Nutritional Management of People Experiencing Homelessness

Ghislaine Swinburn, SRD PCN FCP Dietitian Bristol Inner City, Research dietitian, Clinical Nutrition Fellow, Pathway & **Hannah Style,** SRD Profession Development Lead Dietitian, East London Foundation Trust, FEAST With Us Founder, Research Dietitian, Clinical Nutrition Fellow, Pathway

People experiencing homelessness (PEH) are amongst the most marginalised in our society and endure severe food insecurity.[1] Dietary health inequalities are largely invisible despite anecdotal reports, and nutritional management for PEH is not currently part of core nutrition and dietetics curricula, resulting in inadvertent discrimination by dietitians and wider clinicians. In this article, we seek to raise awareness of the dietary complications experienced by PEH enabling professionals to provide bespoke intervention. Together, authors of this article have established the Pathway Nutrition Committee (PNC) to address dietary health inequalities as a national collective of interested stakeholders.

Defining homelessness

PEH are defined as *'lacking a secure place to live or not reasonably being able to stay'*.[2] Prevalence increased by 12.3% from 2023 to 2024 across the UK.[3] In total 354,000 people experienced homelessness in 2024, equating to 1 in 182 people. It is difficult to quantify the number of people sleeping rough due to the transient nature of this population; however, data recorded in five major English cities in 2024 found 8,360 people who were rough sleepers.[3] Beyond rough sleeping, PEH could reside in hostels, temporary accommodation, mobile homes, houseboats and uninhabitable buildings, or be refugees, asylum seekers, sex workers, or living at risk of violence or domestic abuse.

Pathways are in place for PEH to move out of homelessness,[4] however, due to systemic factors such as the housing shortage and cost of living crisis, this goal is often unobtainable and PEH remain in the system often for years with no improvement in circumstances.

Causes of homelessness

Causes of homelessness are manifold. Social factors include lack of affordable housing, poverty and unemployment. Frequently, people become homeless when they can no longer afford private rental (the most common reason for homelessness),[2] or when asylum seekers are given the right to remain with only two months to find accommodation.[5] Pivotal life events can precipitate homelessness, including a relationship breakdown, job loss, transition from institutions (such as prison, care or the army) or, for women particularly, fleeing violence or abuse.

The profile of PEH is changing due to the cost-of-living crisis, and it is hard to generalise the specific nutritional challenges due to paucity in the literature. This article focuses on those who are rough sleeping, using night shelters, and residing in temporary accommodation where there is emerging evidence. (see **Table 1**).

Table 1: Categories of homelessness[4]

Rough sleeping	People who are sleeping outside (tents or doorways) or in places that aren't designed for people to live in (cars, sheds, abandoned buildings).
Temporary accommodation	*Night Shelters* are a form of temporary accommodation for PEH which meet basic needs, such as a warm bed and a safe place to sleep. Some may offer showers and a hot meal. These are run by charitable organisations and availability is not guaranteed on any given night.
	Emergency accommodation, usually in a shared house, B&B or hotel, may be offered for 56 days during which the PEH must demonstrate that they are seeking longer term accommodation. If not doing so they will be declared intentionally homeless and support to find accommodation withdrawn.
	Hostel accommodation is a type of supported accommodation with an expected tenancy of approximately six months. These usually have shared kitchens and some may provide meals.

Dietary health inequalities

PEH experience greater health inequalities and die approximately 30 years younger than the general population.[2] Additionally, PEH often live with complex multiple co-morbidities that are challenging to manage effectively. Due to the multifactorial causes of homelessness, chaotic lifestyle and compounding poor physical and mental health conditions, managing a healthy nutritious diet is frequently impractical. Pathway[6] describes trimorbidity: the interplay of physical health, mental health and substance misuse. Diet is implicated in each of these facets, including food insecurity and malnutrition, which in turn exacerbate these conditions (**Figure 1**).

