



Westminster   
Primary Care Trust

# The impact of social and cultural activities on the health and wellbeing of homeless people

A research report for Westminster Primary Care Trust (PCT) by Broadway

October 2005

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<sup>1</sup> The Westminster Homeless Health Team, formally known as the Homelessness PMS+ Pilot, was set up to provide primary care specifically for homeless people, including rough sleepers. The nurse-led service provides community nursing, Doctors' services, counselling and other therapies in four day centers across Westminster.

<sup>2</sup> The Health Support Team is primarily a nurse-led team which works intensively with people who are homeless, asylum seekers and refugees. The aim of the team is to improve the health of this client group and to integrate them in to mainstream services. The team will assist people to access services for example by registering with a local GP, dentist or any other services that they may need.

<sup>3</sup> Westminster PCT has established an Enhanced Scheme that seeks to promote access to GP practices for homeless people who do not need targeted care provided through the Homeless Health Team. There are 15 practices across Westminster registered with this scheme.

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## 1 Key findings report

Westminster PCT commissioned the Research Team at Broadway, a pan-London Homelessness charity, to undertake a project exploring the links between social and cultural activities and health. The project was undertaken between April and July 2005.

This key findings report summarises findings from the following:

- A literature review
- Five workshops with a total of 45 homeless people in hostels and day centres across Westminster
- Interviews with seven health and homelessness professionals and two meetings with stakeholders. Those interviewed were doctors (three), a community nurse, a counsellor, a clinical manager, a therapist and a New Initiatives Manager. The meetings were held with project workers and the project manager at the Church Army and at Voluntary Action, Westminster's Homelessness Forum.

People who are homeless or who have experienced homelessness were involved in reviewing research materials and facilitating four of the five workshops.

The findings that follow are based on the three objectives for the project and key recommendations and areas for action emerging from the research.

### 1.1 Objective one: To identify the positive impact that social and cultural activities have on health and wellbeing

*'Culture has a significant contribution to make to health, not least because in all its forms it helps to provide the social fabric of communities, making them 'communities' in the real sense and sustaining the individuals within them'<sup>4</sup>.*

The literature review demonstrates the already proven link between health and social and cultural activities. Although there is little literature specifically about the benefits of activities to homeless people, a wider search found that the benefits identified amongst other groups are of particular relevance to this group, namely, reducing isolation, promoting social networks, self-esteem and communication skills.

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<sup>4</sup> London Health Commission: *Culture and health: making the link* 2002

Benefits at the point of accessing activities include therapeutic and cathartic effects (e.g. in art), improvement in the range of movement (e.g. in singing, music and dancing), developing skills in self-expression (e.g. in creative writing) and the development of social skills and networks (e.g. in group work). In longitudinal studies of older people, regular engagement with meaningful activities has been linked to greater life satisfaction and a healthier and longer life<sup>5</sup>. The literature also indicates that social and cultural activities can provide a temporary distraction from drugs and alcohol.

Participants in the workshops described a holistic view of health and wellbeing. Examples of themes in responses to an exercise to define good health include feelings such as happiness, contentedness, strength and positive attitude, and motivation in life.

The positive health outcomes of social and cultural activities identified by homeless people resonate with those identified in the literature review and those raised in interviews with health and homelessness professionals.

The positive effect of activities on mental health was a theme throughout. This was in relation to reducing anxiety and depression, alleviating isolation, promoting relaxation and good sleeping patterns/ daily routines. Participants in groups discussing sports described physical benefits of exercise around the health of the heart and weight control. The fact that activities could offer a distraction or relief from problems and drugs and alcohol was raised in all groups. Also the groups felt that attending activities could help encourage access to medical care as people engage with services and become more able to communicate their needs. Both homeless people and professionals frequently mentioned the possibility of embedding health promotion into social and cultural activities. This could be done through learning activities (e.g. a talk or group work about a health issue), availability of information and health related services at point of accessing activities, by providing healthy food and creating a 'clean' environment (no drugs, alcohol and possibly smoking).

Several of the potential benefits mentioned in the workshops are relevant to key priority areas in the Westminster PCT Health Promotion Strategy including physical activity, healthy eating, sexual health and substance misuse.

All health and homelessness professionals agreed that social and cultural activities are a source of positive health outcomes. Some felt these to be as relevant to the PCT as clinician interventions. Others were more cautious commenting on the need to retain or develop basic or conventional health services and not to lose sight of the very basic needs that some

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<sup>5</sup> Help the Aged Kim Willcock: Journeys out of loneliness: the views of older homeless people 2004

people have around accommodation and food. Interviewees described a wealth of benefits from social and cultural activities. The areas of benefit were described as being interlinked, for example, social benefits are linked with mental health and the positive impact on mental health is a precursor to more effective engagement with health services.

Social and cultural activities were viewed as a particularly important way of engaging some ethnic minority groups, especially where cultural needs are not met by conventional interventions in the UK such as verbal counselling.

## **1.2 Objective two: Establish and document the links between providers of social and cultural activities and health providers**

Health services for homeless people range from counselling and psychiatry, through to podiatry and dentistry. The health and wellbeing of residents within Westminster is catered for by a wide range of voluntary and statutory (including PCT-led) services. An initial list included 38 agencies and this list is not considered to be comprehensive. Activities for homeless people are generally run from day centres and from hostels. Westminster hosts several day centres including two centres at Connection at St Martin's (over 25s and under 25s), the Church Army Day Centre (for Women), the Cardinal Hume Centre (for young people) the Passage and West London Day Centre. The 2005 Resource Information Service database lists 39 hostels in Westminster with over 1,500 bed spaces.

Health providers are linked with homelessness services through the work of clinicians in homelessness organisations, for example, medical practitioners specifically assigned to work with homeless people through the Homeless Health Team<sup>6</sup>. The co-ordination of services and information was viewed as an area for improvement in most workshops and interviews. Homeless people described receiving out-of-date information and an over-emphasis on written information. Also some felt frustrated by a perception that only regular service-users of the host organisation can take part in some trips and visits.

In interviews some clinicians felt that patients would benefit from health providers being better informed about and able to refer to social and cultural activities. The sense of fragmentation and isolation of health and homelessness sectors from each other, and even specific services and projects within sectors from each other was a recurring theme. Barriers

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<sup>6</sup> The Westminster Homeless Health Service, formally known as the Homelessness PMS+ Pilot, was set up to provide primary care specifically for homeless people, including rough sleepers. The nurse-led Service provides community nursing, Doctors' services, counselling and other therapies in four day centers across Westminster.

to a more collaborative approach in the homelessness sector include competition for funding between agencies and poor mechanisms for publicising activities beyond the host organisation.

Several interviewees suggested that health providers could be involved in the design and delivery of projects. Examples of this include consulting health professionals about the design of projects, having a community nurse to attend activities to undertake health promotion work, and looking into resources within the health sector that could support activities, for example, by offering space to hold sessions in and referring patients to activities.

### **1.3 Objective three: Measuring the health impact of social and cultural activities**

The literature review found that most evaluations of social and cultural activities focus on qualitative data. The benefits and outcomes of activities are often highly subjective, for example, those around confidence and self-expression. These can often only be captured through self-reported/ worker-reported outcomes. Some more quantitative tools can be employed to capture these 'soft' outcomes, for example self-esteem inventories or questionnaires that are completed at set times during the course of an intervention (e.g. before, half-way through and at the end of a six month project).

Interviewees described some quantitative methods which could be applied to help funders monitor the progress of projects, for example, number of attendees, demographic information and information about the take-up of medical services. This type of information may be important for monitoring and accountability but is unlikely to demonstrate the value of a social or cultural activity. The research concludes that evaluations could usefully focus on the specific links between undertaking an activity and changes in behaviour or feelings. For example the finding that 'Billy reports that painting makes her feel more confident' is less revealing than the following: 'Billy reports that the painting group makes her feel more confident as she produces something she thought she couldn't (or) because it has enabled her to mix with other people in a safe space'. Where questionnaires are used it would be useful to allow for the collection of more descriptive data to contextualise reported changes.

Funders have a key role in promoting an evaluative approach. This can be achieved through the following:

- Promoting evaluation as an integral part of delivery rather than an additional pressure, for example, by avoiding excessive requirements for monitoring returns but

encouraging projects to think of creative ways to demonstrate the benefit of interventions through self-evaluation.

- Supporting providers with evaluation and creating a sense of learning rather than inspection from evaluation.
- Providing information and training on evaluation and outcomes if necessary or bringing providers together to discuss issues if this is more appropriate.
- Asking those bidding for funding to demonstrate ability to undertake or openness to achieve inclusive, creative evaluation involving staff and homeless people.
- Ensuring that those awarded funding have developed clear aims, objectives and desired outcomes for their projects to keep qualitative evaluation tight and focused.
- Promoting a creative approach to capturing the 'soft' outcomes of activities, for example, by widening the definition of 'data' to include videos, photo projects and case studies.
- Demanding an evaluative, consultative approach from the outset (e.g. sound justification for project, based on evidence or consultation results) while letting providers take some risks and test new ideas to assist the overall development of and learning about the health outcomes of activities.
- Providing access to relevant materials to guide evaluation e.g. self-esteem inventories and example questionnaires and reports.

#### **1.4 Key themes for the future of social and cultural activities**

This section describes some of the recurring issues that emerged in the research which do not fit clearly into the three objectives for the research. They are summarised from the 'areas of best practice' found in the full report. Not all points are relevant areas of action for the PCT but will be of interest to the wider audiences of the research.

##### **(a) The need for a wider range of better targeted services**

- A key finding from the research was that there are single homeless people who are not engaging with any activities and find it difficult to access meaningful occupation activities.
- Despite the number of providers and range of activities available in Westminster, there are homeless people who feel that there is '*nothing to do*', people who '*literally don't leave their rooms*' or for whom *the 'highlight of the week'* is collecting a prescription.
- Some workshop participants described a sense of alienation from the cultural and sports facilities in the area.
- One response to this is tiered activities including entry level, small-scale activities that people can try out in a relaxed environment without the pressure to make a regular



commitment. Taster sessions in a range of locations may help to engage those who are currently not accessing services.

- At the other end of the scale there was enthusiasm for larger projects and activities that include people who are not homeless e.g. the 'mini marathon' which would provide a time-consuming outlet for those who want to be involved.
- Homeless people in workshops showed enthusiasm for mixed activities that involve non-homeless people. There is potentially tension between the desire for including non-homeless people to activities, e.g. by promoting activities in work places, and the need to prevent issues arising as a result of insensitivity from non-homeless people or conflict between different groups.
- Participants commented that vulnerable people or those in low incomes who are housed would also benefit from many of the activities discussed.

**(b) Supporting the individual**

- The findings stress the importance of the one-to-one support offered to homeless people and the impact this has on the outcomes of accessing services or activities. The need for individual and flexible support was raised in several interviews.
- The need for consistent services once a person has secured accommodation was also raised as an important way of maximising the positive impact of activities and minimising unintended harm.

**(c) Maximising the effectiveness of staff working with homeless people**

- Professionals working with homeless people would like to see cohesive information systems to facilitate signposting and referrals of patients/ clients to the most appropriate projects. Having the right people to deliver activities was viewed as essential. It was suggested that those with expert knowledge of homeless people need to be present, as well as individuals with expertise in creative fields such as art therapy.
- Funders and practitioners should seek to involve a range of people in the design of projects e.g. by asking health providers about ways of making projects more 'healthy'. If possible it was suggested that projects should ask health professionals to attend sessions to break down barriers and build trust, and to undertake health promotion.
- The availability of social and cultural activities should become the accepted and expected norm amongst staff working with homeless people rather than an added extra. Targeted resources and training could help to achieve this.

**(d) Cost-effective ideas for choice and variety in activities**

- Creative fundraising was mentioned in some groups e.g. approaching companies for free tickets to the theatre or sports matches. Homeless people could be supported to develop fundraising and marketing skills through such projects.
- Homeless people in the workshops would like help to access facilities independently. This could be cost-effective and empowering for some people who have lower support needs. Suggestions included discount cards and free open days at sports centres. A related point is that several suggestions for providing activities that can be undertaken independently in hostels and day centres were raised e.g. air-fix modelling and gym equipment.
- Homeless people should be involved in deciding on activities to be run and running them where appropriate.

**(e) Practical suggestions from homeless people**

Key practical issues raised by workshop participants should also be considered for action, notably:

- Provision of services at the weekend and in the evenings
- Somewhere to leave baggage
- The need to actively promote opportunities verbally as well as in writing – to ‘big up’ what is available
- The involvement of homeless people in the design and delivery of sessions.

Regular consultation with those who are not attending activities is an important way of staying aware of simple practical barriers to engagement.

## **2 Introduction and methodology**

### **2.1 Introduction**

Westminster PCT commissioned the Research Team at Broadway, a pan-London Homelessness charity, to undertake a project exploring the links between social and cultural activities and health. The research was designed to meet three clear objectives:

1. To identify the positive impact that social and cultural activities have on health and wellbeing.
2. Establish and document the links between providers of social and cultural activities and health providers.
3. Suggest ways that could be used to measure health benefits and develop tools that could be used to record the number of people who engage with health services following participation in social and cultural activities.

This report presents findings from a literature review, five workshops with homeless people and interviews and meetings with homelessness and health professionals undertaken between May and July 2004. The report aims to use evidence from the report to *describe* the current situation, *identify and confirm* links between participating in social and cultural activities and engaging with health services, and also to *inform recommendations* for future practice.

Findings will be used to inform the health section of Westminster's homelessness strategy and may also inform the funding of future projects.

### **2.2 Methodology**

#### **2.2.1 Literature review**

Broadway's Policy Officer undertook the literature review. The literature search focused on the following areas:

Research and policy documents about social and cultural activities for homeless and other relevant groups such as socially excluded people were used, focusing on the following themes:

- Monitoring and evaluating of the impact of social and cultural activities
- Current policy and thinking on the link between social and cultural activities and engagement with health services
- Research around homelessness and health
- Information about existing social, cultural and health services accessed by homeless people in Westminster.

