

Men Who Have Experienced Homelessness: Perspectives of Health Care Experiences

by

Lisa Crawley Beames  
BSN, University of Victoria, 2004

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

MASTERS OF NURSING

in the School of Nursing

© Lisa Crawley Beames, 2012  
University of Victoria

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

## **Supervisory Committee**

Men Who Have Experienced Homelessness: Perspectives of Health Care Experiences

by

Lisa Crawley Beames  
BSN, University of Victoria, 2004

### **Supervisory Committee**

Dr. Bernie Pauly, School of Nursing  
**Supervisor**

Dr. Joan MacNeil, School of Nursing  
**Departmental Member**

Dr. Stephen Hwang  
**Additional Member**

## Abstract

Dr. Bernie Pauly, School of Nursing  
**Supervisor**

Dr. Joan MacNeil, School of Nursing  
**Departmental Member**

Dr. Stephen Hwang  
**Additional Member**

Homelessness is associated with poor health and premature death. Individual's experiencing homelessness face multiple barriers when accessing health care. Barriers to health care are not limited to administrative issues such as lack of a valid health card or clinic hours but include feeling stigmatized, not respected or marginalized when attempting to access services. These experiences can impact homeless individuals' willingness to engage with health care providers in the future and have the potential to negatively impact the development and maintenance of a relationship with a provider. Nurses are a point of access into the health care services available to individuals experiencing homelessness and can play a key role in facilitating access to health care.

In this research, the experiences of individuals experiencing homelessness when seeking health care were explored. The approach used to guide the research was interpretive description. Interpretive description can have the effect of making one suddenly "see" something in a way that enriches one's everyday understanding of the lived experiences (Thorne, 2008). Interpretive description while reflecting more traditional aspects of grounded theory as themes are identified and developed during research also utilized the constructivist paradigm. The constructivist paradigm with its' focus on truth and knowledge coming from the participant supported the interactive link of the relationship between the researcher and the focus of the research on the experience of individuals who are homeless during interactions with community nurses.

This study involved in-depth tape recorded conversations with eleven men who had experienced homelessness while seeking health care in the community. The transcribed conversations were analyzed utilizing interpretive description. Each of the participant's stories are described followed by identification of shared experiences or themes, giving insight into the phenomena of engaging with health care providers, specifically community based nurses, while experiencing homelessness. The intent is to share the lived experience and perspectives embedded in the experiences participants shared, with nurses and health care professionals in the community. The hope is that, through these stories, health-care providers, in particular nurses may develop insights and understanding that can inform both practice and education.

## Table of Contents

Supervisory Committee .....	ii
Abstract .....	iii
Table of Contents .....	iv
Acknowledgments .....	vi
Dedication .....	vii
Chapter 1 .....	1
Problem Statement .....	4
Research Purpose and Objectives .....	8
Summary and Significance of this Research .....	10
Chapter 2: Literature Review .....	12
Homelessness and Health Care .....	12
Experiences of Adults Who Are Homeless in Health Care .....	14
Health Care Relationships .....	17
Nurses Providing Health Care to Individuals Experiencing Homelessness .....	18
Chapter 3: Methodology .....	20
Interpretive Description .....	20
Sample .....	24
Sample Questions .....	26
Setting .....	27
Recruitment .....	27
Data Collection .....	28
Rigor .....	30
Inductive Coding .....	32
Ethical Considerations .....	34
Chapter 4: Findings .....	36
Introduction to Participants .....	37
Theme 1: “I’m not just homeless” .....	41
Lack of Worth .....	42
Establishing Identity .....	43
Establishing Self Worth .....	44
Theme 2: Treated like Second Class Citizens .....	47
Drug Addicts & Alcoholics .....	48
Criminals .....	50
Theme 3: Creating Safe and Welcoming Spaces .....	53
Building Rapport through Mutual Respect & Empathy .....	55
Creating Time to Listen .....	64
Summary .....	67
Chapter 5: Discussion .....	68
Study Implications .....	72
References .....	75
Appendix A .....	84
Interview Guide .....	84
Appendix B .....	86

Appendix C..... 87  
Appendix D..... 93

## Acknowledgments

**Dr. Bernie Pauly;** your constant support, guidance and passion for this research, from the beginning a very long, long time ago. Your enthusiasm gave me the confidence to do this thesis. Your extreme patience, never-ending encouragement, and expertise have made this possible.

**Dr. Joan MacNeil and Dr. Stephen Hwang;** thank you for your wisdom and expertise from defining the proposal to completion of this thesis.

**My daughter,** Sydney Price, I am proud to be your mom. Your never ending support means so much.

**My mother;** Judy and **brother;** Matthew, your belief in me has sustained me. My late grand-father H.D Langdon; you made my world a better place and in return I vow to do the same for others.

Finally, **my friends;** Craig, Jim, Lou, James, Farrell, Tim and Lianne; who have provided life long, love and assistance. They lent me an ear, poured me a glass of wine and told me to soldier on.

## Dedication

**To the eleven amazing participants;** this work would not be possible without your honesty and strength. Your stories have changed me. This work is dedicated to those who struggle every day to find their place and those who dedicate their lives to support change.

## Chapter 1

There are an estimated 150,000 to 300,000 individuals who are homeless in Canada, living in shelters or on the streets (Canadian Institute for Health Information, 2007). It has been suggested by advocates and researchers that these numbers may vastly underestimate the magnitude of the problem due to difficulties of measuring homelessness (Canadian Institute for Health Information, 2007; Frankish, Hwang & Quantz, 2005). Being homeless is associated with poorer health and individuals who are homeless often go without healthcare. As a result, minor problems can become urgent medical needs (Crane & Warnes, 2001; Daiski, 2005). This is due in part to their circumstances, such as lack of a health card (insurance), fixed address or basic communication devices such as phones. Individuals experiencing homelessness must often choose between meeting needs for food, shelter and meeting other basic needs such as healthcare. Meeting these basic needs often takes priority over accessing health care and barriers often exist in accessing and establishing healthcare relationships with nurses and other health care providers.

Provision and access to health care for individuals experiencing homelessness can be challenging for both clients and providers. Challenges such as stigmatization, lack of continuity in services, and systemic barriers serve to constrain the development and maintenance of a primary care relationship with health care providers (Lewis, Andersen & Gelberg, 2003; McAdam & Wright, 2005; Rosenheck, Resnick & Morrissay, 2003; Trevena, Simpson & Nutbeam, 2003; Zrinyi & Balogh, 2004). Transportation, a lack of culturally appropriate services, as well as traditional business hours and appointment

procedures provide further barriers to care. Moreover, the experience of being stigmatized during health care interactions limits the interest of people who are homeless to follow-up on their health care concerns (Browne & Fiske, 2001; Freund & Hawkins, 2004; Pauly, 2008). Nurses are often a key point of access to health care services in the community through public health and street nursing services (Hilton, Thompson & Moore-Dempsey, 2009).

The purpose of this research was to explore the experiences of homeless adults in developing and maintaining health care relationships with nurses in a community setting. This research was conducted using an interpretive description methodology (Thorne, 2008). In this first chapter, the background of the project, as well as the aims and objectives of the project, are described. The significance of the research is outlined as well as the researcher's interest and understanding of the topic. Current literature exploring what is known about access to health care and the perspectives of individuals who have experienced homelessness are discussed followed by the methodology for conducting the research, findings and discussion.

In Chapter 2, there is a review of the literature regarding provision of health care of individuals who are experiencing homelessness, the experience of individuals who are homeless when seeking health care and what is known about relationships of individuals who are homeless with health care providers. Finally, the specific role of nurses and provision of nursing care to individuals who are experiencing homelessness is described.

The methodology for this research is described in Chapter 3 including the sample, interview questions posed, ethical considerations and the setting of the research. In

addition, data analyses as well as the limitations of the work and the implications of this are defined in Chapter 3.

Contained in Chapter 4 is the introduction to the participants and the setting of the research. In this chapter, findings are explored and described through the identification of three broad themes: 1) “I’m not just homeless”, 2) Treated Like Second Class Citizens and finally 3) Creating Safe and Welcoming Spaces. Each broad theme contains sub-themes that are explored.

Finally, Chapter 5 provides a discussion of what this research data means in terms of its’ ability to inform nurses practice. The identification of gaps in education, research and practice provides a window of opportunity to inform both training of nurses, research and the service provision of health care needs to individuals who experience homelessness.

## **Problem Statement**

Homelessness is a pressing, complex social and political issue in North American society today (Health Care for the Homeless Report, 2010; Hwang, 2001; Hwang, 2009; Morrell-Bellai, & Boydell, 2000). Some have defined homelessness as the experience of living without physical shelter, living in inadequate housing, and sleeping in shelters for the homeless (Government of Canada, 2008). While acknowledging that there is no absolute definition of homelessness, Government of Canada report nevertheless distinguishes between ‘absolute homelessness’, referring to those living out of doors “in places not intended for human habitation, including emergency shelters” and ‘hidden or concealed homelessness’; the report included those “couch surfing” which is the use of temporary accommodation with family and friends. Lastly, “relative homeless includes those who live in inadequate or substandard housing or at risk of becoming homeless” (Health Care for the Homeless Report, 2010).

For the purposes of this research, the European Typology on Homelessness and Housing Exclusion (ETHOS) (2005) definition will be used. The ETHOS typology for homelessness includes four broad categories: roofless (living rough), houseless (shelters), insecure (those without legal tenancy such as couch surfers) and inadequate (temporary, over-crowded or unfit for tenancy). It is important to recognize that people often move through these different housing situations and are vulnerable to poor health and inadequate health care services.

Homelessness has been associated with problems related to maintaining relationships, employment, and increased involvement with the criminal justice system (Dennis, Buckner, Lipton & Levine, 1991; Farrell, Reissing & Aubry, 2002; McGuire

&Rosenheck, 2004). Of particular concern is that individuals experiencing homelessness have a high prevalence of physical illness, mental illness and substance abuse, and many die earlier than the general population (Cheung & Hwang, 2004; Gelberg, Linn, Usatine, & Smith, 1990; Hwang, 2000; Hwang, 2009). Serious mental illnesses such as schizophrenia, major depressive disorders and bipolar affective disorder have been identified in about one fourth to one third of homeless individuals (Koegel, Burnam& Farr, 1988; Stuart & Arboreza Florez, 2000). Outcomes associated with homelessness include increased rates of diabetes, substance use, tuberculosis, mental health issues, assaults and increased mortality (Hwang, 2000; Hwang, 2001; Kidder, Wolitski, Campsmith, & Nakamura, 2007).

People who experience homelessness not only have multiple and complex health problems but frequently face barriers to accessing health care (Crane & Warnes, 2001; Daiski, 2005). People may delay seeking health care because of existing barriers. Individuals experiencing homelessness have poorer health overall (Hwang, 2001; Kushel, Vittinghoff, Haas, 2001; Kushel, Perry, Bangsberg, Clark & Moss, 2002; O'Connell, 2004). This poor health status leads to an earlier death than the general population (Brickner et al, 1984; Hwang, 2000; Hwang, 2009).

Barriers to accessing health care include the inability to provide appropriate documentation (Butters & Erickson, 2003), navigating the current system (Turnbull, Muckle& Masters, 2007), prioritization of immediate needs of shelter or food (Crane & Warnes, 2001; Gelberg, Linn, Usatine, & Smith, 1990; Gelberg, Browner, Lejano & Arangua, 2004; Plumb, 2000) and real or perceived negative attitudes and treatment by health care professionals (Butters & Erickson; Corely & Goren, 1998; Plumb, 2000;

Turnbull, Muckle & Masters, 2007). For example, health insurance cards, identification, and other belongings may be frequently lost or stolen in shelters or on the street. The struggle for survival on the streets means that responding to immediate needs may take priority. When priorities are shelter, food, and safety apart from emergencies, health may become secondary (Gerber, 1997). Therefore, challenges faced when attempting to access care mean that opportunities are lost to build a relationship with a health care provider. Appointments can easily be forgotten due to the complex challenges of managing food and shelter leading to episodic interactions with the health care system (Robertson & Cousineau, 1986). When food and shelter take priority, there may be little time to navigate a complicated or difficult to access system of health care leaving wounds to fester or allowing illnesses to grow severe (Robertson & Cousineau, 1986).

There is a wealth of research describing the negative experiences of people who are homeless in accessing health care (Ensign & Gittelsohn, 1998; Ensign & Planke, 2002; Graham, Denoual & Cairns, 2005; McCabe, Macnee, & Anderson, 2001). In particular, clients often feel judged and feelings of disrespect are reinforced (Kushel, Vittinghoff & Haas, 2001). The perceived impact of health care workers' attitudes has been documented (Price, Desmond and Eoff, 1989, Hilton, Thompson & Dempsey-Moore, 2009 and Ugarriza & Fallon, 1994). When confronted with negative attitudes, individuals may be less likely to seek health care (Daiski, 2007; Pauly, 2008). Further, individuals may not have a regular source of health care and fail to seek health care when needed. If individuals do not seek health care they are more likely to be unable to develop and sustain a relationship with a health care provider.

An important aspect of accessing care is feeling safe enough to access care and positive experiences in health care interactions are critical to accessing health care in the future (Moyle, 2003; Stevens, 1993). Research has suggested that the development of health care relationships is an important way to reduce barriers to accessing health care and can counter stigma, negative attitudes and lack of trust (Daiki, 2007; Hilton, Thompson & Moore-Dempsey, 2009; Pauly, 2008). Further, health care relationships are an important factor for enhancing access to the health care system, facilitating ongoing access to health care, and central to addressing needs associated with the broader social determinants of health (Browne, Roberts, Byrne, Gafni, Weir & Majumdar, 2009).

There has been an increase in targeted health care services, such as outreach, as part of primary care or public health services to address barriers to health care for people experiencing homelessness. Many outreach and health care initiatives working with individuals who are homeless are led and delivered by nurses. However, there is little research regarding health care relationships in these settings or the perspective of people who are experiencing homelessness on relationships with nurses (Daiki, 2005; Daiki, 2007; Hilton, Thompson & Moore-Dempsey, 2009). Specifically, there is a lack of research into client perceptions of what promotes or hinders the development and sustainability of health care relationships with nurses (Hilton, Thompson & Moore-Dempsey, 2009).

Knowledge of both systemic and perceived relationship barriers and facilitators faced by people who are experiencing homelessness seeking health care can further highlight what these individuals view as positive features that promote the development of a relationship with a nurse. Examining what is known and identified by this

population as supportive, facilitative and promoting an ongoing relationship with a nurse, is as important as understanding the barriers. There is an opportunity to begin to understand the factors that should be considered in development of the nursing relationships and the delivery of services that support feelings of safety. Additionally, this knowledge of barriers and facilitators of health care and nursing relationships through the perspectives of the population served can assist in assessing current services, the education of nurses and in future planning.

### **Research Purpose and Objectives**

The focus of this research is an exploration of the perceptions' of people experiencing homelessness of health care interactions with nurses in a community setting. The original purpose of this research was to gain an understanding of the factors that promote or constrain the development and maintenance of a health care relationship in a community setting with a nurse. It became apparent through the research process that the focus of the research participants interviews were detailing the multiple interactions with nurses that can lead or contribute to the development of relationships. The data for this research is drawn from interviews with 11 men with experiences of homelessness.

The original research objectives for this study were focussed on relationships with nurses in the community. What became apparent through the proposal and research process is that it is a series of interactions with nurses that ultimately build the therapeutic relationship and the objectives for this research would need revision. The revised research objectives are as follows:

- a) Factors that foster positive health care interactions with nurses in the community setting.

- b) Barriers that limit the development and maintenance of health care relationships with a nurse in the community setting.
- c) Environmental or organizational factors that support the development and maintenance of a health care relationship between nurses and individuals experiencing homelessness in the community setting.

