

Creation of Advanced Practice Nursing Role for Clinical Nurse Specialist Working with
the Homeless Population

by
Andréa Monteiro BSN, University of Victoria, 2007

A Project Submitted in Partial Fulfillment of the Requirements for the Degree of

MASTER OF NURSING

In the School of Nursing, Faculty of Human and Social Development

Andréa Monteiro, 2009
University of Victoria

All rights reserved. This project may not be reproduced in whole or in part,
by photocopy or other means, without the permission of the author.

Supervisory Committee

Creation of Advanced Practice Nursing role for Clinical Nurse Specialist Working with
the Homeless Population

by
Andréa Monteiro
BSN, University of Victoria, 2007

Supervisory Committee

Dr Marjorie McIntyre (School of Nursing)
Professor, Supervisor

Dr Joan MacNeil (School of Nursing)
Assistant Professor, Committee Member

Darcee Bidgood RN MSN
Vancouver Island Health Authority, Committee Member
Adjunct Assistant Professor (School of Nursing)

Abstract

“Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us. We ask ourselves, who am I to be brilliant, gorgeous, talented, fabulous? Actually, who are you not to be? You are a child of God. Your playing small does not serve the world. There is nothing enlightened about shrinking so that other people won't feel insecure around you. We are all meant to shine, as children do. We were born to make manifest the glory of God that is within us. It's not just in some of us; it's in everyone. And as we let our own light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others.”

Marianne Williamson

The words proffered by Williamson were repeated by Nelson Mandela in one of his eloquent speeches. These same words have echoed in my soul since I came across them a few years ago. In this project, I have chosen Williamson's inspiring poem to guide my reflection on the leadership role for an advanced practice nurse (APN). How can APNs “let their own light shine”? Where should we shine our light? There is an increasing need for nurses to shine, in ways such as sharing their expertise in the political arena, sharing their knowledge through nursing education, participating in policy and decision-making, influencing health care and guiding service delivery (McIntyre, Thomlinson, McDonald, 2006). However, letting their light shine does not correspond to being expert leaders. By working with clients, nurses in advanced practice have learned about their struggles, and the necessity to fearlessly advocate for clients' needs as well as for nursing issues.

In addition to letting our own light shine, we grow to be leaders who inspire other nurses to let their lights shine as well. Our lights shine by identifying needs in our communities and by addressing these needs through nursing's unique contributions. Through this project, I have identified the lack of APN leadership in the work with the inner-city homeless population in the city of Victoria, British Columbia. As advanced practice nurses, our light can shine through questioning the status quo and taken-for-

granted practices, and by refusing to conform to nursing practices that are oppressive to clients as well as nurses.

Table of contents

Supervisory Committee.....	ii
Abstract.....	iii
Table of Contents.....	v
Acknowledgements.....	vii
Introduction.....	ix
How did I come to be interested in working with the homeless population in Victoria....	10
Situating myself	10
What do I bring to this project?.....	12
Academic/professional practice experience	12
Literature review.....	16
APN Framework, CNA Code of Ethics.....	16
Housing and Homelessness course.....	19
The work of Isolde Daiski and Cathy Crowe: Toronto’s Example.....	23
Statement of the problems and Scope of this project.....	24
Who am I calling “homeless”? Are they “others”?.....	25
From a ‘normal life’ to the streets of Victoria (Paul’s story of Homelessness).....	29
Proposed link to nursing practice, education and/or research.....	30
Project focus.....	32
Description of the geographic area involved.....	33
Homelessness in Downtown Victoria, BC.....	33
Historical influences on homelessness in Victoria.....	34
Media Influence.....	35

Political Influences on Homelessness.....	35
The Influence of a Beurocratic System.....	36
Marie’s embodied experience.....	37
Standing Point and Stereotypes.....	42
Strengths and limitations of existing services in the downtown area, including nursing.....	44
The ‘diseased arm’ (Michael’s experience).....	45
Conclusion.....	51
References.....	54

Acknowledgements

According to an African proverb, “it takes a village to raise a child”. I believe that this is also true in raising an Advanced Practice Nurse. I am so thankful to many special people in my life, your support during the development of this project has enabled me to keep grounded and sane during this arduous process. Please know that your presences in my life have deeply touched me and I am forever grateful!

My daughter Vitoria, thank you for your wisdom and patience, for cheering me up with your beautiful smile. For all the many times you have said “you can do it, Mama!” Your radiant presence in my life has filled my heart with joy, love and pride. Te amo meu amor!

I would like to thank my mother Francinete for your unconditional love. I would like to remember my father Climerio and my grandma Almerinda, whose love will always sustain me. Thanks to my cousin Ladejane and her partner for your endless care and support at all times. And thanks to my brothers Fred, Andre and Marcus, their partners and my nieces and nephew. We are physically far but close in our hearts. Muito obrigada, eu amo todos voces!

Thank you Marjorie McIntyre for being a wonderful role model and inspiring mentor. You, Marjorie, ‘walk the talk’ and make me proud of our profession. I cannot begin to describe my gratitude for your presence in my life through these past years. You always challenged me and pushed me to places I did not believe I could go. I was deeply inspired by living the truly egalitarian and collaborative process of student and mentor that we experienced. I hope I can touch others in a similar way. Thank you from my heart.

I would like to express my love and deep gratitude to friends that I call family: Violet Cantwell, Paula Schnare, Barbara Jenks, Barry Jenks, Garth Walmsley, Carolyn Schellenberg, Joan Lawrence, Allen Simms, Beth Bartlett, Kirk Bartlett, Dolly Beaumont, and Art Beaumont. I cannot begin to thank you all for your precious support and friendship, for all the meals, music, laughter and tears we have shared together in this journey. Big hug to you all, from my heart!!

Lynne Crawshaw, Karen McIver and Paula Schnare thank you for your friendship and endless patience with editing my work. Your readiness to support me has been deeply appreciated.

Thank you very much Joan MacNeil, Darcee Bidgood and Carol McDonald for your valuable insights and thoughtful contributions to this work. Also, thanks to Darcee and Reverend Al Tysick my field guides during my practicums, for freely sharing their inspiring work with me.

Last but not least, I would like to thank the anonymous clients, whose faces I can vividly remember anytime I close my eyes. You have profoundly touched my life and you have taught me more than I would ever learn in textbooks. It has been our interaction that brought true meaning to my practice as a registered nurse.

Introduction

“...Any path is only a path...Try it as many times as you think necessary...Then ask yourself, and yourself alone, one question... Does this path have a heart? ... If it does, the path is good, if it doesn't it is of no use” (Castaneda, 1968, p. 106-107)

When pondering about the advanced practice nursing path, I came across something from my journal I wrote at the beginning of this program: “I am learning that there is a place in nursing to express myself; a space where I can humbly reflect on where I am in the universe and I can contribute from that place... there lies a challenge within me and my place on earth. In one way I experience the greatness of every human interaction around me and I can feel with all my senses the great possibilities of human love, service and transcendence. The other side of me feels a call to advocate for others in need, but struggles with how to do that. So, I trust that this calling voice will continue to speak and one day I will know how to respond to it.” Therefore, in answering this calling voice, I hope that this project will greatly contribute to nursing practice and the clients nurses serve.

The road towards advanced practice nursing is not always an easy pathway. Sometimes the path is perfectly laid out, other times it seems that we need to carve our way as we go along. There are many important attributes and competencies one must attain in order to successfully flourish in the APN role. Throughout my master's studies, I have certainly had the opportunity to reflect on the complex and at times uncertain meaning of the APN role. The competencies of leadership, clinical, research, and collaboration underline attributes registered nurses need to perform safely and ethically in a specific APN role and setting (CNA, 2008). The fruit of my reflection on this role has evolved and it has been shaped by literature, class discussion in this masters program, and most importantly, by my work and interaction with homeless clients,

nurses working with these clients, and a Clinical Nurse Specialist (CNS) enacting the APN position.

How I Came to be Interested in Working with the Homeless Population in Victoria

Situating myself

Coming from Latin America (Brazil), I am able to appreciate on a larger scale what poverty does to individuals and to communities. Besides undergraduate and graduate studies in nursing, I have a varied education background that includes speech therapy, cross-cultural studies and theology. My nursing practice experience includes acute medical nursing, nursing education and nursing in the community. In both community and acute care, I am interested in advocacy with homeless individuals.

Although my experience has led me to believe that nurses are in a unique position to advocate for social justice on local, provincial, national and global levels, I have yet to hear our voices in these conversations. If we are speaking, we are very quiet or only talking to ourselves. Or it is possible that we are speaking as loudly as possible and are not being heard. Through this project, in addition to learning what I can from others with whom I interact, I hope to continue sharing my passion for social justice. APNs are in a great position to nurture seeds of inquiry in nurses and nursing students, promoting a generation of motivated and fearless advocates for social justice. We are also in a strategic place to exercise the clinical competency of collaboration and lead nurses and other professionals toward practices that dignify our fellow human beings. Hamric, Spross & Hanson (2009) argue that environments fostering collaboration create a supportive medium to address ethical issues.

Guided by Freire's (1993) ideas on critical social theory, advanced practice nurses use reflection and need to act and be a voice against social inequities in order to transform the

reality of our local communities and areas of care. hooks (1994) takes Freire's ideas further and proposes that "we needed new theories rooted in an attempt to understand both the nature of our contemporary predicament and the means by which we might collectively engage in resistance that would transform our current reality" (p.67). APNs need to engage in planting seeds of nonconformity with taken-for-granted practices in health care that contribute to the oppression of homeless clients. As defended by Lutz, Jones and Kendall (1997), the "construction of emancipatory knowledge involves the critical analysis of a social system or structure with emphasis placed on the power relations and contradictions inherent in the existing status quo ideology"(p.27). Cultural or social critiques geared towards transforming the status quo are derived from critically-oriented knowledge (Kincheloe & McLaren, 2000). We need to continue to engage in questioning the political, social, and economic factors that affect marginalized populations, therefore affecting the health of the community at large. Furthermore, we need to be able to communicate our findings with others and collaborate for solutions (Hamric, Spross & Hanson, 2009).