In light of the absence of literature about the health outcomes of social and cultural activities for homeless people the review looked at wider literature, for example, about the health impact of activities for older people. The publications accessed included government policy documents and research reports from a range of organisations such as academic organisations and charities.

### **2.2.2 User involvement sessions**

Five user involvement sessions were undertaken with clients from different Westminster hostels and day centres. The sample of hostels and day centres was chosen to reflect a range of homeless people in different age groups and with different support needs. Three workshops were held in the south of the borough, one in central Westminster and one in the north of the borough. More information about this is included in chapter (3).

Between five and eleven people attended each group and a total of forty-five people attended the workshops overall.

The groups lasted around an hour and a half and involved working in small groups undertaking activities as well as open discussions. A £10 voucher for a local supermarket was provided to all those who took part and light refreshments were provided. Research feedback was sent to all those who participated in the workshops and distributed to Westminster's day centres.<sup>7</sup>

Broadway is currently working with 'peer researchers' i.e. people who are currently homeless or have been homeless in the past and are trained to undertake research with homeless people. Peer researchers supported or co-facilitated four of the five workshops. Broadway feels that the involvement of peer researchers is beneficial in terms of the experience and expertise that they bring to sessions and in reviewing research materials, and also in terms of providing opportunities to those who wish to develop research skills.

### **2.2.3 Interviews with key stakeholders**

Eight in-depth interviews were conducted with key health and homelessness professionals across a range of services in Westminster. More information about interviewees is presented in chapter (4). In addition to this, Broadway's Research Officer facilitated an agenda item about the health outcomes of social and cultural activities at the Church Army Day Centre and attended the Voluntary Action Westminster Homelessness Forum to gather feedback about the research.

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<sup>7</sup> Hard copies of the full report distributed include a copy of the feedback provided as an appendix.

### 3 Literature Review

*“Culture has a significant contribution to make to health, not least because in all its forms it helps to provide the social fabric of communities, making them ‘communities’ in the real sense and sustaining the individuals within them”<sup>8</sup>.*

#### 3.1 Introduction

Recent government policy publications such as *Reducing Health Inequalities* have recognised that a person’s health is influenced by a wider range of determinants than simply the speed with which they can access health care. The government is therefore moving towards a holistic approach to improving the nation’s health with cross-departmental action. For example the ODPM’s target for all social housing to meet a decent standard by 2010 recognises the effect that poor quality housing can have on a person’s health. Social and cultural activities could be another. This literature review looks at how social and cultural activities can impact on a person’s health and wellbeing, as well as looking at health and homelessness in general.

There have been very few studies directly looking at the impact of meaningful activity on a homeless person’s health and wellbeing. Research projects have tended to focus on a specific aspect, for example, reducing and combating loneliness and isolation and promoting social networks, or meaningful activity being viewed as a progression route to employment.

The direct links between social and cultural activity<sup>9</sup> and improving a person’s health and ability to access health services, have been implicitly recognised but not researched on an empirical level in the homelessness sector. This literature review therefore includes literature in other sectors looking at the impact that cultural and social activities have on health in general as well as the role that art can play.

The literature review is broken down into the following sections:

- Definitions – health and meaningful activity
- Health and homelessness – some facts and figures
- Health and homelessness – barriers to accessing health
- Social and cultural activities – their role in promoting health and wellbeing
- Measuring health and wellbeing and measuring impact of social and cultural activities
- Recommendations

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<sup>8</sup> London Health Commission: *Culture and health: making the link* 2002

<sup>9</sup> These are sometimes referred to as meaningful activity within the homelessness sector

- Bibliography

### 3.2 Health definition

*‘Experience has emphasised the importance of integrating health inequalities into the mainstream of service delivery, with a focus on disadvantaged areas and groups.’<sup>10</sup>*

Health also extends beyond a clinical definition of health to include a person’s emotional, spiritual and psychological wellbeing. Within these aspects of health there are many further strands, for example, within mental health ranging from anxiety and mild depression to psychosis. Health also includes a person’s dependency on addictive substances such as alcohol, drugs or nicotine.

In 1948 the World Health Organisation defined health as *‘a state of complete physical, mental, and social well-being and not merely the absence of disease’*. Other definitions believe that *‘Health is the domain of physical and mental functioning and depends on the degree to which these functions are in equilibrium with the physical, biological and social environment’<sup>11</sup>*. The arts play a pivotal role in achieving this equilibrium<sup>12</sup>.

### 3.3 Social and cultural activities definition

For the purposes of the literature review the definition of cultural activity used is the one developed by the Department of Culture, Media and Sports (DCMS) which states that culture has both a material and a value aspect.

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<sup>10</sup> Department of Health: *Tackling Health Inequalities: A Programme for action* 2003

<sup>11</sup> Lock 2001 quoted in Arts Council Staricoff *Arts in health: a review of the medical literature* 2004b

<sup>12</sup> Janison, 1994 quoted in Ibid.

Material dimension:

- The performing and visual arts, craft, and fashion
- Media, film, television, video and language
- Museums, artefacts, archives and design
- Libraries, literature, writing and publishing
- The built heritage, architecture, landscape and archaeology
- Sports events, facilities and development
- Parks, open spaces, wildlife habitats, water environment and countryside recreation
- Children's play, playgrounds and play activities
- Tourism, festivals and attractions
- Informal leisure pursuits.

Value dimension:

- Relationships
- Shared memories, experiences and identity
- Diverse cultural, religious and historic backgrounds
- Standards
- What we consider valuable to pass on to future generations.

LHC 2002

*"Types of activities that are deemed to make a difference are ones that are characterised by involvement, commitment and skill... they provide not only an experience of meaningful engagement, but they tend to yield a self-definition of worth and ability...preferably challenging mind and body, social and personal skills, such an activity does far more than fill time<sup>13</sup>."*

What is meaningful to a person is subjective and will differ. One person may perceive an activity to be filling time whereas for another it is perceived as useful.

In the routes out of loneliness, meaningful activity is defined as *"an activity that yields a sense of personal accomplishment or the fulfilment of personal goals and a self-definition of work, value or ability. Engagement in an activity that is meaningful to the individual enhances quality of life, self-esteem and sense of wellbeing. Having goals gives meaning to life<sup>14</sup>."*

### **3.4 Health and homelessness – some facts and figures**

*"People who are homeless are amongst the poorest, most vulnerable and least healthy in society.<sup>15</sup>"*

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<sup>13</sup> Kelly 1993 quoted in Help the Aged, Kim WillCock *Journeys out of Loneliness* 2004

<sup>14</sup> Ibid

<sup>15</sup> Health Development Agency *Homelessness, Smoking and Health* 2004

### **Homeless people find it harder to access primary health care**

*Homeless people are 40 times more likely to not be registered with a GP<sup>16</sup>.*

*Homeless people are less likely to be registered with a dentist<sup>17</sup>.*

### **Homeless people use A&E instead of primary health care services**

*Homeless people were four times more likely than the general public to turn to A&E when they could not access a GP<sup>18</sup>.*

### **Homeless people are more likely to commit suicide than the general population**

*Rough sleepers are thirty-five times more likely to kill themselves than the general population<sup>19</sup>.*

### **A large proportion of homeless people have some form of mental health problem**

*Figures relating to this fact vary. Research found that 30-50% of single homeless people have some form of mental health problem this is compared to 10-25% of the general population<sup>20</sup>.*

### **Many homeless people have a combination of mental health and substance misuse issues**

*A high proportion of rough sleepers, about a third, are estimated to have multiple needs, where a mental health problem is combined with an alcohol and/or drug problem<sup>21</sup>.*

### **A high percentage of homeless people have a substance misuse problem.**

*About 70% of homeless people misuse drugs<sup>22</sup>*

*About 50% of homeless people are dependent on alcohol<sup>23</sup>*

*25% of homeless people had a recorded alcohol support need, whilst 32% had a recorded drugs support need in 2002.<sup>24</sup>*

*Among homeless people surveyed, alcohol had contributed to breakdowns of marriages and relationships, loss of tenancies and jobs and affected relationships with children and other relatives.<sup>25</sup>*

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<sup>16</sup> Crisis 2002a *Critical condition*

<sup>17</sup> British Dental Association 2004 *Homeless people and dental health care*

<sup>18</sup> Crisis Op Cit.

<sup>19</sup> Crisis Op Cit.

<sup>20</sup> Crisis: *Homelessness Factfile* 2003

<sup>21</sup> Alcohol Concern, 2000

<sup>22</sup> Crisis: *Home and Dry? Homeless and Substance Use*, 2002

<sup>23</sup> ODPM, Homelessness Directorate Professor Sian Griffiths *Assessing the health needs of rough sleepers*, , 2002

<sup>24</sup> CHAIN – a pan-London database managed by Broadway, that holds information on approximately 10,000 rough sleepers

<sup>25</sup> M Crane and M Warnes, Sheffield Institute for Studies on Ageing *Wet Centres in the United Kingdom*, 2003



### **Certain illnesses are particularly prevalent amongst homeless people**

*It is estimated that about two per cent of street homeless people and direct access hostel users have been found to have active tuberculosis, 200 times the national TB notification rate<sup>26</sup>.*

*There is a marked proliferation of the following problems among homeless people, which have long been associated with harsh living conditions and poverty:*

- *Respiratory disorders*
- *Ear and skin disorders*
- *Gastrointestinal diseases*
- *Circulation problems*
- *Musculoskeletal problems*
- *Nutritional conditions*
- *Vision problems*
- *Sexually-transmitted infections*
- *Exposure-related conditions*
- *Dental conditions<sup>27</sup>.*

### **Homeless people living on the streets are more vulnerable to attack against their person**

*Homeless people's accidents and injuries were four times more likely to be the result of an assault against the person<sup>28</sup>.*

### **Homeless people are more likely to smoke than the general population**

*"Aspects of health such as healthy eating and smoking cessation tend to be low down on people who are homeless and homeless sector workers' priorities for tackling health<sup>29</sup>."*

Smoking is high amongst the homelessness population. The most recent comprehensive survey was conducted in 1996 by Gill et al which found that:

- 90% of people sleeping rough
- 85% of residents in night shelters
- 68% of hostel residents; and
- 49% of residents of private-sector leased accommodation smoked<sup>30</sup>.

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<sup>26</sup> Citron 1997

<sup>27</sup> British Dental Association 2004 *Homeless people and dental health care*

<sup>28</sup> Crisis/IPPR *Unsafe Streets 1999*

<sup>29</sup> Health Development Agency 2004 Op Cit.

<sup>30</sup> Health Development Agency 2004 Op Cit.

## **Homeless people have poor social capital which results in poor health**

Factors influencing a person's health include lack of social support and 'social capital', which is defined by the OECD as the *'pattern and intensity of networks among people and the shared values which arise from those networks'*. It has been suggested that social capital within a given minority group diminishes as it becomes a smaller proportion of the population<sup>31</sup>.

Communities which are characterised by anonymity, limited acquaintances among residents, low levels of civic participation and high levels of violence and crime are likely to have lower levels of social capital. These indicators of social capital are significantly associated with poor self-related health<sup>32</sup>. People who are homeless are likely to suffer a high percentage of these indicators. Therefore it is likely that they have low social capital and that as a result their health is adversely affected.

### **3.5 Health and homelessness – barriers to accessing health**

*“The availability of good medical care tends to vary inversely with the need for it in the population served.”<sup>33</sup>*

It is widely accepted and proved that people who are homeless have difficulty accessing health services. The following is not an exhaustive list but identifies some key barriers to homeless people accessing health services:

#### **Patient related factors**

- People who are homeless are less likely to be registered with a GP.
- Health is not always a homeless person's first priority, when they have more pressing immediate concerns such as finding somewhere to sleep.
- Homeless people remain excluded from services because they lack confidence, have an inability to keep appointments due to their chaotic lifestyles, suffer from paranoia, have had previous bad experiences, and move around and therefore have to re-register.
- People who are homeless feel that they will be looked down upon rather than treated with the same level of respect as the rest of the population.
- A lack of awareness of services available and how to access them.

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<sup>31</sup> McKenzie et al, 2002 cited in London Health Commission *Health in London* 2004

<sup>32</sup> London Health Commission 2002 Op Cit.

<sup>33</sup> Tudor Hart's inverse care law 1971

- People who are homeless may have a limited definition of health believing that it is just their physical health that counts.
- Some people's behaviour due to mental health or substance misuse will mean that they self-exclude themselves.
- People who are homeless will have low self-esteem and high levels of anxiety.
- People who are homeless may be 'out of practice' in social and communication skills.

### **Factors related to the health care profession**

- Attitudes of the health profession towards people who are homeless - perceiving them as unpopular and difficult patients, due to challenging behaviour, poor compliance with treatment, failure to keep appointments.
- Homeless people are sometimes discharged from hospital without anywhere to go, adversely affecting their health.
- Health professionals and their support staff often have a lack of knowledge on issues associated with people who are homeless.
- There is often a lack of flexibility in accessing health care and lack of awareness surrounding the issues of homeless people which can lead to exclusion from services.
- Poor publicity and promotion of services amongst homeless people and homeless sector workers.

### **Wider societal and political issues**

- Inadequate investment in specialist health care services.
- Insufficient understanding of the needs of marginalised groups such as people who are homeless.
- Lack of permanent and stable housing.

*“The most disadvantaged people tend not to use services and benefits as much as others do, or to gain from them as much when they do. [...] it may be the severity and specificity of the multiple needs each very disadvantaged person faces makes it difficult for some current public services to help them. However, unless policy is able to address the needs of disadvantaged groups, the overall risk of social exclusion may be reduced, but people most in need will be left further behind<sup>34</sup>. ”*

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<sup>34</sup> Social Exclusion Unit: *Breaking the cycle* 2004

### 3.6 Social and cultural activities – their role in promoting health and well-being

*‘Resettlement support alone is not enough to help people back into mainstream society. We need to find ways to help people build self-esteem, develop their skills, and reconnect into social networks away from the streets<sup>35</sup>.’ (DETR 1999).*

There are a range of solutions addressing homeless people’s health needs/ care, both across London and in Westminster. Services such as those run from Dr Hickey’s surgery and the Nurse-led Homelessness Service (a Westminster Homelessness Personal Medical Service) offer a range of health services to people who are homeless from counselling and psychiatry, through to podiatry and dentistry as well as offering legal advice. The health and wellbeing of residents within Westminster is catered for by a wide range of voluntary and statutory (including PCT-led) services; an initial list included 38 agencies and this list is not considered to be comprehensive<sup>36</sup>.