## **Summary and Significance of this Research**

First, individuals who are experiencing homelessness have poor health and require ongoing access to health care that is often fragmented. This lack of access to health care further contributes to poor health status and increased mortality (Frankish, Hwang, & Quantz, 2005; Gelberg, Linn, Usatine & Smith, 1990). Many health care services, education programs, quality improvement initiatives and available funded services are built on the beliefs and practices of health care providers, as well as relevant evidence and guidelines/standards of associated regulatory bodies and governments. The perceptions of individuals experiencing homelessness are very rarely factored into the planning and delivery of services, programs and initiatives and even missing in research studies (Corley & Goren, 1998; Daiski, 2007; Robertson, & Cousineau, 1986; Wen, Hudak & Hwang, 2007). Thus, this research provides an opportunity to tell the stories and experiences of recipients of care, from the perspective of individuals experiencing homelessness.

Second, when a group's priorities and experience are articulated, understood and incorporated in the planning of health care services, the ultimate outcome is almost always more beneficial to the group served (Gelberg, Browner, Lejano & Arangua, 2004; Jezewski, 1995; Trevena, Simpson, Nutbeam, 2003; Trevena, Nutbeam & Simpson, 2001). Knowledge of the perspectives of individuals experiencing homelessness can be used to inform the development of primary care services and health care education programs including nursing services with an emphasis on therapeutic relationships that are tailored to their needs (Daiski, 2007). Nurses are a key provider of care in the community and the findings of this research could guide both the application of care

models into clinical practice and policy making decisions designed to improve the health care of individuals experiencing homelessness. Key to implementing effective changes in nursing practice is the understanding of the experience of individuals who are homeless when seeking health care. As such, this is a study of individuals' who are homeless and their experiences with health care provided by nurses and can inform nursing praxis. By exploring the experiences of individuals who are homeless in developing and maintaining a relationship with a nurse in the community setting, opportunities emerge to identify potential areas for improving that experience. The potential benefit of this research is the ability to illuminate real and perceived barriers to health care relationships that may sensitize health care providers (including nurses), managers and educators to what is needed for change.

## Chapter 2: Literature Review

This chapter provides an overview of the current knowledge related to homelessness and health, experiences of individuals who are homeless when accessing health care, as well as the health care relationships between nurses and people experiencing homelessness. Collectively, this literature provides what is known around these key aforementioned issues as well as gaps and areas for further investigation of health care interactions and relationships between people experiencing homelessness and nurses.

### Homelessness and Health Care

People experiencing homelessness not only have a poorer health status overall (Hwang, 2001; O'Connell, 2004) but some individuals may delay seeking health care until they are very ill and some actually avoid accessing health care (Kushel, Vittinghoff, Haas, 2001; Kushel, Perry, Bangsberg, Clark & Moss, 2002). Hwang (2000) found that young men who were experiencing homeless in Toronto had a higher mortality rate, more than eight times higher, than those who were housed. The mortality rate for middle-aged and older adults that are homeless was two to three times higher than similar-aged men who were housed. Women who are homeless and 18–44 years of age are 10 times more likely to die than women in the general population of Toronto (Hwang, 2000). In studies that looked at a total of 7 cities, the risk of death among women who were homeless was greater than that among women in the general population by a factor of 4.6 to 31.2 in the younger age group and 1.0 to 2.0 in the older age group (Cheung & Hwang, 2004).

Factors that shape the health of individual's experiencing homelessness include the conditions in which they live, known as the social determinants of health. Specifically, health is shaped by income, access to health and social services and the ability to obtain quality education, food and housing (WHO, 2003). In the absence of these quality dimensions or in the pursuit to meet these basics needs, overall health status suffers (Raphael, 2007).

Historically, the nursing profession has been providing health care to poor and marginalized individuals since the turn of the 20<sup>th</sup> century, beginning with Lavinia Dock and Lillian Wald who were early public health nursing leaders (Falk-Rafael, 2005; Hardill, 2007). The term "homeless" was not used, but individuals were described as living in substandard housing. Dock's work with socially and economically marginalized families firmly identified the importance of the public health nursing role in promoting the health of this population (Abrams, 2008; Nutting & Dock, 1912). Through the late nineteenth century, Dock made valuable contributions to public health nursing through her work in the slums of New York. As an advocate of legislative control of nursing practice and a prolific author, Dock was a pioneer in the international public health movement and a steward for the improvement of nursing education of marginalized populations.

While outreach has been in existence for at least three decades, there has been insufficient formal examination of factors that influence the effectiveness of outreach and how it is actually performed. Ng & McQuiston (2004) examined the critical role of not only the individual health care provider but the organic nature of the team development. None of these studies were specific to the interaction of nurses with individual's

experiencing homelessness, but rather the outreach clinician or team. According to Buck, Rochon, Davidson & McCurdy (2004) the individual experiencing homelessness and their involvement in a community advisory board (CAB) clearly identified that the health care perspectives of individuals experiencing homelessness are complex and unique. The research participants did not identify a particular health care provider or clinician but endorsed that the over-all experience and treatment led to feelings of mistrust and therefore negatively impacted individuals experiencing homelessness likelihood of seeking health care relationships for treatment (Buck, Rochon, Davidson & McCurdy, 2004). Despite the ongoing activity to improve the health of homeless clients, barriers still exist in accessing health care (Frankish, Hwang & Quantz, 2005; Wei Lim, Andersen, Leake, Cunningham & Gelberg, 2002). Very little research has been devoted to understanding factors, independent of health care costs, which are associated with the use of health services by people who are experiencing homelessness (Bonin, Fournier & Blais, 2007).

### **Experiences of Adults Who Are Homeless in Health Care**

There is limited research focused on clients who are homeless and their experiences in health care as it relates to their satisfaction and experiences of receiving health care (Acosta & Toro, 2000; Craven & Bland, 2006; Wen, Hudak & Hwang, 2007). Wen et al., 2007 (p. 1016) posited that feeling unwelcome, described as the concept of ‘unwelcomeness’, was linked to study participants’ reporting a “decreased likelihood they would seek health care in the future”. Other authors have also found that the experience of being stigmatized during health care interactions limits the interest of those

experiencing homelessness to follow-up on their health care concerns (Browne & Fiske, 2001; Freund & Hawkins, 2004; Pauly, 2008). Positive “welcoming” experiences were described by participants as relationships where they experienced a feeling of “being valued” (p. 1016). In the study by Wen et. al (2007), participants reported that “unwelcoming experiences” negatively influenced their motivation or desire to seek health care in the future.

Some authors in describing the perspective of the “client” or individual’s experiencing homelessness receiving services highlight the challenges that characterize relationships and interactions (Daiski, 2007; Ensign & Gittelsohn, 1998; Ensign & Planke, 2002; Trevena, Nutbeam & Simpson, 2001). The challenges cited extend past simple administrative barriers such as access to health cards, limited clinic times, and lack of appropriate referral (Barkin, Balkrishnan, Manuel, Andersen & Gelberg, 2003; Barry, Ensign & Lippek, 2002; Dennis, Buckner, Lipton & Levine, 1991) to include feelings of stigmatization by health care providers (Corley & Goren, 1998; Wen et. al, 2007). While stigma is not the only challenge faced by individuals experiencing homelessness seeking health care in the community it is most certainly the predominant one noted in existing research that documents the perspective of individuals experiencing homelessness.

Designing effective programs and minimizing barriers to access for clients experiencing homelessness continues to be a major challenge for health service systems that are plagued by limited resources, inflexible eligibility criteria and a high degree of fragmentation (Barry, Ensign & Lippek, 2002) with negative implications for the health of clients (Bowers, Swan, Koehler & William, 1994; Lim, Andersen, Leake, Cunningham

& Gelberg, 2002). Approaches to reduce this fragmentation have focused on efforts to integrate several agencies or the development of specialized teams such as Assertive Community Outreach teams (Rosenheck, Resnick & Morrissay, 2003; Durbin et al, 2006). Through integration of multiple disciplines and service provider integration, individuals experiencing homelessness are serviced by teams uniquely positioned to understand their particular experiences and needs.

More recently, innovative models of nursing specific outreach that take services to individuals experiencing homelessness and attempt to overcome previously identified challenges have contributed to improved relationships and effectiveness of programming for clients and provider (Daiki, 2005; Daiki, 2007; Hilton, Thompson & Moore-Dempsey, 2009). Despite individuals experiencing homelessness increased burden of illness and competing priorities, those who can be engaged through street outreach and mobile services with nurses, use of such services has contributed to improvements in health status and decreased use of emergency services (Hilton, Thompson & Moore-Dempsey, 2009; Lam & Rosenheck, 1999). Thus, highlighting the contribution of nursing outreach and the importance of developing health care relationships as a means to improving access to services and ultimately better health.

In other research, research participants have clearly articulated the importance of collaborating respectfully with individual's experiencing homelessness as a key to building a trusting rapport that supports an ongoing relationship with nurses and other health care provider (Daiki, 2007; Ensign & Planke, 2002; Ensign & Gittelsohn, 1998; Myers, 2003; Pauly, B. in press; Ugarriza & Fallon, 1994). Research into the factors that promote the development and maintenance of a relationship with a nurse provides an

opportunity to generate evidence that can build on a more evidence based understanding of effective and engaging relationships with a health care provider (Ugarriza & Fallon, 1994).

### **Health Care Relationships**

Barriers related to access or constraints on health care relationships, including feelings of stigmatization, can impact access to health care services (Bonin, Fournier & Blais, 2007; Corley & Goren, 1998; Daiske, 2007; Wright, Burns, James, Billings, Johnson, Muijen, Priebe, Ryrie, Watts & White, 2003). Real and perceived barriers impact individuals experiencing homelessness ability to engage with health care providers. Identified attitudes and beliefs of health care providers as experienced by individuals who are experiencing homelessness such as authoritative communication, one-way communication, disrespect, and lack of empathy contribute to reduced access to and quality of care for individual's experiencing homelessness (Hudson, Nyamathi, & Sweat, 2008).

Counterproductive qualities such as those identified above may be the result of training that did not adequately prepare providers to manage their own reactions to this population (Zrinyi & Balogh, 2004). Individual's experiencing homelessness who encounter these attitudes and behaviors seek health care less frequently, which often preempts early treatment and leads to late visits to emergency departments (Cranes & Warnes, 2001; Wen et al., 2007). Negative attitudes perceived by patients also increase their sense of alienation, stigmatization, and despair (Browne, Johnson, Bottorf, Grewal, & Hilton 2002; Coccozza Martin, 2008; Parkinson, 2009; Wen et al., 2007; Zrinyi & Balogh, 2004).

## **Nurses Providing Health Care to Individuals Experiencing Homelessness**

In the development of health care relationships, patient-based determinants of quality and satisfaction play an important role in choosing and sustaining a relationship with health care providers (Bowers, Swan, Koehler & William, 1994; Johansson, Oléni & Fridlund, 2002). Knowledge and particular attributes of nurses such as the personal experience of nurses with patients who were considered marginalized or with patients who had experienced homelessness significantly increase the client's perceived quality of care (Johansson, Oléni & Fridlund, 2002; Zrinyi & Balogh, 2004). Nurse-patient interactions set the tone of the care experience and can have a powerful impact on patient satisfaction (Forchuk & Reynolds, 2001; Johansson, Oléni & Fridlund, 2002). Nurses are often the health care providers who spend the most time with patients and are often the patient's initial point of contact with health care.

Nurses' uses of therapeutic relationship skills are important in preventing the exposure of marginalized patients to unfair, inaccessible and biased health care (Forchuk & Reynolds, 2001; Myers, 2003). Issues such as power, the social and cultural context, and interpersonal competence impact the quality of interactions and the development of relationships. However, there is limited knowledge around individual's experiencing homelessness and their perceptions associated with how to reduce the stigmatization in health care interactions or what constitutes positive health care relationships with nurses. Nurses require an awareness of the role of these factors in shaping interactions and relationships with homeless individuals. Such factors have been the focus of some research and are identified as important for individuals working with clients experiencing homelessness and pivotal to the success of health care relationships (Barry, Ensign &

Lippeck, 2002; Butters & Erickson, 2003; Ng & McQuiston, 2004; Ugarriza & Fallon, 1994).

To summarize, in reviewing the literature it is well documented that individuals experiencing homelessness have poor health status compared to the rest of the population (Hwang, 2001), increased rates of poor physical and mental health, and a shortened life span (Brickner et al., 1984; Hwang, 2000; Hwang, 2001; Hwang, 2009; Kidder, Wolitski, Campsmith, & Nakamura, 2007; Koegel, Burnam & Farr, 1988). Additionally, it is well documented that individual's experiencing homelessness perceive they are 'stigmatized' when seeking health care services and encounter real barriers in their health care relationships (Daiski, 2007; Pauly, 2008).

There is also research that identifies that the 'positive' experience of individual's experiencing homelessness with a nurse significantly increase the client's perceived quality of care and satisfaction (Forchuk & Reynolds, 2001; Johansson, Oléni & Fridlund, 2002; Zrinyi & Balogh, 2004). Innovative models of outreach health care have been developed that attempt to overcome previously identified challenges with opportunities for increased engagement with the health care team. Nurses are positioned as key entry to health care services and an understanding of individual's experiencing homelessness perspectives on their care can ensure that care is reflective of the individuals experiencing homelessness unique health care requirements.

## Chapter 3: Methodology

### Interpretive Description

Given that there is limited understanding of how individual's experiencing homelessness perceive their relationship with nurses in the community, a qualitative design was selected to guide this study. Specifically, the methodology for this thesis is interpretive description (Thorne, 2008). This particular methodology is described along with the research sampling, setting, method, rigor, and ultimately the limitations of the research. Interpretive description allows the particular experience of the individual (homeless and shelter using clients) to be located within the shared reality of the health care environment and with the experience of the researcher (Sandelowski & Barroso, 2002; Sandelowski & Barroso, 2003). Interpretive description generates research questions that emerge from practice which subsequently returns discipline or practice focused findings. Key to this approach is acknowledging reflexivity of the researcher with the degree of interpretation based on the researcher and the context or placement of the research subject (Hunt, 2009). For instance, my understanding of nursing as it relates to individuals experiencing homelessness is quite explicit to the discipline and urban homeless populations. In this my experience, individuals experiencing homelessness reported varying experiences when dealing with nurses in the community setting. It was these reported experiences and perceptions that I sought to understand. This same strength may not be reflective of other disciplines or cultural context. To mitigate this potential limitation, I engaged in the analytical process under the supervision of a committee that included a researcher from another discipline (medicine) with extensive experience both caring for and conducting research with individuals experiencing

homelessness. The chosen supervisor and committee and their combined expertise in research of individuals experiencing homelessness ensures that this vulnerable population was investigated utilizing the committee's strength's and expertise.

The subjectivity of individual experiences within the commonly understood and objectively recognized limitations of current services is best examined by moving beyond more traditional qualitative methodology such as ethnology or phenomenology (Thorne, Reimer Kirkham & MacDonald-Emes, 1997). Interpretive description is a qualitative research method, developed by Thorne, Reimer Kirkham, and MacDonald-Emes (1997). The decision to employ this research method is based on the utility of this particular method and the opportunity for research to inform clinical practice (Thorne, 2008). The use of interpretive description provides the opportunity to utilize the researcher's experience and understanding of the phenomenon of the individuals who are experiencing homelessness and seeking health care in the inductive coding and thematic approach.

