

CLIENT PERCEPTIONS OF A STREET NURSE CLINIC: A QUALITATIVE STUDY

by

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ABSTRACT

The purpose of this study was to discover and understand client perceptions of the Cammy LaFleur Street Clinic (CLSC). The CLSC was a harm reduction strategy that offered health and social care to people living homeless and near homeless in a region known as the North Okanagan, in British Columbia Canada. This naturalistic inquiry utilized qualitative description as its methodology. Twelve clients participated in audio-taped, semi-structured, face-to-face interviews. Eleven interviews were transcribed verbatim and analyzed using constant comparison analysis.

Clients described care found at the CLSC according to four distinct, yet interdependent themes: place, mattering, ability to meet ones' own needs, and being 'OK'. Clients perceived the CLSC to be a safe and inclusive place. Their perceptions of mattering were shaped by the trust they had in the staff's understanding, acceptance, willingness to care for them, and to be there for them. Free and unconditional access to information, basic supplies, and referrals to health and social care and community-based helping initiatives, promoted independence and the development of self-compassion, strengths, and motivation for health and wellness.

The findings of this study reveal that there is more to be gained by drawing on the expertise of people than by shaming them into silence. Clients of the CLSC gave voice to the benefits of being recognized and acknowledged for knowing what was needed to support them in health and wellness. An understanding of their experiences and perceptions may give nursing the foundation to develop a strength-based model of care specific to vulnerable populations. It would be one focused on mattering and the elements of care that promote perceptions of mattering.

PREFACE

This research was approved by the UBC Behavioral Research Ethics Board on March 17, 2008, Ethics Certificate #H08-00242.

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I offer my sincere appreciation and admiration to the volunteers and staff of the Cammy LaFleur Street Clinic and North Okanagan Youth and Family Services Society. Collectively, their understandings and expertise supported me to feel safe and included, and that I mattered. Their unlimited faith in my potential and abilities as a street nurse helped me understand and realize strengths that transformed me into a better mother, wife, daughter, sister, and friend. Not only did they care for me, they made me feel cared about.

For Dave, Tallis, Braydon, and Jerin, who continue to sustain me and keep me grounded in what is really important, despite the many paths I have taken them. I believe my role as the street nurse with the Cammy LaFleur Street Clinic is perhaps one of the more meaningful journeys we have traveled together. We do not choose our life, we live our life. The Cammy LaFleur Street Clinic provided a framework that has shaped how we as a family and as individuals now live our lives. I am proud of how my husband and sons advocate for the removal of the financial and personal barriers that prevent poor and homeless, or near homeless individuals from realizing health and wellness. Their ability to observe, ask questions, and listen as well as hear, has, and will continue to take them to interesting places with amazing people at home and abroad.

DEDICATION

This Study is Dedicated to the

CLIENTS,

FRIENDS,

and

FAMILY,

of the

CAMMY LAFLEUR STREET CLINIC

and

NORTH OKANAGAN YOUTH AND FAMILY SERVICES SOCIETY

CHAPTER 1: INTRODUCTION

1.0 Overview

Many scholars and agencies have recognized that poor health in one dimension of life frequently results in poor health in other dimensions (Canadian Public Health Association, 1997; Daiski, 2005; Hwang, 2001; O'Connell, 2004; Rogers, 1997; Roos, Burchill, & Carriere, 2003). For example, all Canadians are eligible for no cost, primary hospital and physician provided health care (Health Canada, 1984; Health Canada, 2004). Nonetheless, the health and wellness of those who are living in poverty is impacted by their limited or complete lack of access to material and environmental resources (Auger, Raynault, Lessard, & Choiniere, 2004; Bryant, 2004; Canadian Public Health Association, 1997; Frankish, Hwang, & Quantz, 2005; Galabuzi, 2004; Hwang, Martin, Tolomiczenko, & Hulchanski, 2003; Labonte, 2004; Raphael, 2007; Swanson 2001). When healthcare needs compete with immediate and critical survival needs such as shelter, food, clothing, and hygiene, the risk of acquiring and succumbing to a variety of illnesses and injuries intensifies.

Traditional population based, evaluation-type surveys and structured interviews provide important cause and effect data (Binswanger et al., 2008; Carter, McSweeney, Storey, & Stockman, 2001; Gallagher, Andersen, Koegel, & Gelberg, 1997; Nyamathi et al., 2009; Robbins, Wenger, Lorvick, Shiboski, & Kral, 2010). The information captured in these types of studies has laid essential groundwork for the development of preventative and treatment strategies for unmet physical, oral, and mental health needs. However, unmet social determinants of health are a primary reason why the development of primary care services for people who are homeless and near homeless has proven to be challenging (Anderson et al., 2005; Christian, Armitage, & Abrams, 2007; Frankish et al., 2005; Hwang, 2001; Khandor et al., 2011; Lewis, Andersen, & Gelberg, 2003; Lim, Andersen, Leake, Cunningham, & Gelberg, 2002; Low

& Theriault, 2008; O'Connell, 2004; Roos, Burchill, & Carriere, 2003; Shortt, Hwang, & Stuart, 2008; Wong, Watson, Young, & Regan, 2008).

Acosta & Toro (2000) and Frankish et al. (2005) assert that service providers who work with people who are poor and either homeless or near homeless, have traditionally provided care based on what they intuitively believe client needs to be. Few studies have actually sought the perspectives of these individuals about the services and programs they access (Acosta & Toro, 2000; Cunningham, Sanchez, Heller & Sohler, 2007; Neale, sheard, & Tompkins, 2007). Moreover, the studies that have sought out their perspectives have been primarily focused on those living in larger urban centres. Developing comprehensive health care systems that are accessible and utilized means actively seeking out client perspectives of the programs and services they currently access (Canadian Institute for Health Information, 2009; Wong et al., 2008). Therefore the purpose of this study was to discover and understand the perspectives of people who were living homeless and near homeless in non-urban and rural communities located in the North Okanagan region of British Columbia, of a service they accessed.

1.1 The Health Profile and Challenges of People Living Homeless and near Homeless

Canadians who are homelessness and near homeless experience illness more frequently, with increased severity, with greater incidences of co-morbidity, and with higher mortality, as compared to similar segments of the mainstream population (Anderson et al., 2005; Bryant, 2004; Cheung & Hwang, 2004; Auger et al., 2004; Hart, 1971; Hogg et al., 1994; Jerrett, Eyles, & Cole, 1998; Jones et al., 2009; Hwang, 2001; Wood, Sallar, Schechter, & Hogg, 1999). Respiratory infections, problems of the digestive tract, diabetes, coronary heart disease, hypertension, musculoskeletal disorders, skin problems, poor oral and dental health, anxiety and affective disorders, injuries and assaults are particularly prevalent (Cheung & Hwang, 2004;

Crowe & Hardill, 1993; Hogg et al., 1994; Hwang & Bugeja, 2000; Safaei, 2008; Weinreb, Goldberg, & Perloff, 1998; Wood et al., 1999). Furthermore, this group of people faces an increased risk of mortality as a result of HIV/AIDS (Barrow, Herman, Cordova, & Struening, 1999; Cheung & Hwang, 2004; Hwang, 2001), tuberculosis (Hwang, 2001), injectable drug use (Barrow et al., 1999; Cheung & Hwang, 2004; Hwang, 2001), alcohol abuse, exposure to the elements, accidents, violence (Hwang, 2001), and suicide (Cheung & Hwang, 2004).