This literature review will not look at these services, as it is considering the link between improving a homeless person’s wellbeing and health through the use of social and cultural activities. Within the homelessness sector there is no research literature focus on this specific issue, but a wide range of literature from other sectors.

There are two ways of looking at how social and cultural activities promote a person’s health:

- **Medical** - Studies in the medical environment have looked at the clinical outcomes of using art therapy on individuals, as has the mental health world to a certain extent.
- **Community** - What is less well researched is the impact that art and cultural activities have on promoting community regeneration and health in a community setting, which is most relevant to this study. Outside of the medical world, it becomes harder to measure the impact because of other contributing factors.

Most projects that have been included in literature reviews looking at how art benefits health have been psychological, social and even spiritual rather than physical, due to the nature of the work. A small number of projects have focused on the physical e.g. reducing falls in older people<sup>37</sup>.

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<sup>35</sup> DETR *Coming in from the cold: Government Strategy on rough sleeping* 1999

<sup>36</sup> Health Hostels: an interim report ; Westminster PCT 2005

<sup>37</sup> Arts Council 2004b Op Cit.

It is important to remember that for the use of arts in the medical or mental health sector, staff will have been properly trained to have the interpersonal skills needed for gaining the confidence of the patient, as well as being aware of the risks arising from dealing with sensitive personal issues and being able to deal with them. Whilst not being supported with evidence it is possible that this will probably not have been the case in the homelessness sector, as the link between social and cultural activities and health has not always been explicitly drawn.

*'Cultural activities are also effective ways of engaging diverse communities and raising their awareness of a particular issue'<sup>38</sup>.*

It has been found that cultural and social activities can:

- Help in the understanding and alleviation of human distress.
- Empower, enhance self-esteem and make interpersonal communication more meaningful<sup>39</sup>.
- Enable people to find new ways of expressing themselves.
- Improve psychological wellbeing and quality of life in later life, as a result of regular engagement with meaningful activity. Involvement in activity is related to better health in later life; physical and social activities are consistently associated in longitudinal studies not only with higher life satisfaction, but also with better health, longer life and lower rates of institutionalisation<sup>40</sup>.
- Provide a sense of purpose and a continued role in life.
- Reduce isolation and loneliness, develop interpersonal and social skills, build confidence and self-esteem, boost morale and improve motivation.
- Help to alleviate anxiety and depression and distract from drinking<sup>41</sup>
- Improve individuals' and communities' general wellbeing through increased social contacts and networks which are linked to improved levels of health.
- Promote psychological wellbeing. Physical activity and exercise can reduce anxiety, enhance mood and build self-esteem. Physical and mental activity can help to distract from thoughts that maintain anxiety and depressed mood, and structured activities may distract from drinking<sup>42</sup>.

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<sup>38</sup> Association of London Government: *Culture and communities 2005*

<sup>39</sup> Simms 1993 referenced in Help the Aged Op Cit.

<sup>40</sup> Palmore 1979 and Steinback 1991 referenced in Help the Aged Op Cit.

<sup>41</sup> Help the Aged Op Cit.

<sup>42</sup> Taylor 2000: Mutrie 2000: Fox 2000, referenced in Help the Aged 2004 Op Cit.

Apparent social skill deficits can also be associated with anxiety or with depression. The social networks of many who are homeless focus on the 'homelessness circuit which can lead to a cycle of homelessness and substance misuse. Ending this cycle can lead to the loss of existing social networks making it very difficult to do unless opportunities exist outside of the cycle. Social and cultural activities could provide this opportunity<sup>43</sup>.

The following highlights the different outcomes that the varying forms of social and cultural activities can have for people:

**Art** can be therapeutic and cathartic by enabling people to express feeling of pain and anger and deal with such feelings. It can be a form of distraction from distressing thoughts and an escape from the realities of life.

**Creative writing** is a way of discovering and communicating feelings, values and ideas in order to help clarify, analyse and synthesise life experiences. It can help people increase and improve their self-awareness by exploring ideas. Creative writing can also give nursing and medical staff the opportunity to better understand the context and environment which influence the client group.

**Music, singing and dancing** can help mental health patients to remember events from their lives. These activities help people to express themselves better, but also to improve their range of movement on a physical level.

**Group work** can be a positive way of delivering services as it enables people to interact with others, re-develop social skills and learn how to meaningfully interact with other people.

**Meaningful activity** can help people maintain a continued role in life and provide a sense of purpose. Regular engagement in activity is vital for psychological wellbeing.

Evaluations and reviews of art for health services based in the community have suggested that projects work best when they have developed organically or have been identified by local need rather than being funding driven<sup>44</sup>. A couple of the reports recommend that projects do not link arts too rigidly to social or educational messages but instead achieve this through indirect means<sup>45</sup>.

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<sup>43</sup> Help the Aged 2004

<sup>44</sup> Health Development Agency 2000 Op Cit

<sup>45</sup> Health Development Agency 2000 Op Cit., John Angus CAHHM: *A review of evaluation in community-based art for health activity in the UK*, 2002

## Examples of what has happened in the sector already

The majority of programmes using meaningful activity relate to people gaining employment or moving onto training and volunteering, and do not look at people's health.

**The “Rolling Shelter” project** offered ‘engagement activities (City Lit, *Crossing the Threshold* 2003). These are first-step programmes aiming to involve learners in structured activity with a clear outcome, and to encourage the development of learners’ self-esteem and ability to plan for the future.

Benefits of using an **arts curriculum**:

- Creativity – it engages the learners in a holistic way.
- Reduces boredom – a decision not to live on the streets may lead to feelings of boredom and purposelessness.
- Easy entry requirements – involvement must be immediate with no prior learning required.
- Low basic skills requirements – learners can engage in learning without having basic skills problems exposed.
- Expression of personal story – many learners appreciated the opportunity to express and reflect on what had happened to them.
- Mobile – materials can be used in a range of venues.
- Easily differentiated – learners can make progress at their own speed and build upon pre-existing ability.

### **Cardboard Citizens’ Engagement Programme Health Pilot**

Cardboard Citizens is a forum interactive theatre company, a technique that encourages the audience to get involved in solving problems that relate to their own lives. The technique also ‘*provides the opportunity to build confidence, facilitate information exchange and allows a safe space to practise positive behavioural change*’. They were funded in 2003 to work within Westminster and Camden PCTs to engage with health professionals to raise awareness over issues associated with homelessness, and also to take workshops out to hostels and day centres to engage with the audience. The workshops demonstrate the amount to which the audience has been involved in finding solutions and will lead to progression to appointments and discussing options. The actors/mentors will have had experience of homelessness and will have received health care training.

### **Help the Aged**

Help the Aged are funding a meaningful activity worker and have conducted research looking into what older homeless people would like out of meaningful activity to reduce their loneliness and isolation.

### **3.7 Measuring health and wellbeing and measuring impact of social and cultural activities**

The majority of evaluations and suggested ways of monitoring these projects have focused on using ethnographic models. The quantitative approach has not been widely used nor does it seem to be recommended, as the focus on numbers and hard data can lose the worth and value of the project. As mentioned above, this is an area that has not been hugely developed and it appears that there are currently no formal measurements that exist in the health sector. Self-reporting of health is another method of evaluating and measuring the success of projects. There is a need to measure distance travelled by individuals before and after sessions, using the same questionnaire at a series of key points and brainstorming definitions of confidence etc.

One project included in a literature review by Angus<sup>46</sup> used an adapted standardised questionnaire at the beginning and end of a series of workshops. A statistical test was then applied. Another structured mechanism for evaluating a project used the log frame planning model. This same literature review recommended that the aims and intentions of the projects should be made more explicit.

Possible indicators for measuring the impact of social and cultural activities could include:

- Personal development/well-being
  - Developing interpersonal, relationship and social skills
  - Communication skills
  - Building confidence and improving self-esteem
  - Pride in achievement
  - Enhanced motivation
  - Increased social ability
  
- Mental well-being
  - Improving mental health and psychological well-being (particularly anxiety and depression)
  - Reducing social isolation and expanding social networks
  - Alleviating loneliness and forming social relationships
  - Emotional literacy
  - People's own perceptions about having a more positive outlook on life
  
- Drugs and alcohol

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<sup>46</sup> Health Development Agency 2002 Op Cit.



- Reducing alcohol intake and increasing control over drinking
- Reduced consumption of drugs either illegal or prescription
  
- The process
  - Participation
  - Increasing activity levels and engaging in purposeful activity
  - Learning new skills and re-learning forgotten ones
  
- Staff development and awareness
  - Increased empathy and understanding of client group
  - Understanding and recognition of health
  
- Health outcomes
  - Raising awareness of health issues and encouraging people to take responsibility for their health

People who are depressed and lack a sense of self-worth can be poorly motivated and may show little interest in their physical environment which can lead to self-neglect – could there be something about measuring the change in people's appearance?

### **3.8 Recommendations**

Evidence presented in the literature review informs the following recommendations:

- Clearly define aims of social and cultural projects.
- Place emphasis on the social and cultural activities themselves rather than focusing on the mechanisms for promoting health improvements - many of the benefits stem from the engagement with arts, sports and other activities per se.
- Projects which are based on the ideas of homeless people and practitioners are often more beneficial than those largely constructed around the demands of funders. Projects should be based on a clear assessment of need and aims, as well as ensuring that agencies and people who are homeless have played a central role in shaping it.
- Provide opportunities and space for project coordinators to reflect on their practice and gain support from experienced mentor e.g. OT or art therapist.
- Define models of health, and focus project on aspects other than physical health and more about wellbeing.
- A qualitative approach is central to meaningfully evaluating the health outcomes of social and cultural activities.

## Key findings (1) Literature review

- There appears to be no direct research looking at the impact of social and cultural activities on a homeless person's health. As a result, the literature review summarises research and evaluations of social and cultural activities from other sectors, in particular at projects run in a medical setting.
- A holistic approach to health in its broadest sense is taken by the literature from people's social networks and their social capital to depression and anxiety.
- The literature covers a range of social and cultural activities from museums, sport, group work, and social activities such as outings.
- People who are homeless have a range of health needs ranging from physical conditions such as TB, to mental problems such as depression or schizophrenia as well as issues around access to care.
- Research on people who are homeless shows that they experience barriers to accessing appropriate health care. There is no single explanation for this but can be explained through factors relating to people who are homeless such as those created by their chaotic lifestyles or an inability to clearly express their needs and access the appropriate services to the attitude of health professionals.
- Research suggests that social and cultural activities can positively impact on a person's health, in particular their psychological and social wellbeing. Very few studies appear to have directly linked these activities with a person's physical health.
- The literature suggests that the barriers people who are homeless face accessing health services could be partially overcome through participating in social and cultural activities.
- The different outcomes that have arisen from social and cultural activities include improved self-esteem, gaining new social skills such as learning how to interact with each other, reducing isolation and anxiety as well as learning new ways to communicate.
- The projects evaluated in the literature research have measured a number of outcomes/indicators including reduced social isolation, the ability to express feelings, expanded social networks and people's own perceptions about their outlook on life.
- Social and cultural projects are generally evaluated using qualitative data as the outcomes are subjective and based on people's emotional wellbeing.
- The literature suggested that projects worked best when they had clearly defined aims and where ideas were need, rather than funding, led.

## 4 Research findings: workshops with homeless people

### 4.1 Profile of attendees

Workshops were held at five organisations across Westminster. A description of the service offered by the organisations where workshops were held and the number of people attending each session is shown in figure (a).

**Figure (a) Workshop location and number of attendees**

<b>Name and postcode area of service</b>	<b>Description of service/ client group</b>	<b>No people attending</b>
Dean Street Hostel, W1V	Will accept people with medium-high support needs in the areas of mental health, alcohol and drugs, resettlement, employment and training.	8
Cardinal Hume Hostel, SW1P	Young people are aged between 16 and 21. 40% of residents are unsupported refugees.	5
Church Army Centre, NW1	Single homeless women, including refugees and asylum seekers; those in housing need and/or with support needs.	11
Connection at St Martin's day centre for older people, WC2N	Homeless adults aged 26+ with a range of support needs.	11
The Passage Day Centre, SW1P	Homeless adults with a range of support needs.	10
Total		45

Thirty men and fifteen women attended the groups. The age, ethnicity and nationality profile of participants is shown in Figure (b). Participants were asked to write in their nationality and some described their ethnicity as well as their nationality e.g. 'Black British'. The question is asked in addition to ethnicity to show the cultural mix of the workshops. Sixteen participants did not specify their nationality.

**Figure (b) Age, ethnicity and nationality profile of workshop participants**

Age group	No of participants
25 or under	8
26-35	7
36-45	12
46-55	7
56-65	7
66 or over	4
Total	45

Ethnicity	No of participants
White British	16
White Irish	6
Other White	8
Black African	5
Black Caribbean	3
Mixed- other mixed	2
Asian Indian	1
Asian Pakistani	1
Asian- other Asian	1
Mixed White and Black African	1
Not specified	1
Total	45

UK		African		Non UK European		Other	
Nationality	No	Nationality	No	Nationality	No	Nationality	No
Black British	1	Eritrean	1	Austrian	1	Jamaican	1
British Asian	1	Gambian	1	Portuguese	2	Malaysian	1
English	1	Somali	1	Spanish	2	Canadian	1
Irish British	1	South African	1	Total	5	Total	3
Scottish	6	Total	4				
Northern Irish	2						
Welsh	1						
Irish	4						
Total	17						

#### 4.2 Perceptions of health

As a warm-up exercise and introduction to the issue of health, workshop participants were asked to write on post-it notes their views on the following questions:

- What does being healthy mean to you?
- How does it feel to be healthy?