Guba and Lincoln (2005) identified the importance of answering the question "How can the knower go about obtaining the desired knowledge and understandings?" Identifying the epistemology or nature of knowledge creation is central to answering this question and requires identifying the paradigm in which the research will be conducted. This research project was conducted within a constructionist paradigm. A constructionism understanding of knowledge is one in which knowledge is co-created (Appleton & King, 2002). Appleton and King (2002), detail the five key principles of constructionism as reality, causal relationships, unique experience, the relationship between researcher and study subject area as well as the researcher values and their

impact on the research process (p.642). The constructionist paradigm in conjunction with interpretive description as the methodology supports the co-creation of knowledge derived from the participant experience and the researcher's analysis. In choosing interpretive description as the methodology of this research it is important to recognize the importance of the experience of the researcher in framing the research, analyzing and interpreting the data as well as the specific privileging of knowledge of those who are experiencing homelessness.

The aim of this researcher in using interpretive description is to describe as accurately as possible the phenomenon from the perspectives of the research participants. As a nurse with twenty years of work in a variety of inner city settings, most often focused on the care of individual's experiencing homelessness, interpretive description allows for the utilization of the experience of this researcher in the analysis and interpretation of the data. Interpretive description acknowledges that individuals may perceive similar situations or experiences in very different ways. The method captures patterns and themes within these subjective experiences (Thorne, Reimer-Kirkham & MacDonald-Emes, 1997; Thorne, Reimer, Kirkham & O'Flynn-Magee, 2004). Thorne (2008) describes interpretive description as a method that "seeks to understand how context plays out in individual experience to the extent that it can be known" (p.202).

Interpretive description is a method that captures themes and patterns that can be grounded in subjective perceptions. The use of interpretive description in examining the individuals experiences who are homeless and their perceptions of their health care experiences with nurses and then moves beyond that description, through interpretation, to inform opportunities to improve clinical practice. Adopting an interpretive descriptive

approach was appropriate to elicit a thematic description of the participants' experiences with nurses in the community setting. Drawing from a variety of theoretical and methodological constructs, interpretive description provided a bridge between neutrality and theory. This bridge is the acknowledgement that the research is the defined experience of those living without housing in the community while engaging with health care and more specifically with nurses. Thorne (2008) advises that to conduct interpretive description that has integrity, utility, and quality; researchers must describe their learning and what the lessons mean in terms of clinical practice. For this research, the results not only inform clinical practice as to how individuals without housing experience or perceive their interactions with nurses in the community but have implications for nursing education.

This research is intended to document what is the commonly expressed experience of those that are homeless when seeking health care. Using interpretive description, individual's who had experienced homelessness were invited to describe their experiences in accessing health care and relationships with nurses in the community setting to the researcher. Ultimately, as detailed by Thorne, Reimer Kirkham & O'Flynn-Magee (2004) the utility of this research will be tested by its ability to inform the nursing discipline for the purpose of developing insight for practice decisions while allowing for variation in the application. It is the intention of this researcher that the findings will inform the interaction of nurses with individuals who are experiencing homelessness seeking and receiving health care and insights for delivery of services.

## Sample

Purposive sampling was used to recruit participants for this research study. Polit & Beck (2008) describe purposive sampling, also referred to as judgmental sampling, as the selection of participants by the researcher based on a personal judgment about which ones will be most informative (p. 763). I approached an agency that primarily serves individuals experiencing homelessness and my desire to recruit participants who had experiences with homelessness and nursing care. The agency manager provided a letter of support for the research which was submitted with the ethics application. Once ethics approval from both University of Victoria and St. Michael's Hospital, posters (or invitations to participate) was received posters were placed in the agency (Appendix B). The agency is located in downtown Toronto where individuals who are homeless may receive services such as assistance with identification, housing, government services or drop-ins. Inclusion criteria for study participants included being an adult (over age 18) and participants who had past or current experience with homelessness based on ETHOS (2005). As described in the problem statement, the ETHOS typology includes broad categories and this research sample was to include 'couch surfers' and those with inadequate or insecure housing. After establishing that participants met establishing criteria, informed consent for participation in this research was obtained (Appendix C).

Individual face to face interviews allowed for the collection of information about distinct experiences. In choosing to conduct a one on one interview, participants were safe to explore their experience. Without the distraction and influence of co-participants, the interviewer explored the interactions that participants reported and the meaning attached to these experiences. By way of individual interview, participants were asked to

describe interactions and relationships with health care providers and specifically nurses. They were also being asked to what extent they believed that these interactions affected the subsequent access to healthcare and treatment (Appendix A).

The researcher's constructed reality and understanding of the phenomena from working in health care with individuals experiencing homelessness allowed for examination of emerging themes that were correlated with the shared experiences of the research participants (Sandelowski & Barroso, 2003). The self-described experience of homeless individuals, who had current or previous health care interactions, specifically with nurses in the community setting, was examined. Further, the impact of these previous experiences on participants' ability to engage and continue to engage with a nurse in the community to meet their needs was explored.

Data was collected from 11 individuals with past or current experiences of homelessness. This number is consistent with similar sample sizes for qualitative research of this type (Sandelowski, 2007). All interviews were audio taped and transcribed verbatim for analysis. Thorne (2008) purports that a study with the intent of understanding the nature of a phenomenon may use a relatively small sample size as long as the researcher acknowledges that even when similar themes are discussed by many participants in the study, one cannot claim generalizability. It does however provide a meaningful description and interpretation through the lens of a nurse into the experience of those who have experienced homelessness. It is intended that this thesis create a detailed, multi-dimensional, image of the experience of individuals who are homeless in their health care interactions and provide insights for the development of enhanced health

care interactions and relationships between nurses and individuals experiencing homelessness.

### **Sample Questions**

The interview questions were selected based on findings of the literature review, the researcher's experience of health care for individuals experiencing homelessness and in consultation with my supervisory committee. Below are examples of questions posed to participants and the Interview Guide is available as Appendix A:

1. Tell me about a health care experience or interaction you have had with a nurse who works in the community.
2. What was positive about that specific experience or interaction with a nurse in the community setting?
3. What was negative, unpleasant or not good about that specific experience or interaction with a nurse in the community setting?
4. What is different in your interactions or experiences with community nurses as opposed to other health care professionals involved in community care?
5. Please identify both positive and negative elements in the community health care environment that you have experienced.
6. Do you have an ongoing relationship with a nurse in the community and what has helped to foster or sustain that relationship?

## **Setting**

A Toronto agency that serves a population that is predominantly experiencing homelessness was approached for interview space as well as support for recruitment of participants. The site where the invitation to participate was located is the Good Shepherd Centre (GSC). GSC opened in 1963 to provide food, shelter and clothing for people in need. While the GSC continues to provide the basic necessities of life, it has also grown to incorporate programs that address the more serious causes of homelessness such as addictions, health care, and housing. It is reported by GSC that in 2010, an estimated 5,045 individuals used the various services offered at the location where the invitation to participate was placed. Services at GSC are provided 365 days a year by a team of staff and volunteers. All services are provided without distinction and free of charge to anyone in need.

## **Recruitment**

Poster invitations to participate were placed in locations throughout the building that are frequented by clients indicating a cell phone number for potential research participants to contact the researcher. Additionally, the staff and volunteers of the agency were aware of the times that the researcher was on site for the potential participants to meet the researcher in person should they not have access to a phone for screening purposes. No potential participants approached the researcher at GSC. All screening was completed over the phone and all consents were completed in person. Interviews were conducted in authorized space located at St. Michael's Hospital as none of the participants approached the researcher when on site nor chose to meet at the agency. The

length of interview was anticipated to be one hour. However the longest interview was forty-three minutes.

## **Data Collection**

Data were collected through semi-structured interviews with adult males who had either experienced a period of homelessness or were currently experiencing homelessness. Subsequent to ethics approval, participants were interviewed and their experiences audio-taped. Participants identified themselves as being over the age of eighteen years old and having experienced or currently experiencing “homelessness” (ETHOS, 2005). Following a few short structured demographic questions, the interview questions served as a guide which allowed research participants to direct the remainder of the interview based on their interest and experiences (Morse, 1994).

Interview questions were used to prompt discussion around their experiences of interactions and relationships with health care providers and in particular, nurses. The interview questions included asking participants to identify characteristics, attitudes, and experiences of care that supported positive interactions or the development of a health care relationship with a nurse. Ideas about what did not work were explored as well. As stated earlier the original purpose of this research was to gain an understanding of the factors that promote or constrain the development and maintenance of a health care relationship in a community setting with a nurse. During the participant interviews, it became apparent that participants were detailing interactions with nurses. Such interactions are understood to be the basis for the development of a therapeutic relationship. Research participants were provided with an honorarium of \$20.00 each in

recognition of the value of their time and perspectives shared during the in-person interview. Participants were offered a list of community resources and supports at the end of the interview, all participants declined this resource.

## Rigor

A variety of ways of judging the qualities of this research were employed and the individual and collective strengths of these processes are discussed (Graneheim & Lundman, 2004). The criteria for rigor according to Polit and Beck (2008) include authenticity, dependability, credibility and feasibility and fittingness. The interviews were audio-taped and transcribed verbatim. To support study rigor, feedback regarding the researchers' interviewing skills was sought from the supervisor through review of the initial transcripts. Continuing during the analysis stage, this researcher engaged and collaborated with the supervision team to ensure that results were appropriately and critically examined.

By examining the participant transcripts, utilizing inductive coding and examining for researcher bias, the identification of themes and sub themes emerged. One of the most common elements of rigor referred to in qualitative research literature is the concept of authenticity. Authenticity is described variously as the ability of the researcher to critically examine the participants described experiences with "thoroughness, congruence, and sensitivity" (Polit & Beck, p. 540). Thorne (2004) identifies that two of important elements that support the research process in maintaining rigor are journaling and the maintenance of ongoing field notes. Journaling supports the researcher in maintaining self-awareness and therefore authenticity. Maintaining field notes provides an audit trail to support the completed research. Utilizing field notes and journaling for this research, assures that participants experiences are accurately reflected which is key in achieving authenticity (Polit& Beck, 2008). The written notes when combined with the

participant transcripts provide additional reflections outside of what is contained in the interview.

To address dependability and feasibility the interview questions were reviewed by the supervisory committee to ensure that they appropriately reflected and supported the desired information that was being sought. The credibility of this study was determined by assessing the degree to which the findings plausibly explain the phenomenon of interest, the extent to which findings are congruent with what is already known or substantiated through research, any potential for other interpretation, and the congruency between the researcher's and the participant's perspective or experience. Working with the substantial experience of the research committee, it was established that the questions, participant transcripts and findings met this criteria. A study is considered to be credible when it presents truthful descriptions of the human experience, so that it is easily recognisable to those who have experienced it (Polit & Beck, 2008).

Dependability is confirmed through problem description, participant uniformity and research results that are consistent (Polit & Beck, 2008). This is assessed through literature review, establishing appropriate interview questions and screening of participants for inclusion in the area research. For this study, dependability was established by having key concepts from the literature inform the framing of the phenomenon of interest (perceptions of individuals who were experiencing homelessness and their health care experiences), the interview questions and the purposeful sampling technique.

Feasibility was maintained as the explored themes that are identified and the research protocols could be transferred into other settings where individuals experiencing

homelessness seek health care services. This will be determined by the detailed information contained in this thesis that supports the transference of the research into another environment of care for those experiencing homelessness. The credibility of these findings is the ability of researcher to describe the experiences shared by the participants and the ability of participants to find their experience described in the research (Polit & Beck, 2008). Ultimately, the feasibility will be tested by presentation to stakeholders (including invited research subjects) through presentation at research sites during small open group review of the findings.

### **Inductive Coding**

Guba & Lincoln (2005) assert that there is a requirement to match or find congruence between the problem being investigated, the inquiry paradigm, and the context in which the research is conducted for the inquiry to be able to produce meaningful results. Inductive coding within an ID study, the phenomenon of interest exists in the population of interest but informed by my role as researcher. It is with this lens, that I have explored the perspectives of the participants and undertaken the analysis required to allow understanding of the phenomena and to name it explicitly through themes and further details contained in subthemes.

The choice of interpretive description required that as the researcher, I continually synthesized meaning, theorized the causal relationships, and re-contextualized data collected into my findings (Morse, 1994; Thorne, 2008). It is essential to recognize and accept that as the researcher, the interpretation of the researcher is a driver in this method of study. This researcher's knowledge and understanding of health care for those

experiencing homelessness over the past twenty years through work and volunteering as a nurse in health care directed at those experiencing homelessness has provided a particular understanding and meaning both in the interview process and through field notes which ultimately shaped my understanding of the themes that were identified.

Inductive coding was utilized to sort through transcribed field notes, participant transcripts and to establish the coding and identify emerging themes. Descriptive words such as “helpful”, “understood”, “not what I needed”, assisted the development of finding meaning in the research participants’ answers. Interpretive description can draw on a wide range of methods and techniques for coding but inherently requires that the researcher accept that the understanding of the data, synthesizing of meaning, theorizing relationships, and recontextualizing of data into findings (Morse, 1994) are needed to discover and describe the phenomenon. Thorne (2008) describes that despite how open minded we believe ourselves to be, that when we as researchers interactions “anger”, it automatically has a negative connotation (p. 142). Further, she describes the importance of ensuring that the combination of our bias, personality, and particular discipline must be kept in check during coding to allow the researcher to delve deeper and not get stuck on the initial information that may stand out. In the coding of the data, Thorne (2008) likens the initial stages of coding to sorting of the “lights from the darks” much the same as laundry, and then further dissecting or coding the data looking for the more discrete parts that may have been lost on the first or second go through of the data (p. 145). This was completed by immersing myself in the transcripts and thorough line-by-line reading of the content, identifying themes and then reading through the transcripts again looking for previously unidentified subthemes.

## **Ethical Considerations**

Ethics approval was obtained through the Toronto Academic Health Sciences Council (TAHSC) and Human Research Ethics Board (HREB) at the University of Victoria. Ethical considerations recognize the potential benefits and risks to research participants. In exploring these risks, the only identified risks is the inconvenience related to interview participation as well a potential increase in anxiety or depressive symptoms occurring as a result of sharing negative experiences during the interview process. If a participant exhibited or described signs or symptoms of the above, the interviewer was prepared to provide support if indicated and assist the participant in identifying supports to assist them. This did not occur. Full consent was obtained prior to interview and could have been withdrawn at any point during or after the interview process with no negative outcome. No respondents withdrew consent at any point.

Potential participants were made aware of the opportunity to participate through posters placed at the Good Shepherd Centre (GSC). All participants received a sheet titled "Information for Potential Participants". This sheet informed the participant of the details of the participation requested from them and the responsibilities of the researcher. The individual, upon continuing to show interest in participating and meeting screening criteria in the research received a "Participant Informed Consent Form" (Appendix D). Once the participant indicated that they had the read the forms or wished to have them read to him, time was offered to think about the researcher's request. Upon consent to the interview, the "Participant Consent Form" was signed by the participant and remained with this researcher. A blank copy of the "Participant Consent Form" was provided to all

participants for their records. Participants were made aware they could withdraw from the interview at any time without negative consequences. They were also informed that they could decline to answer any question asked of them. If they withdrew from the study they would have been asked at that time whether or not the data already collected could still be used in the research. Without this express permission the data would not be used. There were no participants who neither declined to answer any question posed nor withdrew consent. Research participants were offered a list of resources and community support for their information. No interviews resulted in participants requiring further medical, psychiatric or emergency intervention. Research participants received a \$20.00 cash honorarium at the completion of the interview.

In reporting the research results, pseudonyms were used and all identifying information was removed. The data is stored in a locked filing cabinet and password protected computer files were used. The audio-tapes and transcriptions of the interviews will be destroyed after the defence of the research. The protection of confidentiality would only be breached where required by law, which included disclosure of child abuse, reasonable expectation of harm occurring to either the participant or others, or information subpoenaed for a court of law. This did not occur in any case. In this study, I set out to describe the experiences of individuals who are homeless with community-based nurses. The conversations reported are a snapshot of the experiences of the eleven individuals interviewed. The analysis is one perspective, from the researcher's understanding in conversation, with the eleven participants.