Food insecurity

The Food and Agriculture Organisation (FAO) describes food insecurity as lack of regular access to adequate, safe and nutritious food for a healthy and active life.[7] Food insecurity in the UK has been steadily increasing since the sharp rise in food prices in 2022. The lowest income households, along with people with disabilities, unemployed people and ethnic minorities, are most likely to experience food insecurity.[8] PEH frequently experience severe food insecurity and report not eating for a whole day 7.8 times more frequently than the general population[1] (see **Figure 2**).

Causes of food insecurity

Despite financial support for many PEH, there remains a significant number with no recourse to income. Those with support to navigate the complex system may be in receipt of Universal Credit (UC), enhanced UC or enhanced UC plus Personal Independence Payment. A proportion of PEH experience substance dependence leading to reward-seeking behaviours, with little available money for food.[9]

Food aid for PEH can alleviate the severity of food insecurity, however there are barriers to access. There may be little dignity or choice from charitable donations and food banks; meals may not be culturally or clinically appropriate, or demand food literacy and cooking facilities which are often unavailable for PEH.[10] Depending on location, food provision may not be consistently available, nor at a time when that person wants to eat. PEH may have to travel significant distances to access food aid, limiting those with poor physical health and low finance. Mental illness may result in PEH avoiding or being banned from certain or all providers, making begging and stealing preferable to overcome food insecurity, which is intrinsically linked to mental illness.[11]

Figure 1: Trimorbidity & dietary implications

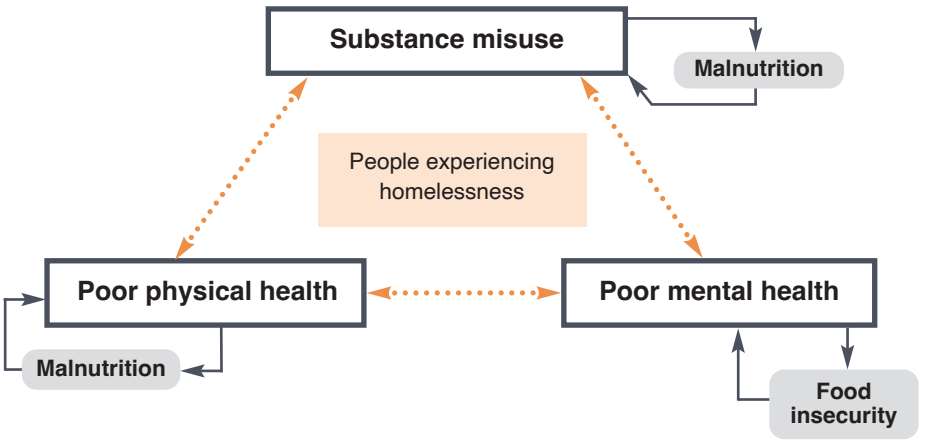
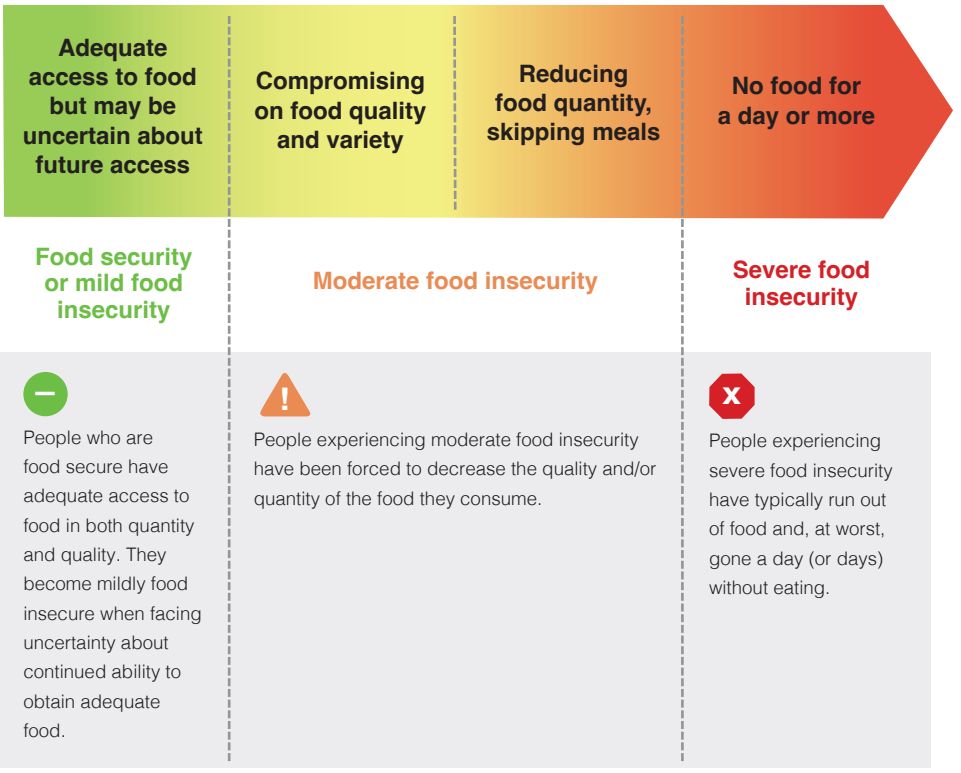


