
449 health and adverse life circumstances. The use of TDF allowed the barriers and  
450 facilitators of participant engagement in self-care to be mapped across domains  
451 that could be targeted in future interventions. Most of the barriers related to non-  
452 engagement in self-care identified in this study centred on the 'environmental  
453 context and resources' domain of TDF and this included lack of stable  
454 accommodation. Participants often expressed lack of motivation to uptake healthy  
455 behaviours, often compromised by other life priorities.

456

457 In this study, participants alluded to the role of charities and social support in  
458 enabling them to undertake self-care such as in enabling a healthy diet or  
459 maintaining personal hygiene. There is scope for health and social care  
460 professionals to offer such provision at the health or social care centres or to  
461 make referrals to services. Emphasis has been placed on healthcare professionals  
462 to recognise and screen for nutritional need of people experiencing homelessness  
463 and their families (The Queen's Nursing Institute, 2016). Participants in this study  
464 expressed low health literacy and hence health and social care professionals need  
465 to be aware of these barriers when referring people experiencing homelessness to  
466 sources of information. Participants described being emotionally vulnerable when  
467 discussing their health and self-care issues with the healthcare professionals  
468 because issues were closely linked to their life circumstances. Our previous study  
469 identified that rapport with health and social care workers was a key factor in

470 homeless people's preference to use SHHC facilities, even when they had  
471 relocated to permanent accommodation (Paudyal *et al.* 2018).  
472  
473 Most of the barriers to the uptake of self-care including healthy eating and  
474 physical activity were linked by participants of this study to their lack of  
475 accommodation. In England, the Homeless Reduction Act is coming into effect in  
476 2018 (Paudyal and Saunders, 2018) following a similar homelessness legislation  
477 in Wales in 2014 (The Welsh government, 2014). While the effectiveness of this  
478 Act is yet to be evaluated, the Act mandates health and social care services to  
479 refer people who are at risk of or facing homelessness to local authorities for the  
480 provision of accommodation. Policy interventions such as **The Housing First**  
481 **initiative (Homeless Link, 2016) are likely to address context and resource related**  
482 **barriers. Research evidence demonstrates that Housing First initiative decreases**  
483 **homelessness and increases housing retention rates and decreases the use of**  
484 **emergency health services, and emergency shelters, particularly in people with**  
485 **severe mental health and substance misuse problems (Woodhall-Melnik and**  
486 **Dunn, 2018).** Screening people experiencing homelessness for mental and  
487 physical health conditions during their housing needs assessment provides an  
488 effective strategy for early intervention (Weinstein *et al.* 2013).  
489  
490 There is a lack of previous literature exploring wider aspects of self-care within a  
491 population of people experiencing homelessness as the literature often tends to  
492 focus on a single behaviour at a time. Therefore, only a limited comparison to  
493 previous literature could be undertaken. A recent study in the United States  
494 showed that poorer self-rated health was associated with the desire to reduce  
495 hazardous drinking and increase fruit and vegetable consumption in this  
496 population (Taylor *et al.* 2016). A recent review of the literature demonstrated  
497 evidence of malnutrition including saturated fat, low fruit and vegetable intake  
498 and numerous micro-nutrient deficiencies, amongst people experiencing

499 homelessness, often leading to physical and mental health consequences (Sprake  
500 *et al.* 2014). Furthermore, that review noted the search for food often takes  
501 priority over healthcare and access to medicines (Paudyal *et al.* 2017).

502

503 Strengths and limitations

504 This study is, to the best of our knowledge, the first to explore people  
505 experiencing homelessness' perspectives on wider self-care aspects. Duplicate  
506 and independent analysis of the data enabled trustworthiness of the findings. Use  
507 of theory enabled mapping of the key barriers and facilitators of engagement in  
508 self-care across domains of the TDF, the pillars of self-care and provides specific  
509 targets for future interventions.

510

511 This study has some limitations. Some participants of this study had recently  
512 been temporarily or permanently housed despite the use of the SHHC and were  
513 waiting to relocate to mainstream general practices. Such participants provided  
514 their retrospective accounts. The study participants were predominantly male,  
515 however, this reflects the data trend of persons experiencing homelessness. Only  
516 the patients with good rapport with the healthcare staff were included. This  
517 approach was used to ensure the safety of both the researchers and research  
518 participants. Therefore, views may not be representative of all participants from  
519 the study setting. In addition, the researchers used the transcripts and initial  
520 analysis when assuming data saturation. As reported in the literature, this is a  
521 common barrier to ascertaining saturation in qualitative studies (Saunders *et al.*  
522 2018).