## Chapter 4: Findings

This chapter is divided into two sections: an introduction to the participants, and a discussion of the themes common to their experiences of health care interactions with a nurse. The second section is a detailed exploration of the themes and the emerging subthemes. The table below contains the research participant demographics as well as any health care challenges they disclosed during the interview. I have assigned a pseudonym to each participant:

#	Participant	Age	Gender	Health Condition Disclosed by Participant	Housing Status at Interview
1	Donald	58	M	None identified	Homeless
2	Matthew	35	M	Diabetes, Epilepsy,	Homeless
3	Willis	44	M	None identified	Homeless
4	Cody	32	M	None identified	Homeless
5	Patrick	39	M	Wound Management/Feet	Homeless
6	Mitchell	48	M	Wound Management/Feet	Homeless
7	Paul	41	M	Wound Management/Feet, Dental Issues	Homeless
8	Henry	43	M	Stroke	Homeless
9	Igor	32	M	None identified	Homeless
10	Philip	48	M	Cancer	Housed
11	Craig	29	M	GI/Reflux, Dental Issues	Homeless

## **Introduction to Participants**

In total, eleven participants expressed an interest in the research and met eligibility requirements based on a screening questionnaire. Eligibility was confirmed over the phone except for one participant who presented with another study subject. Participants met eligibility criteria when they identified as being over eighteen years old and having experiences of homelessness and experiences seeking health care in the community. The one-to-one interviews were completed in late July and early August 2011. Participants reported seeing the study poster at the site as well as through word of mouth from earlier research participants.

All the participants or respondents were male between the ages of 29 and 58. All respondents except one were currently experiencing homelessness. They had been without housing for varying periods of time. Ten of the participants indicated that they had been homeless for at least several years. Most voluntarily indicated that they were currently staying at local homeless shelters except for Philip who was housed following a recent diagnosis of cancer. Only one individual reported that this was his first period of homelessness. When interviewed, this participant reported that this experience of homelessness was new and he had been staying in the shelter for just over two weeks.

Donald identified that he rarely sought health care and when necessary sought care in community clinics that focused on the needs of individuals who are homeless. While he had used services designed to meet the needs of individual's experiencing homelessness, he did not describe having any relationship with a nurse or any long term relationship with a nurse. He sought care only when he felt that he was "really sick". Donald identified that many of his interactions were related to problems with substance

use and in particular alcohol. He described the attitudes of those in the services he sought as “rude”.

Matthew, at thirty-five years old, was eager to share his many experiences with health care providers not only in the Toronto area but from other cities. He had multiple health issues related to long term use of substances. He reported that in his war torn country of origin, his wife and daughter were killed in a car accident and he himself had been in an area of bombing that resulted in a critical injury and now chronic health condition. Matthew shared both negative and positive experiences with providers in the community. He recounted how some nurses followed up with him to let him know that he needed to seek further treatment or investigation in the hospital while he felt others treated him “*like a piece of shit*” and he questioned himself on “*why ??did come to her*”.

Forty-four year old Willis detailed that his access to treatment for various chronic health concerns was episodic and mostly through clinics set-up in shelters and detox centers. Willis was unable to identify an ongoing relationship with a nurse or health care provider but offered suggestions on his ideal place to receive care.

Cody at thirty-two years old was extremely articulate and thoughtful not only about his previous experiences but what he believed would be the best resource for homeless individuals. Cody reported that he had sought out care in the community which was often through nurses. Diagnosed with “*manic depressive, bi-polar*” illness, he has periods where he experiences severe anxiety and needs to access health care.

Patrick at thirty-nine years seeks care from nurses and community health providers for self described minor issues. He was not able to describe an ongoing relationship with a nurse or provider but suggested that based on his limited experience

identified “*they could be more caring*”. Patrick could not remember seeing a physician in the community but he did acknowledge receiving nursing care in various shelters, clinics and drop-ins from nurses. He believed that individuals experiencing homelessness could be encouraged to access health care by streamlining the process and the focus of interactions should be preventative.

Mitchell was unable to indicate any perceived difference in treatment by nurses or doctors in the community. At the age of forty-eight, Mitchell has received treatment for bladder issues. He was however clear that he believed his treatment and services provided or offered in the community was different because of his housing status.

Paul, at forty-one, attends a clinic for individuals that are without housing including provision of a foot massage along with pedicure/manicure. He described an ongoing health care relationship with a particular nurse in the community setting. He was not able to identify any interactions in the community that were negative or unwelcoming. Paul’s perception of his experiences differed significantly from that of the other ten participants. He was unable to identify any negative interactions as opposed to other participants who were able to recount unpleasant or unwelcoming interactions with health care providers.

Henry was quick to tell me how he was valued on the street and within his community. Henry’s experience with health care providers was mixed. Alternatively, he described nurses as “*bitches*” or “*sexy*”. When using the term “*bitches*”, he also suggested he could have perhaps provoked a negative response due to his presentation. He indicated that his use of substances creates problems including ongoing legal issues but is also a source of pride being “*a dealer*” since he earned a good income. While

Henry was not able to identify an ongoing relationship with a nurse, he was clear that he sought out care when needed and has accessed services in multiple places. At forty-three, Henry looked much older and had difficulty at times focusing on the questions during our interview.

Igor described himself as “*different*” than other people experiencing homelessness. Appearing much younger than his thirty-two years, he has a physician in the community where he gets some of his health care. Igor’s interaction and engagement with community nurses is based on his “*psychological*” needs as they relate to being without housing. When seeking care from the resources that are focused on those experiencing homelessness and their health needs, he felt that the services could do more to provide privacy for their clients.

Phillip came to see me by referral. He received my number from one of his friends. Forty-eight years old and fighting cancer, he is no longer without housing. Due to his poor health status he was able to access specialized housing. His interview touched on many aspects of his care in the hospital setting which was not the focus of this particular research project. When describing his experiences with nurses as they relate to his periods of homelessness, they were reported as overall positive. When provided with his compensation at the conclusion of the interview, Phillip initially declined the \$20 but changed his mind moments later, stating he would give the money away.

Finally Craig, the youngest respondent at twenty-nine years, described receiving most of his health care through nurses only and in the community setting. He believed that his outward presentation did not resemble what people assumed characterized people

who were homeless and therefore he felt that providers were less likely to take him seriously or allow him to access services for individuals experiencing homelessness.

In the remainder of the chapter, I identify three broad themes: 1) “I’m not just homeless”, 2) Treated like Second Class Citizens and 3) Creating Safe and Welcoming Spaces. Within those broad themes, I have identified subthemes that help to describe the overall experiences of men who have experienced homelessness and their perceptions of their interactions and relationships with nurses and other health care providers. While the participants were asked specifically about nurses during the interviews, it was not always clear when participants were talking about nurses or other health care providers. When it is clear that participants are talking about nurses, the term nurse will be used. When it is not clear they are talking about a nurse and are discussing health care providers in general which may or may not include nurses, the term health care provider will be used. Those that work in environments and services focussed on homeless individuals may not just be nurses but also social service workers or counsellors. It could be assumed that a participant may have mistaken a social service worker as a nurse or vice versa.

### **Theme 1: “I’m not just homeless”**

All participants identified that in their interactions with health care providers, it was important for nurses to see them as ‘not just homeless; but someone of “worth”. The participants described the common experience of health care providers seeing them as homeless and failing to recognize them as little more than a homeless individual. Patrick reported, *“they tried to brush you off and that’s part of being a homeless. You are always put as last.”* The implication of this was that being homeless is of little worth or

value in society. In this first theme, three sub-themes were identified: Lack of Worth, Establishing Identity, and Describing Themselves.

### **Lack of Worth**

Many participants referenced how individuals were not regarded as having worth and felt that they were ‘treated’ “*like shit*” or “*like crap*” or less than other individuals who didn’t have the experience of homelessness: “*this time I feel like a piece of shit. I feel why I’m doing this? Why I put myself in this position? Why I come to her?*” Mitchell offered:

*Once they see you don’t have an address, it seems it changes. Like you feel it. They don’t look at you the same.” “I know it gets busy and what not, but sometimes you do feel like they just set you off to the side there when you are homeless.*

His perception of his experience is that not only do providers treat him differently because of his housing status but providers minimize interactions because of his homelessness. Participants referenced nurses’ lack of recognition of them having key roles or lives outside of experiencing homelessness:

*I don’t see that. I don’t see that because she thinks we’re ...homeless, we don’t have family, we don’t have nothing to do with it. I’ve been to school. I’ve been at university. After my daughter died, somebody killed her, I have to be homeless. My wife died with her. I don’t have nowhere to go.*

This suggests that seeing someone as homeless erases much of the history that clients bring into their interactions with nurses. Being seen as only ‘homeless’ does not account for the historical and situational context of participant’s lives and the potential suffering that they have experienced. Additionally it does not account for the strengths they may bring to managing their own lives and health care needs, a foundation in the principle of

any strength based model. In nursing, the importance of identifying the individual's strength is established as a principle of developing a therapeutic relationship (reference?).

### **Establishing Identity**

In dialogue with me, all the participants sought to establish their identity in a number of ways. During the interviews, participants were quick to ensure that I, as the researcher, understood their value and the roles that they played outside of being homeless. All participants took the time to ensure that I understood that their personal history included more than 'being homelessness'. For example, one participant stated *"Like believe me, I had a lot of stuff. I had things and I had a house. I had a good job. I had money in the bank"*. Early on in each interview, all participants quickly established with me the many roles, attributes, behaviours, and associations that they considered important about themselves. Participants, aside from assuring me of their worth, also appeared to be reassuring themselves, as to their sense of worth and identity outside of being homeless.

Participants shared that they highly valued when nurses and health care providers acknowledged their worth as a person. For example, like the participant above, they described their previous jobs, education or social circumstances and described the importance of health care providers acknowledging their identity aside from being "homeless". Participants wanted nurses to see who they were as people and to look beyond their current circumstances. They attempted to establish credibility by describing attributes that spoke to their individuality or characteristics as an individual. Self-esteem, value, and personal worth are intrinsic needs and respondents were eager to establish who

they were apart from being homeless. They independently described their family situation, work history and financial status. For example, I interviewed individuals who identified that family members had died, that they had owned businesses or were currently in discussion with banks to finance new ventures. They wanted nurses and other providers to know and recognize this during health care interactions. In establishing their identity with me, the respondents shared several examples of the various roles they held outside of being homeless such as mentors or volunteers with others experiencing homelessness. All respondents indicated the importance of all health care providers listening to and validating these roles beyond their current status of being homeless.

### **Establishing Self Worth**

Respondents had a number of ways of thinking about themselves that helped to establish their self worth. Their sense-of-self associations were based on a combination of the following: occupations or vocations (such as artist, truck driver, football player, and business owner), social or familial relationships, volunteer roles, and abilities and disabilities. In establishing his worth Phillip almost immediately told me, *“My family. They don’t like me on the street, I’m 48 and I’ve got a Grey Cup ring on my finger. I played professional football”* or Henry telling me that *“I drove trucks down here for 21 years”*.

Other respondents indicated current endeavours such as volunteer training:

*I’m in the Toronto Hostel Centre and they teach you certain things – documentation skills and crisis intervention, transgender and stuff. So I mean I’m learning a lot of things.*

Henry told me that he was an artist in addition to starting a business in tattoos with a partner, that he was “*doing our work for the fire department. I do all kinds of murals.*” Other participants referenced disabilities such as their substance use or psychiatric issues, “*I have an anxiety problem*”. Philip made sure that I knew that he was a religious individual by stating, “*I believe in God. He’s the only one helping me*”.

Participants were eager to share and assert that sense of value and self-worth during their interview:

*I’m my own boss. I’m doing hard work tattoos and I got two ... nobody even knows. I’ve got two partners. We’re opening up our own tattoo parlour. We even got financed.*

Phillip explained his identity as a support to other individuals facing homelessness. Demonstrating his value to society through the following statement, he indicates that despite facing many obstacles that people living on the street need not be defined by their current housing status:

*I minister to the people on the street no matter what I’m going through. I let them all know that you’re better than what you’re doing.*

Participants felt that they received lower quality of health care and in some cases came to expect less as a “homeless person”. Another respondent confirmed that because of his homeless situation and the way homeless individuals are regarded that he was used to not receiving the sort of service or experience that other housed individuals would receive:

*It is the experience of homelessness. Homelessness is that the face of homelessness is sort of taboo. So I mean you sort of get used to this push back from everywhere, whether it be from your sergeant or from a regular.*

Recently homeless, Willis indicated a feeling of shame for being seen using the services directed at homeless individuals:

*Just for me personally. No, I mean they have no choice but to have a line-up, but it was just I didn't like being in the line-up. And people not in need of homes or shelter walking past, I kind of felt embarrassed I guess you could say, again, as horrible as that sounds. Like I say, I've changed my view since then. It's been a long two weeks.*

Another way of establishing their self worth was to highlight social or familial relationships (such as spouse, father, son or friend) *"I have kids. I've still got kids"*.

Respondents identified that providers would do best if remembered to *"treat people the way I like to be treated."*

## Theme 2: Treated like Second Class Citizens

Participants described health care providers and community nurses as holding certain beliefs or assumptions about individuals experiencing homelessness. In this second broad theme identified through participant interviews, the following two subthemes were identified: 1) treated like drug addicts & alcoholics and 2) like a criminal. These assumptions had implications for how care was experienced and left participants feeling labelled as drug addicts, alcoholics or criminals which resulted in feelings of shame and blame. All participants reported that they felt they were treated differently and believed that this was related to the assumption that as an individual experiencing homelessness they were either a drug addict and alcoholic or a criminal:

*Well I guess as far as the way that you're talked to, especially about the homeless thing mostly and the waiting as far as Agency A. I know it gets busy and whatnot, but sometimes you do feel like they just set you off to the side there when you are homeless. Now I have a place but for the longest time I didn't. So it's very hard.*

Perceived to be an addict or alcoholic was associated with being a second class citizen and the implication that one was less deserving of care. In the example below, drug use and homelessness interact to shape experiences in health care. Mitchell reported that “when they see you don't have an address or whatever, like they look at you different” and continued to describe the effect of these perceptions had on his interactions with health care providers in general:

*Of course, a lot of us are addicts and alcoholics, so it's not very pleasant going into a place and you're treated like an animal. You're treated like a second class citizen just because you're homeless.*

Overwhelmingly, participants perceived that nurses held negative assumptions, values, attitudes or beliefs about individuals experiencing homelessness that interfered with their interactions and the development of ongoing relationships. Values, attitudes, and beliefs can be expressed through negative stereotyping. Participants' descriptions of their interactions with health care providers and nurses in the community were tainted by these negative assumptions. Participants further described that they were less likely to approach nurses in the community based on past experience. This has implications for many things but the more glaring concern is that it limits the opportunity to do health prevention and promotion, and limiting the impact of intervention earlier in the community.

### **Drug Addicts & Alcoholics**

Overall, respondents indicated that health care providers in the community perhaps did not listen or had a poor understanding of what they were experiencing based on these negative assumptions:

*Well, there was one. She was a lot younger than me and she said she was an alcoholic. And I said how do you figure you're an alcoholic? She said she drank once and got drunk and then she didn't like it. I said look it, I've been drinking probably more than the age of you. How can you say you're an alcoholic? I said I won't come out and tell you I'm an alcoholic. I just said I had a bad drinking problem. And she said, well you're an alcoholic.*

*Yeah. They think are you drunk? Are you high? And I look at him and say listen I'm diabetes #1 only I have a coma. Can I see the doctor? He says you're going to jail.*

The above quotes highlights that these negative assumptions about drug and alcohol use can obscure the need for health care. The indication is that because of assumed drug or

alcohol use that all of their health care needs were somehow related to substance as opposed to pressing health care conditions such as diabetes. He went on further to describe that it had more to do with the understanding of “homelessness”:

*That really doesn't have anything to do with the care itself. It has to do with the personality of the person. I mean the education of the nurses about homelessness and about what homelessness is about, that has a lot to do with it as well.*

Respondents reported that these assumptions changed the way nurses interacted with them, by assuming that they were “*drug addicts*”.

