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Social exclusion, health and hidden homelessness

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ABSTRACT

Objectives: Homelessness and poverty are extreme forms of social exclusion which extend beyond the lack of physical or material needs. The purpose of this study was to explore and expand the concept of social exclusion within the social determinants of health perspective – to understand how the social environment, health behaviours and health status are associated with material and social deprivation.

Study design: Fundamental qualitative description with tones of focused ethnography.

Methods: Participants who identified as hidden homeless described their everyday living conditions and how these everyday conditions were impacted and influenced by their social environments, coping/health behaviours and current health status. Research Ethics Board approval was granted and informed consents were obtained from 21 participants prior to the completion of individual interviews.

Results: Qualitative content analysis examined the descriptions of men and women experiencing hidden homelessness. Participants described the 'lack of quality social interactions and supports' and their 'daily struggles of street life'. They also shared the 'pain of addiction' and how coping strategies influenced health. Participants were hopeful that their insights would 'better the health of homeless people' by helping shape public policy and funding of community resources that would reduce barriers and improve overall health.

Conclusions: Health professionals who understand health behaviours as coping mechanisms for poor quality social environments can provide more comprehensive and holistic care. The findings of this study can be used to support the importance of housing as a key factor in the health and well-being of people experiencing poverty, homelessness and social exclusion; and consequently, reinforces the need for a national housing strategy.

Introduction

Homelessness and poverty are extreme forms of social exclusion that extend beyond the lack of material necessities.[1–5] Canada's homeless population ranges between 150,000–300,000 people, but millions of Canadians experience inadequate or unsafe shelter.[6–9] It is estimated that people who are visibly homeless represent a small proportion of the

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actual number of people who are homeless. People who experience hidden homelessness live temporarily with others but lack immediate permanent housing and remain invisible and further excluded. This exclusion from social and economic resources reinforces invisibility to the public and policy makers.[10–12]

Social exclusion is the inability to participate fully in the economic, cultural, social and political aspects of a society.[2,5,13] The experience of social exclusion contributes to diminished quality social supports, high risk health behaviours and compromised physical and psychological health. The processes that lead to social exclusion within a society have detrimental health outcomes for individuals and populations.[5,13,14] Health, as defined by the World Health Organization, (p. 1)[15] is 'a resource for everyday life, not the objective of living'. This concept of health as a resource includes basic life requirements,[16] which include food, shelter, education, political stability and social justice.[15] When social and economic determinants are not fair or just, these determinants are reflected in low levels of education and unemployment, lack of social and community supports, and physical, psychological and social health impairments. The accumulation of stressors associated with homelessness and poverty have a positive relationship with cardiovascular disease, diabetes and chronic illness.[3,4,17–19]

McEwen's allostatic load hypothesis[18,20,21] links such threats and stressors to the psychological, physical and social dimensions of disease. Allostasis is the ability of the entire body to maintain the stability of internal and external environments, via stress hormones and neurotransmitters, which respond and adapt to daily life stressors.[18] The body's ability to adapt to stressors is an important factor in overall health and well-being. If, however, stress hormones and other mediators of allostasis are not functioning properly, it may lead to allostatic load and allostatic overload.[18] Stress hormones and neurotransmitters in constant use, manifest as physical symptoms in the body and can cause higher rates of morbidity (heart disease, cancer, chronic illness) and mortality.[20–22]

Social environments, health behaviours and health status

To examine the health impacts on people who experience hidden homelessness, there is a need to explore the everyday life of the individual person within their social environment. It is within the social environmental context that the conditions of everyday life are experienced and where poverty and social exclusion directly affect health behaviour and health status.[4,23] Health behaviours may be a representation of coping measures which are directly associated with material and social deprivation.[23] In the broadest sense, health behaviours are the physical, psychological and social health decisions and actions of individuals and societies in response to the quality and quantity of the social determinants of health.[24] When the quality and quantity of material and social determinants of health are poor, health outcomes are poor, and this can lead to social exclusion.[5]

Galabuzi[2,13,25] defines social exclusion as the inability of marginalized populations to participate fully in political, economic, social and cultural aspects of their society. People who lack safe, adequate and affordable shelter experience poorer health and are less likely to access health resources.[3,26] The purpose of this study was to explore and expand the concept of social exclusion among hidden homelessness within the social determinants of health perspective by considering the quality and quantity of social environments, health behaviours and health status.

Methods

The current study obtained Research Ethics Board approval from the University of Windsor, Windsor, Ontario, Canada. The questions asked in the current study were developed to examine social exclusion in relationship with health and hidden homelessness. The current study used fundamental qualitative description with tones of focused ethnography.[27–29] Qualitative content analysis[29] explored the daily life experiences of people who are hidden homeless to help explain the importance of social exclusion when examining health.

Participants were recruited using snowball sampling[30] – sampling that is particularly helpful when trying to access hard to reach populations to share their expertise in research studies[30,31] and through community agency referral; as these agencies provide services for marginalized and vulnerable populations. While 122 potential participants were initially pre-screened by the researchers, if participants did not meet the inclusion criteria, of – being 15 years of age of older, and responding 'no' to the question 'Do you have a permanent residence/home that you can return to whenever you so choose?'; they were not able to participate in the study.[26] While 34 participants were eligible to participate in the larger survey,[26] this current study includes the completed interviews of 21 participants.

Informed consent was obtained from each participant. The letter of consent was read aloud to each participant by the researcher and recorded for later transcription. A monetary honorarium and a referral booklet of community agencies were given to each participant upon completion of the interview. The interviews obtained information from the participants about their current living arrangements, housing resources, use or non-use of community and health resources, health status and suggestions to improve resources for hidden homeless populations. Interviews were reviewed several times and trustworthiness[32] was maintained in this qualitative study. Please note that to protect the identity of the participants, 'P-x' – where 'P' is participant and the numbers '1–21' would be the order the participant was interviewed for this study; therefore, P-8 indicates the eighth participant interviewed.

Results

Several themes emerged through the lens of the three domains used in this study which were: **social environment**; **health behaviours**; and **health status**. The three domains were somewhat interwoven and not isolated from each other, or mutually exclusive domains/categories. When participants did not feel supported by those around them in their 'Social