My interaction with homeless clients, who have experienced marginalization, those "who have suffered from the sentence of history" (Bhabha, 1994, p.172) has profoundly shaped the way I enact my nursing role, and the way I envision this project. In this project I will be describing some of my personal interactions with clients to bring forward a human face on homelessness. Guided by Parse's Theory of Human Becoming, having been present to bear witness to clients' experiences and struggles, and through this project, I am aiming to generate an emancipatory as opposed to an oppressive (Freire, 1993) nursing practice.

What do I Bring to this Project?

Academic and Professional Experience

The opportunity to practice nursing with the homeless community has greatly impacted the way I relate, not only to homeless people, but to others I encounter in my practice. Throughout my nursing career and my activist work as a volunteer I have engaged directly with homeless individuals and groups. As part of my undergraduate and graduate clinical experience at Our Place (OP), an inner-city drop in center in downtown Victoria, I worked under the guidance of a prominent advocate for homeless and low-income groups in Victoria's inner city. Although not a nurse, this advocate provided numerous opportunities for me to deepen my understanding of the multiple issues faced by underserved groups. Through this experience, I was able to bring together my knowledge and skills from earlier activist work with street-involved clients and what I was learning in nursing studies.

The mandate of Our Place is to provide nonjudgmental support and space for homeless individuals and people living in poverty. It provides health assessments through physician and nurse encounters with clients; however, these services are inadequate due to limited time. Other front line workers provide counselling and referrals for issues dealing with welfare, housing and legal affairs. They also offer a space for social networking, spiritual care, personal care services, and meals. In addition, OP provides housing for around 45 people.

As an undergraduate nurse, I organized a health care fair where over twenty nursing students were able to participate in a one-to-one interaction with the clients of Our Place. At a first glance, it may have seemed that the group of fourth year nursing students was providing a service to the population through assessments such as a blood pressure and foot care clinics. However, the intention was for the students to meet clients where they were, and reflect on the

factors that had led them to the streets. The impact on nursing students cannot be measured, but by some students' testimonials, the mere act of being inside a drop-in-center had changed their practice, especially with regard to the way they interact with homeless clients in different health care settings.

On another occasion, this time as a Masters in Nursing student, I had the opportunity to lead a workshop during a retreat weekend for frontline caregivers entitled *Caring for the Caregiver*. This weekend was organized by Our Place and was geared towards workers from various agencies providing services to the downtown street population. This was a multidisciplinary retreat including nurses, social workers, addiction workers, housing advocates, and outreach workers.

Caring for the Caregiver had attendants from Our Place as well as frontline workers from several agencies, among them Pacifica Housing Advisory Association (PHAA), Salvation Army, Cool Aid Society, and Downtown Outreach Team (DOT). PHAA is a non-profit organization that owns and manages over 639 affordable housing units in Greater Victoria and Nanaimo for people with disabilities and low-income families. PHAA also offers housing outreach and support services for homeless individuals. The Salvation Army is a religious organization that works with sheltering, feeding and clothing underserved people. The Cool Aid Society is an agency with programs that include supported housing, community health and dental services, emergency shelter and other services. The DOT is a multi-agency program funded by Ministry of Health, Victoria Police Department, and OP. This team works with homeless individuals who suffer from mental illness or addictions, connecting clients to stable housing services, addictions services and vocational support.

During the weekend, I led a workshop entitled *Healing through Storytelling* where I encouraged participants to share their stories of difficulties and joys of working with homeless clients in downtown. This workshop provided caregivers with an opportunity to express situations that had been buried in their hearts for many years. An emphasis was made on caring for self as you care for others, as well as the need to build a support network for the caregiver. The intention was to provide caregivers an opportunity to share stories that might have caused burnout and moral distress (Storch, 2004) over the years. Storch (2004) describes moral distress as negative feelings occurring when one's moral choices and moral actions are not in agreement.

As a nursing instructor at Camosun College, I provided opportunities for group discussion on issues related to homelessness, and guided students through the streets of downtown Victoria, identifying the resources for the homeless and introducing students to people on the streets, bringing a human face and real meaning to issues we discussed in class. Furthermore, I invited students to question current realities for people on the streets, and to question the adequacy of a system the students would be looking to for support services in the future.

As part of an Anthropology and Nursing graduate course titled *Housing and Homelessness*, I facilitated a discussion on the *Medicalization of Homelessness* using the movie *Bevel Up*, a Vancouver production depicting the experience of nurses working with the downtown population in that city. This was a multidisciplinary class with the participation of students from the disciplines of nursing, anthropology, social work and political science. A more in-depth discussion on the literature discussed in this class will be addressed in my literature review.

In addition to my nursing work, I have participated in the creation of a soup kitchen and a night shelter in a local faith community, serving lunch for around 100 people everyday at present. I have long been interested in local phenomena such as ‘tent cities’ and issues related to homelessness and affordable housing in Victoria. Furthermore, I have interacted with homeless individuals in Vancouver Island Health Authority’s (VIHA) acute care settings, and the circumstances surrounding these encounters have caused me great moral distress. Storch’s (2004) definition of moral distress perfectly fits with my own experience in my nursing practice. Homeless clients were not to blame for my distress, but rather the system that did not allow me to appropriately care for individuals and provide the dignified care I ought to be providing. On numerous occasions, I had to discharge fellow human beings to the streets of Victoria, and when I questioned this common practice, the nursing leadership or colleagues from the multidisciplinary team offered no support and my questions were left unanswered. Instead they emphasized fast discharge of patients, rather than focusing on the place and circumstances to which these people were being discharged. It was in situations such as this that I began to think of the possibilities for an APN in Victoria’s inner city to serve homeless people, and how this role may serve to meet some of the apparent needs of this population.

I believe that there are many nurses struggling to reconcile what they believe to be the ethically right thing to do when addressing the multiple needs of homeless individuals but the system constrains what they are able to do. At the moment there is no infrastructure to support the position of an APN in the downtown core. This project is therefore intended to identify what would be needed to support Victoria’s homeless community and make recommendations on how an APN can contribute through nursing knowledge, to address these complex needs.

Literature Review

The main themes for this project are Advanced Practice Nursing and Homelessness. With these themes in mind, I conducted an extensive literature review that included reviewing the Canadian Nurses Association's (CNA) 2008 National Framework for Advanced Practice Nursing¹, and the CNA's Code of Ethics (2008). In addition, I explored the literature in the graduate course *Housing and Homelessness*. Also, I carried out a comprehensive CINAHL search using the words "homeless", "social justice" and "advocacy" focusing on the work of Isolde Daiski and Cathy Crowe, both enacting APN roles and working in Toronto.

APN Framework, CNA Code of Ethics

Hamric, Spross and Hanson (2009), argued that the evolution of the terminology "advanced" related to nursing practice is unclear. CNA (2008) defines APN as an umbrella term for nurses with graduate educational preparation and an advanced level of clinical practice. CNA (2008) identifies two APN roles in Canada today: that of Clinical Nurse Specialist (CNS) and of Nurse Practitioner (NP). It is important to point out that even though there are nurses practising in an extended nursing role in the downtown core of Victoria, only one was a Nurse Practitioner². Other registered nurses might have been practicing in an extended role, but we must be cautious about addressing these colleagues as "advanced practice nurses". The nurses practising in the downtown core did not have graduate education. APN is defined by advanced clinic skills and graduate education (CNA, 2008). We cannot assume that Diploma and Bachelors prepared Registered Nurses would have the advanced knowledge and skills to carry

¹ In this paper CNA (2008) will be referred to Canadian Nurses Association's (CNA) 2008 National Framework for Advanced Practice Nursing.

² There was only one NP working in the downtown core during my Nursing Praxis I course.

out the APN role. It is generally accepted that a graduate degree is required to successfully enact an advanced nursing role.

In my practicum work with a CNS, I concluded that practitioners had to constantly educate others about their role because it is dynamic and constantly being redefined by the demands of the institution. That is to say that in health systems, the APN role is not well-defined. Role definition was one of the main themes of NURA 517 and 518 courses (Nursing Praxis). Role definition was not an isolated issue in my practicum placement. As discussed by Jamieson and Williams (2002), Australian advanced practitioners also struggle to clearly define and propagate what an APN role is. Brykczynski (2000) utilized Benner's novice to expert model to validate practitioners' feelings of insecurity when articulating a new role. Therefore, it is a complex endeavour to articulate a new role, especially if the role has not yet been established in an area of practice.

A CNS is defined by CNA (2008) as an advanced practice nurse role providing guidance and leadership to nurses dealing with complex care, with the goal of improving quality care and promoting evidence-based practice. In Canada, the CNS role emerged in the 1970s due to the increased complexities of client care (CNA, 2008). This differs from NPs who focus on treatment and management of health conditions through health promotion and direct client care.

One of the challenges of this project is to understand the distinction between different nursing roles. It is important to draw the distinction between these two roles, as a CNS working with the homeless would constantly be dealing with the challenge of articulating the needs of the homeless and educating other professionals and members of the public. A clearly defined role envisioned by CNA's competencies and focused on meeting the needs of the clients in this community would serve to articulate the APN role and its benefits in this setting.

It is important to have a document such as that of CNA (2008) that defines and advocates for the APN role, however just defining APN is not enough. CNA (2008) describes the competencies for APN. Especially important to this project are the emphases on leadership and advocacy. However, the weakness of this document is that it is very general and vague. CNA's document fails to bring life to the APN role by addressing real practice issues, the ones faced in specific areas of care, such as social justice in working with marginalized populations. It seems that our mission as Advanced Practice Nurses is to bring life into this document through the enactment of the APN role thus, contributing to the development of APN role and our profession. I hope this project can be one more drop in this ocean of ever-changing nursing practice. It may be only a drop, but it is a very passionate one!

Remaining with the topic of social justice, I am troubled by the fact that documents that guide nurses such as CNA Advanced Practice Nursing Framework (2008) and CNA's Code of Ethics are not yet powerful enough in addressing this essential theme. Conversely, the Code of Ethics issues a call for nurses to address broad aspects of social justice, which influence people's health and well-being. While I applaud the inclusion of social justice in our Code of Ethics, it intrigues me that the Code does not identify social justice as a core ethical responsibility of nurses. It describes social justice issues as an "endeavour that nurses can undertake to address social inequity" (p.3). That is if nurses have time after exercising the core ethical responsibilities, they may attend to social justice issues. While it is important to have social justice being addressed by the code, having social justice as an endeavour as opposed to being central to ethical nursing practice does not provide strong enough leadership for nurses in the midst of the moral climate in working with underserved groups.