Figure 2: Food Insecurity Experience Scale[7]



Source: Adapted from © FAO 2025 Hunger and food insecurity. Accessed online: www.fao.org/hunger/en (Feb 2025).

Dietary trends

Nutritional deficiencies have been observed alongside food insecurity amongst PEH.[10, 12] Food donations are understood to be of poor dietary quality, often high in fat, sugar and salt.[13] Dependence on food donations therefore limits opportunities for reliable access to a healthy diet. PEH diets are characterised by inadequate fibre, protein, vitamins and minerals intakes from low intakes of fruits, vegetables and protein,[1] and high energy intakes from sugary products.[13, 14] PEH have been found to have low blood levels of iron, folate, vitamins C, D, and B12 and haemoglobin.[12] Emerging studies demonstrate poor catering provision in hostels and charity food provision is suboptimal to meet dietary guidelines.[8, 15]

It is well understood that these facets of poor dietary quality have long-term implications for poor health, including poor dental, gut and skin health, reduced immunity, and other physical health complications.

Comorbidities in homelessness

Substance misuse

Approximately 50% rough sleepers and PEH in hostels are substance and/or alcohol dependent.[16] Opioid-related brain alterations can impair gastrointestinal health and cause impulsive and unhealthy eating patterns due to appetite suppression from decreased levels of dopamine and other competing priorities.[9] Alcohol addiction can mask malnutrition, malabsorption and vitamin deficiencies related to proportionally high energy intakes from alcohol.[17]

"PEH frequently experience severe food insecurity and report not eating for a whole day 7.8 times more frequently than the general population.[1]"

Physical health

PEH often present with multiple co-morbidities, compounded by lack of access to mainstream and specialist clinical services (see **Table 2**). There are dietary implications for each of these conditions for consideration in practice.

Mental health

Amongst PEH, there is a high incidence of mental illness that can impact diet and appetite, including post-traumatic stress disorder, depression, anxiety, schizophrenia obsessive compulsive disorder and psychoses.[19] Additionally, learning disabilities and neurodivergence, including attention deficit hyperactive disorder and autism, feature in 12% of PEH, whilst many remain undiagnosed.[20]

Figure 3 summarises the various complicating factors implicated in dietary health for PEH, including substance misuse, physical and mental illness, as well as social factors.