Behavioural risk factors that are associated with socioeconomic disadvantage such as tobacco use (Alter et al., 2006; Lasser, Himmelstein, & Woolhandler, 2006; Pilote et al., 2007; Weinreb, et al., 1998), sedentary lifestyle, poor nutrition, excessive alcohol consumption (Alter et al., 2006; Lasser et al., 2006; Pilote et al., 2007), lower educational levels (Jerrett et al., 1998), stress (Weinreb et al., 1998), lower service utilization (Algeria, Bijl, Lin, Walters, & Kessler, 2000; Gelberg, Andersen, & Leake, 2000; Steele, Dewa, & Lee, 2007; Weinreb et al., 1998), and lack of preventive screening (Qi, Phillips, & Hapman, 2006; Weinreb et al., 1998), are also thought to significantly contribute to their diminished health status.

Additionally, life experiences and learned behaviours have important ramifications on the homeless and near homeless person's ability to achieve health and wellness (Benoit, Carroll, & Chaudhry, 2003; Lyon-Callo, 2000; McCormack & Gooding, 1993; Raphael, 2006; Raphael, 2007; Reid & Tom, 2006; Sayles, Ryan, Silver, Sarkisian, & Cunningham, 2007; Shiner, 1995; Song et al., 2006; Stein, Andersen, & Gelberg, 2007). Loss of safety, social isolation, stress, a lack of trust, and a diminished sense of self, all serve to shape how individuals perceive health and social care services, programs, and providers (Flaskerud & Strehlow, 2008; Jones Haley & Woodward, 2007; Rogers, 1997). It is perhaps for these reasons that people who are homeless

and near homeless have frequently found the traditional healthcare system difficult to navigate (Auger et al., 2004; Bryant, 2004; Hwang, 2001; Labonte, 2004; Lim et al., 2002).

Completing paperwork, traveling to varying locations where services are offered, making and/or keeping appointments, enduring long waiting times, bearing the cost of prescriptions, and keeping medications safe, are particularly challenging for this group of people (Butters & Erickson, 2003; Daiski, 2005; Hatton, 2001; Hwang & Bugeja, 2000). Moreover, convoluted application processes for entitled health insurance benefits and keeping identification secure when homeless or near homeless, can be complicated. Obstacles such as these often leads to people ignoring, avoiding, or downplaying their need for preventative, acute, and chronic health care (Butters & Erickson, 2003; Hwang, Windrim, Svoboda, & Sullivan, 2000; Khandor et al., 2011). Fear of health care providers, shame associated with the nature of the health problem, lack of a regular healthcare provider, and unfeasible health recommendations have also been found to be barriers to using traditional healthcare services (Butters & Erickson, 2003; Daiski, 2005; Daiski, 2007; Gallagher et al., 1997; Hatton, 2001; Larson, Schlundt, Patel, McClellan, & Hargreaves, 2007).

1.2 Models of Healthcare for People who are Living Homeless and Near Homeless

Supporters of primary health care have explored a variety of alternative approaches to bringing health care services and programs closer to those living homeless and near homeless (Population and Public Health Services, 2007). For example in the late 1980's, health care providers in Canada began offering care in non-conventional settings (Public Health Agency of Canada, 2003). Their intent was to increase the accessibility of health and social care by reducing the economic, organizational, and convenience-of-entry barriers and to promote empowerment and self-determination (British Columbia Ministry of Health, 2005; Chandler,

2008; Pauly, 2008; The Government & Public Awareness Task Group of NPNU Consortium, 2000). With sights set on reducing the harms of behaviours without necessarily eliminating the activity, programs were designed to be low-threshold, value-neutral, and client focused.

Three decades later, primary care providers that align themselves with harm reduction continue to design services and programs that are meant to ensure sensitivity, appropriateness, and responsiveness to priority basic needs as well as healthcare needs (Acosta & Toro, 2000; Christian et al., 2007; Daiski, 2007; Kinzel, 1991; Prendergast, Urada, & Podus, 2001; Reichenback, McNamee, & Vrtiska Seibel, 1998). Staffed by volunteers, peer support workers, nurses and/or doctors, naturopaths, acupuncturists, and mental health and addiction counselors (The Government & Public Awareness Task Group of NPNU Consortium, 2000), these strategies have included reaching out to people on the street (Barry, Ensign, & Lippek, 2002; Benoit et al., 2003; Conviser & Pounds, 2002; Cunningham et al., 2008; Hilton, Thompson, & Moore-Dempsey, 2000; Janssen, Gibson, Bowen, Spittal, & Petersen, 2009; MacNeil & Pauly, 2010; Rogers & Ruefli, 2004; Self & Peters, 2005; Woods et al., 1998), via outreach at established sites of contact (Conviser & Pounds, 2002; Crowe & Hardill, 1993; Cunningham et al., 2008; Daiski, 2005; Hilton et al., 2000; Mund et al., 2008; Rogers & Ruefli, 2004; Rosenblum, Magura, Kayman, & Fong, 2005; Woods et al., 1998), and/or at fixed sites (Attala & Warmington, 1996; Barry et al., 2002; Benoit et al., 2003; Chung-Park, Hatton, Robinson, & Kleffel, 2006; Coccozza Martins, 2008; Connor, Gaines Ling, Tuttle, & Brown-Tezera, 1999; Conviser & Pounds, 2002; Cunningham, Sanchez, Li, Heller, & Sohler, 2008; Dachner, Gaetz, Poland, & Tarasuk, 2009; Exner et al., 2009; Fast, Small, Wood, & Kerr, 2008; Hayter, 2005; Jezewski, 1995; MacNeil & Pauly, 2010; Magee & Hurliaux, 2008; Rew, Rochlen, & Murphey, 2008; Woods et al., 1998).

Some of these models of care have offered services that are focused on the needs of specific groups of people such as youth (Barry et al., 2002; Hayter, 2005; Woods et al., 1998); substance users (Fast et al., 2008; MacNeil & Pauly, 2010; Rogers & Ruefli, 2004; Smye, Browne, Varcoe, & Josewski, 2011); marginalized HIV-infected persons (Cunningham et al., 2008), and/or Aboriginal women (Benoit et al., 2003). In addition, various programs have also provided ancillary services such as holistic therapies, the provision of basic needs services and respite care (safe space, meals/food, showers, and hygiene supplies), peer education and training, educational and support groups, life management counselling, syringe exchanges, and/or transportation. Harm reduction programs and services that strive to care for the whole person have been verified as successful in their endeavours to provide primary care for people who are living in poverty (Allman et al, 2007; Cunningham, Sanchez, Heller, & Sohler, 2007; Daiski, 2005; Daiski, 2007; Fisk, 1998; Hilton et al., 2000; Pauly, Goldstone, McCall, Gold, & Payne, 2007; Self & Peters, 2005).

1.3 Study Background and Purpose

The purpose of this study was to discover and understand client perceptions of the Cammy LaFleur Street Clinic (CLSC). This study represents the first time clients of this nurse-managed street clinic were presented with the opportunity to formally express their perceptions. The CLSC, located in the North Okanagan of British Columbia, began operating in the spring of 1993 as a needle exchange program. In attempting to meet the health and wellness needs of the growing number of homeless and near homeless people living in this non-urban community, the program evolved into one that offered free access to a range of health and social care resources.

1.4 Significance and Relevance of this Study

In seeking out client perceptions of the CLSC, this naturalistic inquiry will contribute to the research-based knowledge available to practicing health and social care professionals working with people who are homeless and near homeless. Knowing what aspects of health and social care and service delivery are perceived by this client group as important, will be helpful in designing and implementing future policies, programs, and services.