The other central focus of this literature review was homelessness. When searching for this theme, I had to deal with my own feelings first. What I find appalling is that the number of homeless people and the complexity of care required have increased to the point that we now need an advanced practicing nurse in the downtown core. However, having acknowledged this need I can see what the APNs have to offer can address this gap in services. For example, Cathy Crowe, a street nurse from Toronto, has said that when she started as a street nurse there were only four or five street nurses in Toronto. Today this number has increased to more than 100 street nurses, showing how much the problem has increased. But that does not mean that we need more nurses on the streets of downtown Victoria: we need leadership! The gap in services that I have identified, is exactly what such leaders are called to do. We need leaders who will collaborate with other nurses and stakeholders in order to bring about social justice. Social justice “focuses on the relative position of one social group in relationship to others in society as well as on the root causes of disparities and what can be done” (CNA, 2006, p.7). We cannot accept homelessness as an issue in our midst. Other nurses working in advanced practice may be working with chronic illness such as renal disease, or conditions that cannot be eradicated; but can be managed. Homelessness, on the other hand, should not be seen as a chronic condition, but a created circumstance. Despite the fact that I am proposing a role for an APN to work with the homeless, it does not eliminate the need to critique the fact that in a rich society it is unacceptable to have people living on the streets.

Besides identifying this need in our community, the creation of this role also becomes an act of denouncing the unjust way some of our fellow human beings have been living. This project is intended to bring both of the CNA documents (Framework and Code of Ethics) one-step further in advocating for social justice. If it was not for a clear need in our community my

wish would have been to do the opposite of creating a role, but to eradicate the need for it in a community with such abundance of resources.

Housing and Homelessness

Homelessness, however, is present in our society today as it has been in the past. I had the opportunity to review literature regarding the history of homelessness and issues generating homelessness in my classes of *Housing and Homelessness*. It is important to point out that the University of Victoria has a specific course with the word *homelessness* on its title; therefore, once more it is evident that there is a clear need in our community. Housing is one of the essential pre-requisites of health (Ottawa Charter for Health Promotion, 1986). Homeless individuals' morbidities and mortalities are greater than those who are housed (Hwang, Martin, Tolomiczenko, & Hulchanski, 2003, Frankish, Hwang & Quantz, 2005), therefore, housing is an important social determinant of health (SDH) to be considered.

The images of homeless individuals have changed over time. In the past, one perspective of homeless individuals were attached to the romantic image of lone man who lived free of attachments (Glasser & Bridgman, 1999). However today, homelessness encompasses a broad range of individuals, and includes men and women, the elderly and families with children. Glasser and Bridgman defined homelessness as the opposite of having adequate housing. Much can be said however about the definition of homelessness. In this paper I will avoid giving one single definition of homelessness recognizing that a single definition may be problematic (Tipple & Speak, 2005) since we have such a variety of individuals who are homeless in our city. For the purpose of this project I will focus on those without a place to call home.

Purdy and Kwak (2007) explored the complex historical process of housing by comparing public housing experiences in the USA, Canada, the Caribbean, and Argentina.

They examined the history of public housing and stressed the political and social significance of state housing provision in the periods of urban crises in the twentieth century. The authors argued that structural and demographic changes influenced state provision of housing. They pointed out that in Latin America, Canada and the United States, three quarters of all Americans live in cities. The authors related these numbers to the increased numbers of slums in the studied areas. They discussed the role played by industrialization, where the population in cities increased compared to a small industrial sector and a large commercial sector. In addition, the authors discussed economic growth versus urbanization in the post World War II period and the concept of how modernization shaped middle class elites who were responsible for the management of urban reforms. Purdy and Kwak (2007) also examined Frederick Engel's contention that industrialization led to poor quality housing due to structural inequalities in society. The authors discussed the public right to shelter. According to Isitt (2008) homelessness in Victoria is a consequence of lack of adequate shelter. Housing, not homelessness, is the significant health determinant to well-being.

Shapcott (2004) addressed the issue of housing as a SDH. He discussed the history of housing problems in Canada beginning with 1900. Shapcott argued that throughout many crises in the period of 100 years, no effective measures were taken by the Canadian government to deal with housing needs of people. The author maintained that only patchwork initiatives were undertaken to address complex issues resulting in what he called a "homelessness disaster". Bryant (2004) went further and related housing to health. A lack of affordable housing and the increased incidence of homelessness are viewed as the Canadian government neglecting Canadians housing needs throughout the years (Shapcott, 2004; Bryant, 2004; Brushett, 2007). Furthermore, Bryant (2004) questioned why researchers have not addressed housing as a major

area of inquiry, considering the ongoing housing crises. I agree with the author as he also argued that research can and should influence policy-making thereby supporting health.

Focusing on another SDH, Lynch and Kaplan (1997) explored income and its influence on health. The authors discussed the development of research on income distribution and argued the need for research to engage in structural determinants at a societal level, as opposed to focusing on the individual. That is to say, that examining structural aspects in society determines who receives good education, jobs and financial compensation. Furthermore, Lynch and Kaplan discuss social inequities and their impact on health, questioning the underlying popular and scientific discourses that inequities are an expression of individual differences. They strongly defend the idea that people with low social economic status have poorer health. Another issue raised by the authors is the medicalization of homelessness. That is to say that poverty is linked to disease. According to these authors, by linking homelessness to medical rather than social issues, the focus becomes the disease supported by biological, behavioral and psychological findings rather than focusing on systemic causes of homelessness.

The SDHs such as housing and income, as opposed to homelessness, have an effect not only at the individual level but also at a societal level. It seems clear that with housing crises, Canada's government has neglected to take effective measures. One way APNs can have an effective role is to advocate for continuing engagement of research on housing issues as a way to guide or pressure decision and policy making, and thereby, positively affect people's health. By pressuring the different levels of government from this long history of negligence towards affordable housing, APNs would be bringing life to the lifeless CNA framework, and would be promoting social justice as an essential ethical nursing responsibility.

Young (2001) explored ways to illuminate structural conditions in society that in many ways constrains individual actions, such as the SDH mentioned above. She argued for the necessity of a group-conscious approach in dealing with structural inequity and its involvement or responsibilities for social policy. Young argued that the way we approach resource distribution, opportunities, influence and privilege are intrinsically related to issues of power and can be perceived as political and philosophical challenges. Young used Frye's vivid metaphor of oppression described as a birdcage. In this description, each wire by itself could not prevent a bird from flying; however, when together, wires can and will restrict the freedom of a bird to fly. Using this analogy, Young commented that if people's life circumstances were looked at in isolation they would not dictate constraint in ability to thrive compared to other people. However, when considered in context, and as a series of events in people's lives, these factors could restrict people's capacity for thriving. Therefore, Young (2001) argued that social inequities are developed in ways that oppress some peoples and benefit other groups of individuals. Young maintained that reflecting on issues of inequity is often problematic because it will challenge the status quo, and thus people in power positions may feel threatened.

Wagner (1993) explored how the homeless and the poor are stigmatized and blamed, not only for being poor, but also for causing social problems. The author discussed differences between "deserving" and "undeserving" poor, meaning that society relates to certain groups of individuals such as families with children as deserving of being helped. Conversely a young man may be feared and a "bag lady" or a young woman alone does not evoke much compassion. Wagner (1993) pointed out that the voice of the homeless is usually not included in discourses surrounding homelessness.

Wagner (1993) also explored the interactions between social scientists and the homeless, as well as the idea that some homeless individuals are challenging the norms of a conventional view of the world. These ideas of resistance made me reflect on the tent cities phenomenon, and locally, think of those who want to live outside of conventional ways, such as the example of the community who lived in Sombrio Beach from 1960s to 1990s. There are also those who are not able to live in institutions due to mental illness. The challenge is to engage in an ongoing commitment to reflect on issues that affect homeless clients while staying aware of public discourse. What remains is the question: Is it possible to break free from these discourses, and if so, how do we do that?

Through my CINAHL search, focusing on the words “homeless”, and “social justice”, I was able to reiterate the need for Advanced Practice Nurses to advocate for social justice issues (Wagner & Menke, 1992) realizing that this is an imperative condition to people’s health. Studies show that physical illness is related to individuals being homeless (Hwang, 2000; Frankish et al. 2005; Bryant, 2004, Shapcott, 2005). It was especially important to see research attending to social justice issues since both CNA’s documents (Code of Ethics and National APN Framework) failed to fully support Advanced Practice Nurses. I would particularly like to focus in the works of Isolde Daiski and Cathy Crowe, due to their compelling ideas of advocacy for marginalized individuals and their work with homeless groups in Toronto.

The work of Isolde Daiski and Cathy Crowe: Toronto’s examples.

Daiski (2005) evaluated a program offered in Toronto for marginalized populations, *The Health Bus*. At the time of the publication, she was volunteering for the Health Bus and had an intrinsic knowledge of the issues faced by the marginalized population in addition to specific APN skills of research and advocacy, which she brings to her work. She concluded her study of

the Health Bus suggesting that nurses improve advocacy for homeless individuals by breaking down stereotypes and challenging health care policies. She also suggested that nurses should take a more active role in political action. Her article fully addressed the homeless population and was very passionate and engaging. Furthermore, this study confirmed the need for continued funding for the services provided by the Health Bus in Toronto.

In addition to her strong advocacy lead, Daiski (2007) argued that many studies succeed in making the relationship between ill health and homelessness, but they fail to include homeless individual's voices. Daiski (2007) pleaded for health care workers to be aware of homeless individuals perspectives. Her study revealed homeless individuals' perspectives of their health, and healthcare needs. The author concluded that there is an increasing need for societal attitudes toward homeless individuals to change. Daiski maintained that health care workers have opportunities to collaborate with clients and to work towards promoting policy changes, such as national housing, that would improve the health of homeless individuals. Finally, Daiski advocated for safe and affordable housing to mitigate homeless health problems. In addition, the author proposed the integration of services such as job counselling and addiction treatment. Through the voices of homeless individuals, the work of Daiski is a wonderful example of how APNs can shine in the competencies of leadership, research and advocacy (CNA, 2008).