Responses are shown in figure (c), over two pages, and have been grouped into themes. Comments are shown exactly as they were written by participants. Responses demonstrated a holistic view of health and a perception of health going beyond the absence of illness or disease. The most common responses (20 responses) were about feelings such as being 'happy', feeling 'strong, vigorous' and being 'content' and 'laugh (ing)'. The second most common themes were about diet (12 responses) and physical fitness (11 responses).

Comments on the meaningful occupation of time (10 responses) are particularly relevant to this research project. Examples given included sports, crafts activities, 'stimulating mental exercise' and learning new skills.

Responses themed under 'attitude and motivation' indicate the impact of being healthy on the life of participants:

*'When you are healthy you feel well, happy and ready to take on everybody, good or bad.'*

*'Health mean to me? Living on the street has shown me how important this is - having to stay on top and mentally being positive even when you don't want to.'*

*'If you are healthy you have power to achieve things.'*

**Figure (c) What does being healthy mean to you? How does it feel to be healthy?**

Theme	Comments
<b>Feelings</b>	<ul style="list-style-type: none"> <li>▪ Happy (4 responses)</li> <li>▪ Brings you out of yourself</li> <li>▪ Content</li> <li>▪ Happy and positive - acting and thinking</li> <li>▪ No hassles</li> <li>▪ To laugh</li> <li>▪ Feel good/ Good/ It feels good to be healthy (3 responses)</li> <li>▪ More energy</li> <li>▪ Fresh, feel clear</li> <li>▪ Physical and mental well-being</li> <li>▪ Feel good each day and enjoying good living and getting back to normal</li> <li>▪ Strong vigorous, all systems go, clear-headed</li> <li>▪ Peace &amp; friendliness</li> <li>▪ Feel comfortable</li> <li>▪ Feeling well in mind and body</li> </ul> <p style="text-align: right;"><b>Total= 20 responses</b></p>
<b>Diet</b>	<ul style="list-style-type: none"> <li>▪ Money for decent food / having enough money to eat (2 responses)</li> <li>▪ Fresh fruit and vegetables instead of rice everyday</li> <li>▪ Better food (3 responses)</li> <li>▪ Good food/ Eating well/ Eat well, eat healthy food (3 responses)</li> <li>▪ Having food to eat/ To have food (2 responses)</li> <li>▪ Vitamins</li> </ul> <p style="text-align: right;"><b>Total= 12 responses</b></p>
<b>Fitness</b>	<ul style="list-style-type: none"> <li>▪ To be fit (4 responses)</li> <li>▪ Active (2 response)</li> <li>▪ Exercise</li> <li>▪ Fitness living well “living” sporty energetic</li> <li>▪ Sports</li> <li>▪ Kept fit: Don’t be lazy. If you healthy you wealthy</li> <li>▪ Active in running</li> </ul> <p style="text-align: right;"><b>Total= 11 responses</b></p>
<b>Meaningful occupation of time</b>	<ul style="list-style-type: none"> <li>▪ I believe a good stimulating mental exercise (environment) can aid good health</li> <li>▪ Football &amp; space to play games (chess, dominos etc)</li> <li>▪ Sports &amp; activities.</li> <li>▪ A civic centre with qualities of equipments for sports volleyball, classes etc</li> <li>▪ There are all activities/ happenings etc. so you see all the walks of all homeless places (sic)</li> <li>▪ Making progress and learning new skills (liked the woodwork as things keep moving and developing)</li> <li>▪ Work crafts</li> <li>▪ Being able to attend classes at women’s centre</li> <li>▪ Being happy, being energetic finding more activities</li> <li>▪ Having enough money for traveling</li> </ul> <p style="text-align: right;"><b>Total= 10 responses</b></p>
<b>Housing</b>	<ul style="list-style-type: none"> <li>▪ Accommodation/ shelter/ having a place to sleep/ having somewhere to live/ house/ housing (6 responses)</li> <li>▪ Having house- enough money to pay bills</li> </ul> <p style="text-align: right;"><b>Total= 7 comments</b></p>

**Figure (c) cont. What does being healthy mean to you? How does it feel to be healthy?**

<b>Theme</b>	<b>Comments</b>
<b>Attitude and motivation</b>	<ul style="list-style-type: none"> <li>▪ When you feel healthy you feel well, happy and ready to take on everybody good or bad</li> <li>▪ Being healthy means being able to come out of homelessness and become of new energy new happiness</li> <li>▪ Health mean to me? Very important being on the street has shown me how important this is. Having to stay on top and mentally being positive even when you don't want to.</li> <li>▪ If you're healthy you will have will-power to achieve things</li> <li>▪ Getting up in the morning</li> <li>▪ Trying to be happy</li> <li>▪ Not sleeping all day</li> </ul> <p style="text-align: right;"><b>Total= 6 responses</b></p>
<b>Personal care</b>	<ul style="list-style-type: none"> <li>▪ To be clean, to be active</li> <li>▪ Easier access to washing facilities</li> <li>▪ Health- looking after yourself</li> <li>▪ Looking after yourself - cleanness.</li> <li>▪ Being healthy to me means treating your body right and knowing what you are doing to your body and FEEL GOOD.</li> <li>▪ Look after body</li> </ul> <p style="text-align: right;"><b>Total= 6 responses</b></p>
<b>Access to care/ help</b>	<ul style="list-style-type: none"> <li>▪ Better health care i.e. at (name of GP surgery) I have problems with my legs- they will not treat me</li> <li>▪ Good people to talk with over 0800 phonenumber</li> <li>▪ Rehab</li> <li>▪ More places for more health</li> <li>▪ Good foot care</li> </ul> <p style="text-align: right;"><b>Total= 5 comments</b></p>
<b>Working</b>	<ul style="list-style-type: none"> <li>▪ Paid for work</li> <li>▪ Able to hold job down</li> <li>▪ Working</li> <li>▪ Good lifestyle, back in work</li> <li>▪ Good health means 'can work and enjoy life'</li> </ul> <p style="text-align: right;"><b>Total= 5 responses</b></p>
<b>Social well-being</b>	<ul style="list-style-type: none"> <li>▪ Friends/ making friends/ to have friend/ to have friends (4 responses)</li> <li>▪ Socialise (2 responses)</li> <li>▪ Friendly atmosphere</li> <li>▪ No isolation from people</li> </ul> <p style="text-align: right;"><b>Total= 5 responses</b></p>
<b>Other</b>	<ul style="list-style-type: none"> <li>▪ I'm healthy but don't feel well in this situation</li> <li>▪ Too much alcohol! Feel bad</li> <li>▪ Drawing breath</li> <li>▪ To be able to read and write</li> </ul> <p style="text-align: right;"><b>Total= 4 responses</b></p>
<b>Rest, relaxation, state of mind</b>	<ul style="list-style-type: none"> <li>▪ Free from the pressure of modern day living</li> <li>▪ Peace of mind (2 responses)</li> <li>▪ Sleep</li> <li>▪ Relaxation</li> </ul> <p style="text-align: right;"><b>Total= 5 responses</b></p>

<b>Mobility/ physically able</b>	<ul style="list-style-type: none"> <li>▪ Able to get around</li> <li>▪ To be 1) physically 2) all round good able to run and walk far</li> </ul> <p style="text-align: right;"><b>Total= 2 responses</b></p>
<b>Physical condition</b>	<ul style="list-style-type: none"> <li>▪ It means you are healthy you don't have health problems</li> <li>▪ Health means to live a happy life, healthy condition</li> </ul> <p style="text-align: right;"><b>Total= 2 responses</b></p>

### 4.3 Current involvement in social and cultural activities

The extent to which workshop participants were engaged in social and cultural activities varied across the groups. A summary of feedback from each group is presented in Figure (d).

Some groups felt very negative about the availability of opportunities to take part in activities- for example at Dean Street Hostel participants commented that there was little or nothing for them to do in Westminster except go to the pub and play pool. This group had heard about activities by word-of-mouth but few could name any they had taken part in. The exception was two clients who had been on trips away with the Passage.

Although there was less of a sense of having 'nothing to do', these comments were echoed by participants at Connection at St Martin's who had heard about trips out for homeless people in Westminster but never accessed them. This group made more mention of independent activities such as attending libraries. At the Passage there was more of a balance between comments about independent and organised activities, although only a few people in the group referred to specific organised activities that they had undertaken.

Participants at the Cardinal Hume Hostel reported a lack of sports facilities although a couple of people played sport. Again the group had heard about trips out taking place in the borough but felt frustrated by the perception that activities were linked to specific organisations to the exclusion of other homeless people. In terms of group activities some participants attended or had previously attended sessions at the Cardinal Hume Centre - including a men's group, cooking and cinema trips.

At the Church Army participants described a wide range of activities that they had accessed at the centre including arts, crafts, exercise and social and cultural events.



**Figure (d) Activities currently undertaken in Westminster and barriers to accessing activities**

<b>Current activities</b>
<p><b>Dean Street Hostel</b></p> <ul style="list-style-type: none"> <li>▪ Several people in the group commented that they play pool in the pub as there is little else to do.</li> <li>▪ Participants had heard about some activities for example at the Hungerford Centre but they had not taken part in these.</li> <li>▪ Two participants had accessed trips - one to Brighton and one to Wales.</li> </ul>
<p><b>Cardinal Hume</b></p> <ul style="list-style-type: none"> <li>▪ The male participants indicated that they sometimes play sports but that there are no good facilities in the area: <i>'Elephant and Castle and round South London have more sports facilities'</i>.</li> <li>▪ The participants had heard about a lot of activities which go on but found it frustrating that they were often linked to a specific organisation e.g. one person commented that you can go to the gym free but only if you are with Centrepoint.</li> <li>▪ The group mentioned that Cardinal Hume Centre provides life skills including cooking, cinema trips and a men's group.</li> </ul>
<p><b>The Church Army</b></p> <ul style="list-style-type: none"> <li>▪ Participants in the group spoke about a wide range of social and cultural activities that they undertake at the centre. These included keeping fit and dancing to music, trips out, painting, music classes, sewing with numeracy.</li> <li>▪ The group frequently mentioned bringing people together when discussing activities for example: <i>'Getting people together- one-off occasions like BBQs'</i> <i>'Meeting people from other cultures'</i> <i>'Opportunities to do more things and be supported- meeting friends... Caring attitude of those leading.'</i></li> <li>▪ Some members of the group were very active in seeking opportunities for getting involved in activities outside the centre. For example some had attended Crisis Skylight and another attends bingo at the Passage.</li> </ul>
<p><b>Connection at St Martin's</b></p> <p>Members of the group attended libraries and swimming- one person mentioned that you can get a free sports centre pass at libraries.</p> <ul style="list-style-type: none"> <li>▪ Other members of the group accessed computers at the Passage and Connection.</li> <li>▪ One person mentioned trips out to the seaside from the Passage which he thought happened about two times a year.</li> <li>▪ One person in the group had been to the ballet in Covent Garden (this was not part of an organised trip).</li> </ul>
<p><b>The Passage</b></p> <ul style="list-style-type: none"> <li>▪ Members of the group mentioned several independent activities:             <ul style="list-style-type: none"> <li>○ Feeding the ducks</li> <li>○ Walking all day</li> <li>○ Jogging</li> <li>○ Going to the library.</li> </ul> </li> <li>▪ Group activities were mentioned by several people, these were:             <ul style="list-style-type: none"> <li>○ Relaxation and art classes at the Church Army</li> <li>○ Chess at the Salvation Army</li> <li>○ Bingo at the Passage</li> <li>○ Gardening</li> <li>○ Going to Wales and a boat trip.</li> </ul> </li> </ul>

#### 4.4 Barriers to accessing social and cultural activities

Groups were asked about the barriers to accessing social and cultural activities currently on offer- both those undertaken independently and those supported by an organisation or group (figure (e)). The issues common to all groups were a lack of money to access leisure facilities independently and a lack of information about what is on offer in the area.

Issues regarding money included the entry fees to leisure facilities, the number of cultural buildings or resources that have entry fees such as churches and museums, the high cost of accessing some facilities such as theatre, and transport costs:

*'London is for rich people- you live in the centre of London but you don't get to do stuff. People who come to London get to see it all and they ask 'have you done this' or 'been to that' but you haven't done it even though you live here.'*

Various solutions to this issue were suggested:

- Providing a residents card or a discount card for homeless people
- Having regular days/ sessions when homeless people have free access to specified facilities
- Negotiating free theatre seats, gym sessions etc with managers of social and cultural facilities.

There was a recurring issue about the lack of co-ordinated information about activities across the borough. The Church Army group perceived a need for a regularly updated, centralised list of the activities on offer. A point made in the Cardinal Hume workshop, which highlights this was:

*'They nearly cancelled a trip to the Isle of White as there were not enough people, but there are so many people who would have wanted to go.'*

Other issues were people reading out-of-date leaflets, becoming over-loaded with written information and needing some verbal direction on what type of activities they may be able to access, and activities being linked to one homelessness organisation to the perceived exclusion of other potential clients. The Cardinal Hume group had ideas for engaging young people in activities through enhanced and creative publicity such as text updates and competitions.

Another barrier raised in the groups was stigma- people in two groups mentioned that they feel that the way homeless people dress means they are excluded from or not welcomed at social or cultural facilities in the area.

In two groups opening hours/ the times and day when activities are organised was mentioned. One group felt that the absence of things for homeless people to do at the weekend and in the evenings, when other people tend to relax and enjoy themselves, is a form of social exclusion.

Very practical issues raised by one group were (a) the absence of a place for rough sleepers to leave belongings so you are free to go on a trip without taking everything with you and (b) the danger of missing out on a bedspace if you '*take your eye of the ball*' and go out for the day. Related to this was the perception that social and cultural activities should come second to sorting out benefits and accommodation issues; and also, for one person, a fear of enjoyment and relaxation while in a homeless situation.

A lack of personal motivation due to laziness and addictions was felt by some to constitute a barrier to accessing facilities.