523

524 Practice and research implications

525 The results of this study suggest that promotion of self-care amongst people  
526 experiencing homelessness requires addressing the resource-related barriers such  
527 as provision of stable accommodation and their co-morbidities. Such barriers

528 collectively compromises their self-efficacy and motivation to uptake self-care. In  
529 addition, the results provide recommendations for the development,  
530 implementation and evaluation of health and social care interventions that can  
531 positively impact on their self-confidence, belief about capabilities, intentions and  
532 behavioural regulations. The Medical Research Council, UK provides a framework  
533 (Craig *et al.* 2013) for development of complex interventions. This study provides  
534 targeted areas for multi-faceted interventions and the data provides a valuable  
535 foundation on which to base development of interventions. It has been postulated  
536 that unhealthy behaviours, such as poor diet, drugs and alcohol misuse, tend to  
537 “cluster” together in individuals (International Self Care Foundations, 2018), so as  
538 the healthy behaviours cluster amongst certain sectors of the population. Such  
539 multi-faceted targeted interventions can be delivered at temporary  
540 accommodations, charities, outreach services, or health and social care settings  
541 that can enable homeless population to develop their self-confidence, improve  
542 health seeking behaviour and their intentions to lead a healthy lifestyle. People  
543 sleeping rough will also benefit from provision of healthy diet, tailored health  
544 related information, facilities for personal hygiene under one roof.

545

546 Poor mental health including the experience of stigma and discrimination was a  
547 recurrent theme in the data. Poor mental health can often be the cause and  
548 consequences of homelessness (Bowen *et al.* 2019). Various barriers to people’s  
549 access to mental health services have been described in the literature with  
550 concurrent substance misuse and history of self-harm often excluding patients  
551 access to mental health services (Gunner *et al.* 2019). Hence, people  
552 experiencing homelessness may benefit from multi-morbidity models of case  
553 management, and these are best embedded as part of housing-related  
554 interventions such as the Housing First initiative (Aubry *et al.* 2015). The  
555 Assertive Community Treatment (ACT) is one example where multi-morbidity  
556 including mental health and substance misuse is managed by a multidisciplinary

557 team with home based treatment and out of hours availability by also integrating  
558 peer support (Nugter *et al.* 2016). Stigma and discrimination were also commonly  
559 cited in relation to societal attitude towards homelessness and people  
560 experiencing homelessness. However, previous research showed that people  
561 experiencing homelessness also face stigma and discrimination when accessing  
562 health services (Paudyal *et al.* 2018; Gunner *et al.* 2019). Anti-stigma  
563 interventions for healthcare professionals such as the 'targeting the roots of  
564 healthcare provider stigma' which involves improving the ability of healthcare  
565 professionals to cope with the feelings and emotions when working with  
566 vulnerable patients; improving their competence and the confidence of staff; and  
567 addressing the lack of awareness of one's own prejudices have been shown to  
568 minimise perceived stigma and discrimination (Knaak and Patten, 2016). In  
569 addition, health and social care workers are able to better support people  
570 experiencing homelessness when they have the knowledge of patients'  
571 backgrounds and life circumstances (Padget and Henwood, 2012).

572

573 While health professionals based in specialist homelessness healthcare facilities  
574 may be more aware of the factors associated with non-engagement of people  
575 experiencing homelessness in self-care, as identified in this study, many  
576 homeless patients use mainstream services or may not come in contact with  
577 healthcare staff. Wider awareness will enable health promotion and self-care  
578 improvement in this population. Health and social services should avoid blaming  
579 individuals for their behaviours and low perceived engagement in self-care as  
580 often many of these barriers including context and societal factors need system  
581 based approach for change.

582

### 583 **Conclusion**

584 Low engagement in self-care was noted amongst the study participants. There is  
585 scope for targeted interventions focused on specific determinants to promote

586 each pillar of self-care by addressing contextual barriers, physical and mental co-  
587 morbidities, health literacy and people's self-efficacy. Health and social services  
588 should work with persons experiencing homelessness in designing and delivering  
589 targeted interventions.

590  
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597

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763  
764



765 **Table 1: Pillars of self-care**

Pillars of Self-care	Example of topic guide prompts based on TDF
Self-awareness of physical and mental condition and use of health services	Awareness about their health and illness, use of healthcare services
Healthy eating	Seeking and consuming healthy food and balanced diet
Health literacy and seeking health related information	Whether participants actively seek health related information, ability to access and interpret information
Good hygiene	Maintenance of personal hygiene and associated barriers and facilitators
Physical activity and sleep	Physical activity levels, associated barriers and facilitators
Risk avoidance or mitigation	Substance misuse including drugs, alcohol and illicit substances
Rational and responsible use of medicines, services and products	Using medicines, services and products responsibly when necessary