Another prominent example from Toronto is the well-known APN and activist Cathy Crowe. She seems to prefer to be called Street Nurse and even though she has shown great leadership in advocating for social justice issues such as homelessness, she has said in interview that others have seen her as a leader, but she has not always identified herself as one (ONC, 2008).

Crowe has advocated for health issues affecting homeless people such as decreased

access to health care, overall deteriorating health, the incidence of tuberculosis, unacceptable shelter conditions, the danger of SARS, and an increasing death rate. She has modeled the collaboration competency (CNA, 2008) working alongside homeless activists and friends with whom she has built coalitions and initiated advocacy campaigns. One example is the Toronto Disaster Relief Committee (TDRC) co-founded by Crowe in 1998, which declared homelessness a national disaster. Besides being a great example of collaboration, TDRC worked on many levels challenging the federal, provincial and municipal government to come up with solutions to the homeless disaster and housing crisis. Their 1% slogan required all levels of government to assign an additional 1% of their budgets to social and affordable housing programs.

Crowe and Daiski are certainly great examples of leadership, collaboration and advocacy; however, I am skeptical of placing any nurse as the only expert on social justice, because somehow this would exempt us all from working towards a more just society. Studies have shown that homelessness is a real issue, and some nurses have been witnessing and speaking out against practices that further oppresses homeless individuals. These nurses have shown us that we need additional well-prepared nurses to lead the way. This is a call for unifying our efforts because together, we can be very effective for a human rights plea.

Statement of Problems and Scope of this project

Reflecting on my advocacy work as a professional, nursing student and volunteer has led me to conclude that there are no APNs working with the homeless population in downtown Victoria. Although this lack was readily apparent when I began my volunteer work some time ago, it was during my work in graduate studies where I began to see that a higher level of preparation in nursing could make a difference in this area. Once I began to understand what was needed, I realized that an APN could fulfill that need and I set out to find an APN carrying out

this advanced nursing role in downtown Victoria. I was amazed and dismayed to find that no such person or position existed. Despite the presence of nurses working in the downtown core, the role they played was significantly different from how I understood an APN to function. Registered nurses working with the homeless in Victoria provide an essential service of attending to the emergent health needs of individuals. They focus on health promotion, harm reduction, and primary care for the homeless in the downtown area. They work tirelessly and their work is highly commendable. However, they do not enact the APN role in that they are not able to provide significant leadership among all service providers in their area. The nursing service in the downtown area is completely fragmented. Nurses are operating in silos and hardly communicating among themselves. The ability to identify the gaps in the service, and evaluate the overall service provision and quality of client care is not happening, neither is the leadership potential to support all nurses in the provision of best care practices being recognized. Their ability to advocate for better services and environments for nurses work is also compromised by their workload and lack of communication between agencies.

For this reason I spent my first practicum (Nursing Praxis I) located at Our Place, doing outreach investigation. I visited most agencies where homeless people were seeking the services of nurses and health professionals. I interviewed as many of the RNs from these agencies as I could arrange. In addition to facilitating one of the retreat sections (*Caring for the Caregiver*) previously mentioned, I had the opportunity to interview nurses working in most agencies dealing with the homeless and low-income population in the downtown core. This experience informed me of the heroic work my colleagues perform in serving this population, but also revealed their inability to provide their best care. They are doing a fabulous job within current working conditions. However, some of the barriers such as lack of communication between

agencies providing health care were identified and will be addressed in this paper in the section entitled Strengths and Limitations of Services.

For my final practicum I took a hiatus from the inner city to develop the knowledge and skills I would need to practice as an APN. To learn what I now know I needed to work with a vulnerable population I went into another area (palliative care), in order to expand my understanding and make sense of the APN role. My preceptor was an exceptional CNS working for VIHA's End of Life program.

I participated in discussion of two ongoing research projects. One was studying family perceptions of care provided to their loved ones dying in four different inpatient settings-- and another study developing tools to enable clinicians to more accurately predict illnesses. I had the opportunity to gain a vivid insight on the engagement of the CNS in research, and the great potential for the use of research as an advocacy tool and to change practice based on evidence. In addition, I participated in a meeting of nurses in a variety of care settings who provide palliative care (Island Palliative Nurses Group), where the term collaboration became alive and I could grasp the importance of sharing information between sites and geographic locations, and share support for similar issues in practice that are common to all settings. I also had the opportunity to assist in the revision of an education material (video) for training new nurses. I observed the End of Life Quality Council meeting where my field guide, as chair, facilitated discussions around quality end of life care. During this practicum I participated in two Palliative Education Series and on a workshop for clinicians working with clients of a newly developed VIHA program-- Seniors at Risk Integrated Network (SARIN). Therefore, through discussion with my field guide and much reflection, I was able to gain a much broader understanding about the complexities of the CNS role working within systemic structures.

Observing the CNS's work within an organization such as VIHA gave me a real perspective of operant ideologies and power dynamics of working within a hierarchical institution. To me, it reinforced the need of CNS being knowledgeable about discourses and their implication for client care and nursing practice.

In addition to gaining a better understanding of the APN role enacted through the practice of the CNS, I was able to see the CNA Framework for APN enacted and its competencies come alive. I was able to exchange ideas with my field guide and question the lack of advanced practice working directly with the homeless population.

Advanced Practice Nurses are called to enact leadership and advocacy, challenging the status quo. In the downtown scenario, is it possible that we are overlooking the need for APN in downtown Victoria? An APN is in a perfect position to challenge societal paradigms and call us to act, to advocate with a strong voice for an equitable society (Daiski, 2008). A CNS working with the homeless population needs to be aware of what goes on in our communities, outside the hospital or the office. Moreover, we need to relate our understanding of what happens provincially, nationally and globally to what affects homelessness. It may be difficult to voice our concerns when the environment surrounding us is not supportive of questioning existing practices (McIntyre, Thomlison & McDonald, 2006) but a CNS working with the homeless needs to be continuously engaged in reflective practice directed to action (Freire, 1993), propagating social justice within and outside nursing.

Who am I calling the homeless client? Are they "others"?

From a 'normal life' to the streets of Victoria (Paul's Story of Homelessness)

A few winters ago, I met a polite young man on a cold night in a shelter here in Victoria. He appeared to be in his mid-forties. Paul dressed casually, not the stereotypical dirty homeless

person one would imagine. He could easily have been one of the shelter's volunteers. But the difference was that he entered the shelter with a big backpack. He had no place to sleep that night, or any other night. Like many others, Paul was a homeless person in our city. I changed his name to maintain his confidentiality and dignity. His story could potentially happen to any one of us. He used to have a house and a job. He suffered from undiagnosed depression that, combined with the lack of social support, contributed to the loss of his job and house, and he found himself on the streets.

In our society today there are people who think that every person has the capacity to guide their lives and make positive lifestyle choices in order to live well. That is a common belief for many people, by that I mean, people who don't appear to make good choices are created as "other" or "less than" deserving. McDonald (2001) related the historical roots that influenced the health care system in Canada and the world. In her historical review, McDonald described how the behavioural approach influenced health promotion, and argued that the Lalonde report portrays the clients as victims to be blamed for the unhealthy choices they make. Some people often make comments such as: "the poor are poor because they make bad choices" or that homelessness is a chosen lifestyle (Klodawsky, Farrell & D'Aubry, 2002). I would argue that poverty is not a choice; it is a product of social forces that are in many cases beyond an individual's capacity to choose. Storch, Rodney and Starzomski, (2004) described the meaning of poverty as:

Poverty is want of the necessities of life. From a capability perspective, poverty means the absence of basic capability to function, like being well nourished, adequately clothed and sheltered, and able to avoid preventable mobility, as well as being able to participate in community life. (p. 343)

The Canadian Health Network supports the idea that peoples' well-being is affected by circumstances or contexts. Issues such as income, social support, employment, access to health care, and education among others, are key factors in determining how healthy a person is. APNs have a duty to reflect, act and be a voice against social inequities in order to transform this reality. Being at Our Place and meeting people like Paul has confirmed my belief that people who are homeless and poor are not in this situation by choice. There are real obstacles that constrain peoples' ability to thrive and live better, healthier lives (Young, 2001). Furthermore, these obstacles are directly influenced by the political, social, and economic factors that affect this population, therefore affecting the health of the community at large.

Paul is only one example, and mental health is only one factor affecting people on the street. Issues such as addiction, loneliness, abuse, neglect, and racism also affect homeless people. Societal *indifference* is one of the most terrible 'disease' that sadly contribute to a cycle of poverty. APNs are called to fight this 'disease' that has corrupted the health care system and our society. Indifference, and the inability of our society to care all its members contribute to homelessness. APNs can lead a counter-culture denouncing this societal numbness and indifference and promoting social change.

Proposed link to Nursing Practice, Education and Research

Today, I ask myself as an APN, what would influence my interaction with Paul? How can an APN contribute to improving his situation? A CNS working with the homeless could provide education to new staff and nursing students about issues related to nursing such as mental health, communicable diseases, as well as the importance of understanding the complex issues such as addiction (Maté, 2008). In addition, a CNS is in a position to promote social justice by encouraging inquiry, advocacy and nonconformity with the status quo, in the

generation of nurses who are being educated. A CNS could create educational material (e.g.: video, orientation tools) for training new nurses and could promote best practice, as well as facilitate discussions around quality of care for the street population in order to determine more effective care provision. A CNS could develop and carry out an education series and workshops for clinicians working with street related clients. Other contributions could include involving homeless individuals in research so that their voice is heard, and they can help to identify and develop programs that better met their needs.

A CNS needs to articulate the importance of adequate care in preventing systemic issues (CNA, 2008) such as the “revolving door” phenomenon, and articulating to the institution about the benefits of properly addressing clients’ multiple needs. By that I mean working with staff in care settings so that compassionate discharge plans are in place that prevent patients being discharged to the streets, and by providing adequate referrals to resources in the community. In addition, the CNS would be involved in supporting RNs and other staff to provide the best care they can and validating their concerns, such as the difficulty in providing best care due to the lack of support from the work environment, and dealing with negative attitudes toward patients who are addicted and/or homeless. The CNS would help RNs to identify a specific problem, such as the lack of dignity and justice in care as promoted by nurses’ professional Code of Ethics. Another way the CNS could support nurses is by providing evidence-based research (CNA, 2008) that supports and validates RNs’ concerns about patients who are homeless and vulnerable, and who are needing a stronger network of support. Furthermore, the CNS could collaborate with RNs assessing resources in the community, such as the Sobering Center, Detox Center, shelters and Umbrella (an organization composed by ex-addicts who now work as

advocates). The CNS's goal is to assist the RN to develop clinical competency in complex decision-making when caring for this population (CNA, 2008).