1.5 Research Questions

The broad research question that guided this study was: What are client perceptions of the services and programs offered by the Cammy LaFleur Street Clinic program? In order to answer this question a number of contextual factors were taken into consideration. The following two sub-research questions also guided this research project:

- * What meaning did the street clinic have for clients?
- * What were client perceptions of the impact of the street clinic on their health and wellness?

These questions served to illuminate the perceptions of CLSC clients concerning the elements of the program that promoted health and wellness.

CHAPTER 2: LITERATURE REVIEW

2.0 Overview

Canada's system of universal health care plays a vital role in delivering preventative, outpatient, and hospital care services. Many researchers agree that a universal healthcare system positively impacts the health of the general population in the short, intermediate, and long-term (Alegria, Bijl, Lin, Walters, & Kessler, 2000; Butters & Erickson, 2003; Heaman, Green, Newburn-Cook, Elliott, & Helewa, 2007; Hogg et al., 1994; Hwang, 2001; James, Wilkins, Detsky, Tugwell, & Manuel, 2007). No cost access to essential primary care services and programs improves the ease of seeing a doctor, receiving treatment in a hospital, and improving access to public health prevention and control measures (Acosta & Toro, 2000; Anderson & Newman, 1973; Arah & Westert, 2005; Butters & Erickson, 2003; Hwang & Bugeja, 2000; Jezewski, 1995; Qi, Phillips, & Hopman, 2006). However, despite having universal health care benefits, Canadians who are living in poverty with unstable housing, homelessness, and/or street involvement have increased rates of mortality and morbidity as compared to the general population (Auger, Raynault, Lessard, & Choiniere, 2004; Bryant, 2004; Cheung & Hwang, 2004; Crowe & Hardill, 1993; Daiski, 2007; Hogg et al., 1994; Hwang, 2001; Jerrett, Eyles, & Cole, 1998; Jones et al., 2009; Safaei, 2008; Wood, Sallar, Schechter, & Hogg, 1999).

Analyzing health states, health risks, and social needs, can only partially predict and explain the use of health and social care services and programs (Khandor et al., 2011; Penchansky & Thomas, 1981). These quantitative methods are unable to capture the many structural and personal forces that mould the health and wellness of individuals, groups, and communities (Andersen & Newman, 1973). Perhaps it is for that reason that some researchers, including Andersen and Newman (1973), Gallagher, Andersen, Koegel, & Gelberg, (1997), and

Khandor et al. (2011), have questioned the benefits that comprehensive health insurance programs have for those who are poor, in poor health, and most in need of care.

Shortt, Hwang, & Stuart (2008) believe that Canada's model of *Primary Care for All* is unable to reach those who are living homeless or near homeless. Furthermore, many have suggested that for some segments of the population, including those who are poor and are homeless or near homeless, better health frequently correlates with societal non-medical determinants of health (Andersen & Newman, 1973; Arah & Westert, 2005; Gallagher et al., 1997; Sayles, Ryan, Silver, Sarkisian, & Cunningham, 2007). In addition, others have also noted that access to healthcare might be better defined by perceptions rather than the existence of services (Barry, Ensign, & Lippek, 2002; Christian & Abrams, 2003; Daiski, 2007; Fast, Small, Wood, & Kerr, 2008; Gelberg, Browner, Lejano, & Arangua, 2004; Hilton, Thompson, Moore-Dempsey, & Hutchinson, 2001; Hudson et al., 2010; Jones Haley & Woodward, 2007; MacNeil & Pauly, 2010; Mallinson et al., 2005; McCabe, Macnee, & Anderson, 2001; Rogers & Ruefli, 2004; Sayles et al., 2007; Shiner, 1995; Song et al., 2006; Wen, Hudak, & Hwang, 2007). For example, the review of literature reveals that client satisfaction with the attitudes and actions of providers is a significant factor in the realization of wanted or needed healthcare.

Research findings suggest that clients' perceptions of their relationships with providers give context to the activities that occur within health and social care encounters (Attala & Warmington, 1996; Carr, 2001; Coccozza Martins, 2008; Daiski, 2005; Davis-Berman, 2011; Dyer, Patsdaughter, McGuinness, O'Connor, & DeSantis, 2004; Dzul-Church, Cimino, Adler, Wong, & Anderson, 2010; Ensign, 2004; Fast et al., 2008; Jones Haley & Woodward, 2007; MacNeil & Pauly, 2010; Magee & Hurliaux, 2007; McCabe et al., 2001; Neale, sheard, &

Tompkins, 2007; Reutter et al, 2009; Ribner & Knei-Paz, 2002; Sayles et al., 2007; Shiner, 1995; Song et al., 2007; Wen et al., 2007; Zickmund, Ho, Masuda, Ippolito, & LaBroque; 2003).

Therefore it reasons that in order to design services and programs that clients will willingly utilize requires an understanding of their perceptions of the positive and negative characteristics of services and programs they currently access. Accordingly, this literature review explores factors that influence the health and social care experiences of homeless and near homeless people. It will focus on the health and social care encounter, both negative and positive, and how such clients cope with these encounters.

2.1 The Health and Social Care Encounter

Researchers have observed that health insurance positively impacts the health of those who are living homeless or near homeless (Heaman, et al., 2007; Hogg et al., 1994; Hwang, 2001; James et al., 2007; Khandor et al., 2011). Yet, other factors also shape a person's ability to use available health and social care services and programs. Perceptions regarding the emotional costs of seeking out and accepting care is one of those factors. For example, negative and positive experiences with previous care providers influence the health and wellness beliefs of individuals as well as their significant others (McCabe et al., 2001; Pascoe, 1983; Verbeek et al., 2001; Young Mahon, 1996). The timing of when professional care is sought is frequently based on the anticipated emotional costs of the care process rather than the probable physical outcomes (Butters & Erickson, 2003; Lasser, Himmelstein, & Woolhandler, 2006; Shiner, 1995).

The short, intermediate, and long-term consequences of previous negative and positive health and social care experiences are far reaching, extending beyond the individual.

Researchers have noted that the enactment and experience of power within the provider-client relationship either diminishes or enhances the health of people living in conditions reflective of

extreme poverty (Barry et al., 2002; Bungay, Johnson, Varcoe, & Boyd, 2010; Geanellos, 2002; Gelberg et al., 2004; Minick, Kee, Borkat, Cain, & Oparah-Iwobi, 1998; Shiner, 1995; Wen et al., 2007). People cope differently with their fears of real or anticipated stressors associated with past or present health and social care encounters. Coping strategies to avoid health encounters of a negative nature could include substance use to mask symptoms of poor health, a dependence on peers and non-professionals for health information, and self-isolation. These strategies serve to either protect people from assaults to the self or affirm inner strengths and resources (Barry et al., 2002; Bungay et al. 2010; Fast et al., 2008; Hilton et al., 2001; Neale et al., 2007; Reutter et al., 2009).

2.1.1 Negative Perceptions of Provider-Client Experiences

Personal experiences with health and social care providers vary. Based on descriptions provided by people who are living homeless and near homeless, one type of experience that has been identified between care providers and clients is the “I-It” interaction. “I-It” experiences are those in which the provider objectifies the client rather than treating them with respect (Geanellos, 2002; Minick et al., 1998; Wen et al., 2007). When people are treated as though they have no right to make choices and/or no right to complain about aspects of care because of their life circumstances, they feel dehumanized. Homeless and street involved persons report these dehumanizing experiences as frequent and anticipated (McCabe et al., 2001; Smye, Browne, Varcoe, & Josewski, 2011; Swanson, 2001). Researchers frequently report this group as having experienced healthcare encounters that they perceived as being dismissive and discriminatory (Butters & Erickson, 2003; Gelberg et al., 2004; Hudson et al., 2010; Sayles et al., 2007; Wen et al., 2007), ageist (Rew, Rochlen, & Murphey, 2008), sexist (Bhui, Shanahan, & Harding, 2006),

and lacking in cultural sensitivity (Benoit, Carroll, & Chaudhry, 2003; Bungay et al., 2010; Shiner, 1995).