**Figure (e) Barriers to accessing social and cultural activities**

<b>Barriers to involvement in activities/ ideas to get people involved</b>
<p><b>Dean Street Hostel</b></p> <ul style="list-style-type: none"> <li>▪ Several people mentioned that they would like to exercise but that this is too expensive</li> <li>▪ There was a high degree of negative feeling about accessibility to the arts in Westminster, and a sense of alienation from the cultural facilities in the borough e.g. <i>'There are lots of galleries in Westminster but they are not accessible to homeless people, the way you dress prevents access- it's about presentation.'</i></li> </ul>
<p><b>Cardinal Hume</b></p> <ul style="list-style-type: none"> <li>▪ Issues with information and publicity were perceived to be key barriers: <i>'They nearly cancelled a trip to the Isle of White as there were not enough people, but there are so many people who would have wanted to go.'</i> <i>'You only get the adverts if you are at a certain place- need centres to join up.'</i></li> <li>▪ The group agreed that 'making a big thing of it' was a way of attracting people to activities and to avoid negative peer pressure around taking part in activities which are viewed as peripheral.</li> <li>▪ Promotional ideas included offering text updates on activities and '<i>getting people's attention with a competition</i>'.</li> <li>▪ Lack of money to access sports facilities was viewed as a barrier.</li> </ul>
<p><b>Connection at St Martin's</b></p> <ul style="list-style-type: none"> <li>▪ Lack of information was viewed as a key barrier by this group. Although one person stated that you can get hold of information from various locations, others found that it hard to know where to start.</li> <li>▪ Staff training was an issue raised in relation to information- it was felt that verbal communication as well as written information should be provided about opportunities for activities, as people get written information overload.</li> <li>▪ A major issue for people in the group was the absence of a safe place to leave belongings.</li> <li>▪ One member of the group said he doesn't want to enjoy himself while he is homeless- he would rather sort things like benefits out. Another participant commented that there is a fear that you may miss a hostel bedspace if you go out for the day. Some members of the group commented that once you know you have a hostel you need things to do to fill your days.</li> <li>▪ Opening hours of centres was perceived to be a problem. It was reported that there are many more homeless people who are very drunk at the weekend when services are often closed.</li> </ul>
<p><b>The Passage</b></p> <ul style="list-style-type: none"> <li>▪ Financial reasons were a key issue for members of the group. There was some frustration about the number of attractions you have to pay to access including churches and museums. Some felt people should be given a residents card with discounts or to get free entry.</li> <li>▪ Discrimination against homeless people and particularly the way people dress was felt to be a barrier by one member of the group e.g. <i>'You may get laughed at if you go to the sports centre- or you could be kicked out of shops.'</i></li> <li>▪ Personal issues with motivation and addictions were also viewed as a barrier.</li> </ul>
<p><b>The Church Army</b></p> <ul style="list-style-type: none"> <li>▪ The first issue raised was '<i>Money, money, money</i>' and related to this, transport.</li> <li>▪ Accessible, up-to-date information was raised as an issue. The group perceived the need for a '<i>fully centralised list</i>' or a '<i>co-ordinated collection of leaflets</i>'.</li> <li>▪ Opening hours of services was viewed as a barrier to access, with some people wanting to use computers earlier in the day than was possible or at weekend when many services are closed.</li> <li>▪ Stigma was raised as an issue: <i>'If you look OK you get access- if you don't then you won't- well people (sic) limit you just by looking at you.'</i></li> <li>▪ Some services put age limits on activities. Consistency of staffing was raised especially as services are sometimes dependent on the skills of</li> </ul>

volunteers:

*'Sometimes volunteers leave or staff are off sick.'*

- Health and safety legislation means that some activities are not possible.

#### **4.5 Making the link- the health impact of social and cultural activities**

To facilitate discussion and feedback on the link between social and cultural activities and health, at each workshop participants were split into three groups to discuss one of three made up, but realistic, projects for homeless people; a football club, an arts and crafts session and a series of trips out. Three or four key facts about the projects were supplied to stimulate discussion. The groups were asked to reflect on the health benefits of these activities in terms of mental health, social well-being, physical health and accessing health services.

In all workshops participants were able to identify a wide range of health benefits from the activities- this was the case whether or not the individual was currently participating in social and cultural activities. The health benefits of different activities were similar and are presented on pages 38-39- where a benefit applies to a specific activity only this is indicated in brackets. Participants also considered any negative impacts of taking part in the activities and these are marked with a ✖ symbol.

The impact of activities on mental health and the related area of social well-being was emphasised in all groups. Reasons for included the fact that activities encourage people to spend time away from their hostel rooms, that they allow people to socialise and meet others in a safe environment and that activities have a positive impact on self-esteem and confidence.

Several of the potential benefits mentioned are relevant to key priority areas in the Westminster PCT Health Promotion Strategy including physical activity, healthy eating, sexual health and substance misuse:

In terms of physical activity the benefits of sports activities as well as physical activity involved in some arts and crafts and trips out were described in the groups. Specific benefits mentioned were around having a healthy heart and weight control.

It was suggested that activities can provide a distraction from addictions to drugs and alcohol- having an activity planned may reduce the levels of substances taken. Having activities in a 'clean', drug, alcohol and smoke free environment was viewed as a way of ensuring that projects are as 'healthy' as possible.

Another potential way to create social and cultural activities which are as 'healthy' as possible is to incorporate health promotion into activities for example by providing meals or snacks and information to promote healthy eating, by providing information about GUM services and free condoms to promote sexual health and by giving people information about drug services and harm minimisation.

**a) Impact of social and cultural activities on mental health**

- ✓ Preventing isolation- e.g. helps people avoid spending excessive amounts of time spent in a hostel room which was viewed as a trigger for or symptom of depression and anxiety. Activities are *'good for people who become anxious and withdrawn if they are alone'*.
- ✓ Diversionary impact- the activities help take participants' minds off negative issues through enjoyment or happiness and providing a temporary distraction from substance addiction.
- ✓ Releasing tension (football and trips to football matches) - *'letting off steam instead of keeping it boiled up and causing aggravation in the hostel'*.
- ✓ Relaxation- especially when relaxing in a different environment (trips out), promoting *'calmness and serenity'* (arts and crafts).
- ✓ Therapeutic impact of art- *'paintings and pictures can bring back memories good and bad and this can help you cope'* (trips out).
- ✓ Promoting self-esteem and self-worth - *'Evidence that you can do what they said you couldn't'* (arts and crafts), sitting down and thinking about what you would like to do.
- ✓ Exercise for the brain - promoting concentration, alertness, use of imagination and learning.
- ✓ Taking part could help break down paranoia.
- ✗ Could trigger paranoia or agoraphobia or problems for people who fear being around others.
- ✗ If there's a lack of support, taking part could bring out some issues that people have e.g. anger.
- ✗ Could drag you further into homeless mentality i.e. if you are only doing things with other homeless people.

**b) Impact of social and cultural activities on social well-being**

- ✓ Meeting new people, making new friends: *'finding out about new things from other people'*, *'brings isolated people together in a neutral environment where relationships develop...[creating] social bonds'*, *'sharing experiences leads to better problem solving'*.
- ✓ Interaction with others helps many people to increase their confidence (although one person stated that being a bit of loner was OK for him).

- ✓ Challenges stigma - *'you are just a person - a person with a problem but enjoying a trip out the same as anyone else'*.
- ✓ Activities and interests give you something to talk about with others.
- ✓ Teamwork, having an input into group activities - being valued.
- ✗ *'If you make a mistake when acting as part of a team you may feel responsible or upset'* (football).
- ✗ Bullying from others taking part e.g. *'people making your life a misery'* on trips.
- ✗ Personality clashes.

**c) *Impact of social and cultural activities on physical health***

- ✓ Exercise - walking around (trips out), improved fitness and strength (football), helps you maintain a healthy weight.
- ✓ Reduction in alcohol and drug intake - *'being in a clean (no substances), safe environment'*.
- ✓ Eating different food even just for one day (trips out).
- ✓ Better breathing when relaxed and calm.
- ✓ Getting out of bed and doing things can result in developing routine and better sleep patterns.
- ✓ Health promotion- where participants are given information about health services or about healthy lifestyles.
- ✗ Medical conditions may stop or prevent enjoyment of activities.
- ✗ Accidents and injuries can occur e.g. sports injuries (football) or injuries to the hands (arts and crafts).

**d) *Impact of social and cultural activities on accessing health services***

- ✓ People who regularly take part in activities may address health problems and seek help more quickly so they are fit to play/ attend, and *'companions may encourage you to register with a GP', 'the coach may tell you to go to the doctor'* (football).
- ✓ You can find out about other services while taking part in activities both through leaflets and posters and through verbal information, *'helps you engage with organisations', 'other services are often in the same building as the activities'*.
- ✓ Incentive to be healthy enough to attend trip, one member of the group told an anecdote about a hostel resident who was reluctant to seek help for an abscess and eventually saw the doctor so that his leg was healthy enough to go on the rides on a visit to Chessington World of Adventures.

- ✓ Enhanced confidence may enable you to attend health services, communicate about your needs and *'help you become friends with a new nurse'*.
- ✓ You could get information and advice at the activities e.g. sex education, advice about diet.
- ✓ If activity helps you with structure and routine you are more likely to keep appointments.

After thinking about the links between social and cultural activities and health, participants were asked to think about how the activities could be improved. The practical, although sometimes ambitious, suggestions are summarised below.

***Trips out:***

- ❑ Have a wide range of trips and include trips overseas
- ❑ Let participants choose the trips e.g. in a questionnaire
- ❑ Include: a trip to the countryside with long walks, fruit picking, camping trips, trips to festivals, fishing
- ❑ Have healthy food options on trips out
- ❑ Make trips regular, *'every few weeks would be really good'*
- ❑ Have an on-going programme of trips, *'for a year or more'*
- ❑ Advertise in advance- a least a week before the session

***Arts and crafts:***

- ❑ Have a wide range of activities such as mosaic, sculpture, trips to relevant places e.g. galleries or other craft centres for inspiration
- ❑ Have one-to-one help available
- ❑ Have some sessions outside
- ❑ Make the session 'clean' - no smoking, no alcohol and no drugs
- ❑ Make the sessions organised and help people work in groups
- ❑ Have sessions as regularly as possible
- ❑ Have background music chosen by participants to help people relax
- ❑ Ensure there is no compulsion for people to attend
- ❑ Use the room for a singing session too

***Football:***

- ❑ Play regularly, maybe more than once a week
- ❑ Provide kit
- ❑ Have rewards such as playing abroad
- ❑ Have women's football groups as well as men's groups
- ❑ Have outings to see teams play - especially premier league teams



- ❑ Invite people who aren't homeless to play too
- ❑ Have the chance to play competitively e.g. against other hostels
- ❑ Ensure that players have health checks before they join and then at regular intervals
- ❑ Have monthly meetings at the club to talk about any issues and make decisions
- ❑ Have healthy food on offer after sessions
- ❑ Fundraise for equipment and opportunities e.g. request donations for old kit from professional sides, training sessions from coaches at professional clubs.

#### **4.6 For the future – participants' ideas for social and cultural activities**

Each participant was asked to contribute an idea for a future project they would like to see in Westminster or how they would like current provision to change. Responses are presented below.

##### **Trips and visits**

- ❑ Day trips inside and outside London e.g. the London Eye and boat trip in London
- ❑ Bowling (two responses)
- ❑ Fishing
- ❑ Access to theatres and galleries - asking for some free tickets so homeless people can access these activities
- ❑ Holidays - ideally abroad (two responses).

##### **Sports and exercise**

- ❑ A basketball court with a coach and training
- ❑ More physical outdoor activities such as cycling
- ❑ Free days or open days at the gym/ sports club/ being linked to a gym and swimming pool (three responses)
- ❑ Five-a-side football games (two responses)
- ❑ Sports equipment in hostels (two responses).

##### **Classes and groups**

- ❑ Drama to express feelings and meet new people/ drama workshops and performances
- ❑ More music sessions and more instruments available
- ❑ Air-fix modelling
- ❑ Computers

- ❑ Arts and crafts
- ❑ Dance classes - salsa, reggae, line dancing.
- ❑ A language class - maybe to learn Polish so we can communicate with more of the people here
- ❑ An evening club with late hours with board games, free tea and coffee maybe like a café
- ❑ Drug and alcohol centre with various sessions/activities like exercise and camping trips.

### **Events**

- ❑ A big event including a mini marathon with a prize *'a big thing with all the hostels'... The event could be sponsored to raise money for things like pool table for something to do after curfew.'* (Cardinal Hume Hostel).

### **Other**

- ❑ Hairdressing and braiding (two responses)
- ❑ Massage
- ❑ A workshop where you can do *'messy work'* such as stone craft, woodwork, cycle mending, or just go to clean your shoes
- ❑ Free TV and VCR for when people move into new flats
- ❑ More centres with things to do – *'more than just food and get kicked out - a place where you work as a group and you have meetings to say what you want to do such as chess, badminton, cards.'*
- ❑ More books in the centre/ another mobile library
- ❑ Movies at the centre.

## **4.7 Including or excluding – participants' views on recruiting to activities**

There are many issues to consider when organising social and cultural activities and the workshops could not explore them all. An issue selected for discussion by the facilitator was who should be recruited to take part in events, and how participants felt about the fact that activities are often exclusively for homeless people.

Overall there was great enthusiasm for mixed, inclusive activities - where age and ethnic background were mentioned it was always felt that activities should be as diverse as possible. Responses in the workshops centred around two key issues: firstly the possibility of inviting a wide range of people e.g. advertising in offices, and secondly the need to reach out to vulnerable or socially excluded people who are not homeless. As well as reflecting on the

benefits of inclusive activities, some important concerns were raised and these are included in the analysis that follows.

**a) *Inviting a wide range of people by advertising widely e.g. in work places***

It was considered beneficial to homeless people to attend activities where people are not, in part at least, defined by housing status. One person commented *'When I went to the ballet, in the break the people next to me shared their food with me... they didn't know I was homeless though, they just saw I didn't have food and shared it'*. A related benefit is the positive experience of meeting people who are not homeless *'you never know you might meet someone who will help to lead you out of homelessness'*, *'mixing with non-users you see a different way of life'*, *'you may get a chance - contacts into jobs'*.