Project focus

The focus of the proposed project is to promote the APN role in different areas where it is not yet established. It seems like an overwhelming task at times, but from seeing the benefits of the APN role's competencies in a specific area of care (end of life) and from believing in the potential of these same competencies to serve another area of care (street nursing), I remain optimistic and open to the possibilities that will arise, even if I am the one who envisions the possibilities and carves the path. This is what I have observed and am called to do as an advocate and professional nurse. By making my voice heard and listening to the voices and callings of those who travel with me I am determined to advocate for social justice issues for the street-involved people in inner city Victoria.

The role of the APN in any area expands the boundaries of a nurse's scope of practice (CNA, 2002) and it is adaptable to different areas (e.g. palliative, gerontology, street nursing). A CNS for Street Nursing requires caring, collaborative, compassionate and innovative attributes. An APN will bear witness to the client's situation and needs and enacts a specific way of being in relationship. The APN can enact all the competencies (clinical, research, leadership, collaborative, change agent) in their areas of practice.

In this project, the APN role is enlarged upon and specific examples of what the enactment of the role would mean for street involved people in downtown Victoria is provided. This project creates a CNS position prepared to enact the advanced practice role. As previously mentioned, there are currently various Registered Nurses working with the homeless population, but no nursing leadership. It is my hope to promote the APN role in downtown Victoria where

there is a lack of APNs working with the homeless population. This project will promote the need for APNs to become stronger leaders and instruments of change that will bring more understanding to struggles faced by the street population, and remind nurses and the public that street-involved individuals “instead of others” (Canales, 2000) are human beings like you and me.

Description of the Geographic Area Involved

Homelessness in Downtown Victoria, BC

It is shocking and sad to witness how many changes and financial cuts have been made to social welfare programs in Canada at both Federal and Provincial levels. These cuts have affected the life of the most vulnerable in our population and led to the increase of homelessness in Victoria and other cities in Canada. In addition, increases in rental prices and the lack of affordable housing have affected underserved populations (Bryant, 2004) in Victoria and in the entire country. Through my personal communications with a frontline worker from Pacifica Housing Advisory Association, the number of outreach workers dealing with housing has increased from two to twelve in the last six years. According to the outreach worker, they have so much work that they cannot deal with it. Our Place, a drop-in-center for underserved groups had twelve paid workers in 2006, and has increased their number to 70 workers in 2008. The number of homeless individuals has also increased, from 700 in 2005 to around 1200 in 2007, according to Cool Aid Society’s homeless needs survey (Cool Aid Society, 2007). The last homeless count in Victoria was in 2007 and from observation of daily life downtown, one assumes that the number of homeless individuals in this area has further increased in the last two years.

This clearly shows that there is an emerging industry of poverty that has been created in the downtown core. What I mean here, is that some organizations proudly share with the media and the public about their huge accomplishment of increasing their services to the homeless, glorifying service providers. While efforts by many agencies are addressing some of the issues, services do fall short of this city's need to address homelessness. Should we as a community be proud of having a first class drop-in-centre for the poor? Does increasing the number of shelters, soup kitchens, and drop-in-centers represent a permanent solution to the homeless individual? Whose needs are they addressing? Are the homeless also participants in the creation and expansion of services provided to them? Are their voices being heard? If so, I wonder if homeless individuals would prefer having access to decent affordable housing or would they choose to continue surviving on the charity of church groups? These questions provide basis for further analysis of the needs in the downtown core.

Historical Influences on Homelessness in Victoria

Homelessness is a world-wide phenomenon. Complex political, historical and economical factors play a part in perpetuating the cycle of homelessness and increasing the number of people on the streets of Victoria. Homelessness is such a significant issue because housing is one of the socioeconomic determinants of health that intrinsically relates to people's well-being (Bryant, 2004). Lack of affordable housing and the process of marginalization results in people living at the edges of society. Bishop (1994) characterizes marginalized groups as those who have a history of oppression and exploitation and are moved away from the centers of power that control the fate and shape of the society.

Media Influence

Victoria's newspapers print many articles weekly on homelessness, as this has been a growing concern in this city. An activist for the 'right to sleep' and tent cities, was quoted as the top newsmaker of 2008 according to Victoria News. In the recent election for mayor, homelessness was a hot topic with mayoral candidates who took sides for or against tent cities. In May of 2007 the Mayor's Task Force on Breaking the Cycle of Mental Illness, Addiction and Homelessness was created to address the increased concern with the homelessness issue in Victoria. Following the Mayor's Task Force we now have the Greater Victoria Coalition to End Homelessness, a group working on issues of homelessness composed of community organizations, government and non-governmental agencies and members of the community.

Political Influences on Homelessness

One change that greatly impacted the lives of vulnerable groups was the abolition by the Federal Government of the CAP (Canada Assistance Plan) (Varcoe, Morrow & Hankivsky, 2003) in 1996. This change in legislation greatly impacted the poor, leaving them even further marginalized. It affected the vulnerable in our society because underserved individuals no longer had access to income when they needed it. Once those human rights were denied, there was a direct and inevitable effect and increase in homelessness in Victoria. The cascade happened in the following form: with some pressure from the corporate sector to reduce business taxes, the Federal Government restricted its role in health care, pressuring provincial governments to manage a combined and reduced budget for health, social services and education (Varcoe, Morrow & Hankivsky, 2003). By denying their responsibility for healthcare, the Federal Government (with the shared responsibility of the Provincial Government) condemned the principle of provision of accessible health to all to failure. With this unjust equation, the results are the emergence of privatization that has begun to insidiously permeate

health and education in order to rescue a failing system and provide “high quality and cost-effective” care, as promoted by the study released by the Atlantic Institute for Marketing Studies, prior to the Romanow report release (AIMS, 2002). We live within a globalized world with globalized culture, market, and information technology and the Canadian health care system is not immune to the effects of this stage. The reforms that affect Canadians are fueled by corporate ideology (Varcoe & Rodney, 2002) and are not in the best interest of the population.

The Influence of A Bureaucratic System

Besides being marginalized, low income individuals have to overcome many other barriers in order to obtain their rights and have their needs met. They often find the bureaucratic process of a three-week wait following making an application for welfare assistance before obtaining support very cruel, and some of them are forced to submit themselves to informal and desperate ways of survival, such as prostitution. I had the opportunity to accompany people to the welfare office when working with immigrants and refugees prior to nursing. It is not easy to navigate the bureaucratic system; it seems designed to keep out people who need assistance!

In the province of BC, another hardship is applying for income assistance. A person has to prove that they were financially independent for the previous two years. This reality raises questions regarding the intent of the laws and who they are serving. Which homeless person would qualify for these out-of-reality rules? How could someone from this population break the cycle of poverty? It is virtually impossible to do so. For all intents and purposes, it is hard not to see this as a cruel system. The question is, will the present system enable someone to find work or is it so flawed that it does the opposite? One can only wonder if this system was driven by a

discourse that people who are homeless are really only being lazy. Building on that myth is the unrealistic expectation that “if you just stop drinking today, you will get you a job tomorrow”.

It is possible that this system is built on the ideology of individual responsibility and the supportive discourses reflect this ideology of the poor as “lazy, worthless or freeloaders”. Ideology is defined by Thomas (1993) as a “shared set of fundamental beliefs, attitudes, and assumptions about the world that justify ‘what is’” (p.8). Discourses are defined by Smith (1999) as the utilization of talk, writing, and other forms of text derived from people’s experiences and activities representing some reality grasped as real. In my practice as a nurse, I daily question the ideologies represented through discourses in health care today.

Marie’s Embodied Experience

In order to talk about the humanity of the homeless, I will also examine the lived experience of a woman I will call Marie. I have reflected on the way we are all connected and how separated we may feel or appear by society’s invisible walls but so real that they are almost touchable. In this context, I am a nurse and she is a homeless individual. I wonder what that means? What should that mean? Does it mean that I am better than her or know more than her? I don’t think so. It means that I have more access to resources such as housing, job opportunities and education. How distant from each other are we? How different are we? How much of an “other” is she? How much of an “other” am I, in her eyes? From which point of view am I reflecting on Marie’s embodied experiences? Sometimes I feel that we are not so different at all. Her experiences of oppression and marginalization may not be that far away from my own. How can I relate to her wounds, visible or invisible?

I believe that reflecting on the embodied lived experience exposes the suffering and vulnerability of us all. It involves journeying inwards and facing what we try to avoid so

desperately, by hiding behind our busy lives. It involves facing our solitude, our need for others, our need for connection, and our need for belonging, for community, our need to touch and be touched.

I first encountered Marie, a young woman in her early twenties, in the hospital and on isolation due to MRSA precaution. She was a street person so was screened for infectious diseases but cleared from isolation after her results came back negative, a few days later. She was then walking through the hallways. She was clean but with visible bruises and wounds on her body. Some staff members treated her with prejudice for a being street drug user; but she was treated with compassion and care by others. She would help herself with extra cookies and juice from a common kitchen area in the unit. She was eating decent meals and having proper sleep. She was coming and going for cigarettes. She generally looked cared for, but did not trust others easily. She seemed to feel that she did not belong, and I often wondered if that was the way we health care providers made her feel. She would barely talk, and usually did not smile.

The next time I saw her was a few months later at Our Place. I recognized her right away. The body I saw, however, was so much more wounded. She had multiple bruises and lesions on her arms and face, the only areas visible to me. It was a prostituted, wounded, fragile, drugged, dirty, smelly, empty body. Those are strong words, but if I am going to be really honest and honour the experiences of her body, I have to express it in the way it appeared to me. I mentioned the word empty, but she was not empty. Both her inner and outer shell had been extremely abused. She was wounded but not empty. It is a mistake to pretend it is an empty body, and maybe it is easier to pretend that those abused homeless bodies are empty. To me she seemed to have been tortured. I could not help but thinking that dogs in our society are better treated than she had been. That does not mean that dogs should be mistreated. It does, however,

mean that as a society, we should not allow this young body to be degraded to that point. As nurses, we have been present and attended to others' miseries. We need nurse leaders who will take us one step further from being present to denounce this unacceptable ways some fellow human beings are living.