*Yes. The first nurse, she don't look at my hand. She goes like this after she wears two gloves, two/three gloves. She put the hand like this. She touched like this. And I say Miss, I'm hurting. And she's looking at me, doing opiate. I said Miss I'm not an opiate man. Nurse, I drink, I do drugs, but I'm not smack myself. I don't do opiate.*

Participants reported that they all were treated as though they were somehow at fault for their housing status and that it was likely related to addictions:

*Then it's like a prejudice. Not everybody had to be addicted. Not everybody has to have a beard in order to be homeless.*

The assumption raised by participants here is that individuals experiencing homelessness look or present a certain way. When nurses disregard the client's personal history, self-worth or needs as described above was confirming of what was reflected in other participants' experience and this had a negative effect on the individuals experience with the nurse. Cody reflected that “*You don't see people in business suits in the morning time lined up to the methadone clinic*”. He endorsed that “*a lot of the people are homeless, have mental issues, or just poor income*”.

These negative assumptions extend past initial interaction to affect individuals who need particular treatments. Craig, who reported that when he needed help to manage

his pain, providers were not willing to assist, based on the assumption that he was “drug seeking”:

*I'd have to say serious pain because I remember when I had the abscessed tooth and because I didn't have a family doctor, I wasn't able to get prescribed anything a little heavier. And I remember it hurt so bad and it lasted about two weeks because they had to give me penicillin and they wouldn't give me anything for the pain. So I was kind of hoping to get something a little bit stronger like a T3 or something like that because I'm not into medication. I won't take it unless needed, but I can guarantee that day, I really needed it, and I wasn't able to get that help.*

The experience described above is an example of how these negative assumptions of substance use has a negative implication for patient care and the likelihood that the patient will return for further necessary care.

### **Criminals**

Participants indicated that not only were they assumed to be using substances but they also felt treated “like criminals”:

*I don't care what you look like. I'm not going to bug you. Everybody knows that about me. I might fuck around and stuff and yeah, I've hurt a lot of guys. But I'm not Paul Bernardo. But I like to joke around. Who cares?*

Henry said that, “*there are some nurses that look down on us guys and think we're street thugs.*” One respondent seemed angry at a system that assumed he ran afoul of the law, “*I ran my own business for 15 years. I'm not a total street thug.*” Those individuals who described incidences of stigma when seeking out health care in the community because of the presumption of criminality reported that “*it sucks*”.

Participants reported that drug use and criminalization get conflated with homelessness. Further, people do not understand the relationship between the issue of

presumed criminality and how that affects their interaction with the individual experiencing homelessness. Patrick responded that:

*They would see crack addicts, prostitution, and if they don't have the proper understanding of what causes it, they might not give them the respect to be cared for anyway in the first place.*

However, one participant, Igor, reported a very different experience when he was seeking care and during interaction with the nurse. He described reverse prejudice, in that he “didn't look the part” of an individual experiencing homelessness:

*Because I was new and because I didn't have a beard ... See for me it's different because on the outside I look great and I have like a brain, so it's different. It's not like a lot of these guys; the outside doesn't look that great. But for me it's the other way around. So other people think that I'm doing fine; everything is great. And really it's not. So sometimes I get a little subjected to like prejudice. Are you really homeless, like stuff like that?*

Respondents described that these negative assumptions extended through most interactions:

*And that if you want to see the doctor, you go and see a doctor at Shelter A. You want to see God in the morning. Do you know what I mean? barrier to getting there? Yeah, a piece of crap.*

Matthew reported that some of his difficulty in seeking care was the result of the “barriers” such as security officers on site and the negative stereotyping and prejudicial treatment of providers because of his housing status. Security officers represent a form of policing and participants reported being the subject of harassment by security because of the supposed association of homelessness with drug use and criminalization. This highlights the role security guards play in health care and can present a barrier to care:

*I'm a homeless. I don't have a doctor to sign me a notice for my insulin. And he told the security. He said listen we test your diabetes. If you're high, your diabetes is high, we put you in the hospital, if not, you're going to jail. I say deal. I go inside. It's my diabetes.*

The respondents overwhelmingly reported that they had been subject to prejudicial or different treatment during interaction with nurses because of assumed substance use or criminality. What became apparent through the coding and the analysis process is that these described assumptions negatively affected the willingness of participants to return for follow-up care subsequently negatively affecting the ability to establish a relationship with the nurse or any health care provider.

### Theme 3: Creating Safe and Welcoming Spaces

Participants in their interviews affirmed that community nurses were key in creating a situation where they felt able or welcome to engage in meaningful dialogue. Overall, participants' reported that being homeless affected communication and interactions with the nurse as it created an inequitable distribution of power in the relationship and feelings of low self worth that interfered with establishing a relationship. However, participants indicated that nurses working with individuals experiencing homelessness were uniquely positioned or qualified because of education or experience with individuals experiencing homelessness to create safe and welcoming spaces in which they felt comfortable or able to disclose their concerns. Research participants reported that a sense of empathy, developing a rapport and taking the time to listen were key to creating safe and welcoming spaces for individuals experiencing homelessness when seeking health care. Another participant indicated that he did not believe that the negative or positive interactions was based solely on the care provided by a nurse but on the "personality" and understanding of the nurse. Participants' referenced positive qualities and actions that nurses could undertake that counter these labels of alcoholic or criminal and the shaming that they repeatedly interactions.

Igor described the key attributes the community nurse should display and likened it to customer service by way of accepting people without prejudice:

*The very first thing is hospitality. Customer service is number one – first thing. You make the person feel like yes, we do want you, and yes, you do want us, you need us to help work with you. Yeah, just the very first thing that I'd make sure I do is everybody is really customer service oriented. That's the very first thing in that everybody is being accepted and nobody is being ... you write it down without any prejudice, nothing at all, and no does he look that bad or not that good or whatever. So basically keep on follow through everything. After that, you know, do as procedures. Customer service would be my main thing.*

The ability to convey genuineness, respect, build rapport or foster an empathetic relationship or experience was described as critical to creating a welcoming environment and a positive relationship with the nurse. Willis described that that community nurses and those working in health care services for individuals experiencing homelessness would need specific training in issues related to substance use and mental health. Mitchell went further to indicate that he felt a community nurse would be welcoming if they were:

*Down to earth and that understands that there are predicaments that people get themselves into. It's not that they're homeless because they want to be.*

Mitchell described that the welcoming environment was more about being knowledgeable of the challenges homeless individuals face:

*Well I found her to be a lot more pleasant and that I guess because it is Agency "A" maybe and they're used to dealing with street people.*

In the absence of these positive welcoming qualities in the interactions, participants indicated they were less likely to engage with nurses in the community for their care.

Donald indicated that he was unsure who was responsible for the poor interaction but acknowledged that it required both individuals to be open and respectful:

*To me she was like rude and all that, but it made me stop and think about going to the meetings. After you listen to people that's there, you're along changing their attitudes. So I don't know if it was my attitude. Between me and her, right, who had a bad attitude?*

Igor detailed that individuals experiencing homelessness wish to be accepted for who they are for them to be welcomed and feel safe:

*When doing their job, for the nursing to be more effective, is they need to accept everyone. That way they can get more patients in and get a program going. They just need to accept everyone and not be ... They're thinking okay maybe other people will come in and just try to use it, well off people will come in and try to use it. But not really. A lot of people they don't really want to. But just to be more accepting.*

Furthermore, these findings suggest that individuals experiencing homelessness do not feel comfortable seeking health care in the wake of previous negative experiences. In such experiences, they felt they were “othered”, not heard, nor respected and not afforded the time or invitation to freely discuss their concerns. Participants described that such negative interactions and experiences led to feelings of distrust by participants. Due to these negative interactions, participants reported that based on this experience they were not conducive to building a relationship based solely on their homeless status. They felt marginalized due to the assumption that they were little more than drug addicts and criminals.

### **Building Rapport through Mutual Respect & Empathy**

Analysis of the interview data revealed that participants identified that the ability of individuals experiencing homelessness to establish rapport with nurses and other health care providers during interactions ultimately rested on the ability to build a relationship that was free of negative assumptions and valued the individual as having an identity outside of that of a “homeless person”. This positive interaction supported and sustained individuals ‘experiencing homelessness and their relationships with nurses in the community setting.

Participants referenced a need for nurses and other health care professionals to learn to provide welcoming and supportive environments, as well as compassionate care. Participants valued the nurse’s ability to be natural or authentic in their interactions with the patient. Nurses, while bound by professional and college codes must be in accordance

with their values and beliefs (Parkinson, 2009). It was resonant through all interviews that participants felt that nurses saw them at “their worst times”. As Henry stated “*and I respect a nurse because they see blood and lots of shit. They see crap. They see our crap. They see the aftermath*”. Participants were grateful when nurses took the additional time to understand their particular circumstances regardless of substance use or criminality. The nurses 'genuineness' was determined through the level of consistency displayed between their verbal and non-verbal behaviour as evidenced by participants noticing that some nurses were not interested in their complaints or concerns but focussed on other items such as playing with their phones or mobile devices.

Paul referenced mutual respect as “*I was treated like I was treated the way I should have been I was treated like a human being and I was treated the way they wanted to be treated*”. Nurses who conveyed ‘genuineness’ formed an alliance with participants and this was valued throughout all responses. Participant Paul described this genuineness as sincerity:

*Well she was nice. She was asking me do I need this or do I need some more bandages or how's your feet. She was nice. She was sincere about her job.*

Cultural mores, norms, ideas, and customs provide the basis for ways of thinking about homelessness, substance use and mental illness. All of these are highly stigmatized in society and as evidenced by these findings associated at times with criminalization. Respondents indicated that providers needed to have a sound knowledge of the issues related to homelessness, mental health and addictions rather than acting on stigmatized stereotypes:

*I tell you one thing. For the shelter I need the nurse to study before she be a nurse, she be a human being. She have a course for psychology. The nurse is not only to be like a nurse. You live in the shelter, you work in the shelter, people with*

*mental health, people have drug issues. You need a nurse to feel. Like I don't want them to be smiling in my face. I don't want to be like that.*

This quote highlights both the importance of knowledge and bringing one's self into interactions. They indicated that nurses were, in particular, largely responsible for positive interaction and creating an environment that helped to foster a positive relationship. Participants described the passion or desire to accept all people that is required by a nurse in the community to be engaging:

*Well I think if the nurses are going to be in the community serving the homeless, there are going to be a few different kinds. Some of them they're going to embrace them and some are going to reject them.*

Participants identified the importance of respect in interactions with nurses as well as other health care providers. Craig detailed his experiences with nurses and the issue of respect “*the positive thing is they're always willing to help as long as you're respectful*”, Craig continued, “*obviously they respect you if you respect them back. And they listen, which is always good, like active listening. They wait until you're finished and then they decide to help you from there.*”

The relationship is the foundation on which nursing is established. The therapeutic interpersonal relationship is the process by which nurses provide for individuals in need of intervention or care. Participants reported the importance of nurses to engage individuals experiencing homelessness in a positive interaction could lead to an ongoing relationship with nurses. The client is the one who decides if and who will participate in their care. Interview participants indicated that all health providers need to know how to gain trust and gather information from the patient, to involve them in an effective treatment plan. The way that they felt this could be done is through establishing an empathetic dialogue.

Therapeutic use of self is the instrument for delivery of care to clients in need of psychosocial intervention. It is this use of self that helped establish a rapport and led to positive interactions. Interpersonal communication techniques are the “tools” of psychosocial intervention. Because of their past negative interactions and inability to find a supportive relationship with a health provider in the community, they often sought care first in small agencies focused on individuals experiencing homelessness and when that failed, acute care settings. The community nurses accessibility and their ability to create safe and welcoming environments had the ability to change or influence where individuals experiencing homelessness sought and received care. Paul described the way he wants to be treated *“A good positive attitude. No negativity. I don’t like negativity because I like to be treated the way people like to be treated.”* Lack of a safe and welcoming environment in the community setting meant that participants choice for health care delivery was concentrated in emergency departments and in the various agencies and institutions set up to address their health, shelter and social needs. These results suggest that participants feared being judged and that they avoided health care interactions to avoid the experiencing the blame and shame that they would feel.

When I asked Donald whether he was likely to return to a community clinic and speak with a particular nurse because of a reported interaction, his response was *“Yeah, it did because the way she was friendly and she was listening to me”*. They reported that nurses were well-situated to provide that environment secondary to their ability to spend more time with individuals:

*Most nurses I find they like their jobs. I can’t see why somebody would want to do something they don’t enjoy unless it’s middle class. But I mean nurses do quite well for themselves nonetheless and it has to be something that they’d want to do. And I just find doctors a little more serious and they’re the ones that have got to*

*put up with a little bit more. Like the nurses do too but I mean it's the doctors that have really got to write the prescriptions or do the analysis. So they're a little more serious and a little bit less good to talk to, where the nurse will take the time to listen and not pretend to hear what you're saying like a doctor would.*

Another participant offered a comment on the difference in seeing a physician in the community:

*Well one time I went to see, in the walk-in clinic, a doctor. To me he was more or less like rushing you through. He wanted to give you ... like I call them pills. When I run out, come back and get more. To me he wasn't really taking his time to figure out. Because that's what I figure a walk-in clinic is. It's just something like a drive-through.*

Participants commented on the nurse's ability as opposed to doctors, to establish relatedness, to structure dialogue and interventions that were unique and centred solely on the participant. Nurses were identified as possessing the qualities of self-awareness, self-understanding, and a philosophical belief about their individuals experiencing homelessness and their needs that made the relationship 'hopeful'. Matthew reports seeking service from a particular location because of the feeling of "hope" he receives from a nurse in her approach, "*But she comes to you. She smiles in your face. She gives you hope how you talk to her*". Mitchell continued his explanation on how a nurse can provide such a powerful feeling, "*A nurse can give you hope and a nurse can put you down. The nurse who can give you hope if she comes to you and she gave you, you can feel her how she talks to you, you feel good.*" It is this perceived notion of hope reflected in the nurse's interaction with research participants that is powerful. Individuals like Matthew articulated that the sense of hope was key to establishing a rapport and conveying a sense of empathy with individuals experiencing homelessness:

*I'll tell you one thing, Lisa. For you because you're Canadian and you know the style in the street, you can go and talk in the government and talk with the people. We need one thing. We need one thing. We need hope. Why do you need hope?*

*I think I've found it really. Hope is nothing you can buy. You can't buy hope. You can't. If you had a million dollars, you can't buy hope. You make money. You make anything. But one day you come home and you die*

Participants described the importance of the collaborative partnership with the community nurse. In describing positive aspects of the interactions with a community nurse, they described the ability of the nurse to hear and understand who they were as individuals outside of being homeless. That ability of the community nurse was well regarded through all interviews. Patrick described the variance he found in community nurses and hypothesized how this affects the interaction:

*And the ones that are going to embrace them, they're going to be loved and they're going to love their job because that's the way they are; I mean they're caring. But there are people that they won't. They would embrace it at first, but then they would see crack addicts, prostitution, and if they don't have the proper understanding of what causes it, they might not give them the respect to be cared for anyway in the first place.*

Participants identified that the nurses' ease of establishing a rapport and a positive interaction was core to establishing an environment in which they felt safe to access health care and seek an ongoing relationship. This was accomplished through a variety of ways but evidenced by participants most often through listening:

*The conversations worked well. That one's a little hard to answer because I mean I've only seen a few here and there, but I mean they're very nice. Obviously they respect you if you respect them back. And they listen, which is always good, like active listening. They wait until you're finished and then they decide to help you from there.*

Another participant reported that respect was a two-way street and influenced how individuals experiencing homelessness were received.