The principle of inclusiveness was also raised. One person commented that activities are designed to help homeless people be included in society and having exclusive activities is contrary to this.

Participants at Cardinal Hume Hostel felt that inviting people who are not homeless to activities would help to challenge stereotypes about homeless people: *'Other people should come along. Sometimes we feel like lowlifes- like people look down on us, but they would see that we are doing what they are doing if the activities were mixed.'* At the Passage it was felt that mixed activities would promote wider awareness of homelessness issues and one participant suggested inviting MPs and 'Government Officials' to activities.

One group (Dean Street) focused on inviting office workers to play football with a homeless football group. There was agreement that this could be positive, but a lack of consensus on whether it would be possible. Some thought that people working in offices would like the chance to attend and would perceive that this as a positive thing to do. Others disagreed: *'Where would you get people who are not homeless? What bloke in an office earning a grand a week is going to want to play with a load of homeless people?'*

The potential problems of an inclusive approach to recruiting to activities were also discussed. It was felt that untrained volunteers (and therefore probably non-homeless people recruited to activities) *'can be patronising and insensitive - need to have caring people...need to be treated like an equal and not like a child... and (I) don't need unsolicited advice from people'*. In terms of team sports, possible problems were felt to be discrimination and stereotyping towards homeless people from non-homeless people and arguments and friction. Mixing the teams up was felt to be one way of minimising this risk.

## **b) Ensuring that vulnerable people who are housed can access activities**

The group from the Church Army pointed out that there are *'isolated people living in flats'* (including some of those attending the workshop) who benefit from social and cultural activities. It was felt that sometime services are withdrawn when people secure accommodation: *'it's a long journey to being well and services are taken away from you just as you begin to improve'*.

Members of the Cardinal Hume group identified with socially excluded young people, possibly more than they appeared to with the wider homeless population, and commented that *'kids in flats should get the chance to come along - who come from...[homes] with low incomes'*. One person suggested that young people (including those living in hostels) who had appropriate training e.g. the Sports Leadership Award (that the participant himself was working towards) could be given the opportunity to run activities for other young people in the area: *'not just get a certificate but use the skills you have learnt'*.

## **4.8 Messages for the Primary Care Trust and other decision makers**

At the end of the workshop participants were invited to take about fifteen seconds to record their 'key message' to the PCT and other decision-makers on a tape recorder. Messages about health and social and cultural activities were particularly welcomed although those who had other issues were invited to express these having worked within the boundaries of the research for the preceding hour or so. A full transcription of messages is found in appendix (a). Some key messages of relevance to the research include:

### **Information**

- *'I want to speak about the way information is given to homeless people ...we spoke about it being verbal information or visual information and I believe verbal is the best way and I think staff should be trained on speaking to individuals.'*
- *'...please provide as much as you can but more importantly please publicise what you provide as widely as possible so that information concerning every activity is available at every outlet.'*

### **Inclusion**

- *'There should be more inclusion of ordinary people with the homeless and no stigma.'*

### **Weekend and evening activities**

- *'Activities should be spread over the week not just Monday and Fridays.'*
- *'Some weekend cafes for the homeless'*
- *'More centres open longer during the day and the evenings where people can come in off the streets when there is nowhere else open for them to go.'*

***The need for more/ additional resources for social and cultural activities***

- *'I think we need more activities for African and Caribbean people.'*
- *'I think you need to realise the importance of sport and fitness in young people's lives and start sorting it out.'*
- *'I think that the council have to find the right person to organise this kind of sports because we cannot organise it - there has to be someone to organise it and that's what's missing.'*
- *'I think there should be some type of schools for homeless people who want to better themselves like little career centres so they can go in and have training for them.'*

At the end of two of the sessions participants had unprompted discussions about how they would like decision-makers to come and speak with them in person. At Dean Street someone suggested that the PCT could ask one resident to go round and get views of other residents on key issues, at the Passage it was felt that even if not everyone would come along to a consultation, staff from the PCT or Local Authority could come and speak to individuals who are interested in having their say. Several participants commented that they had appreciated having their say on the issues discussed in the group and did not simply attend to receive the incentive voucher - this was reinforced by others in the groups.

## Key findings (2)

### Workshops with homeless people

- Participants described a holistic view of health. Themes of particular relevance are positive feelings such as happiness, contentedness and strength and comments around attitude and motivation.
- There was wide variation in the extent to which participants had taken part in social and cultural activities. Some felt that there was nothing for homeless people to do and others spoke about activities they had taken part in at the location of the workshop, at other services and/or independently. Some commented that a significant minority of people just stay in their rooms all day.
- It was generally felt that cultural and sports facilities are inaccessible for homeless people to access independently due to entry fees and in some cases the stigmatisation of homeless people. Another issue was the practical consideration about where to leave your possessions if you don't have accommodation.
- A key issue was a lack of up-to-date information. There is a need for verbal as well as in written communication.
- Some frustration was voiced in groups about the fragmentation of services and the perception that you can only access leisure opportunities if you are a regular services user at the host organisation.
- Participants made clear links between example activities and positive health outcomes. Positive effects on mental health and social well being included reduced isolation, a diversion from substance misuse, a distraction from problems and a source of relaxation. All the groups felt that attending activities could help encourage access to medical care as people engage with services and feel more able to express health needs.
- Several of the potential benefits mentioned are relevant to key priority areas in the Westminster PCT Health Promotion Strategy including physical activity, healthy eating, sexual health and substance misuse.
- Participants described a wide range of ideas for future activities. A more informed or focussed consultation with homeless people prior to planning specific activities would be beneficial. Participants in two groups also commented that they would welcome opportunities to meet with decision-makers from the PCT directly to give their views.
- It was felt that inviting non homeless people to activities would be beneficial in terms of breaking down stigma and enabling homeless people to meet with those who are not in a homeless situation due to the opportunities and insight this brings. Two groups expressed caution around inviting non homeless people to activities. Risks included tension and arguments and people being insensitive or patronising towards homeless people.
- Themes in the key messages that participants recorded on tape for the PCT were around providing information about services and the need for more choice in, and opportunities for, social and cultural activities.

## 5 Research findings: interviews and meetings with clinicians and homelessness sector professionals

Seven depth interviews with clinicians and homelessness professionals were undertaken in addition to a short discussion session at a Church Army project meeting. A researcher also attended the Voluntary Action Westminster meeting to inform attendees about the project and get feedback on key issues.

### 5.1 Profile of participants

Interviews were undertaken with people working in the following organisations/ roles (figure (f)). Participants were asked to describe the service they provide and the client/ patients they work with. The sample was designed to capture professionals working in a wide range of roles with diverse homeless communities including refugees, rough sleepers, drug-users, people with mental health issues, young and older people, and homeless women as well as men.

**Figure (f) Organisation and role of interviewees/ attendees**

Organisation	Interviewee/ attendee role
Cardinal Hume Centre	New Initiatives Manager
Church Army Team Meeting discussion	Project workers and Centre manager
Great Chapel Street Medical Centre	Doctor- specialist practice for homeless people only
Fitzrovia Medical Centre	Doctor- general practice with some homeless patients through an Enhanced Scheme*
Homeless Health Team**	Therapist
Health Support Team***	Community Nurse
Homeless Health Team	Clinical Manager
Soho Centre for Health and Care	Doctor- general practice with homeless patients

- \*Westminster PCT has established an Enhanced Scheme that seeks to promote access to GP practices for homeless people who do not need targeted care provided through the Homeless Health Team. There are 15 practices across Westminster registered with this scheme.
- \*\*The Westminster Homeless Health Team, formally known as the Homelessness PMS+ Pilot, was set up to provide primary care specifically for homeless people, including rough sleepers. The nurse-led Service provides community nursing, Doctors' services, counselling and other therapies in four day centers across Westminster.
- \*\*\* The Health Support Team is primarily a nurse led team which works intensively with people who are homeless, asylum seekers and refugees. The aim of the team is to improve the health of this client group and to integrate them in to mainstream services. The team will assist people to access services for example by registering with a local GP, dentist or any other services that they may need.

## 5.2 The health benefits of social and cultural activities

### 5.2.1 The relevance of social and cultural activities for a health provider

Interviewees were asked how relevant they thought social and cultural activities are to the PCT and how they felt about the concept of running social and cultural activities with a specific view to achieving positive health outcomes. Responses were mixed although all could see the rationale and the potential benefits of a health provider having interests in such activities.

The most positive responses indicated that social and cultural activities are, arguably, as much about health as many clinical interventions. The point was made that these activities can address aspects of health and well-being that traditional health interventions do not focus on, for example self-esteem and communication issues. A key theme was the role that such activities have in enabling engagement with service providers, such as clinicians, through enhanced self-worth and self-expression:

*'it's all about trying to inspire people, to get their attention so you can work with them more effectively...'*

*'One issue is about self-esteem; if an activity makes a client feel important, valued, entitled... it makes them feel that their health is important ...(that) they are worth it... they are (then) more likely to access health services, including preventative services.'*

Two respondents commented on the importance of activities in facilitating engagement with people from refugee and other BME communities. One stated that some conventional interventions, such as verbal therapy, are difficult in terms of language and cultural norms for some clients. Another said:

*'Very relevant area as we have a multi-cultural homeless population- we need to find the most effective way of working with a wide variety of people.'*

More cautionary responses were expressed on the following grounds by three respondents:

- Resources: basic services are competing for resources, concern that this type of work could divert funds from current clinical services
- Challenges: *'sustained interest and involvement is what brings about positive health outcomes'* and this is very difficult to achieve, *'interest often drops off very quickly'*
- Message: concern that providing and publicising this type of work *'glosses over'* the real issues *'people won't play football if they haven't eaten for a week... need to spend money'*



*on the simple things. Information about accessing basic services, reaching those who don't access any care at all'.*

## **5.2.2 The health benefits of activities**

Interviewees were asked to describe the potential health benefits of social and cultural activities for homeless people. Responses indicated a wealth of potential benefits which are summarised under five headings below. The areas of benefit are interlinked, the social benefits are linked with mental health, and positive impact on mental health is a precursor for more effective engagement with services.

### **Mental health**

- The positive impact of activities on mental health was emphasised by all respondents. This echoes the key themes in the workshops with homeless people. A key factor in improving mental health was the social contact with people - the *'socialising, contact, team work, conversation and context'* that activities bring.
- One respondent specifically identified and another touched on the therapeutic effects of activities, especially those that facilitate self-expression.
- A recurring theme was increased self-esteem that comes from developing skills and producing for example art work, sewing or creative writing.

### **Socially**

- Closely related to mental health benefits of activities are social benefits. Activities can reduce isolation as they *'...provide an opportunity to fit into a group - many homeless people are on the fringes and this helps with increased socialisation and reduced isolation – [through] sharing experiences and knowing it is not exclusively them facing homelessness and the issues it brings.'*
- One respondent commented that seeing how others have progressed may give people inspiration for improving their own situation.
- Taking part in activities can also present a chance to *'make decisions... become stronger individuals'*. Related to this is the fact that activities represent *'doing something that you have chosen to do'* and a sense of *'being capable'*.

### **Structure and meaningful occupation of time**

- The constructive use of time by undertaking a social or cultural activity had two main benefits: (a) diversionary *'a diversion from petty theft and drugs'* and (b) in terms of gaining structure in an individual's life which can be applied to wider areas. Both were

thought *'Useful for chaotic people if they get into it - may help with a move towards other structured things such as running a flat or attending therapy.'*

### **Engaging with health services**

- There were several ways in which it was felt that activities could aid access to and engagement with health services. The possibility of embedding health promotion in activities was a recurring theme. Specific suggestions were around advice/ education on smoking cessation, obesity and sexual health (an area felt to be related to self-esteem). *'The general population is offered so much around obesity and smoking cessation - this group get a bum deal'*.
- Enhanced communication skills through increased capacity for self-expression and effective communication were viewed as a way of moving towards *'not just accessing but engaging with health services.'*
- One respondent felt that health services become more culturally acceptable if they are associated or integrated with popular activities. Another commented that activities could help to *'alleviate suspicion of services and their agenda'* if a range of professionals are involved and/ or attend.
- Social and cultural activities were felt to help staff in getting to know individuals and their needs better. As a result they are more able to help them, for example in identifying appropriate services or advocating more effectively for the client.
- The relationships that can be built up at a service providing social and cultural activities was referred to by staff at the Church Army as a factor for some people in starting to engage with health providers:  
*'Employing a nurse to administer treatment or drugs is not the same as building up a relationship...for some people they wouldn't have gone near a nurse if it wasn't for building up that relationship.'*

### **Physical health**

- Fitness, weight loss and cardiovascular health benefits of participating in sport was mentioned by several people. One interviewee expressed this benefit with some caution as he feels that physical activity *'needs to be consistent to have a health benefit'* i.e. that it is necessary to partake in an activity regularly and for a sustained period of time to reap benefits to physical health.

## **5.3 The current context of health services working with providers of social and cultural activities?**

One of the objectives of the research was to identify current links between health professionals and the providers of social and cultural activities. It is clear from interviews that while a lot of social and cultural activities are run, the current landscape from the clinicians' perspective is one of opportunities which are fragmented and poorly publicised, and that communication between agencies is often limited. The comments selected below illustrate the range of views on this issue.

### ***Current relationships/ achievements***

In two interviews, ways in which the health and voluntary homelessness sectors are working together was described:

*'We are already connecting with (name) day centre...and we have the homelessness forum.'*

*'We already are. A big success of the PMS is that we are in the day centres. The voluntary sector asked for this. It's an important first step - it has taken away some of the barriers. A key aim was to improve access for homeless people...GPs make efforts to link with staff who know about patients. Doctors go out onto the floor in day centres.'*

### ***Issues faced***

The most frequently mentioned issue was the lack of information about other services. Clinicians reported it difficult to recommend activities to patients to assist them in addressing wider health needs than those addressed in consultations. A sense of fragmentation and isolation in service provision was a recurring theme. Evidence from interviews and the workshops suggests that providers of activities are not reaching all those who would benefit:

*'There are people who literally do nothing - the social event of the week if coming to pick up their prescription'.*

One respondent commented that funding produces some competition, which does not aid communication between service providers. A clinician stated that the stipulations of funding mean that it is hard to maintain a flexible and responsive approach to meeting the needs of individuals.