Nutrition screening

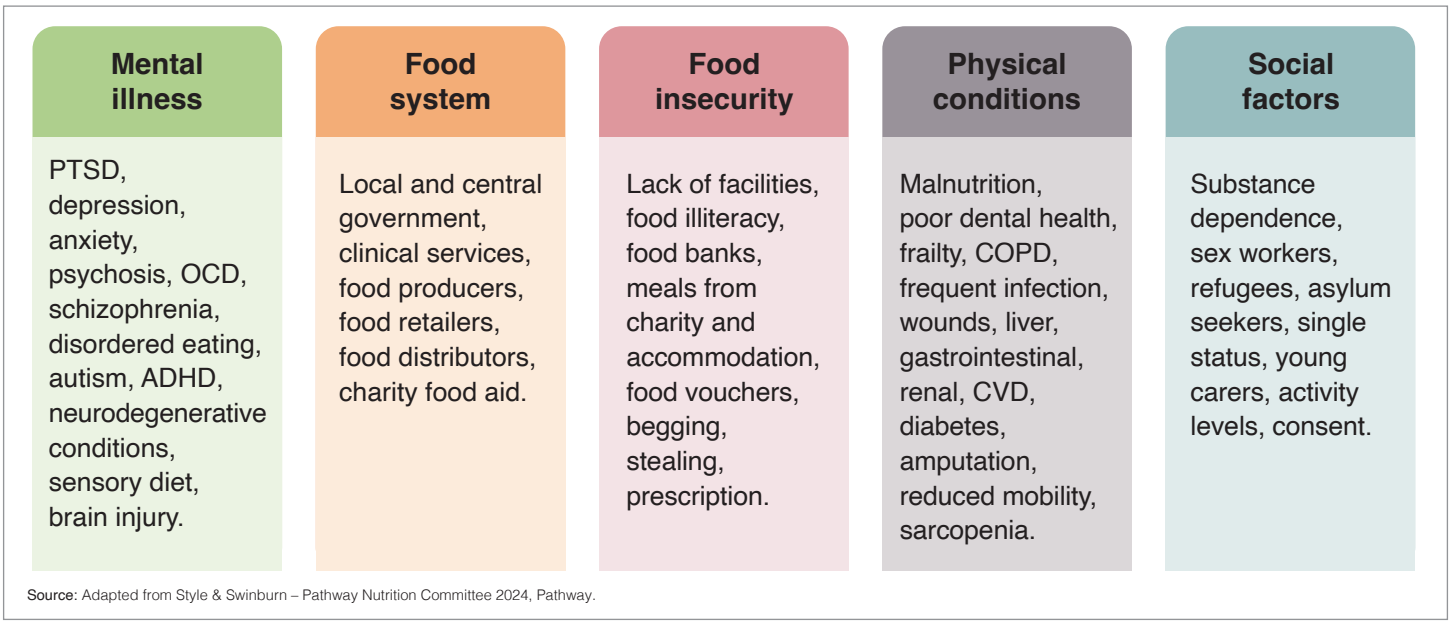
Currently there is no validated nutrition screening tool for PEH specifically. Despite this, malnutrition and obesity have been identified in this population group.[1] The 'Malnutrition Universal Screening Tool' ('MUST') is widely embedded within both secondary and primary settings, however it is insensitive when used with PEH (see **Table 3**). Findings from recent research demonstrate that 60% of PEH experience malnutrition, as screened by 'MUST', mostly related to disease risk; and that a further 19% experience sarcopenic handgrip strength readings undetected by 'MUST'.[1] Malnutrition was predicted by food insecurity, age and mental illness. However, the majority of PEH presented with healthy body mass index (BMI) and low intakes of micronutrients. Other studies identified 33.3-68.3% PEH present with raised BMI, indicating obesity,[12] mirroring general population trends. Studies recommend improvements to nutrition screening practices to promote referrals to local food aid and dietetics services. In response to this, the authors of this article are currently conducting research to co-develop a population-specific nutrition screening tool for PEH in collaboration with the PNC.