In the cities of Toronto and Edmonton, people living on or close to the street reported feeling that higher income people thought it was acceptable to ignore those who are poor (Reutter et al., 2009). Others explained that they had been treated as “dirt”, “the scum of the earth,” as “criminals abusing the system”, and “undeserving of care and respect” by health and social care providers and programs from whom they had attempted to obtain care (Butters & Erickson, 2003; Coccozza Martins, 2008; Daiski, 2007; Dzul-Church et al., 2009; Hudson et al., 2010; Lynn-Callo, 2000; Reutter et al., 2009; Shiner, 1995). As people have increasingly adopted a personalized concept of health, illness, and disease (Lalonde, 1974), perceptions held by others (Chung-Park, Hatton, Robinson, & Kleffel, 2006; Hill, 2010; Minick et al., 1998; Reid & Tom, 2006; Sayles et al., 2007) and the self (Reid & Tom, 2006; Reutter et al., 2009; Sayles et al. 2007; Smye et al., 2011; Song et al., 2007) have found their way into the provider-client experience.

The identification and subsequent treatment of acute and chronic health issues, as well as preventative screening for health related risks have been reported as being dependent upon whose perception of the risks, the cost, and the benefits of care is given more weight (Irestig, Burstrom, Wessel, & Lynoe, 2010; Reid, Roos, MacWilliam, Frohlick, & Black, 2002; Ruefli & Rogers, 2004). Lifestyles and skills adopted by homeless and near homeless clients to survive street life can hurt them when they attempt to access mainstream health and social care. Health issues such as tobacco use, sedentary lifestyle, poor nutrition, excessive alcohol consumption and/or substance use, illiteracy, promiscuity, prostitution, and incarceration, are frequently

interpreted by care providers and researchers as reflecting a lack of interest in personal health issues (Crowe & Hardill, 1993; Gelberg et al., 2004; Gelberg et al., 1997).

In contrast, other researchers have discovered as false the assumption that people who are homeless or near homeless do not care about their health. McCormack & Gooding (1993) and Shiner (1995) found that good health is important to people who are sleeping rough because poor health makes the ability to survive homelessness even more daunting. Hwang & Bugeja (2000) found that men who were homeless and diabetic were serious about trying to control their blood sugars through diet and medication. Their lack of food choices and poor access to medications and supplies were the major contributors to the difficulties they encountered in trying to be healthy when homeless. Furthermore, Exner et al. (2009) found that people using injection drugs in Victoria, British Columbia worried about their overall personal security, as well as the health risks and infectious diseases associated with their injection drug use.

Researchers have suggested that societal-based stigmatization and labeling influence how service providers relate to their client(s), their health concerns, and their issues. Stereotyping becomes particularly evident when they are asked to care for the complex needs of clients who are marginally housed (Chung-Park et al., 2006; Daiski, 2007; Dinos, Stevens, Serfaty, Weich, & King, 2004; Ensign, 2004; Kisely et al., 2007; Mallinson et al, 2005; Rogers, 1997; Smye et al., 2011; Steele, Dewa, & Lee, 2007; Stevens, 1993; van Ryn & Fu, 2003; Zickmund et al., 2003). Providers who lacked an understanding of the context behind health issues contributed to clients' experiences of feeling ostracized and marginalized. For example, some nurses have been found to be afraid of caring for individuals who are homeless and near homeless (Martino Maze, 2004; Pauly, 2008; Zrinyi & Balogh, 2004). It has also been noted that nurses can be judgmental and label those who do not follow instructions as non-compliant (Chung-Park et al., 2006; Minick et

al., 1998). Dickson-Gomez, Convey, Hilario, Corbett, & Weeks (2007) found this to be also true of social care providers.

Miscommunication between care providers and their clients who are living in poverty and homeless negatively impacts the helping relationship. Researchers found that some physicians perceived this group of people as failing to recognize their medical authority, being disrespectful, and threatening their control as professionals (Hill, 2010; Vanderbilt, Wynia, Gadon, & Alexander, 2007; Willems, Swinnen, & Maeseneer, 2005). Perceptions of being prematurely discharged (Cocozza Martins, 2008), treated as unworthy of care (Butters & Erickson, 2003; Irestig et al., 2010; Reutter et al., 2009; Shiner, 1995), talked down to (Irestig et al., 2010), being refused needed treatment for pain control (Bungay et al., 2010; Irestig et al., 2010; Smye et al., 2011), and forced to accept whatever is given to them (Bhui et al., 2006; Dickson-Gomez et al., 2007) has resulted in this group of clients feeling that they receive inferior care because of their life circumstances (Cocozza Martins, 2008; Gelberg et al., 2004; Sayles et al., 2007). Rather than creating safe and supportive health and social care environments, providers blamed their clients for their life circumstances and poor health (Chung-Park et al., 2006; Cocozza Martins, 2008; Dickson-Gomez et al., 2007; Rew et al., 2008). Previous humiliating experiences served to heighten the client's sensitivity to provider behavior (Sayles et al., 2007; Shiner, 1995; Smye et al., 2011).

2.1.2 Coping Strategies Associated with Negative Perceptions

Struggling to maintain a sense of self-worth, self-esteem, and self-efficacy, people who live homeless and near homeless develop coping strategies to protect themselves from future negative encounters with providers (Smye et al., 2011; Song et al., 2007). The coping strategies they utilize can change their perception of need changes and their willingness to accept care.

2.1.2.1 Changed Perception of Needs

The perceived risks and benefits of participating in health related behaviors are thought to be prominent determinants in how people who are homeless prioritize their needs (Gelberg, Anderson, & Leake, 2002). Services and programs perceived as non-essential are particularly affected and given low priority. Living homeless or near homeless alters a person's perception of the world and re-defines their attitudes about health and wellness (Shiner, 1995).

Serious chronic health issues such as cardiovascular and infectious diseases, diabetes, mental illnesses, and addictions have been found to go unreported by those who are poor, homeless, and near homeless (Butters & Erickson, 2003; Jones et al., 2009; Rosenblum, Magura, Kayman, & Fong, 2005). Yet researchers studying health inequalities in relation to socio-economic status frequently rely on participants' perceptions of their health status (Cunningham, Sanchez, Heller, & Sohler, 2007; Daiski, 2007; Gallagher et al., 1997; Gelberg et al., 2000; Khandor et al., 2011; Lewis, Andersen, & Gelberg, 2003; Lim., Andersen, Leake, Cunningham, & Gelberg, 2002; McCormack & Gooding, 1993; Stein, Andersen, & Gelberg, 2007). Jones Haley & Woodward (2007), McCormack & Gooding (1993), and Shiner (1995) found that people who were homeless identified health issues when their acute (including trauma), and chronic health issues threatened their ability to meet their basic needs. They were more likely to seek care when their health issues interfered with their daily lives or they were unable to hide their poor health from others. Their expectations for health were not less, just different, than the expectations of those who were housed (Shiner, 1995).

