Implementing nutrition guidelines that will benefit homeless people

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The nutritional status of single adult homeless people is often overlooked, with many of the homeless population being malnourished due to a variety of reasons. This paper looks at the government’s policies relating to nutrition and at the current research concerning homelessness and diet. It also offers various strategies for improving the nutritional intake and status of this client group. It discusses the issues surrounding the use of dietary supplements, ways to minimise the risk of misuse, and highlights possible alternatives. A guideline has been devised with the specific aim of identifying people who are at risk of malnutrition within hostels.

It has long been established that malnutrition can adversely affect a person’s physical health and mental well-being in a number of ways (Malnutrition Advisory Group, 2003). These include:

- An impaired immune response;
- Delayed wound healing;
- Higher rates of depression;
- Increased anxiety;
- Delayed recovery from illness;
- Reduced muscle strength and fatigue;
- Impaired thermoregulation;
- An increased rate of respiratory difficulties.

Saving Lives: Our Healthier Nation (Department of Health, 1999) focuses on the importance of a balanced diet. It suggests that this should incorporate plenty of fresh fruit and vegetables while reducing the amount of fatty and salty foods consumed.

In 1998 the Acheson report was published and this was paramount in highlighting the discrepancies between the socioeconomic classes with regard to their health and nutritional intake. Acheson found that the lower socioeconomic classes eat less fruit and vegetables compared with their counterparts in the higher socioeconomic classes and that as a consequence the lower socioeconomic classes have a lower intake of antioxidants, vitamins, and minerals. He also discovered that those receiving income support were even more likely to have a restricted diet, leading to a deficiency in iron, calcium, dietary fibre, and vitamin C.

Acheson’s key recommendation relating to nutrition is to make healthy food affordable to everyone. More specifically the report recommends development of policies that will ensure there is adequate retail provision of food to those who are disadvantaged.

The DoH has released a number of papers relating to the inequalities in health and, within this, to nutrition. Tackling Health Inequalities (DoH, 2003), for example, recommends improving access to food and increasing the amount of fruit and vegetables eaten each day.

**Homelessness and nutrition**

Langnase and Muller (2001) looked at the nutritional status of an adult urban homeless population in Germany. They found that 29 per cent of the homeless people they interviewed were classed as being malnourished.

Darmon et al (2001) studied the diets of 97 homeless men visiting an emergency night shelter in Paris. They found that the subjects tended to have a low body mass index (BMI) and a large percentage of their total energy intake per day was a result of alcohol consumption. The researchers also discovered that 80 per cent of the non-alcoholic energy consumed by the men was provided by charities, thus highlighting the need for the provision of well-balanced meals within hostels and day centres.

In a study of 423 homeless men and women, Evans and Dowler (1999) found:

- Only just over one-quarter ate vegetables daily;
- Nearly two-thirds said they rarely consumed fruit, salads, wholemeal products, and fruit juice;
- The subjects’ diets tended to be high in saturated fats and sugar.

However, 70 per cent of the population interviewed said that they wanted to improve their diets.

**Improving dietary intake**

Many charitable organisations for homeless people already provide some free or heavily subsidised food. However, there is a lack of fresh fruit and vegetables, so providing these free of charge may be an incentive for people to improve their diets. Bowls of fruit could be left in the canteen area and at reception to encourage people to help themselves.

Another option would be to provide snacks that are high in carbohydrates, such as chocolate and cereal bars, to people whose lifestyles are so chaotic, for example as a result of substance misuse, that they do not always remember to eat. The snacks could be left in places people regularly access such as the reception area. Staff could encourage people to help themselves to these snacks with the sole aim of ensuring that at least something high in calories and energy is eaten, with the intention that at least some of these snacks will be consumed.
FIG 1. NUTRITIONAL ASSESSMENT GUIDELINES

Are you concerned about a client’s dietary habits?

YES

Does your client have a BMI of less than 20? Or is the client consistently losing weight?

Undertake a nutritional assessment and record the client’s height, weight, and BMI.

Does your client’s lifestyle hinder her or him from eating a balanced diet? For example is the person’s lifestyle chaotic?

Before each mealtime remind the client of the time and the need to eat properly. Encourage the client to buy meal tickets in bulk to save the client having to remember to buy them daily. Provide free snacks that are high in carbohydrates such as cereal and chocolate bars that are kept in easily accessible places.

If dietary supplements are needed as a last resort, then refer the client to the community dietitian.

Review the client’s height, weight, and BMI every four to six weeks. However, if the client is receiving dietary supplements then review weekly.

Review the client’s height, weight, and BMI at three-monthly intervals and encourage the client to eat a balanced diet. Provide additional snacks and if dietary advice alone is not sufficient in improving the client’s nutritional intake, then consider a referral to the dietitian.

Treat underlying medical condition (refer to the GP if necessary) and encourage the client to eat properly. The client may benefit from receiving food supplements so refer to the community dietitian.

Review client’s height, weight, and BMI every four to six months to ensure that the client is maintaining a consistent weight and is eating a balanced diet. Educate the client on the importance of eating properly.