766 Source: International Self Care Foundation (2018)

767  
768

**Table 2: Theoretical domains framework (TDF)**

<b>TDF domains and descriptions</b>	
<b>1. Knowledge</b>	Knowledge of condition /scientific rationale, Procedural knowledge, Knowledge of task environment
<b>2. Skills</b>	Skills, skill development, Competence, Ability, Interpersonal skills, Practice Skill assessment
<b>3. Social/ Professional Role and Identity</b>	Professional identity, Professional role, Social identity, Identity, Professional boundaries, Professional confidence Group identity, Leadership, Organisational commitment
<b>4. Beliefs about Capabilities</b>	Self-confidence, Self-confidence Perceived competence Self-efficacy Perceived behavioural control Beliefs Self-esteem Empowerment Professional confidence
<b>5. Optimism</b>	Optimism Pessimism Unrealistic optimism, Identity
<b>6. Beliefs about Consequences</b>	Outcome expectancies, beliefs, anticipated regret, consequents
<b>7. Reinforcement</b>	Incentives, Rewards (proximal/distal, valued/not valued, probable/improbable), Incentives, Punishment, Consequents, Reinforcement, Contingencies, Sanctions
<b>8. Intentions</b>	Stability of intentions, Stages of change model, Trans. model/stages of change
<b>9. Goals</b>	Goals (distal/proximal), Goal priority, Goal / target setting, Goals (autonomous/controlled), Action planning Implementation intention
<b>10. Memory, Attention and Decision Processes</b>	Memory, attention, decision making, cognitive overload, tiredness
<b>11. Environmental Context and Resources</b>	Environmental stressors, Resources / material resources, Barriers and facilitators, Organisational culture /climate Person x environment interaction, Salient events / critical incidents
<b>12. Social influences</b>	Social pressure, Social norms, Group conformity, Social comparisons, Group norms, Social support, Intergroup, conflict, Power, Group identity, Alienation, Modelling
<b>13. Emotion</b>	Anxiety, Fear, Affect, Stress, Depression, Positive / negative affect, Burn-out,
<b>14. Behavioural Regulation</b>	Self-monitoring, Breaking habit, Action planning

770

Adapted from Cane *et al.* 2012, Atkins *et al.* 2017

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**Table 3: Participant demography**

	<b>Demographic Data</b>	<b>Number of Participants (%)</b>
Sex (n=28)	Male	21 (75.0)
	Female	7 (25.0)
Age (n=28)	25-35 years old	9 (32.1)
	36-45 years old	10 (35.7)
	46-67 years old	9 (32.1)
Highest Level of Education (n=28)	Left school before 16	6 (21.4)
	Left school with GCSE/CSE/O-Level/Standard Grade or equivalent	14 (50.0)
	Left school with A-Level/Higher or equivalent	4 (14.3)
	University degree	1 (3.6)
	Other	3 (10.7)
Marital Status (n=28)	Single	16 (57.1)
	Divorced or separated	2 (7.1)
	Widowed	2 (7.1)
	Living with a partner (co-habiting)	6 (21.4)
	In a long term relationship	2 (7.1)
Where do you normally sleep? (n=28)	Hostel	5 (17.9)
	Council, housing association	11 (39.3)
	Sleeping rough	2 (7.1)
	Other such as with friends or relatives, B&B, Caravan	5 (17.9)
	Privately rented or owned accommodation	3 (10.7)
	Other	2 (7.1 (bedsit & shared house))
	Where do you normally obtain daily essentials?*(n=27)	Mostly buys own food
	Churches	4 (14.3)
	Charity shelters or hostels	4 (14.3)
	Friends or relatives	5 (17.9)
	Begging	1 (3.6)
	Other	5 (17.9)
How did you become homeless?*(n=28)	Alcohol misuse	3 (10.7)
	Drug misuse	17 (60.7)
	Gambling	2 (7.1)
	Abusive situation	3 (10.7)
	Relationship breakdown	7 (25.0)
	Injury	0 (0.0)
	Loss of Job	2 (7.1)
	Mental Illness	8 (28.6)
	Other	9 (32.1)
	How long have you been homeless for? (n=28)	Less than 6 months
	6 months to a year	8 (28.6)
	1-2 years	6 (21.4)
	3-4 years	3 (10.7)
	5 or more years	6 (21.4)
How old were you when you first became homeless? (n=27)	Younger than 20 years old	8 (28.6)
	Between 20 - 30 years old	6 (21.4)
	Older than 30 years old	13 (46.4)
Responsible for any children? (n=28)	Yes	7 (25.0)
	No	21 (75.0)
Employment Status (n=28)	Unemployed and currently not looking for work	20 (71.4)
	Unemployed and currently looking for work	4 (14.3)
	Unemployed and student	1 (3.6)
	Employed full time	2 (7.1)
	Employed part time	0 (0.0)
	Retired	1 (3.6)
	How would you describe your general health? (n=28)	Very good
	Good	4 (14.3)
	Fair	9 (32.1)
	Bad	12 (42.9)
	Very bad	2 (7.1)

774 \*multiple choices were allowed

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**Table 4: Results of framework analysis**