The stress and anxiety that accompanies having insufficient resources to meet basic physiological and safety requirements compels individuals to re-evaluate their perception of the meaning of health and wellness (Gelberg, Gallagher, Andersen & Koegel, 1997; Gelberg et al.,

2000; Gelberg et al., 2004; Hayter, 2005; Jezewski, 1995; Smye et al., 2011; Stevens, 1993). People who live in poverty tend to tolerate and normalize what others may see as a serious and threatening symptom (Alter, Naylor, Austin, & Tu, 1999; Cunningham et al., 2007; Gelberg et al., 2000; Lim et al., 2002; Mallinson et al., 2005). They have been found to see poor health as a common and anticipated characteristic of their standard of living (Fast et al., 2008; Shiner, 1995).

In addition, as the effort required to seek out healthcare appears increasingly overwhelming, people who are homeless and near homeless are more inclined to cope by downplaying their need for preventative, acute, and chronic healthcare services (Butters & Erickson, 2003; Daiski, 2005; Heaman et al., 2007; Hwang, 2001; Hwang, Martin, Tolomiczenko, & Hulchanski, 2003; O'Connell, 2004; Rogers, 1997; Trevena, Simpson, & Nutbeam, 2003; Wasylenki, 2001). Lack of funds to pay for prescriptions, transportation, housing, food, a telephone, and government issued identification (Galabuzi, 2004; Jerrett, Eyles, & Cole, 1998; Martino Maze, 2004), limited clinic hours, and the difficulties of making and/or keeping appointments (Gelberg et al., 2004; Hudson et al., 2010), not having a regular healthcare provider (Butters & Erickson; Hwang & Bugeja, 1999; Hwang & Gottlieb, 1999; Hwang, Windrim, Svoboda, & Sullivan, 2000; Kushel, Vittinghoff, & Haas, 2001), and anticipating long wait times to meet with providers (Daiski, 2005), shape how healthcare needs are prioritized. For example, Fast et al. (2008) found that the clients of a supervised injection facility in Vancouver were receptive to preventative health care teaching when they were not preoccupied with meeting needs that they perceived to be essential.

Confusion between perceptions of health and wellness and perceptions of deservingness have been noted to occur when people who are poor, homeless, and/or near homeless, experience

a loss of control and strong feelings of powerlessness when attempting to access care (Butters & Erickson, 2003; Hill, 2010; Kinzel, 1991; McCormack & Gooding, 1993; Reichenback, McNamee, & Vrtiska Seibel, 2001; Reid & Tom, 2006; Reutter et al., 2009). Feeling ignored, rushed, brushed aside, and/or treated rudely while struggling to balance the needs of healthcare and basic survival needs, impacts how they choose to deal with their physical and mental health concerns (Cocozza Martins, 2008; Gelberg et al., 2004; Hudson et al., 2010; Irestig et al., 2010; Powers, 2003; Reutter et al., 2009; Sayles et al., 2007; Shiner, 1995; Smye et al., 2011; Song et al., 2007). Jones Hayley & Woodward (2007) found that homeless people living in San Diego perceived their need to be shaped by the fear of being emotionally assaulted by the provider. Shiner (1995) observed that people who were homeless or near homeless viewed general practitioners and emergency departments as sources of stigma that needed to be avoided.

Health and social care providers who appear preoccupied with their own agendas when their homeless clients ask for help, impact client motivation to care for themselves (Gelberg et al., 2004; Hudson et al., 2010; Irestig et al., 2010; Song et al., 2007; Wen et al., 2007). When these clients perceived their needs not to be a priority for service providers, they questioned their perception of what types of symptoms required care. Cocozza Martins (2008), Gelberg et al. (2004) and Wen et al. (2007) discovered that people who were homeless frequently had experiences with clinical and volunteer staff who seemed unwilling to know and empathize with them, while Bhui et al. (2006) found them to have been sensitized to prejudiced-based treatment. Their heightened sensitivity to this type of treatment prevented them from admitting that they had health needs that required professional care. Furthermore, Song et al. (2007) discovered that the attitudes of homeless people about their end of life needs were also altered by previous negative interactions with health care providers. Seeking out and accepting health and social

care was perceived by some as risky. The harm to one's self-esteem has been found to hold more decisional weight than perceptions of benefit to health (Bhui et al., 2006; Brener, von Hippel, & Kippax, 2007; Bungay et al., 2010; Butters & Erickson, 2003; Rew et al., 2008; Sayles et al., 2007).

2.1.2.2 (Un)Willingness to Accept Care

When people become unwilling to seek out and accept the care that is available to them, the issue of willingness to accept care moves to the forefront when designing services and programs (Boyd, Johnson, & Moffat, 2008; Gelberg & Andersen, 1997; Gelberg et al., 2000; McCormack & Gooding, 1993). The structural characteristics of access are no longer related to the existence or availability of free services and programs when prospective clients are unwilling to accept care unless they perceive their need as urgent, with no other possible options (Gelberg et al., 2004; Hudson et al., 2010; Irestig et al., 2010; Jones Hayley & Woodward, 2007; Shiner, 1995; Song et al., 2007; Wen et al., 2007). Population health reports of hospitalization and use of discretionary service outcomes are not a true reflection of the service delivery needs of people who are living homeless and near homeless (Shortt et al., 2008).

The literature suggests that when homeless and near homeless people perceive their needs as being unimportant to care providers, they become resistant to accepting care (Gelberg et al., 2004; Hudson et al., 2010; Irestig et al., 2010; Song et al., 2007; Wen et al., 2007). Avoiding care is a coping strategy that can serve to preserve their sense of dignity and self-esteem (Hudson et al., 2010; Pauly, 2005; Reutter et al., 2009; Shiner, 1995). Ensuing delays in seeking out and receiving timely healthcare results in the development of more serious and multiple medical problems (Gelberg et al., 2000; Gelberg et al., 2004; Kushel et al., 2001; Lim et al., 2002). The need of the homeless and near homeless for expensive emergency care and more frequent and

longer hospital stays as compared to those who are not homeless, places large demands on the healthcare system (Engebretson, 2003; Gallagher et al., 1997; Harvey, 2006; Hwang, 2001; Jones et al., 2009; Lim et al., 2002; O'Connell, 2004; Roos, Burchill, & Carriere, 2003; Roos, Forget, Walld, & MacWilliam, 2004).

Studies demonstrate that people living in poverty are knowledgeable about where to obtain care if they perceive there to be a need (Cunningham, Sanchez, Li, Heller & Sohler, 2008; Gallagher et al., 1997; Gelberg et al., 2000; Gelberg et al., 2004). For instance, Butters & Erickson's (2003) findings revealed that many women working in the sex trade believed that it was important to know their human immunodeficiency virus (HIV) and sexually transmitted infection (STI) statuses. They independently and proactively sought out HIV testing and recommended treatment. Lim et al. (2002) noted that the proportion of homeless women who reported their health as fair or poor was double that of women in a national sample. Yet unlike women who were more financially secure, the use of ambulatory care services was not discretionary. Women who were homeless chose to use emergency and hospital inpatient health care services rather than doctor's offices, walk-in clinics, and mainstream screening health care services. Additionally, O'Toole et al. (2007) found a link between active addiction and utilization of acute care services. Searching for identifying characteristics of service utilization frequency by substance users, they concluded that high frequency hospital admissions of homeless persons was primarily driven by serious chronic health issues such as HIV/Acquired immune deficiency syndrome (AIDS), kidney disease, and substance use.

Researchers have discovered there to be a climate of distrust amongst members of the marginally housed community towards health and social care services and providers (Cocozza Martins, 2008; Daiski, 2005; Dinos et al., 2004; Lim et al., 2002; Pauly, 2005). Sayles et al.