Table 2: Common comorbidities of PEH vs. working age comparative

Condition	PEH reported incidence %	General population incidence %
Alcohol or drug related problems	43	0.5
Muscular skeletal	27	20
Respiratory	24	12
Cardiovascular	16	12
Gastrointestinal and renal	19	6
Skin conditions/allergy	14	14
Diabetes	2	3.2
Cancer	1.6	0.8

Source: Adapted from Hard Edges: Mapping severe and multiple disadvantage.[18]

Figure 3: Dietetic considerations for PEH



Source: Adapted from Style & Swinburn – Pathway Nutrition Committee 2024, Pathway.

Table 3: Case study – using 'MUST' for people experiencing homelessness

Assessment	Comment
Assessment was carried out during an outreach street clinic: • 32-year-old male living in a residential hostel • Methadone prescription • Daily use of spice • Alcohol dependant 4 x 2000 ml 5% cider daily • Co-morbidities: IVDU, alcoholism, chronic hepatitis C, COPD, asthma, poor mental health	• Patient volunteered for assessment as he was concerned about his nutritional state • Engaging with drug and alcohol support services
Anthropometry: • Weight 67.8 kg • Height 1.84 m • Weight gain 6.8 kg in 6/12 (11%) • BMI 20 kg/m^2 • Grip strength right hand 32.5 kg	• Patient was wearing two hoodies and shoes when weighed • BMI normal range • Grip strength <10th centile for age. Normal range for age: 36-55.8 kg
Diet history: • Not accessing meals in accommodation or from charity food provision • Intake: no meals, irregular snacks when donated • Reports no food intake at least 3 days per week • Calorie intake from alcohol: 2240 kcal Estimated requirement: • Energy (27 x weight x PAL 1.4) = 2562 kcal • Protein (1 -1.5 g/kg) = 68-102 g	• Receives Universal Credit but using this to support drug and alcohol addiction • Not using charity food provision due to poor mental health • Meeting majority of energy requirements from alcohol intake • Protein and micronutrients severely deficient
Observations: • Loss of cheek fat pads • Distended abdomen • Appears slightly jaundiced • Sarcopenia observed in shoulders	• 'Looks' malnourished despite normal BMI • Distended abdomen required further review as possible opiate related constipation/ascites
'MUST' score: • BMI: 0 • % Weight-loss score: 0 • Acute disease score: 0	• Overall 'MUST' score is zero in the presence of observable and measurable protein malnutrition

Dietetic interventions & nutrition care planning

PEH are infrequently referred to dietetics in acute settings, despite higher attendance to hospitals than the general population.[9] Hospital catering and dietetic interventions aptly offer opportunities for high dietary intake and quality to mitigate nutritional risks that this vulnerable group of people face. PEH are also excluded from community settings related to systemic discrimination and challenges in setting realistic food-first advice given the high prevalence of food insecurity; namely, poor access to cooking facilities, food illiteracy, limited dietary sources and cultural dietary beliefs. Therefore, working with local services is pivotal to promoting nutritional screening and prompt dietetics referrals. There is a role for other practitioners to assess markers of nutrition to 'Make every contact count' and signpost to suitable services at key touchpoints with health and social care services given the transient nature of this population group.

Conclusions

PEH suffer dietary health inequalities related to trimorbidity, systemic discrimination within the food system and are at high risk of malnutrition related to food insecurity. Clinicians working across settings are ideally placed to improve dietary health outcomes through offering tailored intervention, understanding the context of food insecurity. Nutritional screening practices are insensitive to nutrition risks for this group and should be improved to promote prompt referrals for nutrition support. There is an urgent need to develop targeted nutrition standards for temporary accommodation settings to promote both food security and improved dietary health for PEH.

Recommendations

Addressing malnutrition for PEH may be challenging, and yet possible. To improve dietary health inequalities, nutritionists and dietitians could:

- Partner with local charitable, social and clinical teams working in homeless and inclusion health to develop nutrition policies and standards
- Offer training for partners in nutrition screening to prompt dietetics referrals
- Empower partners to improve dietary quality of food provision
- Assess functional (handgrip strength) and social (food insecurity screening) markers to improve identification of malnutrition in addition to standard nutrition screening tools where feasible
- Consider challenges with accommodation and food access in dietetic consultations with PEH when providing dietetic advice
- Consider prescription of oral nutritional supplements, vitamin and mineral supplements in the absence of consistent food provision.