<b>TDF<sup>18,19</sup> domains</b>	<b>Self-awareness of physical and mental health</b>	<b>Healthy eating</b>	<b>Health literacy (Health information seeking behaviour)</b>	<b>Personal hygiene</b>	<b>Risk avoidance Rational and responsible use of products, services, diagnostics and medicines</b>	<b>Physical activity and rest (sleep)</b>
<b>1. Knowledge</b>	Knowledge of personal health conditions, knowledge of the impact of homelessness on health	Knowledge (or lack of) about nutritional values of food; knowledge of the role of good food on health	Knowledge (or lack of) where to seek health information	Knowledge about facilities available in the locality for a wash	Knowledge of drug misuse about negative impact on health	Knowledge on the importance of physical activity or quality sleep to health Knowledge about medicines prescribed for better sleep quality
<b>2. Skills</b>		Lack of skills to prepare (cook) food	Ability (or lack of) to interpret health related information available online			
<b>3. Social/ Professional Role and Identity</b>	Being personally responsible for the homelessness and poor health		Identity as a patient, being an 'open book'		Social influence in taking up and giving up risky behaviours	Identity as a 'rough sleeper'
<b>4. Beliefs about Capabilities</b>	Losing self esteem	Poor health impacting on ability to eat healthily... not being able to 'open a tin.'	Self-confidence in asking health information from other individuals	'Nothing I could do' to maintain personal hygiene	Self-confidence in avoidance of risky behaviours	Disability, morbidity impacting Self-confidence or lack of in using physical exercise facilities
<b>5. Optimism</b>	Pessimistic about bringing positive change to health				Having already done 'irreversible' damage to health	Pessimistic about adopting better sleep pattern
<b>6. Beliefs about Consequences</b>	Consequences of prolonged homelessness on health	Consequences of not eating healthily			Consequences of illicit use of drugs, smoking and alcohol misuse to the health of	Consequences of good physical activity and sleep on health

<b>7. Reinforcement</b>	Positive health to enable job, work Lack of motivation to maintain health in temporary accommodation					
<b>8. Intentions</b>	Intention (or lack of) to maintain a good health such as keeping warm	Intention to eat healthily, e.g. through family, friends, charities	Intention (or lack of) to seek health information	Intention (or lack of) to remain clean	Intentions to come off drugs, smoking or alcohol	Lack of intentions to exercise Intentions to sleep well Seeking medications for better sleep quality
<b>9. Goals</b>	Good health a goal or in the 'back burner' Decision to make positive changes to health	Non-intention to spend on good food due to illicit drug habits Eating healthily a goal or not a goal		'More important things to worry about'	Goal setting in giving up risky behaviours	Physical activity not a goal or a priority  Too tired to think about exercise, sleeping with 'one eye open'
<b>10. Memory, Attention and Decision Processes</b>						
<b>11. Environmental Context and Resources</b>	Vulnerable/ prone to poor health due to environmental hazards, lack of sleep  Barriers of using health services including difficulties registering to the health care services and also lack of	Lack of facilities to store, cook or warm up food  Lack of money to buy quality food Charity monetary resource to buy food  Shoplifting to satisfy hunger	Resources including doctors, nurses and online sources or lack of seek health information	Lack of facilities for showers, Use of available facilities for shower, Use of limited facilities such as toilets for shower  Charity facilitates to wash or dress clean	Importance of rehabilitation centres, methadone programmes and smoking cessation services on participants giving up of risky behaviours	Use of gym and exercises in temporary accommodation Weather having a big impact on sleep quality when rough sleeping

	Not being able to keep warm, Lack of place to store medicines					
<b>Social influences</b>	Alienation due to homelessness, lack of social support in maintaining health	Family and friends support to eating healthily Positive role of health care professional advice on healthy eating		Support from friends and family in maintaining personal hygiene	Social influence on taking up or giving up risky behaviours	Negative social attitude to rough sleeping, violence faced during rough sleeping
<b>13. Emotion</b>	Impact of stigma and discrimination Poor mental health, stress, depression, paranoia, suicidal ideation, feeling vulnerable, lack of self-esteem	Hunger often lasting several days	Mental health issues leading to fear and anxiety in learning new things  Reluctance to speak about homelessness and its impact on health to HCPs they are not acquainted with	Fear of abuse due to poor hygiene	Illicit drug use as a coping mechanism	Personal worries disabling any sleep
<b>14. Behavioural Regulation</b>	Adoption (or non-adoption) of positive health behaviour; Adherence to the treatment to improve health	Discontinuation of drugs to eat healthily  Attempting to eat as healthily as possible		Being able to maintain hygiene despite sleeping rough, actively seeking shower and clean up facilities	Determination (or lack of) giving up risky behaviours	Walking (instead of public transport) to improve health when no longer homeless

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