(2007) found that HIV positive persons, some of whom lived homeless, frequently hid their HIV status from medical professionals because they did not trust that healthcare provider(s) would provide stereotype free treatment. Shelter residents in Wen et al.'s (2007) study perceived themselves as being stereotyped as freeloaders and lazy by healthcare providers. Rough sleepers who participated in Shiner's (1995) study expressed their opinion that mainstream healthcare providers assumed that they faked illness to get a hospital bed for the night. Moreover, Reutter et al. (2009) found that people living in extreme poverty tried to conceal their poorness to cope with their distrust of service providers to provide nonjudgmental care. Withdrawing, self-isolating, and physically distancing themselves from others who were poor were strategies utilized to give the impression that they were not poor. These findings are similar to those of other researchers who have explored the experiences and perceptions of people who are homeless and near homeless of health and social care services and providers (Bhui et al., 2006; Cocozza Martins, 2008; Gelberg et al., 2004; Irestig et al., 2010; Reutter et al., 2009; Song et al., 2007).

2.1.3 Positive Perceptions of the Provider – Client Experience

Researchers have found that people who are living in poverty with unstable housing, homelessness and/or street involvement, perceive a positive provider-client experience to be shaped primarily by provider characteristics. A provider's positive beliefs and attitudes about the client are internalized by the client, and subsequently impact their perception of self and the encounter (Davis-Berman, 2011; Dzul-Church et al., 2010; McCabe et al., 2001; Nyamathi, Stein, & Swanson, 2000; Powers, 2003; Reutter et al., 2009).

Although structural and organizational program features challenge the ability of people who are homeless and near homeless to access care, these features are often overlooked when the

provider-client experience is perceived as a positive one. Accessible locations (Daiski, 2005; Jones Haley & Woodward, 2007), extended clinical hours that include evenings and weekends (Gelberg et al., 2004; Jones Haley & Woodward, 2007; Shiner, 1995), comprehensiveness that offers flexible same-day and/or drop-in service (Daiski, 2005; Fast et al., 2008; Gelberg et al., 2004) with minimal bureaucratic processes and incorporates provisions for anonymity and confidentiality (Butters & Erickson, 2003; Daiski, 2005; MacNeil & Pauly, 2010) have been identified by both clients and providers as increasing service convenience and accessibility. Although primary care strategies that align themselves with harm reduction are sensitive to these needs and challenges, the services and providers are often isolated from the resources and support found within the traditional health care system (British Columbia Ministry of Health, 2005; Chandler, 2008; Pauly, 2008; The Government & Public Awareness Task Group of NPNU Consortium, 2000). Services and programs for the poor and homeless are frequently developed through individual and/or volunteer community efforts without paid staff, equipment, or support services (Hunter, Crosby, Ventura, & Warkentin; 1997). Nevertheless, organizational resources and policies that might contribute to difficulties in accessing care have been found to be easily forgiven and adapted to when clients perceive their needs to be understood by the provider, and that the provider is doing their best (Benoit et al., 2003; McCabe et al., 2001).

Positively perceived attitudes and behaviors of providers have an affirmative impact on the relationship that homeless and near homeless clients have with their provider(s). Providers who are attentive, supportive, and non-judgmental (Butters & Erickson, 2003; Carter, McSweeney, Storey, & Stockman, 2001; Fast et al., 2008; Neale et al., 2007; Reutter et al., 2009; Wen et al., 2007), respectful, caring, and willing to make allowances for differences in culture, language, and lifestyles (Gelberg et al., 2004; Jezewski, 1995; Jones Haley & Woodward, 2007;

O'Toole et al., 2007), and work towards building and enhancing positive self-concepts (Conviser & Pounds, 2002; Daiski, 2005; Gallagher et al., 1997; Hamilton & Coates, 1993; Lim et al., 2002; McCabe et al., 2001; Stein et al., 2007), are perceived by clients as being interested, understanding, and empathetic to their life circumstances (Shiner, 1995). Gelberg et al.'s (2004) found that provider characteristics of honesty, competency, experience, and demonstrated willingness to take the needed time, were important to homeless women.

Using a Heideggerian phenomenological approach, McCabe et al. (2001) discovered that positive care experiences are shaped by providers who are perceived by homeless people as being committed, respectful, non-judgmental, and honest. Dzul-Church et al. (2010) concluded that client-provider relationships were perceived by patients who were both homeless and palliative as positive when they received affirmation of their whole person by being treated as a unique and complex individual with history and values. Exploring stigma among HIV- positive people who were marginalized by poverty, addiction, sexual orientation, and homelessness, Sayles et al.'s (2007) findings shed light on the value of a safe, supportive provider initiated environment. Provider familiarity with the health and social concerns of HIV- positive clients was a major contributor to clients' experiences of safety.

2.1.4 Coping Strategies Associated with Positive Perceptions

Researchers agree that positively perceived health and social care services and programs are those that promote the co-construction and co-participation of a caring relationship (Brener et al., 2007; Daiski, 2005; Fast et al., 2008; Reutter et al., 2009; Sayles et al., 2007; Wen et al., 2007). The caring practices of providers contribute to the development of client self-understanding, self-acceptance, and self-forgiveness (Carr, 2001; Dzul-Church et al., 2010;

Hilton, Thompson, & Moore-Dempsey, 2000; McCabe et al., 2001; Ricketts & Kirshbaum, 1994; Sayles et al., 2007).

2.1.4.1 Changing the Attitudes of Health and Social Care Providers

One protective coping strategy used by people who are living homeless and near homeless is changing the attitudes of health and social care providers. Clients who actively challenge the biased attitudes held by many providers can raise awareness of the multiple pathways to homelessness and the government decisions that keep people in poverty (Brener et al., 2007; Chung-Park et al., 2006; Mineck et al., 1998; Rew et al., 2008; Zrinyi & Balogh, 2004). Moreover, the attitudes and beliefs of providers about specific groups of people have also been found to change according to the amount of direct contact time providers spent with them. When providers have a better understanding of the context behind health issues, the stories they tell themselves about people who are poor often change for the better.

For some providers, it was noted that working with people who were poor and homeless, or near homeless, served to reinforce and augment negative attitudes (Brener et al., 2007; Minick et al., 1998). However many others, such as Chung-Park et al. (2006) and Rew et al. (2008) discovered that as providers came to know their clients as individuals, stereotypes were refuted. Their changed attitudes were reflected in the type of care they provided and the empathetic manner in which it was provided. Brener et al. (2007) found that the time providers spent caring for Hepatitis C virus (HCV) positive intravenous drug users positively correlated with their self-reported attitudes as well as client perceptions of the care received. However, they question if the high level of provider attrition commonly associated with working with this client group to be related to negative implicit attitudes held by providers.

In addition, Chung-Park et al. (2006), Davis-Berman (2011), Hilton et al., (2000), and Jezewski (1995) found that as the attitudes of providers changed, their view of their role(s) as providers broadened. Their new perspective lead to an eagerness to advocate on behalf of patients to remove barriers related to financial resources, lifestyle factors, wait times, social stigma, multi-level communication barriers to obtaining specialized healthcare, and linking patients to physicians who would take their health concerns seriously and treat them with respect. Facilitating a positive healthcare encounter became integral to how healthcare providers perceived their role and changed the felt-value of the care they provided for their clients. They also became more adept at offering achievable health and social care strategies. Providers who collaborated with their homeless and near homeless clients were better able to help with, and advocate for, effective street-based chronic health management strategies (Brener et al., 2007; Chung-Park et al., 2006; Mineck et al., 1998; Rew et al., 2008). Changing the perceptions of providers about homeless and near homeless clients has served as an effective coping strategy in improving the health and social care experience of clients.