Mitchell reported instances of witnessing disrespect of nurses by clients:

*A lot of the people there, some of them are a little bit offside and some are demanding even though they're not offside. They're just rude. So it would take a lot.*

The above quote is congruent with the identified societal level of respect that nurses hold and this is vital to participants' ability to engage with community nurses. *"I respect a nurse because they see blood and lots of shit. They see crap. They see our crap. They see the aftermath, I respect them all"*. Henry's thoughts on respect in the relationship with the nurse: *"The way they run it. You respect them; they respect you"*.

Nurses were identified as partnering with participants to create supportive environments for health that could lead to more positive interactions and strengthen existing health care relationships.

*She did give me the office number and her extension. She wanted me to follow up with her. And so I haven't done so yet, but I will. It definitely made me think well just because you have a few bad experiences, you can't hold on to everybody because this was a great one and so it just makes me more ... I don't know what the word is. I'm not really articulate today. It kind of just makes me feel like okay like there are still good people out there who do care and who you can get the care you need.*

A participant noted that the difference in the interactions with a nurse in the community is that he didn't feel the stigma of being homeless. He experienced his treatment as any other person seeking health care would, with no prejudicial treatment because of his homelessness:

*I mean some people who do even work in those fields; they almost kind of treat you like you're a leper. But I actually felt, you know, like I could have been anybody in any hospital or whatever, speaking to a medical professional and getting advice. Yeah, I was pleasantly surprised.*

Paul continued *"She's a very professional lady. It means she likes her job. She does well for her job and she'll take care of her clients the way they should be taken care of. Nursing competencies focus on care across the lifespan of the client who is*

experiencing changes in health. This respect for participants was shown by accepting the individual regardless of the presentation or setting:

*I hit the back of the bus and I just remember this nurse putting this shit on my head or whatever and I woke up and I said what happened. She says you displaced your shoulder and you've got a concussion. Do you know what I told her? I've got to go. She says why? I said I've got eight warrants for my arrest. She goes oh my God.*

Matthew recognized simple aspects such as eye contact and a smile for creating a space where he felt open to expressing himself:

*She's an old woman and in his face she gave you the hope she can help you. She don't have attitude and she don't call you hey what's your name. She knows your name because she did your file. And before she talks to you about your hand and anything, she chats with you. She talks to you.*

Essential aspects of nursing care were noted through all interviews. Participants indicated that nurses were often the first entry or introduction to health care services. Patrick acknowledged that nurses are unique in that they provide access to a variety of engagements, directly with them through treatment or education but also to other services, *"They could suggest maybe it's time for you to go there and stop eating sugar or go to a specialist"*. Participants' responses indicated a collaborative relationship with nurses that assisted them to identify health priorities and empower them to improve their own health. More than one respondent noted that the core to this empathy and understanding would be to have nurses learn in the community *"I would ask her to come outside. There are so many good people out there. But you don't think they're good because you think they're homeless"*.

In the interviews, respondents identified the importance of the nurse in maintaining a positive therapeutic relationship with patients in whatever setting that may be. The fundamental elements of health care in the community revolve around

interpersonal relations and interactions established between health care professionals and clients. Participants identified that either they or other individuals experiencing homelessness may have increased mental health needs (stress/depression) or substance use issues. Caring for people with mental health issues or substance use can require an intensified presence and a strong desire to be supportive. Conveying an understanding of the issues they are experiencing is important because it provided participants with a sense of importance. Participants identified that not only were nurses the entry into health care services, they also had the most contact with individuals experiencing homelessness therefore creating a unique understanding of their needs. Regarding the nurse's role in health care:

*She have to be treated like a doctor. You say the doctor have more degree. Nah. Sometimes the nurse may work more a doctor. You understand? The nurse is there all the time so she knows more about perhaps the people who are coming in the door maybe has a better understanding of what they need.*

The value of participants to be able to freely express their thoughts and feelings without blaming, judging or belittling was frequently referenced. This dynamic was described by one respondent as the simple act of comforting them through holding their hand. Such personal connections have the ability to uplift people's spirits and secure confidentiality. This ability by nurses to provide non-judgemental care was described as customer service oriented:

*Yeah, just the very first thing that I'd make sure I do is everybody is really customer service oriented. That's the very first thing in that everybody is being accepted and nobody is being ... you write it down without any prejudice, nothing at all, and no does he look that bad or not that good or whatever. So basically keep on follow through everything. After that, you know, do as procedures. Customer service would be my main thing.*

### Creating Time to Listen

Cody reported that his interaction was “the best” with the nurse when “*I was almost more trying to get out of there and she was like still going on*”. Mitchell reported being surprised by the time the nurse spent with him, “*Yeah. Yeah, I was actually surprised really. When I first went down there I thought they would have been all in a hurry because, like I say, they need patience really*”. This comment speaks to the importance of time and patience which participants identified as key to providing an environment where they felt recognized as individuals and supported a positive interaction and the potential for development of the therapeutic relationship.

Mitchell identified that the time the nurse spent was reflective of patience:

*Because he was right on what I needed – like right on top of it. He didn’t look down on me, you know what I mean. Maybe because again he’s used to dealing with homeless people, but still you get a lot of people in there that are demanding and whatnot so you’ve got to give them the patience. And I know that he had patience.*

Of particular importance to participants was a positive interaction that would lead to establishing and maintaining a therapeutic relationship with nurses. Cody described the interactions with the community nurse as such, “*I didn’t feel rushed. She asked me to sit. And many times you feel like you’re almost bothering them*”. The time that community nurses spent with participants of this study validated the individuals need to receive recognition of their societal status outside of being homeless. It is this identified time, lack of rushing and “patience”, that participants valued and such validation was held with high regard by participants and important to a positive interactions with nurses.

The outcome of the additional time nurses spent interacting or what was also described as “patience”, resulted in participants identifying nurses as making every effort

to present a non-biased point of view. In contrast, they identified some nurses and other health care providers as having an agenda that was neither focussed on their needs nor collaborative. Respondents recognized that the length of time that all providers were able to allocate to interactions with them affected the quality of interaction and proved beneficial in establishing a rapport. Alternatively, they identified that rushed interactions or not listening to participants resulted in misunderstandings and feelings of lack of worth:

*Well just either they don't listen or they take what you're saying the wrong way type thing. So it's more of rigmarole. Like it should be a ten minute thing and it ends up being an hour, or sometimes the information is wrong.*

Having nurses available for the time the respondents desired, was identified as important in allowing them to open up and disclose personal stories, which enabled providers to understand the meaning behind each story. Donald described the experience of feeling rushed when seeking care from physicians:

*Tome he was more or less like rushing you through. He wanted to give you ... like I call them pills. When I run out, come back and get more. To me he wasn't really taking his time to figure out.*

The ability to take time to truly listen and discuss concerns during interactions opened up the opportunity to build a better relationship that engaged participants:

*Well she was nice. She was asking me do I need this or do I need some more bandages or how's your feet. She was nice. She was sincere about her job. With that particular nurse, she was very informative. I was almost more trying to get out of there and she was like still going on. She was very informative and I mean I didn't really care about the anxiety at that time, but I felt for not getting any medication or anything, that was like the best interaction that I could have experienced at that point.*

Therapeutic relationships are goal-oriented and participants were quick to identify that nurses were more likely to take into account the individuals goals and priorities. *“it was great because she was nice, she listened, and then she give her what she thought about it as well, like her advice, and she also hooked me up with an appointment with the doctor”*. Cody recounted a positive interaction where *“I didn’t feel rushed. She asked me to sit. And many times you feel like you’re almost bothering them”*.

Matthew was clear during his interview that he had much more difficulty accessing the care of a physician due to availability. He felt that nurses took more time which made him feel hopeful and welcome. Alternatively, he recounted that some of his interactions with nursing were negative as the nurse was dismissive and not paying attention to him which was shown through *“texting her boyfriend”*, or *“she was focused on her phone”*.

Cody found that the time that nurses were able to devote to listening to him helped establish a “rapport”. That rapport made is easier for him to disclose his concerns and worked to minimize his anxiety. Cody felt that every shelter in the city needed a *“psychologist or mental health nurse”*.

## Summary

In summary, participants found it important to establish their credibility with nurses and health care providers when accessing care in the community. They did this through describing the various roles that they held outside of being a homeless individual. Participants perceived that health care providers treated them significantly differently than 'housed' individuals. Because they were experiencing homelessness, there was an assumption that they were somehow responsible for their circumstances. As described by participants, it was assumed by providers that they were 'addicts', 'alcoholics' or 'criminals'. These assumptions were identified as having had a significant impact on how and whether relationships were formed with nurses in the community. More over these negative stereotypes not only impacted on their options for care but on the likelihood that individuals experiencing homelessness would seek care.

Some nurses were reported to be empathetic and understanding of their particular issues as evidenced by their listening and taking extra time with individuals experiencing homelessness to truly understand their needs. By taking the time to listen they created space that allowed for respect and rapport to grow. Participants noted that they were able to evaluate when nurses weren't listening or paying attention. This was indicated through subtle cues such as distraction to their cell phone, poor eye contact or not truly hearing the dialogue. As well, respondents indicated that they found some nurses in the community more accepting, understanding and empathetic to their circumstances which improved the quality of the interaction and uniquely positioned nurses to impact their health care experiences and outcomes.

## Chapter 5: Discussion

This chapter is divided into three sections. I begin with a discussion of the strengths and limitations of the research, followed by a discussion of the findings in relationship to current research. Finally, the last part of this chapter explores the implications for the findings in relationship to practice, policy, service planning and research.

The purpose of this qualitative research study was to provide an in-depth perspective from key informants who have direct knowledge and experience with the phenomena of being homeless and accessing health care through a nurse in the community setting. Purposive sampling was used and the sample was limited to adults who had experienced homelessness while seeking health care in the downtown Toronto core. A requirement of qualitative data is the expectation to provide a close-up, detailed and contextualized picture of the experiences and perceptions of the subjects (Kirkevold & Bergland, 2007). In the development of the inclusion criteria, the focus on adults who had experienced homelessness while seeking health care was to allow the perspectives of those who may not have a voice nor be captured in more routine research of populations experiencing homelessness. While it was not the intention of this researcher to interview only men, no woman responded to the posters inviting them to share their experiences. While it cannot be definitively known why no woman responded, I would suggest that the choice of agency, while offering services to both men and women, very few women attend anything other than meals. It is likely that they may not have seen the invitation to participate.

Including vulnerable participants in qualitative research is important to bring forth their perspectives, even if this poses challenges. The inclusion of these vulnerable participants in this qualitative study required that the researcher address several issues related to sampling and data while ensuring that the participant interviews were reflective of the phenomenon and research question.

The findings in this research are subject to several limitations. While the invitation to participate was posted in an area frequented by both men and women, only men responded to the poster. Second, while this data meets the sampling criteria for key informants who have experience with the topic, it is a relatively small self selected group of men who met the inclusion criteria. It does not account for individuals experiencing homelessness who do not attend the GSC. In addition, certain venues attended by individuals experiencing homelessness who have experience seeking health care might be underrepresented. Third, because the interview was conducted by an interviewer, certain behaviours might have been underreported or over reported. For example, participants might have underreported socially undesirable behaviours (e.g., showing up under the influence of substance) or might have over reported socially desirable behaviours (e.g., not swearing and respectful dialogue when approaching providers). Finally, there is no certainty when participants referenced nurses that the individuals that they were referring to were confirmed nurses. Those that work in environments and services focussed on homeless individuals may not just be nurses but also social service workers or counsellors. It could be assumed that a participant may have mistaken a social service worker as a nurse and vice versa.

The data collected and the experiences described are consistent with other current research. Trevena, Simpson & Nutbeam (2003) found that one quarter (25%) of the respondents failed to return for follow-up care based on attitudinal barriers identified such as lack of trust. The ability to create a welcoming environment and a trusting relationship were previously identified as crucial as study participants often linked unwelcoming experiences with stigma of homelessness (Pauly, 2012; Wen, Hudak & Hwang, 2007). This finding is consistent with respondents' views that development of relationships requires recognition of who they are beyond 'being homeless.' For example, establishing of rapport that translated into the creation of an environment in which respondents felt safe to access health care was supported a positive interaction. Establishing rapport was accomplished through a variety of ways and participants reported that is happened most often through active listening, acknowledgement of their previous strengths or accomplishments and a non-judgemental or un-biased reaction regarding individual's circumstances. Wen, Hudak & Hwang (2007), encourage all health care providers to approach individuals experiencing homelessness with openness and to guard against stereotyping. As described by participants in this research, nurses' ability to create a safe environment through displaying respect and providing additional time in which to engage individuals experiencing homelessness was well regarded. This finding, particular to nursing, is not particularly well researched or articulated in current literature.

It is imperative with interpretive description methodology, that the results are framed and contextualized within the specific study, knowing that the results are connected to the time and the situation within which they were generated (Thorne, 2008).

These limitations reinforce the understanding that the research is not necessarily representative of all those attempting to build a relationship with a health care provider or a nurse, but the context, and to geography (situatedness). This research was conducted in an urban centre and research participants in a rural setting may have a different experience.

What is surprising and certainly an area for further research is the clearly articulated response from participants that some nurses were uniquely positioned to create a welcoming space where individuals experiencing homelessness could access health care. As nurses are often the first point of contact into health care, a negative interaction where individuals don't feel welcome is likely to minimize the chance that they would return for further care. Participants experiencing homelessness perceived that nursing has an important role to play in minimizing the negative effects experienced by participants related to the stigmatization experienced when seeking health care. Additionally, participants clearly identified the role that nurses have in creating welcoming interactions that are free of blaming is important in both the education of nurses and successfully engaging with individuals experiencing homelessness in any environment.

## **Study Implications**

Accessible and engaging interactions that meet the expectation and needs of the client experiencing homelessness and promote a health care relationship with a community nurse is urgently needed to meet the complex needs of this population. Nurses are uniquely positioned to make effective use of existing resources and establish collaborative interventions. This research began to identify what is necessary to successfully engage this vulnerable group in appositive interactions that can lead to an ongoing relationship that informs health care practice. These populations of individuals with their significant impairment and unmet needs are often those who do not regularly seek health care. Knowledge informed by the perspectives of individuals who have experienced homelessness is key to understanding how to welcome them in health care.

The positive collaborative aspects of clients in their health care are important to understand. Based on this research community nurses working with individuals experiencing homelessness reminds us to approach all clients or patients as individuals not 'homeless people'. Nurses would benefit from understanding the importance of recognizing the need to approach individuals experiencing homelessness with an awareness of the effect of negative stereotypes and allowing time for individuals to open up. By creating a welcoming space, individuals are more likely to engage with nurses and establish a relationship that is open and collaborative with clients identified goals. Providing additional time as needed clearly assists clients in establishing a rapport that supports individuals experiencing homelessness to feel respected and heard.

Additionally, the context in which care is experienced by way of examining relevant policies of the settings in which care is provided is an area for future inquiry.

Identifying the key components of a positive interaction and the subsequent relationships with the community nurse from the perspective of the client experiencing homelessness may be helpful in broadening and strengthening the pathways to enduring comprehensive health care for this challenging client group. Based on this research, organizations providing health care in the community setting to individuals experiencing homelessness may reflect on the core elements of developing relationships and what supports nurses and others to do this. The next step would be to look for both organizational process and procedure that has a negative impact on the ability of a community nurse to establishing a rapport that is both genuine and collaborative with individuals experiencing homelessness. Additionally, organizations can reflect the identified needs of those experiencing homelessness to inform both the hiring and training of nurses working with individuals experiencing homelessness.