Is the client’s weight and BMI stable but the client is unable to meet nutritional requirements from diet alone?

Is there a medical reason that your client’s BMI is less than 19? For example diabetes mellitus?

Educate the client on the importance of a balanced diet and ensure that the client’s dietary requirements are being met, for example vegetarian or halal.

If dietary advice is unsuccessful in increasing the client’s BMI, then consider a referral to the dietitian for further management advice.

Review the client’s height, weight, and BMI every four to eight weeks. However, if the client is receiving dietary supplements then review weekly.

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References


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
eventual aim of increasing that person's body fat and encouraging them to remember to eat regular meals.

This may appear to be providing homeless people with conflicting advice – healthy eating is being encouraged while at the same time the clients are being offered 'unhealthy' snacks that are high in carbohydrates and fat. But the reasoning behind it is based in practicality. Not everyone will want to eat healthier foods and rather than risk further deterioration in this group's nutritional intake, it is sensible to provide an alternative in the knowledge that at least something is being eaten. There is room for promoting a healthy diet at a later date when the clients' nutritional needs have stabilised and a relationship has been established between client and staff.

Although there is a cost to be incurred with the provision of free food, it may prove to be more cost-effective to introduce free food and snacks and encourage people to consume them, than to wait until the situation worsens and nutritional supplements and the involvement of other services are needed.

The role of community dietitians

The involvement of the community dietitian can be beneficial in assessing an individual's need. A dietitian may be able to suggest appropriate alternatives, ensuring dietary supplements are used only as a last resort. However, it is recognised that there are too few community dietitians available, so although it is good practice to involve the dietitian, it may not always be practical.

The dietitians who work within GP practices are another source of information but they require a client to be registered with that particular surgery and registration can be a major problem for homeless people. Therefore, the only practical solution may be to involve a dietitian in only the most serious of cases.

The use of supplements

There is much debate around prescribing dietary supplements to homeless people because they can be misused, although it is important to remember that it is only a minority who do this. Anecdotal evidence from hostel staff has shown that dietary supplements can have a relatively high value on the street, so some clients may be tempted to sell their supplements instead of taking them. Another problem is that dietary supplements can sometimes be viewed as an alternative to food. They are calorific and contain essential minerals and vitamins. Therefore, the client may think that the benefits from taking supplements outweigh the damage caused by their lifestyle choices, such as a high alcohol intake.

However, it is possible to give out supplements at mealtimes to those who need them in a glass rather than a carton. The canteen staff would be required to have a list of who had actually been prescribed dietary supplements, but this should encourage people to consume them immediately and so reduce the likelihood of them being misused. It would only be important to ensure that the supplements were low in protein if the client had encephalopathy that was secondary to liver disease due to alcoholism. As these clients are often malnourished, it is of particular importance to ensure that they have a sufficient intake of protein – restricting them to a low-protein diet because of their alcohol intake would be counterproductive.

Another issue involved in prescribing dietary supplements is that according to the British National Formulary (British Medical Association and Royal Pharmaceutical Society of Great Britain, 2004) they should be prescribed only for people who are medically ill or malnourished due to disease. This has implications for people who are malnourished due to their lifestyle. Nevertheless, it is important to note that dietary supplements are often used in mental health settings, in particular for those with anorexia nervosa, often with very satisfactory results (Imbieroweiz et al, 2002). If people who have made a conscious decision not to eat can benefit from nutritional supplements, it could be argued that the homeless population should be permitted to as well.

If a homeless person has other issues, such as substance misuse, it may be necessary to start a course of nutritional supplements when dietary advice alone has failed. It may be appropriate to ensure a number of criteria are met in order to minimise the risk of misuse. One suggestion would be for the individual to sign a contract stating she or he agrees to several conditions, such as:

- Attending check-up appointments;
- Being weighed weekly;
- Agreeing to consume the supplements on site – for example, in the canteen.

It would also be necessary to review the client weekly to ensure the supplements are not being prescribed unnecessarily. A nutritional screening tool such as the new malnutrition universal screening tool (Malnutrition Advisory Group, 2003) should be used. If this highlights any areas of concern, it is considered good practice to conduct a thorough nutritional assessment (Fig 1) and monitor these clients regularly. It is also good practice to use dietary supplements only as a last resort and to provide dietary advice instead.

If there is no evidence of any weight gain over a set period, for example 6–10 weeks, then the client's medical condition should be investigated. If the lack of weight gain is due to the dietary supplements being misused, they should no longer be prescribed and other methods should be considered.

It should be stressed to the client that dietary supplements do not or should not take the place of food. They should be taken alongside regular meals for a short period with the aim of increasing nutritional status.

Conclusion

A nutritional assessment should identify those at risk of malnutrition and prevent them from becoming malnourished through education about the importance of a balanced diet and through the provision of free snacks and fruit. A nutritional assessment should also aim to prevent those who are already malnourished from further nutritional deterioration. This could be achieved through a combination of education, dietary supplements, and the provision of free snacks and fruit.