2.1.4.2 Changed Perception of Healthcare Needs

Study findings reveal that when members of street-based populations perceive that their needs are considered legitimate and important to the care provider, their personal wants and needs become increasingly more important to them (Carter et al., 2001; Daiski, 2005; Hilton et al., 2000; Irestig et al., 2010; Jones Haley & Woodward, 2007). Strong self-esteem, self worth, and self-efficacy, are personal attributes that have been identified as supporting the early self-identification of non-urgent, but potentially serious, healthcare needs (Bhui et al., 2006; Fast et al., 2008; Jezewski, 1995).

Health and social care providers, who recognize and acknowledge the strengths of homeless and near homeless clients, enhance the client's development of a positive self-concept. Praising them for their ability to overcome life challenges (Bhui et al., 2006; Hamilton & Coates, 1993; Shiner, 1995; Slesnick, Prestopnik, Meyers, & Glassman, 2007) and partnering with them in their health and wellness (Gelberg et al., 2004; Irestig et al., 2010; Jezewski, 1995; Jones Haley & Woodward, 2007; Reutter et al., 2009; Sayles et al., 2007) serves to engage clients with their health and wellness. MacNeil & Pauly (2010) concluded that the experience of having had a safe place to sit, talk, and have a cup of coffee with their provider(s) significantly impacted personal perceptions of health and social care needs. When that place was no longer available, clients who were homeless, near homeless, or street involved either no longer sought out healthcare or sought it only for needs they perceived as being urgent. McCabe et al. (2001) found that people who were homeless were willing to wait for long periods of time to obtain healthcare from providers who they perceived as incorporating their social care needs into their healthcare experience. Exner et al., (2009), studying the array of possible worries that characterize the daily lives of people who use injection drugs, had similar findings. They concluded that through the street nurse at a fixed needle exchange site, clients willingly returned for a broad range of health and wellness care services that included hot meals, referrals to shelter, counseling, and HIV/ HCV testing, in the provision of a safe, dry, and warm place to sit.

2.1.4.3 Willingness to Accept Care

Perceptions of the personal benefits that people living in poverty with homelessness or unstable housing attribute to the receipt of care influences the value they place on health and social care services and programs. When the value of healthcare efficacy outweighs the

perceived risks associated with care, they become more willing to accept care (Andersen & Newman, 1973; Fast et al., 2008; Shiner, 1995).

For people who are living homeless or near homeless, the emotional safety experience of being treated as human beings by providers was found to be primary, and the receipt of needed health and social care was secondary. When they began to trust that the care they received would be personal, appropriate, realistic, and professional, their perception of the amount of emotional effort required for seeking out and accepting care lessened (Barry et al., 2002; Irestig et al., 2010; McCabe et al., 2001; Neale et al., 2007; Shiner, 1995). Shiner (1995) found that men who were homeless defined such care as high quality and a defining feature of their willingness to seek out and access care. Upon finding a provider perceived as high quality, clients who were homeless and sleeping rough returned for future care as well as referred others for their healthcare needs. Barry et al. (2002) and Irestig et al. (2010) found there was a strong association between level of trust and a homeless person's perception of how they were treated. Other researchers have found that providers were perceived by clients who were poor as providing high quality care when they demonstrate their willingness to come to know them as individuals (Barry et al., 2002; McCabe et al., 2001; Neale et al., 2007; Shiner, 1995).

Service providers who focus on the existing strengths and resources of their homeless and near homeless clients have been noted as promoting a culture of trust and hope (Barry et al., 2002; Coccozza Martins, 2008; Fast et al., 2008; Hilton et al., 2000; Irestig et al., 2010; Jones Haley & Woodward, 2007; Sayles et al., 2007). Providers, services, and programs that work from this perspective were better able to reconnect clients with their health and wellness and support them to reintegrate into their communities (Hilton et al., 2000; Reutter et al., 2009; Sayles et al., 2007; Slesnick et al., 2007). Clients who trusted that they would be treated with

respect and compassion with a focus on their strengths and resources were more likely to attend to their health concerns.

Clients who trust that the provider offering them care has their best interests at heart are found to perceive the provider-client encounter more positively. Rather than focusing on the social costs of accepting care, clients began to look towards the experienced benefits. For example, providers who showed unconditional positive regard and respect for the strengths of homeless and near homeless clients were those who were attentive to the small successes. This changed the client focus from what they did not have to what they did have (Barry et al., 2002; Bhui et al., 2006; Bungay et al., 2010; Coccozza Martins, 2008; Fast et al., 2008; Hilton et al., 2000; Irestig et al., 2010; Jezewski, 1995; McCabe et al., 2001; Reutter et al., 2009). The findings of studies conducted by Daiski (2005) and Fast et al. (2008) also spoke to the impact that providers who work from this perspective can have on client perception of self. They found that it was particularly meaningful for clients who were living in poverty when they believed that the provider knew and remembered them. Dickson-Gomez et al. (2007) had alternative, yet similar, findings. Unofficial policies of favoritism and deservingness were perceived by clients as having evolved out of the relationships that staff had with individual clients. Clients believed this to be a benefit for some and unfair for others. People living in poverty perceived positive client-provider relationships to be built upon health and social care encounters that felt welcoming (Brener et al., 2007; Shiner, 1995; Wen et al., 2007), safe (Daiski, 2005; Shiner, 1995); and caring (Bhui et al., 2006; Carter et al., 2001; Irestig et al., 2010; Song et al., 2007).

Specialized, harm reducing health and social care services, strive to minimize the barriers to care that street life presents and facilitate the experience of fair and equal treatment. People who are poor who have a greater sense of control over their lives, are happier, and more self-

reflective (Bhui et al., 2006; Magee & Hurliaux, 2008; Reutter et al., 2009; Shiner, 1995; Vanderbilt et al., 2007). Being in the company of others who are experiencing similar challenges and working with service providers who are knowledgeable about their needs has been identified by clients as an important service and program element of this perspective (Brener et al., 2007; Daiski, 2005; Davis-Berman, 2011; Dzul-Church et al., 2010; MacNeil & Pauly, 2010; Reutter et al., 2009; Shiner, 1995). These provider and program characteristics have served to increase the comfort level of members of this client group, and promote their willingness to access care. Magee & Hurliaux (2008) found that homeless and near homeless women in San Francisco attending an evening drop-in program felt that being accepted for their differences was empowering, inspirational, and significantly impacted their willingness to return. The stories they told themselves about themselves changed. Their self-confidence, self-efficacy, and motivation to actively seek a different life for themselves and their children improved.

The findings of Butters & Erickson (2003), Crowe & Hardill (1993), and Neale et al. (2007) suggest that improved mental health that promotes a positive attitude about the self to be an important feature of staying healthy when homeless. Furthermore, attitudes may impact willingness to obtain care. Others who have explored the perspectives of people who are poor and homeless, or near homeless, in relation to their healthcare experiences have reported similar findings (Bhui et al., 2006; Bungay et al., 2010; Daiski, 2005; Fast et al., 2008; Hatton, 2001; Sayles et al., 2007).

2.2 Summary

People who are poor and homeless, or near homeless, are seldom consulted about health and social care programs. However, they have strong views about the adequacy of the services

they access. Their use or non-use of services and programs is embedded in their perceptions of previous provider-client experiences.