This research further highlights the importance of the community nursing role in improving engagement with individuals experiencing homelessness. Using the role of the nurse as a framework, recommendation and suggestions for nursing education are to increase awareness of the unique needs of individuals experiencing homelessness for learners and novice nurses. The importance of knowledge related to the experience of homelessness, mental illness and substance use to counter societal stigma and associations with criminalization can only improve the perceptions of individuals experiencing homelessness when seeking care. Nursing has a long and proud history of responding to the needs of vulnerable and under-served populations and as health care continues to shift from institutions to the community, there is a unique opportunity to

build collaborative interactions with clients experiencing homelessness that will result in better engagement and ultimately a much more therapeutic relationship.

It is imperative to understand not only the experience of individuals who are homeless seeking health care but also investigate the perceptions of nurses working with individuals experiencing homelessness. Some individuals experiencing homelessness present with significant burdens of substance use disorders and mental health conditions coupled with complex physical health concerns and present a unique challenge to nurses. Additional research to understand the experience of nurses working with individuals experiencing homelessness would refine nursing education and specialized training. The application of these research findings have the opportunity to improve the experience of individuals who are homeless seeking health care in the community as well as better prepare nurses to work with this stigmatized population.

## References

- Abrams, S. (2008). The Best of Public Health Nursing, Circa 1941, *Public Health Nursing*, 25(3), 285–291.
- Acosta O. & Toro P.A. (2000). Let's ask the homeless people themselves: A needs assessment based on a probability sample of adults. *American Journal of Community Psychology*, 28(3), 343–361.
- Appleton, J.V., & King, L. (2002). Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health services research. *Journal of Advanced Nursing*, 40(6), 641–648.
- Aday, L. (1993). *At risk in America: The health and health care needs of vulnerable populations in the United States*. San Francisco: Jossey-Bass Publishers.
- Atkinson J. (2000) *Nursing homeless men: A study of proactive intervention*. London: Whurr.
- Barkin, S., Balkrishnan, R., Manuel, J., Andersen, R., & Gelberg, L. (2003). Health care utilization among homeless adolescents and young adults. *Journal of Adolescent Health*, 32(4), 253-256.
- Barry, P., Ensign, J., & Lippek, S. (2002). Embracing street culture: Fitting health care into the lives of street youth. *Journal of Transcultural Nursing*, 13(2), 145-152.
- Bonin, J., Fournier, L., Blais, R. (2007). Predictors of mental health service utilization by people using resources for the homeless. *Psychiatric Services*, 58, 936-941.
- Bowers, M., Swan, J., Koehler & William, F. (1994). What attributes determine quality and satisfaction with health care delivery? *Health Care Management Review*, 19(4), 49-55.
- Browne, G., Roberts, J., Byrne, C., Gafni, A., Weir, R. & Majumdar, B. (2009). The costs and effects of addressing the needs of vulnerable populations: Results of 10 years of research. *Canadian Journal of Nursing Research*, 41(1) 193-203.
- Buck, D., Rochon, D., Davidson, H., & McCurdy, S. (2004). Involving homeless persons in the leadership of a health care organization. *Qualitative Health Research*, 14(4), 513-525.
- Buhler-Wilkerson, K. (1993). Bringing care to the people: Lillian Wald's legacy to public health nursing. *American Journal of Public Health*, 83(12), 1778-1786.

- Butters, J., & Erickson, P. (2003). Meeting the health care needs of female crack users: A Canadian example. *Women & Health, 37*(3), 1-17.
- Canadian Institute for Health Information (2007). Improving the health of Canadians: Mental health and homelessness. Retrieved from [http://secure.cihi.ca/cihiweb/products/mental\\_health\\_report\\_aug22\\_2007\\_e.pdf](http://secure.cihi.ca/cihiweb/products/mental_health_report_aug22_2007_e.pdf)
- Canadian Nurses Association Position Paper. Social determinants of health: A summary of the issues. Retrieved from <http://www.hrsdc.gc.ca/eng/homelessness/index.shtml>
- Cheung, A. M., & Hwang, S. (2004). Risk of death among homeless women: A cohort study and review of the literature. *Canadian Medical Association Journal, 170*(8), 1243–1247.
- Corley, M., & Goren, S. (1998). The dark side of nursing: Impact of stigmatizing responses on patients. *Scholarly Inquiry for Nursing Practice, 12*(2), 99–118.
- Crane, M., & Warnes, A. (2001). Primary health care services for single homeless people: defects and opportunities. *Family Practice, 18*, 272–276.
- Craven, M.A., & Bland, R. (2006). Better practices in collaborative mental health care: An analysis of the evidence base. *Canadian Journal of Psychiatry, 51*(Supplement 1), 7S-72S.
- Daiski, I. (2005). The health bus: Healthcare for marginalized populations. Policy politics. *Nursing Practice, 6*, 30-38.
- Daiski, I. (2007). Perspectives of homeless people on their health and health needs priorities. *Journal of Advanced Nursing, 58*(3), 273–281.
- Dennis, D., Buckner, J., Lipton, F., & Levine, L. (1991). A decade of research and services for homeless mentally ill persons: Where do we stand? *American Psychologist, 46*, 1129-1138.
- Denzin, N., & Lincoln, Y. (1998). Introduction: Entering the field of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (1-34). Thousand Oaks, California: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (2000). The discipline and practice of qualitative research. *Handbook of qualitative research, 2*, 1-28.
- de Witt, L., & Ploeg, J. (2006). Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing, 55*(2), 215-29.

- Dock, L., & Nutting, A. (1912). A history of nursing from the earliest times to the present day, with special reference to the work of the past thirty years (volume four). New York, NY: G.P. Putnam's Sons
- Durbin, J., Goering, P., Streiner, D.L., & Pink, G. (2006). Does systems integration Affect continuity of mental health care? *Administration and Policy in Mental Health*, 33, 705-717.
- Ensign, J., & Gittelsohn, J. (1998). Health and access to care: Perspectives of homeless youth in Baltimore City, USA. *Social Science & Medicine*, 47(12), 2087-2099.
- Ensign, J., & Planke, A. (2002). Barriers and bridges to care: Voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing*, 37(2), 166-172.
- European Typology on Homelessness and Housing Exclusion (2005). European Federation of National Associations Working with the Homeless AISBL. Retrieved from <http://www.feantsa.org/code/en/pg.asp>
- Falk-Rafael, A. (2005). Speaking truth to power: Nursing's legacy and moral imperative. *Advances in Nursing Science*, 28(3), 212-223.
- Farrell, S., Reissing, E., & Aubry, T., (2002). Street needs assessment: An investigation of the characteristics and service needs of persons who are homeless and not currently using emergency shelters in Ottawa. Centre for Research on Community Services, University of Ottawa.
- Farrell, S., & Reissing, E. (2004). Picking up the challenge: Developing a methodology to enumerate and assess the needs of the street homeless population. *Evaluation Review*, 28, 1-12.
- Farrell, S., Huff, J., MacDonald, S., Middlebro, A., & Walsh, S. (2005). Taking it to the street: A psychiatric outreach service in Canada. *Community Mental Health Journal*, 41(6), 737-746.
- Forchuk, C., & Reynolds, W. (2001). Client's reflections on relationships with nurses: Comparisons from Canada and Scotland. *Journal of Psychiatric & Mental Health Nursing*, 8, 45-51.
- Fossey, E., Harvey, C., Mcdermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research, *Australian and New Zealand Journal of Psychiatry*, 36(6), 717-732.

- Frankish, C.J., Hwang, S., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health*, 96 (Supplement 2), 23-29.
- Geber, G. (1997). Barriers to health care for street youth. *Journal of Adolescent Health*, 21(5), 287-290.
- Gelberg, L., Linn, L., Usatine, R., & Smith, M. (1990). Health, homelessness, and poverty: A study of clinic users. *Archives of Internal Medicine*, 150(11), 2325-2330.
- Gelberg, L., Browner, C., Lejano, E., & Arangua, L. (2004). Access to women's health care: A qualitative study of barriers perceived by homeless women. *Women & Health*, 40(2), 87-100.
- Government of Canada (2008). Defining and Enumerating Homelessness in Canada.
- Graham, J., Denoual, I., & Cairns, D. (2005). Happy with your care? *Journal of Psychiatric and Mental Health Nursing*, 12,173–178.
- Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 105–112.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and Emerging influences. *The Sage Handbook of Qualitative Research* (3rd ed.)(191-215). Thousand Oaks, CA: Sage.
- Hardill, K. (2007). From the grey nuns to the streets: A critical history of outreach nursing in Canada. *Public Health Nursing*, 24, 91–97.
- Hilton, B., Thompson, R., & Moore-Dempsey, L. (2009) Evaluation of the AIDS Prevention street nurse program: One step at a time, *Canadian Journal of Nursing Research*, 41(1), 238-258.
- Human Resources and Skills Development Canada (2009). Homelessness Partnering Strategy.
- Hunt, M. (2009) Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research*, 19, 1284-1292.
- Hwang, S.W. (2000). Mortality among men using homeless shelters in Toronto, Ontario. *Journal of the American Medical Association*, 283, 2152-2157.

- Hwang, S.W. (2001). Homelessness and health. *Canadian Medical Association Journal*, 164, 229-233.
- Jezewski, M. (1995). Staying connected: The core of facilitating health care for homeless persons. *Public Health Nursing*, 12 (3), 203–210.
- Johansson, P., Oléni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care: A literature study. *Scandinavian Journal of Caring Sciences*, 16(4), 337–344.
- Kidder, D., Wolitski, R., Campsmith, M., & Nakamura, G., (2007). Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. *American Journal of Public Health*, 97(12), 2238-2245.
- Koch, T. (2006). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, 53(1), 91-100.
- Kushel, M., Vittinghoff, E., & Haas, J. (2001). Factors associated with the health care utilization of homeless persons. *Journal of American Medical Association*, 285, 200-206.
- Kushel, M., Perry, S., Bangsberg, D., Clark, R., & Moss, R. (2002). Emergency department use among the homeless and marginally housed: Results from a community-based study. *American Journal of Public Health*, 92(5), 778-784.
- Lam, J., & Rosenheck, R. (1999). Street outreach for homeless persons with mental illness: Is it effective? *Medical Care*, 37(9), 894-907.
- Lewis, J., Andersen, R., & Gelberg, L., (2003). Health care for homeless women. *Journal of General Internal Medicine*, 18(11), 921 – 928.
- Lim, W., Andersen, R., Leake, B., Cunningham, W., & Gelberg, M. (2002). How accessible is medical care for homeless women? *Medical Care*, 40(6), 510–520.
- Mackey, M. (2007). Evaluation of qualitative research. In P. L. Munhall (Ed.), *Nursing Research: A qualitative perspective* (4th ed)(555). Sudbury, MA: Jones and Bartlett Publishers.
- McAdam, M., & Wright, N. (2005). A review of the literature considering the role of mental health nurses in assertive outreach. *Journal of Psychiatric and Mental Health Nursing*, 12, 648–660.
- McCabe, S., Macnee, C., & Anderson, M. (2001). Homeless patients' experience of satisfaction with care. *Archives of Psychiatric Nursing*, 15(2), 78-85.

- McGuire, J. & Rosenheck, R. (2004). Criminal history as a prognostic indicator in the treatment of homeless people with severe mental illness. *Psychiatric Services*, 55, 42-48.
- Minghella E., Gauntlett, N., & Ford, R. (2002). Assertive outreach: Does it reach expectations? *Journal of Mental Health*, 11(1), 27-42.
- Morrell-Bellai, T., Goering, P., & Boydell, K. (2000) Becoming and remaining homeless: A qualitative investigation. *Issues in Mental Health Nursing*, 32, 581-604.
- Morse, J. (2004). Emerging from the data: Cognitive processes of analysis in qualitative inquiry. In J.M. Morse (Ed). *Critical issues in qualitative research methods* (23-43). Thousand Oaks, CA: Sage.
- Morse, G., Calsyn, R., Klinkenberg, T., Helminiak, T., Wolff, N., Drake, R., Yonker, R., Lama, G., Lemming, M., & McCudden, S. (2006). Treating homeless clients with severe mental illness and substance use disorders: Costs and outcomes. *Community Mental Health Journal*, 42(4), 377-404.
- Moyle, W. (2003). Nurse-patient relationship: A dichotomy of expectations. *International Journal of Mental Health Nursing*, 12, 103-109.
- Murphy, F. (2005). Preparing for the field: Developing competence as an ethnographic field worker. *Nurse Researcher*, 1, 52-60.
- Myers, S. (2003). Relational healing: To be understood and to understand. *Journal of Humanistic Psychology*, 43(1), 86-104.
- National Health Care for the Homeless Council Homelessness and Health (2010). Policy Statements. Retrieved from <http://www.nhchc.org/Advocacy/PolicyPapers/2010/Health%202010%20final.pdf>
- Ng, A., & McQuiston, H. (2004). Outreach to the homeless: Craft, science, and future implications. *Journal Psychiatric Practice*, 10, 95-105.
- O'Connell J. (2004). Dying in the shadows: The challenge of providing health care for homeless people. *Canadian Medical Association Journal*. 170(8), 1251-1252.
- O'Grady, B., & Gaetz, S. (2004). Homelessness, gender and subsistence: The case of Toronto Street Youth. *Journal of Youth Studies*, 7(4), 397-416.
- Oliffe, J. (2005). Why not ethnography? *Urologic Nursing*, 25(5), 395-399.
- Parkinson, R. (2009). Nurses attitudes towards people who are homeless: A literature review. *Diversity in Health and Care*, 6(4), 227-240.

- Pauly, B. (2008). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, 195-204.
- Pauly, B. (in press). Close to the street: Nursing care for people marginalized by homelessness and substance use. In M. Younger, S. Hwang (Eds), *Homelessness and Health in Canada*.
- Peplau, H. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly*, 10(4), 162-167.
- Polit, D. F., & Beck, C.T., (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (8th Ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Plumb, J. (2000). Homelessness: Reducing health disparities. *Canadian Medical Association Journal*, 163(2), 172-173.
- Raphael, D. (2007). Interactions with the health and service sector. Poverty and policy in Canada: Implications for health and quality of life (173-203). Toronto, ON: Canadian Scholars' Press.
- Robertson, M., & Cousineau, M. (1986). Health status and access to health services among the urban homeless. *American Journal of Public Health*, 76(5), 561-568.
- Rosenheck, R. (2000). Cost-effectiveness of services for mentally ill homeless people: The application of research to policy and practice, *American Journal of Psychiatry*, 157, 1563-1570.
- Rosenheck, R.A., Resnick, S., & Morrissay, J. (2003). Closing service system gaps for homeless clients with a dual diagnosis: Integrated teams and interagency cooperation. *The Journal of Mental Health Policy and Economics*, 6, 77-87.
- Sandelowski, M. (2002). Reembodying qualitative inquiry. *Qualitative Health Research*, 12(1), 104-115.
- Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship*, 34, 213-219.
- Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative research. *Qualitative Health Research*, 13(7), 905-923.