This day at Our Place, Marie was sleeping with her face down on a table. One young man around her called me. He asked if I could lift her so that he could place a pillow underneath her head. As I did I could smell the rotten odour from her long and filthy black hair. At the same time, I was touched by the young fellow's request. He did not know her; they were not together, which made his action even more touching. He showed compassion for that dirty body that society does not seem to care about. There was a sense of community I did not observe at the hospital. People did not appear to have many material things, but their ability to be empathic with the suffering of others was very visible. Homeless individuals I have encountered have a resilient character and are resourceful in the midst of difficulties. This homeless youth had not lost his ability to care for another human being as others in our society might. He was not indifferent to Marie's needs. Then later I saw Marie awake. She was walking, half smiling, but her body could not stop moving, and her arms randomly and uncontrollable trembled because she was under the influence of street drugs. She was however peaceful, and as she greeted a friend, she was smiling. I did not see her beautiful, toothless smile at the hospital. I wondered why?

Who is the homeless body? Once my family and I were in Vancouver and we chose to walk along Hastings Street. Our friends said; "You don't want to walk there". But we intentionally wanted to walk in that neighborhood, with my young daughter. We wanted to witness what we read on the news. We wanted to see the people and to bear witness to their

struggles. I find it takes intention sometimes to understand what is happening to our society. Shouldn't we feel ashamed to have such disparity of wealth and poverty? The numbers on the streets keep growing, and I wonder how the current recession will affect this group.

I have heard many comments such as; "I do not go to downtown anymore", "I am scared of the homeless that are all around downtown, and so, I do all my shopping in Oak Bay". What we do not see does not seem to exist. The discourse behind this way of thinking seems to be "if it does not affect me personally, it is not my problem". This seems to be the underlying rationale to the comments I have heard. I agree with McDonald and McIntyre (2001) when they argue that the bodies of both nurse and patient has been objectified and sanitized. I did not find myself questioning Marie's embodied experience when she was at the hospital. She superficially appeared to be well. I did not dig any further. As McDonald and McIntyre suggest, a field that compartmentalizes this patient's experience has silenced the nursing profession. I too found myself attending to Marie's needs from a dominant, empirical, and biomedical perspective. Parker (1997) and McIntyre and McDonald try to include the patient's lived experience into their knowledge base. To hear these authors calling for an acknowledgement of the embodied experience as a source of knowledge to the nurse is a sign of hope in the midst of despair. To witness Marie's embodied experience from an environment that compartmentalizes her experience, is to repeatedly go against my moral and ethical bases causing moral distress.

Some people are proud to support a child in Africa, and they feel that by doing so they have fulfilled their duties as good citizens. However, they see no connection with the poverty for which we are all responsible, whether it is here or abroad. I understand that there are many barriers that prevent us from relating to one another's struggles. I understand that those barriers are huge and overwhelming, and it is indeed easier to pretend that we do not see it because the

reality is very cruel, and we would not know where to start, or how to help. I also understand that many of us also experience our own suffering and miseries, which may not be as visible as my client Marie's degraded body, but nevertheless, they are wounds and they can be deeply rooted in our souls. We are complex beings, and life does not seem to be easy. It seems to me that in order to relate to Marie's embodied experience as an APN, I need to continue to reflect on our experience as professionals. Within our busy lives that we are so proud of, many of us do not have the time, energy or intention to reflect on our own grief and pain, let alone to reflect on how we are contributing to the oppression of our clients.

Standing Point and Stereotypes

Another important fact, as well as reflecting on our personal experiences, is to define where we are standing, our point of view. As I reflect on who Marie is, on how her body is perceived, I reflect on the dominant views of the body in my area of practice, and the consequences of those views for this population. I cannot forget that I am located in a privileged position as professional. I am someone who can eat three to five times a day, have a decent job, a home to go to every day, friends to call upon when I need to have good cry, a family, and love, which feeds my spirit. Furthermore I have a body of knowledge that can benefit the lives of a large and underserved group in our society; therefore I am morally and ethically obligated to share this knowledge in my community.

We analyze people's experiences depending on where we stand. I use the bus system and I walk a lot. It is amazing not to drive a car for a period of time, the new insights we gain when following the same old route walking. The richness of details, time slowing down, and all of a sudden there is so much to see. It all varies depending on where we stand. Many in our society have a way of looking at the homeless from the centre. They perceive homeless individuals as

being at the margins. hooks (1984) argued that the view from the margins, as opposed to the centre, is wonderful. It takes a lot of personal effort to be present and to have a deeper understanding of the lives of many homeless individuals, and to see clients as experts in their lives. The media portrays much of what is known, and there are many powerful agendas and interests behind this way of viewing homeless groups. People in general sympathize with the work that is done on behalf of the poor. Church groups give money and prayers for this sad reality in downtown. However, deep inside some people have barriers that prevent them from relating to and understanding the homeless.

In talking to another parent from my daughter's school, she said that she was looking for work, and had applied to work at the Salvation Army. However, after applying she decided to decline the job for the fear of working with homeless individuals, adding that her teenager daughter had said; "Mom, what if they kidnap you, for money?" This conversation made me reflect on how the media and society influence our ways of thinking, and how insidiously the seeds of fear are planted in our beings, germinating and growing throughout the years.

An APN can contribute to breaking the stereotypes and through education, encourage community members to work together and to help them to recognize that we have more in common, our needs are more similar than we may expect. Through disseminating her/his knowledge, an APN can navigate against the stream of ideologies and dominant discourses, becoming more connected to people's realities and struggles, willing to embrace their embodied experiences of life. An APN can lead a change in society towards becoming more human, learning to love more deeply and unconditionally. Yes, I said the word love. I do not fear it, and I believe that we all need so much more of it. Love. Love. Simply love. For the earth, for all living beings, for our fellow human beings, who are just like us.

Another expression on the views of homelessness was shown in the movies

Homelessness in Paradise set in St. Monica and *Something to eat, a place to sleep and someone who gives a dam* set in Vancouver. These movies shared the stories of homeless individuals that are similar to the experiences of the homeless in other cities. These two movies however, do not seem intended to question political responsibilities on homelessness. They introduce real individuals, their life stories and lived experiences in hopes of giving homelessness a human face. For nurses, we encounter homeless individuals in acute care and community settings. While seeing the problem of homelessness in a movie is a good teaching tool, it does not change practice as nurses look into the eyes of real people and discharge them to real streets.

The issue of homelessness in Canada is not a new one. Brushett (2007) has reflected on Toronto's Emergency Housing Program and on the Canadian Social Housing Policy, during the years from 1944 to 1957. The author discussed the housing shortage and explored whether the responsibility for housing provision should fall under provincial or federal governments. Brushett (2007) used Toronto's post World War II as an example to make his case of challenging the lack of affordable housing and issues surrounding Toronto's homeless. The author discussed the difficulties for municipalities to provide affordable housing to replace emergency shelters. Furthermore, the author shed light on how the Canadian government has neglected to provide social housing programs.

Strengths and Limitations of Existing Services in the Downtown Area Including Nursing

The homeless population in downtown Victoria is served by different service providers. These distinct groups provide various services to attend to the needs of homeless individuals. Some of the services are shelter, health care, and a Detox program. As previous mentioned, during my NURA 517 course, I was based at Our Place. Through my practicum work, I had the

opportunity to shadow and interact with nurses working in some of these places such as the Cool Aid Health Clinic, Detox Sobering and Assessment Centre, Downtown Outreach Team (DOT), Victoria Integrated Community Outreach Team (VICOT), and informally with VIHA Street Nurses. In addition, I had the opportunity to connect with other frontline workers such as physicians, social workers, housing advocates, addiction workers, and mental health workers. After this fieldwork with different service providers, it became apparent that those services were struggling to survive, and were not connected with one another. For example, the Detox program that operates a seven-bed unit downtown is well known to have a long waiting list for their services. It seems contradictory to have a service to treat addiction without taking into consideration that people have different times and levels of motivation that lead them to enter a Detox program. For instance, when a bed becomes available at the Detox Center, Cool Aid Clinic nurses, or Our Place workers are not aware of the empty bed, since the agencies do not communicate on an everyday basis. The empty bed might come up at the same time a worker or a nurse is in contact with a client who would be ready for the services provided by Detox. It has happened that Detox has had empty beds due to the inability to find the client who was on the waiting list. Why? Because the client is homeless, and has no contact information. The nurses at Detox, as well as nurses at Cool Aid Clinic are committed professionals to the clients they serve. It is not their fault that a bed goes empty at Detox. This is a systemic problem that affect nurses' work and client care. This is good example that can be addressed through an Advanced Practice Nurse position in the downtown core through the enactment of collaboration and effective communication between settings.

Another difficult issue is the fact that all these agencies that attend to the homeless population's needs are permanently experiencing financial crises and often competing for the

same funding opportunities. These factors impair their ability to work collaboratively and have clients as the focus of their attention. It becomes difficult for nurses to focus on the client when they are also involved with issues such as decreased funding, shortage of staff, and increasing acuity of clients in their care.

In the downtown core another example of an agency providing service that is struggling just to survive financially, is our local Together Against Poverty Society (TAPS). Cut backs to social programs and lack of funding affects their ability to advocate and provide the best support they can for this population. In the last four to six years some of the agencies that support and advocate for homelessness have been experiencing extreme cut backs from the government (Shapcott, 2004), and have been forced to reduce or end services. Our Place has increased their services to the homeless population, however according to Our Place's director, debts and expensive infrastructure create many financial challenges (personal communications).

Last but not least, clients are the ones who face the most challenges. They are the ones who experience prejudice, labeling, othering (Canales, 2000), and marginalization. It is shameful treatment that some homeless clients suffer in their encounters with the health care system (Pauly, 2005). It provides one more barrier to a population who already encounter so many constraints in the pursuit of a healthy life.