One doctor pointed out that he feels that clinicians are not best placed to deliver social and cultural activities but that they could support those who already have expertise in this area through promoting activities, referring patients, providing space etc.

### ***Possible solutions***

Most of the suggestions for addressing issues raised were about joined up working and information.

One person commented that *'Staff need to meet one another'*, although in this interview and one other the idea of bringing relevant professionals together was viewed as positive in principle but sometimes problematic in practice as staff often feel they have too many meetings to attend.

One interviewee suggested bringing specialists in to help hostels and other organisations improve the activities they provide.

A comment illustrating the perceived lack of information about homelessness services was *'Health practitioners need knowledge of other health services (working with homeless people)...we also need knowledge of homelessness services in the area. The PCT should provide a directory which is kept up-to-date.'*

Criteria for mainstream services were viewed by one respondent as being set up to exclude people who do not fall within strict remits of work. The respondent also commented that *'There is an inevitability about this but the way that health care is set up needs to be looked at, there are lots of people working with homeless people with so many skills, podiatry etc, but in hotchpotch places. We need to come together and provide a flexible and unified service for everyone...secondments are useful and we also need more unified computer systems.'*

A doctor suggested that specialist nurses are in a good position to be involved with the design and delivery of activities as they often have a good understanding of issues, are already embedded in hostels, and are equipped to build health promotion into activities.

## **5.5 Promoting positive health outcomes**

Interviewees were asked about how the positive health outcomes of activities can be maximised.

A joined up approach to design and delivery of projects was a common theme in responses. One respondent stated that there was a need to *'Co-ordinate efforts being made by agencies (to provide activities) at the moment...avoid duplication and providers being at cross purposes.'* Good referral systems were also viewed as a way of maximising benefits by facilitating access to the most appropriate services available.

Related to the communication of homelessness and health agencies, and between homelessness service providers, is the need to make links with other experts, for example

consulting community groups and religious organisations when targeting activities to refugees and asylum seekers. Also consulting counsellors to get a different perspective on what would benefit different groups of homeless people, or even what would serve the needs of an individual client/ patient.

Cultural sensitivity is key to making activities work for people from minority groups including refugees. Staff at the Church Army described how a health project employed social activities to help form group bonds and enable discussions to take place about sensitive health issues such as female genital mutilation (please note that the below is not a verbatim quote but taken from researcher's notes):

*Mental health stagnating was an issue amongst refugees who often don't accept counselling. There was a need for a centre based approach - medical intervention with anti-depressants was not a good option. The project set up in response to this focused on health issues and we feel changed lives. It started with a sewing class just sitting together and bringing issues to the group to talk about. Then we could invite people from outside, then we invited the nurse to do health education.*

Another theme was working with the individual to help them engage with activities. This highlights the importance of the wider context of support offered to homeless people in determining the success of activities. Activities will have more benefit for those with support needs when accessed by people receiving high quality support. Having a range of ongoing activities to explore the best ways to engage individuals was also viewed as important.

*'Working with the individual - people don't always know what they are interested in, this can change so need to try different things to see what engages someone...continued, varied, innovative.'*

*'Visiting people and working one-to-one in a therapeutic way.'*

*'Culture of organising and running varied activities so this is the norm - not an added extra.'*

Another way of working with the individual in accessing social and cultural activities mentioned was through befriending and mentoring.

In responding to an individual's needs one interviewee mentioned the importance of *'ensuring that the person is always involved...'* - not having one professional talking to another professional about the patient/ client - but the person being *'part of the decision-making themselves'*.

The need for consistency in services was also highlighted. It was felt that short-term projects have less benefit. Consistency following a move out of homelessness was also raised by one respondent. Sustained engagement even once accommodation is secured and the individual is no longer homeless was viewed as an important source of stability and a potential factor in successfully sustaining a tenancy. Participants in the Church Army workshop echoed this view.

One respondent suggested that *‘training and management of staff so they have a solid and agreed approach’* improved the quality of services provided. Another respondent mentioned the need to constantly and energetically ‘big up’ projects to keep clients interest, and that this requires a motivated team.

The client/ patient group they work with informed interviewees’ perspective on what activities would have the most benefit. All agreed that a range is required to engage people with diverse needs and backgrounds. Some views on activities that could be targeted to specific groups for maximum health benefits are found in figure (g). This information should be treated with a degree of caution as it represents some assumptions about what people may be interested in. One person commented *‘people surprise you with what they will try and the opportunities they will take up, for example don’t assume that young people won’t do drawing’*.

**Figure (g) Activities for particular groups of homeless people**

Client/ patient group	Type of activity
Young people	<ul style="list-style-type: none"> <li>• Inspiring activities - something related to developing skills for getting a job</li> <li>• Music, dance, media and fashion</li> <li>• Drama groups</li> <li>• Activities to enhance communication skills</li> </ul>
Older people	<ul style="list-style-type: none"> <li>• Something to get people active e.g. gardening</li> </ul>
Refugees and asylum seekers	<ul style="list-style-type: none"> <li>• Culturally sensitive and sometimes culturally relevant</li> <li>• Informal activities which do not rely on people speaking up straight away e.g. sewing</li> </ul>
General	<ul style="list-style-type: none"> <li>• Activities that connect old and young people - many homeless people lack a family unit and any substitute for this is beneficial</li> </ul>

**5.6 Unintended impact of activities**

Respondents were asked if there are any potential negative effects of social and cultural activities that providers and funders should be aware of. Some key issues raised were:

- ⇒ If people try something they are not up to, people with mental health problems and drug and alcohol issues may feel worse and become withdrawn
- ⇒ There can be negative health impact for addicts withdrawing from substances while taking part in longer activities
- ⇒ Possibility of accidents, fights and injuries - risk assessments need to be done
- ⇒ People can be highly disruptive
- ⇒ If there is coercion or perceived coercion to undertake activities the benefits will not be as great
- ⇒ There is a danger that funders and providers will see people not attending as a negative - *'this shouldn't mean that you try for the seventh, eight and ninth time'*
- ⇒ Any cultural insensitivity may have negative effects
- ⇒ Danger of imposing values on homeless people - need to keep checking whether we are truly *'trying to help people develop meaning in their lives or to change them to make them 'normal'.*
- ⇒ It is important to create boundaries and manage expectations so that clients know what is appropriate and what they can expect. If people have a bad experience it can put them off engaging with activities in the future.

## **5.7 Reaching those most in need**

A question for all providers of services to vulnerable people is how do we reach those most in need? There were several slants on this issue. Some interviewees felt that most homeless people would benefit from activities to meaningfully occupy their time. Others focused on how to engage with those who are most vulnerable, quiet or withdrawn from services. Approaches to the latter centred on one-to-one contact and referral to and support in accessing services. A case study example from the Church Army shows that the process can work the other way round - with social and cultural activities providing a doorway to accessing services for vulnerable people (please note that the below is not a verbatim quote but taken from researcher's notes):

*X appeared to have deteriorating mental health and was hard to engage. Attending music lessons was the only link we had with her. She was determined to learn the piano though. The lessons provided structure and continuity. This helped with finding a way for us to communicate concerns about her health.*

Two interviewees felt that there is a need for a range of activities at different levels to aid the engagement and sustained interest of homeless people with a range of support needs:

*'The level of involvement needs to be appropriate to the capacity of the individual...Groups with high support needs require... first step services and activities. The most important thing is to ensure that people know about activities. Whether people take part is up to them. People need to have a choice... activities need to offer a range of levels of involvement and these need to be clearly defined so that providers and clients can identify appropriate services.'*

*'Would be useful to have a hierarchy of activities. Entry level would be very easy, you can try something out in a relaxed environment. Then there would be a more formal level. Often people say they would like to 'try this' but I don't know where to refer them...need a cohesive inter-agency referral system.'*

## **5.8 Monitoring and evaluation**

Respondents were asked about ideas they had for capturing the health outcomes of social and cultural activities. Responses were mixed with some interviewees suggesting indicators around attendance and take up of services, and others advising caution in attempting to use a traditional quantitative approach to capturing the 'softer' types of outcomes resulting from social and cultural activities. Ideas for quantitative indicators, qualitative evidence and comments on the approach to and evidence used in monitoring and evaluation follows:

### ***Possible quantitative indicators:***

- How many people attend activities
- How many people make contact to say they won't be attending
- Reduced uptake of A&E services
- Reduced need for medical services
- Tenancy sustainment
- Health questionnaires asking about changes in lifestyle (self-reporting of reduced behaviours such as drinking and crime etc)
- Visual analogue scales asking about happiness and contentedness
- Produce a standard questionnaire which staff and clients are asked to fill in before, during and after clients have engaged. This could measure stress levels to see if there was a change - wouldn't have to be with every client but a sample e.g. one in ten.



### ***Ideas for qualitative evidence***

- Videos of sessions
- Poetry and writing
- Ad hoc case studies
- A qualitative look at people's health before and after the project e.g. one-to-one interviews

### **Comments on approach to evaluation**

- *Need all workers and clients involved in evaluation.*
- *Not project-by-project evaluation but a joined-up approach to measure the full benefit of activities*
- *I don't think that audits and questionnaires are very good, people are not honest, others aren't able to fill them in - some like to please. Think about what will give a fair reflection... promote learning (empowering) model for evaluation.*
- *Need to think about monitoring and evaluation at the beginning*
- *Look at the cost of getting the data. If there is already evidence that these things are beneficial don't set out to re-prove it... use methods to get the descriptive, subjective data*
- *You need an evaluation plan for each project - a less structured approach to evaluation for clients. They don't like paperwork... staff can talk to clients about the activity and then record the results afterwards.*

### **Key findings (3) Interviews with health and homelessness professionals**

- A range of opinions were expressed about the relevance of social and cultural activities to the PCT. Some felt that this type of service could be as relevant to health as clinical services while others expressed caution, commenting on the need to retain and develop more basic or conventional health services and not to lose sight of the very basic needs some people have around accommodation and food. All participants expressed agreement with the idea that social and cultural activities are a source of positive health outcomes.
- As in the workshops there was a particular emphasis on the mental health benefits of activities and the related impact in terms of social well-being.
- There were several ways in which social and cultural activities were viewed as having potential to increase engagement with health services. One was to embed health promotion and education into activities. A less tangible link was that enhanced communication skills aid the ability to express health concerns.
- There are connections between health and homelessness providers through the Homeless Health Team. The work of doctors and nurses in day centres and hostels was raised as a welcome development.
- Clinicians commented on the lack of comprehensive information about the range of activities available to homeless patients. Related to this is the lack of options in terms of identifying appropriate interventions which clinicians can signpost or refer to.
- Other possible areas for development are the involvement of health professionals in the design and delivery of activities.
- Some interviewees tended to speak about supporting individuals and facilitating the access to social and cultural facilities once someone is ready as part of this. Others focussed on the fact that some people who are hard to engage become easier to work with when they tap into social and cultural activities.
- Social and cultural activities were identified as a particularly good way of engaging some BME communities including refugees. In some cases conventional services do not meet the cultural needs. One interviewee suggested involving community groups in the design of activities for homeless people.
- Interviews and workshops indicate that there is a raft of homeless people who do not access opportunities for meaningful occupation of time and tend to remain in hostels or drinking.
- Interviews highlighted the need for choice and variety in activities offered, possibly with entry level, taster style sessions for those who do not wish to make a regular commitment and opportunities for more challenging activities for people seeking more structured or demanding options.
- Having the right people to deliver activities was viewed as essential. Having those with an expert knowledge of homeless people present as well as bringing in people with expertise in creative fields such as art therapy were suggestions.
- Several interviewees touched on the need for realistic expectations of providers. Where few people engage this should not always be viewed as a failure or a reason to stop providing a service and where an individual does not engage further attempts should be made to inspire them.
- Interviewees suggested some hard monitoring indicators which could be used to assess the progress but most often felt that a more qualitative approach to evaluating success including case studies is appropriate. Before and after questionnaires about health and confidence were also suggested.
- Other comments about evaluation included the need to involve staff and homeless people, use of a learning, empowering rather than inspection or audit style model and the importance of thinking about evaluation at the outset of a project.

## 6 Conclusions and recommendations

The conclusions and recommendations are structured around the objectives for the project which were:

- To identify the positive impact that social and cultural activities have on health and well-being
- Establish and document the links between providers of social and cultural activities and health providers
- Suggest ways that could be used to measure health benefits and develop tools that could be used to record the number of people who engage with health services following participation in social and cultural activities.

In addition to this there is a section to stimulate further discussion. This gives some key ideas for good practice in developing or improving social and cultural activities, and two models for the PCT becoming involved in the provision of social and cultural activities.

### 6.1 The impact of social and cultural activities on health and well-being

The literature review provides a compelling account of the health benefits of undertaking social and cultural activities when taking a broad and holistic view of what being healthy means. Many of the benefits are of particular relevance to homeless people, for example reducing isolation, promoting social networks, self-esteem and communication skills.

Evidence presented shows that where activities characterised by 'involvement, commitment and skill' are appropriate and of a high quality they have health-related benefits at the point of participation. For example *'art can be therapeutic and cathartic'*, many of the activities described can aid self-expression, some can improve the range of movement, and group work can enable the development of social skills and networks.

Many of the issues which can potentially be addressed by participating in social and cultural activities relate closely to barriers that homeless people face in accessing the appropriate health services. Barriers such as inability to keep appointments and difficulty communicating about health needs could be addressed by participating in social and cultural activities.

The literature review indicates that health benefits can be lasting and wide-reaching. For example, in longitudinal studies of older people regular engagement with meaningful activities has been linked to greater life satisfaction and a healthier and longer life.

The positive health benefits of activities described by homeless people and health and homelessness professionals were similar to those presented in the literature review. The mental health benefits and the impact of activities on self-esteem were emphasised throughout interviews and workshops, and these were often linked with better physical health e.g. reduced intake of substances. Workshop attendees were challenged to think as widely as possible and made convincing links between activities and physical health and access to health services.