References: **1.** Style H, Brown A, Vickerstaff V (2025). Nutrition Status of People Experiencing Homelessness Residing in Temporary Accommodation in London. J Hum Nutr Diet.; doi.org: 10.1111/jhn.70024. **2.** Crisis (2025). About homelessness. Accessed online: www.crisis.org.uk/ending-homelessness/about-homelessness/ (Jan 2025). **3.** Gov.UK (2024). Homelessness statistics. Accessed online: www.gov.uk/housing-local-and-community/homelessness-rough-sleeping (Jan 2025). **4.** Advice Now (2024). Emergency and Temporary Accommodation. Accessed online: www.advicenow.org.uk/get-help/housing-and-homelessness/eviction/emergency-and-temporary-accommodation (Jan 2025). **5.** Right to Remain (2024). The right to remain toolkit. Accessed online: www.righttoremain.org.uk (Jan 2025). **6.** Pathway (2018). Homeless and Inclusion Health standards for commissioners and service providers. Accessed online: www.pathway.org.uk/wp-content/uploads/Inclusion-Health-Standards-for-Commissioners-and-Service-Providers.pdf (Jan 2025). **7.** Food and Agriculture Organisation of the United Nations (2025). Hunger and Food Insecurity. Accessed online: www.fao.org/hunger/en (Jan 2025). **8.** House of Commons Library (2024). Who is experiencing food insecurity. Accessed online: https://commonslibrary.parliament.uk/who-is-experiencing-food-insecurity-in-the-uk/ (Jan 2025). **9.** Chavez M, Rigg K (2020). Nutritional Implications of Opioid Use Disorder: A Guide for Drug Treatment Providers. Psychol Addict Behav.; 34(6): 699–707. **10.** Seale JV, Fallaize R, Lovegrove JA (2016). Nutrition and the homeless: the underestimated challenge. Nutr Res Rev.; 29(2): 143-151. **11.** Smith J, *et al.* (2023). Food insecurity and severe mental illness: understanding the hidden problem and how to ask about food access during routine healthcare. B J Psych Adv.; 29(3): 204-212. **12.** Huang C, *et al.* (2022). A systematic review of the nutritional status of adults experiencing homelessness. Pub Health.; 208: 59-67. **13.** Loopstra R, Lambie-Mumford H (2023). Food banks: Understanding their role in the food insecure population in the UK. Proceed Nutr Soc.; 82(3): 253-263. **14.** Prayogo E, *et al.* (2018). Who uses foodbanks and why? Exploring the impact of financial strain and adverse life events on food insecurity. J Public Health (Oxf.); 40(4): 676-683. **15.** Ravikumar-Grant D, Kelly C, Gabhainn SN (2023). The determinants of the nutritional quality of food provided to the homeless population: a mixed methods systematic review protocol. Systematic Reviews.; 12(1): 118. **16.** Advisory Council on the Misuse of Drugs (2019). Drug-related harms in homeless populations and how they can be reduced. Accessed online: www.assets.publishing.service.gov.uk (Jan 2025). **17.** Ijaz S, *et al.* (2018). Interventions for preventing or treating malnutrition in homeless problem-drinkers: a systematic review. Int J Equity Health.; 17: 1-16. **18.** Lankley Chase Foundation (2015). Hard Edges, Mapping Severe and Multiple Disadvantage, England. Accessed online: https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf (Jan 2025). **19.** Padgett D (2020). Homelessness, housing instability and mental health: making the connections. B J Psych Bull.; 44: 197–201. **20.** Churchard A, *et al.* (2019). The prevalence of autistic traits in a homeless population. Autism: the international journal of research and practice.; 23(3): 665-676.