- Sandelowski, M. (2007). Sample size in qualitative research. *Research in Nursing & Health, 18*(2), 179-183.
- Social determinants of health: The solid facts (2003). World Health Organization.  
Retrieved from  
[http://www.euro.who.int/data/assets/pdf\\_file/0005/98438/e81384.pdf](http://www.euro.who.int/data/assets/pdf_file/0005/98438/e81384.pdf)
- Springer, S. (2000). Homelessness: A proposal for a global definition and classification. *Habitat International, 24*(4), 475-484.
- Stevens, P. (1993). Marginalized women's access to health care: A feminist narrative analysis. *Advances in Nursing Science, 16*(2), 39-56.
- Stuart, H., & Arboreza Florez, J. (2000). Homeless shelter users in the post deinstitutionalization era. *Canadian Journal of Psychiatry, 245*(1), 55-62.
- Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A non-categorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 2*, 169-177.
- Thorne, S. (2000). Data analysis in qualitative research. *Evidence Based Nursing, 3*, 68-70.
- Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1).
- Thorne, S. (2008). *Interpretive Description*. Walnut Creek, CA: Left Coast Press, Inc.
- Trevena, L.J., Nutbeam D., & Simpson J.S. (2001). Asking the right questions of Disadvantaged and homeless communities: The role of housing, patterns of illness. *New Zealand Journal of Public Health, 25*(4), 298-304.
- Trevena, L. J., Simpson, J. M., & Nutbeam, D. (2003). Soup kitchen consumer perspectives on the quality and frequency of health service interactions. *International Journal Qualitative Health Care, 15*, 495-500.
- Turnbull, J., Muckle, W., & Masters, C. (2007). Homelessness and health. *Canadian Medical Association Journal, 177*(9), 1065-1066.
- Ugarriza, D., & Fallon, T. (1994). Nurses' attitudes toward homeless women: A barrier to change. *Nursing Outlook, 42*(1), 26-29.
- Wei Lim, Y., Andersen, R., Leake, B., Cunningham, W., & Gelberg, L. (2002). How accessible is medical care for homeless women? *Medical Care, 40*(6), 510-520.

- Wen, C., Hudak, P., & Hwang, S. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in healthcare interactions. *Society of General Internal Medicine*, 22, 1011-1017.
- Wharne, S. (2005). Assertive outreach teams: Their roles and functions. *Journal of Interprofessional Care*, 19(4), 326-337.
- Wilson, D., & Neville, S. (2008). Culturally safe research with vulnerable populations. *Contemporary Nurse*, 33(1), 69-79.
- Wright C., Burns T., James P., Billings J., Johnson S., Muijen M., Priebe S., Rylie I., Watts J., & White I. (2003). Assertive outreach teams in London: Models of operation: Pan-London assertive outreach study, part 1. *British Journal of Psychiatry*, 183, 132-138.
- Zrinyi, M., & Balogh, Z. (2004). Student nurse attitudes towards homeless clients: A challenge for education and practice. *Nursing Ethics*, 11(4), 334-348.

## Appendix A

### Interview Guide

The interview will be started by providing the following preface to the participant:

"I want you to think about your experiences with health care in the community (for example, The Health Bus, The Good Shepherd or Maxwell Meighen), not experiences you may have had at a hospital (ER or inpatient)". "Please indicate your age and gender for demographic purposes".

- 1) Tell me about a health care experience or interaction you have had with a nurse who works in the community.
  - How did you come to receive care in a community setting?
  - Were you referred by someone or did you seek care on your own?
  - What was the setting or location of the interaction?
  - What was the purpose of the interaction?
- 2) What was positive about that specific experience or interaction with a nurse in the community setting?
  - What do you think worked well?
  - Were your needs met?
  - Did this person identify themselves to you as a nurse and identify what services they could provide?
- 3) What was negative, unpleasant or not good about that specific experience or interaction with a nurse in the community setting?
  - What did not work well?
  - Were your needs met?

- 4) Tell me what could have been changed to make this a positive experience? What is different in your interactions or experiences with community nurses as opposed to other health care professionals involved in care in the community?
  - What other health care professionals have you interacted with or come in contact with in the community setting?
  - What was the purpose of these interactions with other health care providers?
  - Can you tell me if your needs were met by these other health care providers?
  - Would you describe these interactions with other health care providers overall as negative or positive?
  - Why would you describe them as such?
- 5) Please identify both positive and negative elements in the community health care environment that you have experienced.
  - Where do you like to receive care?
  - Does location make a difference?
  - What kind of health care services and where do you usually seek care?
  - What hours do you prefer?
  - If you were planning a community health setting, what elements are essential?
- 6) Do you have an ongoing relationship with a nurse in the community and what has helped to foster or sustain that relationship?
  - To what extent have these interactions or this relationship affected your care and access to treatment?



## Appendix C

### Information Sheets and Consent to Participate in a Research Study

**Study Title:**

**Homeless Clients Perspective of Health Care Experiences**

**Principal Investigator:**

Lisa Crawley Beames, RN, BSN

Clinical Leader/Manager, Department of Family and Community Medicine,  
St. Michael's Hospital, 30 Bond Street, Toronto, Ontario

Student, Department of Graduate Studies, University of Victoria, Victoria, British  
Columbia

Telephone: 416-605-6581 (Monday to Friday, 9 am – 5 pm)

**Faculty Supervisor:**

Bernadette Pauly, RN, PhD

Associate Professor, University of Victoria, School of Nursing, and  
Scientist, Centre For Addictions Research of British Columbia (CARBC)

Telephone: 250-472-5915 (Monday to Friday, 9 am – 5 pm PST)

Lisa Crawley Beames, principal investigator, is conducting this study as part of her education to complete a thesis for a Master's degree in Nursing, thus she also has an academic interest in completing this study.

---

**Introduction:**

You are being asked to consider taking part in a research study. Before agreeing to take part in this study, it is important that you read the information in this research consent form. It includes details we think you need to know in order to decide if you wish to take part in the study. If you have any questions, please ask the principal investigator of the study. You should not sign this form until you are sure you understand the information.

All research is voluntary. You may also wish to discuss the study with a family member or close friend.

**Background Information:**

People who are homeless often face many barriers in accessing health care services. For example, it may be difficult to access health care services because a person does not have a health card or feels uncomfortable and/or not respected in previous health care visits. In addition, people may be caught up trying to deal with other priorities like housing appointments or the meal time at a shelter and miss their health care appointments. There are a few studies that suggest that the development of a relationship with a health care provider can help to overcome these barriers. Nurses in the community are one source of health care but there is little documented knowledge about relationships between nurses and people experiencing homelessness. To address this gap, this study will explore the positive features in healthcare relationships that helps to build a relationship with a nurse and maintain access to healthcare. This will be explored from the perspective of homeless adults. The research will focus on exploring what components (parts) of the healthcare relationship facilitate (help), and what components hinder (interfere with) the relationship.

**Purpose of the Research Study:**

The purpose of this research study is to gain an understanding of the factors that promote or constrain (limit) the development and maintenance of a health care relationship with a nurse in a community setting.

Identified research study objectives include exploring:

- a) Factors that foster positive health care relationships with nurses in the community setting.
- b) Barriers that limit the development and maintenance of health care relationships with a nurse in the community setting.
- c) Environmental or organizational factors that support the development and maintenance of a health care relationship between nurses and homeless clients in the community setting.

**Description of the Research Study:**

You are being asked to consider taking part in this research study because you have experienced or are experiencing homelessness. Participation in this study will include a 60-minute interview which will be audio-recorded. The audio-recording is needed to ensure that we do not miss any of the important points that will be brought up during the discussion. This interview will be conducted one-on-one with the principal investigator in person at a time that is convenient for you. Basic demographic information such as age and gender will also be collected. During the interview, you will be asked questions about your experiences with health care in the community, including health care you received from community nurses. You are free to speak openly in the interview, and you also have the option of not answering any questions in the interview that you do not wish to answer. The audio-recording of the interview will be transcribed (typed out word for word). Notes will also be taken by the interviewer. The content of the interview will be considered confidential. Approximately 15 adults from the downtown Toronto core, who have experienced or are experiencing homelessness, will participate in this study.

**Potential Harms (Injury, Discomforts or Inconvenience):**

There is very minimal risk to participating in this study. Participation may involve some inconvenience related to the scheduling of the interview. One potential harm is that during the interview, you may find that recounting your experience with health care providers brings up negative or unpleasant feelings or emotions related to those experiences. If you feel uncomfortable about answering any of the interview questions, you can choose not to respond. The principal investigator will work with you to help connect you with any appropriate resources to help you with those feelings, if required.

**Potential Benefits:**

There are no direct benefits to you for your participation in this study. The findings from this research may be helpful in the development of future health care initiatives focussed on homeless individuals, including with respect to nursing care.

**Privacy and Confidentiality:**

All the persons associated with this study, including the principal investigator, are committed to respecting your privacy. No other persons will have access to your identifying information without your consent, unless required by law. Your voice when

audio-recorded is considered to be identifying personal information. Any personal information collected about you will be 'de-identified' by replacing your personal information with a 'subject code number'. The principal investigator is in control of the study code key which is needed to connect your personal information to you. Data collected/related to you (e.g., notes, transcript of audio-recording) will be identified using this code. Any personal information collected about you (including your name, contact numbers) will be stored separately from the study data collected and will be accessible only to authorized study personnel. Confidentiality will be respected and no information that discloses your identity will be released or published without your consent unless required by law. The audio-recordings and study records will be securely stored and handled at all times. You are requested not to state your name or the names of anyone else or any institutions during the audio-recording. However if this does happen, you should know that the audio-recorded interview will be transcribed in such a way that any potentially identifying information is removed or coded. A trained transcriptionist will transcribe the audio-recorded interview in a secure manner. Only authorized study personnel, such as the principal investigator and the transcriptionist will have access to the audio-recording of the interviews.

The audio-recording of the interviews will be securely destroyed when the information has been transcribed and verified to be accurate. Any other personal information collected will also be securely destroyed by or at study completion. Any links to your identifying personal information will thus be broken at that point. All other study information, including the notes and transcription will be securely stored until the data have been analyzed and the results of the study have been published, and then this information will be securely destroyed. We will keep all the study information and data either in paper forms or electronic files securely stored at St. Michael's Hospital. All study data will be securely disposed of no longer than 5 years after the completion of the study.

It is important to understand that despite these protections being in place, there continues to be the risk of unintentional release of information. The principal investigator will protect your records and keep all the information in the study file confidential to the greatest extent possible. The chance that this information will be accidentally released is small.

By signing this consent form, you are authorizing access to your identifying personal information collected to the principal investigator and authorized study personnel and also to the St. Michael's Hospital Research Ethics Board, for the purpose of monitoring the study, without violating your confidentiality to the extent permitted by applicable laws and regulations.

Federal and Provincial Data Protection laws and regulations protect your personal information. They also give you the right to control the use of your personal information and require your written permission for the personal information to be collected, used, or disclosed for the purposes of this study, as described in this consent form. You have the right to review and copy your personal information collected in this study, and the right to request corrections to any information inaccurately recorded.

Please be advised that if the principal investigator judges you to be at risk to your safety or to the safety of others, then steps will be taken to help ensure your safety or the safety of others, including dissolving confidentiality as necessary, and enlisting appropriate medical assistance, such as your family doctor, or appropriate mental healthcare staff.

In no way does signing this consent form waive your legal rights nor release the principal investigator or involved institutions from their legal and professional responsibilities.

### **Study Results:**

The principal investigator will publish study findings (results) in academic journals and may also present study findings at medical or scientific meetings. The study results may also be presented at shelters or drop-ins in the downtown Toronto core. Lisa Crawley Beames, principal investigator, intends to present and publish this study as part of her Master's thesis. Study findings will be presented/published using reference to general themes and quotes. Any identifying information will be removed (i.e., will not be presented/published).

If you are interested in obtaining information about study results or attending a presentation of the study results, please contact Lisa Crawley Beames, principal investigator.

### **Potential Costs and Compensation:**

Participation in this study will not result in any costs charged to you. You will be compensated \$20 for your time and inconvenience in taking part in the interview for this study. If you agree to participate in this study, this form of compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research

participants. If you would not participate if the compensation was not offered, then you should decline

**Participation and Withdrawal:**

Participation in any research study is voluntary. If you choose not to participate, this will not have any negative impact or consequences. If you decide to participate in this study you can change your mind without giving a reason, and you may withdraw from the study at any time without any negative effect. Your decision to participate or not to participate will not affect the services you receive from The Good Shepherd. The information you provide will not be shared with staff at The Good Shepherd.

The principal investigator may also withdraw you from the study at any time, if, for example, it would not be in your best interest to continue in the study. If you withdraw or are withdrawn from this study, information gathered from you up to that point will be kept and used in the study, unless you tell the principal investigator that you do not want it to be used, and then it will be removed.

**Study Contact:**

If you have any questions about the study, please contact Lisa Crawley Beames (Principal Investigator) by telephone at 416-605-6581, or by email at [beamesl@smh.ca](mailto:beamesl@smh.ca). You may also contact Dr. Bernadette Pauly, Faculty Supervisor, by telephone at 250-472-5915 (PST) during business hours if you have any questions about supervision of the study.

**Research Ethics Board Contact:**

If you have any questions regarding your rights as a research participant, you may contact Dr. Bob Hyland, Chair, Research Ethics Board, St. Michael's Hospital, at 416-864-6060, ext. 2557, during business hours.

You may also contact the Human Research Ethics Office at the University of Victoria 250-472-4545 (PST) or [ethics@uvic.ca](mailto:ethics@uvic.ca) if you have any questions regarding your rights as a research participant.

## Appendix D

### **Telephone Script and Eligibility Confirmation for potential participants in response to telephone call to the researcher**

My name is Lisa Crawley Beames and I am conducting this study as part of my education to complete a thesis for a Master's degree in Nursing. I am the Principal Investigator and the title of the study is Homeless *Clients Perspective of Health Care Experiences*. This study has received ethics approval from St. Michael's and the University of Victoria.

#### **I would like to explain the background and purpose of the research study:**

People who are homeless often face many barriers in accessing health care services. For example, it may be difficult to access health care services because a person does not have a health card or feels uncomfortable and/or not respected in previous health care visits. In addition, people may be caught up trying to deal with other priorities like housing appointments or the meal time at a shelter and miss their health care appointments. The purpose of this research study is to gain an understanding of the factors that promote or constrain (limit) the development and maintenance of a health care relationship with a nurse in a community setting.

#### **Next I will need to confirm your eligibility to participate:**

The following two questions will confirm your eligibility to participate:

1) Are you over 18 years?

**YES (continue to question #2)**

**NO (do not continue)** Thank the caller for their time and indicate that they are not eligible.

2) Are you now or have you experienced homelessness or living in a shelter since turning 18?

**YES (continue to Next Steps)**

**NO (do not continue).** Thank the caller for their time and indicate that they are not eligible.

**I would like to outline the next steps:**

If you answered yes to both of these questions, the next step would be to arrange a time for me to provide you with further information about your potential participation and obtain informed consent. You need to understand that all research is voluntary. You are being asked to consider taking part in this research study because you have experienced or are experiencing homelessness. Participation in this study includes a 60-minute interview which will be audio-recorded. The audio-recording is needed to ensure that we do not miss any of the important points that will be brought up during the discussion. This interview will be conducted one-on-one with me, in person at a time that is convenient for you. Basic demographic information such as age and sex will also be collected. During the interview, you will be asked questions about your experiences with health care in the community, including health care you received from community nurses. You are free to speak openly in the interview, and you also have the option of not answering any questions in the interview that you do not wish to answer. The audio-recording of the interview will be transcribed (typed out word for word). Notes will also be taken by the interviewer. The content of your interview will be considered confidential. Approximately 15 adults from the downtown Toronto core, who have experienced or are experiencing homelessness, will participate in this study. You will receive \$20 for your participation in the interview.

You may also wish to discuss the study with a family member or close friend. Would you like to arrange a time to speak in person?

If the caller is interested in arranging a time, I will book a mutually convenient time to obtain consent and interview the participant, one-to-one.

If the caller indicates they are not interested in participating, I will thank them for their time.