## **6.2 Links between providers of social and cultural activities and health providers**

Health providers are linked with homelessness services through the work of clinicians in homelessness organisations, for example doctors and nurses working in day centres. However issues around the co-ordination of services and information were viewed as a concern in most workshops and interviews.

In interviews with professionals some clinicians, especially those who work in general practice rather than specialised services, feel that patients would benefit from health providers being better informed and able to refer to meaningful activities. The sense of fragmentation and isolation was a recurring theme.

Joint working between providers of social and cultural activities was also raised as a possible area for improvement. In workshops the provision of information was an issue which was consistently raised without prompting. It was felt that information is often out-of-date, inaccessible (focusing on written rather than verbal communication), and restricted to the organisation hosting an activity or event. In some workshops participants mentioned that they would like to take part in activities that were not just based at the service they regularly access. This could also bring about positive outcomes in terms of building social networks and confidence.

Several interviewees suggested that health providers could be involved in the design and delivery of projects, for example by:

- Key professionals such as counsellors advising on the design of projects
- Having Community Nurses attending activities to help providers undertake health promotion during activities
- Looking into resources that could support activities such as accommodation and referral of patients' to activities.

The need for more joint working between homelessness agencies that provide social and cultural activities was also raised in interviews. It was felt by some interviewees that current efforts and results are limited due to issues such as competition between agencies and poor mechanisms for publicising activities beyond the host organisation.

### **6.3 Measuring the health benefits of social and cultural activities**

There are some quantitative measures that can be applied to projects to monitor progress and delivery of agreed objectives. These include number of attendees, demographic information and information about the use of medical services. However, these indicators should not, be viewed as providing a comprehensive assessment or account of the quality of, or outcomes achieved by, the project.

The literature explains that most evaluations of the impact of social and cultural activities focus on qualitative data. The benefits and possible outcomes of engaging with social and cultural activities are often highly subjective, for example progress in terms of confidence and self-esteem are a central benefit but hard to capture.

Benefits of activities are also hard to trace back to an intervention, for example if attendance at A&E drops it may be hard to attribute this to an activity without asking the participant how the project is linked to changes in their life. For this reason it is suggested that qualitative evaluations of activities focus on identifying what it is about an intervention that results in positive outcomes. This will help providers and funders move away from a black box approach towards identifying the 'mechanisms of change': *'the mechanisms of change are not the program activities per se but the response that the activities generate'*.<sup>47</sup>

Funders have a key role in promoting an evaluative approach. For example by:

- Promoting evaluation as an integral part of delivery rather than an additional pressure to collect excessive monitoring data.
- Supporting providers with evaluation and creating a sense of learning rather than inspection from evaluations.
- Providing information and training about outcomes and self-evaluation if necessary or bringing providers together to discuss issues if this is more appropriate.
- Asking those bidding for funding to demonstrate ability to undertake or openness to achieve inclusive, creative evaluations involving staff and homeless people.

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<sup>47</sup> Weiss, C, H 1997 Theory based evaluation past present and future New directions for evaluation No. 76 Winter

- Ensuring that those awarded funding have developed clear aims, objectives and desired outcomes for their project to keep qualitative evaluation tight.
- To promote a creative approach to capturing the 'soft' outcomes of activities, for example by widening the definition of 'data' used to include for example videos, photo projects and case studies.
- Demand an evaluative, consultative approach from the outset (e.g. sound justification for project based on evidence) while letting providers take some risks and test new ideas to assist in the overall development of and learning about the possible health benefits of activities.
- Providing access to relevant materials to guide evaluation e.g. self-esteem inventories and example questionnaires and case studies.

#### **6.4 Key ideas for Best Practice and areas for change from the research**

All elements of the research raised ideas on delivering high quality social and cultural activities and maximising the positive health outcomes of activities. Key ideas have been taken from the report and are summarised below. Not all of these points should necessarily be addressed by the PCT as they include wider suggestions for improving opportunities for homeless people in the area.

##### **(a) The need for a wider range of better targeted services**

There are people currently slipping through the net of provision for meaningful occupation of time. A key finding from the research is that there are people who are not engaging with any activities and find it difficult to access meaningful occupation activities. Despite the number of providers and range of activities available in Westminster, there are a significant number of homeless people who feel that there is '*nothing to do*', people who '*literally don't leave their rooms*' or for whom *the 'highlight of the week'* is collecting a prescription. Some workshop participants described a sense of alienation from the cultural and sports facilities in the area, which is likely to be more acute in some of those who decided not to attend the workshops. One response to this is tiered activities including entry level, small-scale activities, that people can try out in a relaxed environment without the pressure to make a regular commitment. Taster sessions in a range of locations may help to engage those who are currently not accessing services. At the other end of the scale there was enthusiasm for larger projects and activities which include people who are not homeless e.g. the 'mini marathon' which would provide a time consuming outlet for those who want to be involved. Homeless people in workshops showed enthusiasm for mixed activities which involve non-homeless people. In one group the fact that activities were organised exclusively for homeless people was felt to constitute a form of social exclusion. In some sessions the

potential for insensitivity from non-homeless people and conflict between different groups were raised as issues which would need to be considered by a provider arranging inclusive activities.

**(b) Supporting the individual**

The findings stress the importance of the one-to-one support offered to homeless people and the impact this has on the outcomes of accessing any services or activities. The need for individual and flexible support was raised in several interviews. The consistency of services once a person has secured accommodation was also raised as an important way of maximising the positive impact of activities and minimising unintended harm.

**(c) Maximising the effectiveness of staff working with homeless people**

Professionals working with homeless people would like to see cohesive information systems to facilitate signposting and referrals of patients/ clients to the most appropriate projects. Having the right people to deliver activities was viewed as essential. It was suggested that those with an expert knowledge of homeless people need to be present as well as individuals with expertise in creative fields such as art therapy.

Funders and practitioners should seek to involve a range of people in the design of projects e.g. by asking health providers about ways of making projects more 'healthy'. If possible it was suggested that projects should ask health professionals to attend sessions to break down barriers and build trust, and to undertake health promotion.

There was some comment on staff training to improve the delivery of services. However clinicians commented that skilled people are already working with homeless people so funders should avoid trying to re-invent the wheel.

The availability of this type of activity should become more the accepted and expected norm amongst staff working with homeless people rather than an added extra. Targeted resources and training could help to achieve this.

**(d) Cost-effective ideas for choice and variety in activities**

Creative fundraising was mentioned in some groups e.g. approaching companies for free tickets to the theatre or sports matches. Homeless people could be supported to develop fundraising and marketing skills through such projects.

Homeless people in the workshops would like help to access facilities independently. This could be cost-effective and empowering for some people who have lower support needs.

Suggestions included discount cards and free open days at sports centres. A related point is that several suggestions for providing activities that can be undertaken independently in hostels and day centres were raised e.g. air-fix modelling and gym equipment.

Homeless people should be involved in deciding on activities to be run and running them where appropriate.

**(e) Practical suggestions from homeless people**

Key practical issues raised by workshop participants should also be considered for action, notably:

- provision of services at the weekend and in the evenings
- somewhere to leave baggage
- the need to actively promote opportunities verbally as well as in writing- to 'big up' what is available
- the involvement of homeless people in the design and delivery of sessions.

Regular consultation with those who are not attending activities is an important way of staying aware of simple practical barriers to engagement.

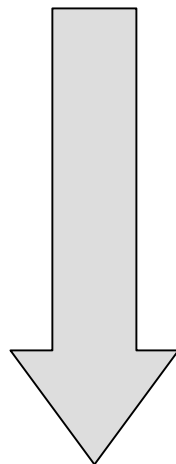


## 6.6 Models of PCT involvement in providing social and cultural activities

Model 1: PCT invests in co-ordination and training to improve the health outcomes of existing and new projects

PCT funds improvements to existing projects and co-ordination of projects/ communication with health services - strategic role

Training on maximising and monitoring positive health outcomes for service providers



PCT takes on information co-ordination role - finding out about existing databases and developing new ones if needed

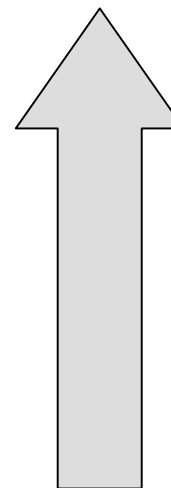
Projects on the ground are supported to develop and become more 'healthy'. PCT is active in promoting best practice.

Promise	Pitfall
✓ Funder can influence change on wide scale	✗ Even with consultative approach could be viewed as top-down
✓ Could be an initial phase before funding projects	✗ Could take time to see the benefits
✓ Improving existing projects could be more efficient than starting new ones - avoid duplication and maximise results of existing work/activities	✗ Would require a lot of work getting people on side given that money is staying with the PCT rather than going to projects directly

Model 2: PCT provides funding for a range of new or developing projects

PCT establishes a fund for the development of 'healthy' social and cultural activities to be contracted out

PCT funds innovative 'healthy' social and cultural projects inviting tenders from organisations that already provide social and cultural activities



Funding stipulations are used to test methods of evaluation and promote best practice

The PCT establishes a group of model projects who influence practice in the sector

Promise	Pitfall
✓ Could provide incentive for organisations to work in partnership and to target groups who do not currently access activities - it is clear that there is a real need for this	✗ It can be hard to avoid a funding driven response to new resources in a competitive environment
✓ Could represent a bottom-up approach defined by expertise from the 'ground'	✗ Challenge to make this fund different from others
✓ Lower risk - funding is spread between projects, if one fails learn from this without too much loss	✗ Hard to respond to consistent request for longer term funding

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## **Appendix 1            Messages recorded at workshops for the PCT and other decision makers**

Give us some more money.

People should be encouraged to mix more and not take so much money off us when the hot water doesn't work and things go wrong with the place. Windows get broken and they don't get fixed.

Will we get any feed back from this session? And if we do when can we expect.

I would like more put on homeless issues and the government to look at homeless issues more carefully and to make us more comfortable and make it a better environment for us.

Put more money in to people like ourselves- in the community.

We should given more of a choice as we are generally told what we can and can't do and not asked what we want to do.

To be told about these sort of things a little bit more then when are at the moment as we were only told about this (workshop) yesterday.

I think we should get more help from the authority because we don't get the help that we need off all the authorities like the hostels, the social and they don't help the people that they should.

Hi, I want to speak about the way information how it's given to homeless people. We spoke about it being verbal information or visual information I believe verbal is the best way and I think staff should be trained on speaking to individuals.

All I can say is discussion groups and an expert talking to you to sort your problems out- that's all I can think of.

Westminster to stop printing stuff in the papers that isn't true. I am referring to what was in the papers the West End News about the tea runs that are going to stop.

There should be more inclusion of ordinary people with the homeless and no stigma.

I would just like to say I think there should be more trained staff and homeless people should be treated with bit more respect.

Activities should be spread over the week not just Monday to Fridays.

Well the people here in this group want to get out- what about the people in the other room (in the workshop venue) that don't want to even talk about it?

I would like to see an easier benefit system.

Some weekend cafes for the homeless.

More health centres for the homeless and more information on health for the homeless.

There is about six hundred of you in parliament just fucking wake up.

We are just human beings you know, I think life is an experience you can learn a lot off us homeless people as we have been though a lot and that's experience.

The day centre (Church Army) is a life line thank you very much.

I hope you hear what we have said this afternoon and take it on board- some of it anyway. There are other doctors besides GPs such as homeopathic medicine is really good.

I would like the nurse to come here once a week I live on my own I am waiting to go to hospital, I live on my own and I am very frightened I will be at the day centre at least five days a week.

Id like lots of music lesson and free all activities free.

My name is... I have been coming to this centre for quite along time I would like it that the centre will have more money so that we can have more days opening and we can have more cultural and art activities.

Hello it's... speaking now. Please provide as much as you can but more importantly please publicise what you provide as widely as possible so that information concerning every activity is available at every outlet. Thank you very much.

Hello I think we need more activities for African and Caribbean people.

If you're healthy your wealthy no matter what if you don't have money- it's true if you are healthy you are wealthy!

Hi, this is ... these people should advertise homeless places- places where you can be and refresh yourself and fix up because I never heard about it for a long time.

Hi my name is..., I think homeless people should not feel hopeless while they are living in the hostel or in shared accommodation they should feel like they are at home.

And the CAT workers- they should not be all about the people on the street because I never slept on the street because it is cold- I would rather sleep on a night bus where it is warmer you understand- fix up with that.

Hi this is... I think you need to realise the importance of sport and fitness in young people's lives and start sorting it out.

Hi my name is.... and you have to provide more housing and accommodation for homeless people (and for genuine homeless people).

More better environment, no serious, better environment for homeless people.

At the end of the day it doesn't matter what people say about people being homeless nothing gets done about the homelessness- nothing gets done- Tony Blair another one how many times has he been told about the homeless and he stills does nothing and there's still homeless on the streets.

I think that the council have to find the right person to organise this kind of sports and because we can not organise it. There has to be someone to organise it and that's what's missing.

What do we need in Westminster? To get more help to help the homeless people and the alcoholics and drug users and the old people get off of the streets- give them good help do they can look after themselves in there future lives as they do not have a lot of help.

I think there should be some type of schools for homeless people who want to better themselves like little career centres so they can go in and have training for them.

More centres- open longer during the day and in the evenings where people can come in of the streets when there is no where else open for them to go. Where they can relax in the evening.

More beds more hostels more helpful mental health and especially for the disabled.

If you have any questions or comments for the Broadway's Research Team please contact Joanne Fearn, Research and Information Manager at Broadway on 020 7089 9560 or [joanne.fearn@broadwaylondon.org](mailto:joanne.fearn@broadwaylondon.org). If you have any comments or questions for Westminster PCT please contact Anna Waterman, Community Health and Regeneration Manager on 020 7150 8123 or [anna.waterman@westminster-pct.nhs.uk](mailto:anna.waterman@westminster-pct.nhs.uk).