One of the barriers homeless individuals encountered this past year was the closure of the fixed Needle Exchange site. The site was closed after complaints from the parents from a school close by, and from members of the community around the site. The Needle Exchange supporters reported that since the site had been closed there have been more dirty needles found in the area than before. This is directly related to the concepts of harm reduction, and disease prevention. Nurses have a great responsibility to inform the public of the benefits of harm reduction not

only to the addict population but also to the community at large. Dr. Maté, a physician working in Vancouver Eastside in a public presentation of his book: *In the Realm of Hungry Ghosts: Close Encounter with Addiction*, posed a poignant question when he referred to the legacy we want to pass to our children and he asked: “Do we care for them or do we care for the entire community around them?” I agree with his approach. Dr. Maté spoke about the fact that we cannot change people’s lives; only they can change their patterns.

Nurses are knowledgeable about nursing theories such as those of Parse, Watson and Newman who have constructed theories around people’s unique patterns. For the purpose of this project I utilized Parse’s Theory of Human Becoming. Parse’s theory’s underpinnings are illuminating meaning, synchronizing rhythms and mobilizing transcending (Parse, 1987, Parse 1998). “Structuring meaning multidimensionally is co-creating reality through the language of valuing and meaning” (Parse, 1987, p 163). Through being truly present with the clients, nurses support client to explore and explicate thoughts and feelings, and support the clients to move toward their hopes and dreams. Nurses do not tell clients what they should or not do. Clients themselves are the one able to explore their options, based on their personal meaning of the world.

Parse’s (1998) theory calls us to move beyond seeing the individual reduced to the biological, psychological or social parts. Parse forges a very specific basis for the client-nurse relationship, where the nurse exercises true presence.

“True presence is a special way of “being with” in which the nurse is attentive to moment-to-moment changes in meaning as she or he bears witness to the person’s or group’s own living of value priorities. True presence is an intentional reflective love, an interpersonal art grounded in a strong knowledge base” (Parse, 1998, p. 71).

In this relationship, the individual is respected as the author of his/her lived experiences. Nurses are not called to change individuals' behaviours but respect people's unique patterns of health. Parse's theory supports nurses to practice in a non-judgmental way, respecting each human being through true presence. The theory is one way of living nurse's important contribution to our society, by modeling a way of being that eradicates boundaries.

The 'diseased arm' (Michael's experience)

Michael (pseudonym), was a homeless individual admitted with an abscess on his arm to the medical unit where I worked. Michael was addicted to alcohol. He presented an opportunity for nurses to support him through an understanding of his embodied experience (Lawler, 1991). However, during his stay, little attention was placed on his emotional and psychosocial needs, with his needs being reduced to treating his abscess with antibiotics, and getting the bed free as fast as possible. He mentioned that he would like to become sober and wished to seek assistance for that. However, the multidisciplinary team ignored his wishes, and it became an enormous effort for an individual nurse to advocate for his needs. In addition the pressure to discharge this patient was the emphasis in all multidisciplinary meetings I attended. The fact that he was to be discharged to the streets was never a factor to be considered.

If nurses could take the leading role in seeing beyond the abscess in his arm, the picture would be much different. We need to allow ourselves to dig deeper and understand the "experience of the lived body", proposed by Lawler (1991). Therefore, as I am placed in this reality, and upon reflection, I cannot practice in the same way: in silence. Liberal individualistic ideologies underlie our health care system and affect real people (Doane & Varcoe, 2005). It is not only frustrating to be complacent in a culture of silence, I believe it is immoral. I believe seeing and walking alongside the voiceless is an ethical and moral choice. In other words, it is

an intentional choice to work and bear witness to the struggles of the poor. An APN again has a great potential to break this culture of silence surrounding homelessness.

When I think about the dominant discourses on the body, I can easily relate to the views of body as machine explored by Parker (1997). When working on a busy medical unit, some nurses get trapped in the routine and the demands of task-oriented and time efficiency discourses. If I focus on more specific discourses about the body, I view it as a system divided by parts and only what is physiologically malfunctioning will be attended to. The ultimate goal seems to be that the medical-reductionist view of the patient predominates in the nursing routine and we seem to act as mere coadjutants in fixing the patients problems. “It is a way of understanding the atextual body” (Parker, 1997, p. 12). If all that matters is an abscess in a patient’s arm, is not having a home to house the “arm” an ethical issue? We only treat a symptom, medicalizing homelessness, not the individual (Lyon- Callo, 2000). Lyon-Callo explains medicalization of homelessness as a continuum of care approach, where a disease model focuses on addressing a symptom, not the structural violence that affects an individual. In other words, we do not explore the political, economical, and historical factors contributing to homelessness. This perspective does not invite nurses to question the lack of housing for Michael.

An APN would develop and work on research projects identifying with other stakeholders, gaps in services and would continue to evaluate service delivery. Some examples are issues that directly affect underserved groups such as access to health care, evaluation of services provided by street nurses, and the quality of life on the streets. Use of research has a great potential as an advocacy tool and to evaluate and improve practice based on evidence. A CNS could coordinate a discussion group on related issues such as poverty, addictions, service

delivery, policy, ethics with nurses from a variety of settings, such as acute care, Cool Aid Health clinic, Detox, Sobering Centre, Downtown Outreach Team (DOT), Victoria Integrated Community Outreach Team (VICOT), and VIHA Street Nursing. There is a need to provide bridges between these service providers, because at the present, communication among these organizations is virtually nonexistent. A CNS needs to enact the term collaboration and educate service providers about the importance of sharing information between sites and geographic locations, and share support for similar issues in practice that are common to all settings. Building community and bridges between service providers is essential to improving care.

In addition, an APN would need to build hers/his own support network by collaborating with CNSs from other areas (e.g. mental health and addiction). Also, the CNS would collaborate with other members of the team, and provide education on issues surrounding stereotyping, the effects on client's experience of prejudice and othering (Canales, 2000) and the relationship between homelessness and poorer health (Pauly, 2005). A CNS could work alongside other members of the team providing leadership and consultation to physicians, nurse practitioners, RNs, family and clients, pharmacists, and social workers.

It is very important for a CNS working with homeless groups to have a good understanding of the Victoria area, such as services providers, housing access, shelter, harm reduction, and pathophysiology of addiction and mental health. In addition, an understanding of the impact of social inequities on individual wellbeing is needed. A CNS also needs to be engaged in ongoing reflection about the complexities of the role within systemic structures, understanding the perspective of operant ideologies and power dynamics of working within a hierarchical institution and its implication for client care and nursing practice. Discourses of oppression operating in institutions such as VIHA's generates a need to keep raising issues and

challenging the status quo as supported by the CNA's Framework for Advanced Practice Nursing and CNA's code of ethics.

Another important role for this CNS position is the consulting role. Baron and White (2005) distinguish consultation from co-management, referral and supervision. These authors classify the consultation process as one that improves patient's outcomes and systems, enhances problem-solving resources, involves education, and the development of consultee (Baron and White, 2005). I recognize the importance of an APN sharing his/her knowledge and expertise in a specific area (CNA, 2008), and the consultation role to be one that interacts with nursing colleagues, clients, and other professionals through a collaborative process. In addition, the APN position differs from other disciplines for its specific disciplinary knowledge. Furthermore, I recognize the importance of the CNS's understanding of systems and power dynamics (Chinn, 2008) and being cautious of not exercising power-over through the consultation process. In this project, I have critiqued operant discourses around power imbalances in our communities.

Conclusion

A great part of a CNS's work with street nursing is breaking down stereotypes and preconceived ideas about this population -- starting with themselves and sharing the fruits of their reflections with others. That is where the leadership and change agent competencies for APN are enacted (CNA, 2008). This specific APN role is expressed through a voice attempting to promote change, through a respectful and collaborative process. The leadership position is one where power is shared, and others opinions are heard and valued (Chinn, 2008). A CNS working with the homeless needs to continue being a change agent within the field, one that is willing to challenge the status quo.

In this project, I have witnessed and reflected on the ongoing struggles nurses face in reconciling what they believe to be the ethically right way of practising nursing when addressing the multiple needs of homeless individuals in our community. For the reasons explored throughout his project, such as lack of communication between agencies and lack of leadership and collaboration in the downtown core, I conclude that our current system constrains nurses' abilities to provide best care. As this project pointed out, presently there is no infrastructure to support an APN position in the downtown core. My recommendation is that a CNS position should be established in downtown Victoria and through advanced nursing knowledge we will contribute to addressing the complex needs of that area.

We need APNs to provide leadership in ways such as sharing their expertise in the political arena, sharing their knowledge through nursing education, affecting policy and decision-making, influencing health care and guiding service delivery (McIntyre, Thomlinson & McDonald, 2006). In order to promote emancipatory action, it is the group of individuals who need to raise consciousness of their place of oppression, and together find solutions to transform their reality (Freire, 1993). Advocacy for people who are less privileged is to advocate for our families, our neighborhood and our society; it is to promote health where people's needs are. When all members of our society have their basic needs met, and when the distribution of the wealth is equitable (Young, 2001), it has a direct link with the individual's health and the community. Most nursing clients are vulnerable. This is also true of those working with the street population. Through this practicum, I have witnessed how sociopolitical, historical and economic contexts affect both the homeless population and nurses who work with them. The need for advanced nursing practice positions in many areas in our health care system became quite clear to me. We need APNs who can articulate the pressing issues that are related to the downtown

core. We need APN leaders who can be role models to others and question current ideologies and operant discourses in our society and health care.

I heard a call, I chose to respond to it. I chose to respond to the call for leadership through Advanced Practice Nursing, to share my experiences, to advocate for nurses' work and the clients' struggles I have witnessed. I wonder if that is what First Nation elders refer to as "hearing the drums from their ancestors". I hear the songs of the nurses who have come before me and who are my mentors. I recognize the need to continue a legacy of support and opening dialogue on the topic of this project within the nursing profession. Nurses have indeed much to contribute to health care service and society. We are in the perfect place to promote change, and we have the same potential and capacity that we can identify in our clients. We can find this incredible potential within ourselves. Time is ripe to let our light shine!

References

- Atlantic Institute for Marketing Studies (2002). *Health plan: Definitely not the Romanow report*. Retrieved February 2, 2009, from <http://www.aims.ca/aimslibrary.asp?cmPageID=192&ft=1&id=78>
- Barron, A. M. & White, P. A. (2005). Consultation. In A. B. Hamric, J. A. Spross & C. M. Hanson (Eds.) *Advanced nursing practice: An integrative approach* (pp.225-255). Toronto: W.B. Saunders.
- Bishop, A. (1994). *Becoming an ally*. Halifax: Fernwood Publishing.
- Bhabha, H. (1994). *The location of culture*. London: Routledge.
- Braverman, M. (Director, Producer), Braverman, C. (Producer), & Smee, B. (Producer) (2005). *Homelessness in Paradise*. USA: Braverman Productions.
- Bryant, T. (2004). Housing and health. In D. Raphael (Ed) *Social Determinants of Health: Canadian Perspective*. (pp.217-231). Toronto: Canadian: Scholaris Press.
- Brykczynski, K. A., (2000). Role development in the advanced practice nurse. In A. B. Hamric, J. A. Spross, & C. M. Hanson (Eds.), *Advanced nursing practice: an integrative approach* (2nd ed., pp.107-134). Toronto: W. B. Saunders.
- Brushett, K. (2007). Where will the people go. *Journal of Urban History*. 33 (3) 375-399.
- Canadian Nurses Association (2006). *Social Justice: A means to an end, an end in itself*. Retrieved March, 25, 2009, from <http://www.cna-aiic.ca>
- Canadian Nurses Association (2008). *Advanced nursing practice: A national framework*. Retrieved January, 15, 2009, from <http://www.cna-aiic.ca>
- Canadian Nurses Association (2008). *Code of ethics for registered nurses*. Retrieved

- January, 15, 2009, from <http://www.cna-aiic.ca>
- Canales, M. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science*, 22(4):16-31.
- Castaneda, C. (1968). *The teachings of Don Juan: A Yaqui way of knowledge*. New York: Washington Square Press
- Chinn, P. L. (2008). *Peace and power: Creative leadership for building community*. Ontario: Jones and Bartlett.
- Cool Aid Society (2007). *Homeless needs survey: A pathway for home*. Retrieved October, 14, 2008 from http://www.coolaid.org/publications/HNS_Final_Report_2007.pdf
- Daiski, I. (2005). The health care bus: Healthcare for marginalized populations. *Policy, Politics and Nursing Practice* 6(1), 30-38.
- Daiski, I. (2007). Perspectives of homeless people on their health and health needs priorities. *Journal of Advanced Nursing*, 58(3), 273-281.
- Doane, H. & Varcoe, C. (2005). *Family nursing as relational inquiry: Developing health promoting practice*. Philadelphia: Lippincott Williams & Wilkins.
- Frankish, J. Hwang, S. & Quantz, D. (2005). Homelessness and health in Canada. *Canadian Journal of Public Health*. 96, S23-S29.
- Freire, P. (1993). *Pedagogy of the oppressed*. New York: Continuum.
- Glasser, I. & Bridgman, R. (1999). *Braving the street: The anthropology of homelessness*. New York: Berghahn.
- Hamric, A.B., Spross, J.A., & Hanson, C.M. (2009). *Advanced practice nursing: An integrative approach*. Toronto: Saunders.
- Herbert, E., & McCannell, K. (1997). Talking back: Six First Nations women's stories of

- recovering from childhood sexual abuse and addictions. *Canadian Journal of Community Mental Health*, 16(2), 51-68.
- hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom*. New York: Routledge.
- hooks, b. (1884) . *Feminist theory: From margin to center*. Boston: South End Press.
- Hwang, S.W., Martin, R.E., Tolomiczenko, G.S., & Hulchanski, J.D. (2003). The relationship between housing conditions and health status in rooming house residents in Toronto. *Canadian Journal of Public Health*, 94 (6), 436.
- Isitt, B. (2008). Housing for all: The social economy and homelessness in British Columbia's capital region. Victoria, BC: UVic CSERP.
- Jamieson, L., Williams, L. M. (2002). Confusion prevails in defining 'advanced' nursing practice. *Collegian*, 9(4),29-33.
- Kincheloe, J. L. & McLaren, P. (2000). Rethinking critical theory and qualitative research. In N.K. Denzin & Y. S. Lincoln (Eds). *The SAGE handbook of qualitative research*, (2nd ed., pp.279-314). Thousand Oaks, CA: Sage.
- Klodawsky, F., Farrell, S., & D'Aubry, T. (2002). Images of homelessness in Ottawa: Implications for local politics. *The Canadian Geographer*, 46(2), 126-143.
- Lawler, J. (1991). *Behind the screens: Nursing, somology, and the problem of the body*. (pp1-5). Melbourne, Australia: Churchill Livingstone.
- Loomba, A. (1998). *Colonialism/Postcolonialism*. London: Routledge.
- Lutz, K.F., Jones, K.D., & Kendall, J. (1997). Expanding the praxis debate: Contributions to clinical inquiry. *Advances in Nursing Science*, 20(2), 23-31.
- Lynch, J., Kaplan, G. (1997). Understanding how inequality in the distribution of income

- affects health. *Journal of Health Psychology*. 2(3) 297-314.
- Lyon-Callo, V. (2000). Medicalizing homelessness: The production of self-blaming and self-governing within homeless shelters. *Medical Anthropology Quarterly*. 14(3): 328-345.
- MacDonald, M. (2001). Health promotion: Historical, philosophical, and theoretical perspectives. In L. Young & V. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues and application* (pp.22-45). Philadelphia, PA: F. A. Davis Company.
- Maté, G. (2008). *In The realm of hungry ghosts: Close encounters with Addiction*. Toronto: Knopf.
- McDonald, C., & McIntyre, M. (2001). Reinstating the marginalized body in nursing science: Epistemological privilege and the lived life. *Nursing Philosophy*, 2, 234-239.
- McIntyre, M. Thompson, E. McDonald, C. (2006). *Realities of Canadian nursing: Professional, practice, and power issues*. Philadelphia: Lippincott Williams & Wilkins.
- Merson, L., Villeneuve, K. (Producers). (2008). *Something to Eat, a Place to Sleep & Someone Who Gives a Damn* [Motion Picture] Vancouver, BC: Motion Pictures.
- Ontario Nursing Connection (2008). *Interview with Cathy Crowe*. Retrieved March 11, 2009 from <http://www.ontario-nursing.ca/nursing-in-ontario/profiles/cathy-crowe-profile>
- Ottawa Charter for Health Promotion (1986) Ottawa Charter, Ottawa. Retrieved January 16 2009 from http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

- Parker, J. (1997). The body as text and the body as living flesh: Metaphors of the body and nursing in postmodernity. In J. Lawler (Ed.), *The body in nursing* (pp. 1-29). Melbourne, Australia: Churchill Livingstone.
- Parse, R. R. (1987). *Nursing science: Major paradigms, theories and critiques*. Philadelphia: W.B. Saunders.
- Parse, R. R. (1998). *The human becoming school of thought: Perspective for nurses and other health professionals*. California: Sage.
- Pauly, B.M. (2005) Close to the street: The ethics of access to health care. Doctoral dissertation, University of Victoria (Canada), Canada. Retrieved January 7, 2009, from ProQuest Digital Dissertations database. (Publication No. AAT NR07058).
- Purdy, S., Kwak, N. (2007). New perspective on public housing history in the Americas. *Journal of Urban History*, 3 (3), 357-374.
- Raphael, D. (2004). Introduction. In *Social Determinants of Health: Canadian Perspective*. Toronto: Canadian Scholaris Press.
- Reutter, L. (2000). Socioeconomic determinants of health. In M. Stewart (Ed.) *Community nursing: Promoting Canadians' health*, 2nd Ed. (pp.174-193). Toronto, ON: Elsevier Science Canada.
- Shapcott, M. (2004). Housing. In D. Raphael (Ed) *Social Determinants of Health: Canadian Perspective*. (pp.201-215). Toronto: Canadian Scholaris Press.
- Shapcott, M. (2005). Social (subsidized) housing cures homelessness. Retrieved December 1 2008 from <http://www.tdrc.net/responsetohomeless2005>
- Smith, Dorothy, E. (1999). *Writing the social: Critique, theory, and investigations*. Toronto: University of Toronto Press.

- Stepherson, P. (1999). Expanding notions of culture for cross-cultural ethics in health and medicine. In H. Coward & P. Ratanakul (Eds.), *A cross-cultural dialogue on healthcare ethics* (pp. 68-91). Waterloo, ON: Nelson.
- Storch, J. L. (2004). Nursing ethics: A developing moral terrain. In j. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and Practice*. (pp.1-16). Toronto: Pearson.
- Storch, J. L., Rodney, P., Starzomski, R. (2004). *Toward a moral horizon: Nursing ethics for leadership and practice*. Toronto: Pearson.
- Tipple, G., & Speak, S. (2005). Definitions of homelessness in developing countries. *Habitat International*. 29, 337-352.
- Thomas, J. (1993). *Doing critical ethnography*. Newbury Park, CA: Sage.
- Varcoe, C., & Rodney, P. (2002). Constrained agency: The social structure of nurse's work. In B. S. Bolaria & H. D. Dickinson (Eds.), *Health, illness and health care in Canada* (3rd ed., pp. 102-128). Toronto, ON: Nelson.
- Varcoe, C., Morrow, M., & Hankivsky, O. (2003). No lessons learned: BC Provincial cuts and their potential impact on woman who experience violence. Williams & Wilkins.
- Young, L. & Hayes (2002). *Transforming health promotion practice: Concepts, issues, and applications*. Philadelphia: F.A. David Co.
- Young, I. M. (2001). Equality of whom? Social groups and judgments of injustice. *The Journal of Political Philosophy*. 9 (1), 1-18.
- Wagner, D. (1993). Beyond the conventional wisdom on the homeless. In *Checkerboard Square: Culture & Resistance in a Homeless Community*. Boulder, CO:

Westview Press.

Wagner, D. & Menke, E. M. (1992). Case management of homeless families. *Clinical*

Nurse Specialist: The Journal for Advanced Nursing Practice, 6 (2): 65-71.

Wild, N. (Director). (2007). *Bevel up: Drugs, users, and outreach nursing* [Motion

Picture]. Canada: National Film Board of Canada.