Researchers have illuminated the importance of developing in-depth understandings of the life challenges that are specific to this unique subgroup of the population. The literature also provides voice to their insights concerning their health and wellness needs (Exner et al., 2009; Hwang & Bugeja, 2000; McCormack & Gooding, 1993; Shiner 1995). Collectively, their understandings reveal that it is of primary importance to clients to feel positive about health and social care services and programs, themselves, and their current health and social care issues. How they are treated by the provider serves to shape their perceptions of need and deservingness in the short term, as well as the long term.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Overview

There is a need for qualitative research that explores the perceptions of people who are homeless and near homeless about the health and social care services they access.

Understanding the impact that existing services have on their health and wellness can assist in the development of services and programs that may better meet their needs. It is for that reason that a qualitative descriptive study was conducted with clients of the Cammy LaFleur Street Clinic (CLSC). Since the findings are dependent upon “the perceptions, inclinations, sensitivities, and sensibilities” of participants (Sandelowski, 2000, p. 335), a straight description of the phenomena under study is produced. The findings will be focused on the perceptions of clients. In the following chapter I will share with the reader the qualitative frame of reference and emergent design.

3.1 Design

This study used qualitative description, a naturalistic inquiry, to understand client perceptions of the health and social care found at the CLSC.

3.1.1 Naturalistic Inquiry

Naturalistic inquiry strives to enhance current understandings about an issue or a phenomenon by exploring multiple constructed and holistic factors that shape the perceptions of individuals and groups (Maykut & Morehouse, 1994). This type of inquiry involves an interpretive approach to qualitative research. Researchers attempt to make sense of phenomena by looking for clues, shapes, and forms in the natural setting (Denzin & Lincoln, 2004; Schwandt, 1997).

The perspective of naturalistic researchers in the beginning stages of the research process is that their discoveries will be “open-ended and not clearly focused” (Maykut & Morehouse, 1994, p. 34). While the inquiry process does have a characteristic pattern of development: orientation and overview, focused exploration, and member checking (Lincoln & Guba, 1985; Patton, 2002), its’ inductive nature makes it inappropriate, as well as impossible to design a study in any definitive way before it begins. For that reason, there were no attempts made during this research to control or manipulate the participants, the environment, or the study. In addition, the researchers purposefully avoided any actions poised to distinguish cause(s) from effect(s) (Lincoln & Guba, 1985; Sandelowski, 2000).

3.1.2 Qualitative Description

Qualitative description was chosen not only for the knowledge it could produce, but as a vehicle for presenting and treating research methods as living entities that resist simple classification (Sandelowski, 2010). Qualitative description is described as the least theoretical method of inquiry, the “least encumbered by pre-existing theoretical and philosophical commitments” (Sandelowski, 2000, p. 337). In addition to being non-conventional, it easily lends itself to naturalistic inquiry ontology.

Sandelowski (2000) asserts that qualitative description is suited to answering questions that are of relevance to care providers and policy makers. It strives to identify and illuminate all of the facts and to provide a global understanding of the issue or phenomenon under study. Interpretation is low-inference and stays close to the data (Sandelowski, 2000; 2010) to enable fellow researchers and readers to judge for themselves and agree more easily upon, internal study consistencies. Hence, data is collected with participants in their natural setting, and events are communicated in their proper sequence.

Despite the use of the participants' own words and language to recount their experiences, sensations, and perceptions, study findings are dependent upon how participants select, organize, and interpret, the researchers' questions (Lincoln & Guba, 1985). However, it is acknowledged that the process of describing the context of the issue or phenomena can transform participants' perceptions of their experience (Sandelowski, 2000). Therefore, in an attempt to minimize the separateness between fact and interpretation, the researchers in this study made every effort to provide enough details so that descriptions are both recognizable and credible.

3.2 Study Setting

The CLSC was purposefully positioned so that its' entrance was inconspicuous to the mainstream populace. Located off a secluded alleyway, clients discretely accessed the street clinic through the back door of the North Okanagan Youth and Family Services Society (NOYFSS) building in Vernon, British Columbia. At the time of data collection the street clinic was preparing to close its doors. NOYFSS had grown weary of the efforts required to support non-government funded health and social care and ancillary resources. To meet a new contract's criteria with no additional resources, service delivery was being moved from an on-site clinic with an outreach component, to a population based outreach model of care.

3.3 Sampling

While qualitative naturalistic researchers attempt to plan ahead as much as possible, they must also be flexible (Patton, 2002). Consequently, the emerging nature of naturalistic research fit well with the organizational structure of the CLSC. In this study participants were recruited as part of a larger mixed methods study that included both quantitative and qualitative components.

Akin to the ideals of qualitative research (Maykut & Morehouse, 1994; Polit & Hungler, 1997), the goal of the current study was to collect and analyze data concurrently in an ongoing process until no new information was uncovered, redundancy was achieved, and data saturation had been reached. As part of the quantitative component of this study, a survey was administered to a convenience sample of clients visiting the clinic on data collection days. Initially the intent was to purposefully select a subgroup of clients from survey participants to obtain maximum variability in the sample age, sex, age, ethnicity, length of time coming to the CLSC, usual sleeping distance from the street clinic, referral source, their experience with other street clinics, and their source of income, for the qualitative part of the study. This approach had to be modified after the first 2 days of data collection as the number of clients accessing the street clinic dwindled with pending closure.

To obtain a minimum sample size of 10, convenience sampling was adopted to recruit participants who were 19 years of age and older, who spoke English, were able to give informed consent, and were visiting the CLSC on the few remaining days that data collection was occurring. The number of participants who agreed to be interviewed was twelve. Mechanical failure resulted in the loss of one digital recording, leaving a total of eleven participants.

3.3.1 Recruitment Procedures

According to Lincoln and Guba (1985), the key to gaining entry to a research site is almost always in the hands of multiple, formal and informal, gatekeepers. In this study, to fully protect the privacy and safety of those who visited the street clinic, members of the CLSC volunteer staff were recognized as the gatekeepers. They were asked by the research investigators to be the first point of contact. These volunteers had developed trusting and cooperative relationships with the client group in their daily roles as the ‘meeters and greeters’.

On several occasions prior to the commencement of data collection, co-investigators met with the volunteers to explain and discuss the purpose of the inquiry and provide an orientation of the planned data collection process. This was meant to make the recruitment procedure as unobtrusive as possible for both the prospective participant who would be in search of care, as well as for the volunteers who would be having to multi-task with the addition of this new role.

3.4 Data Collection

According to Lincoln and Guba (1985), “naturalistic ontology suggests that realities are wholes that cannot be understood in isolation from their context nor can they be fragmented for separate study of the parts (the whole is more than the sum of the parts)” (p. 39). Therefore it is essential that the researcher(s) be the primary data collection instrument. Their ability to respond to, adapt to, and present the everyday consciousness of multiple realities, is depended upon for uncovering the true nature of the issue or phenomena being studied (Lincoln & Guba, 1985).

Sample recruitment and data collection occurred simultaneously in this study because of the transient nature of the target group. As one of the co-investigators was also the primary care giver at the CLSC, to avoid any conflicts of interest, she was not directly involved in data collection. Alternatively, two third year nursing students and two of the thesis committee members collected the data. The students had volunteered for this opportunity, and were subsequently trained and supervised in their role as research assistants by their professor/co-investigator, the projects’ faculty advisor, and the street nurse/co-investigator. In addition, orientation sessions were held to introduce all those involved in data collection to the study’s proposed recruitment strategies, the consent process, interview techniques, fieldnotes, and possible safety concerns.

Prospective participants were invited by the volunteers to complete a questionnaire and possibly a taped interview. Volunteers used a script (see Appendix A) and an accompanying recruitment brochure (see Appendix B) to ensure they provided each client with the information required to make an informed decision. If clients expressed an interest in participating, they were introduced to a research assistant who escorted them to a private room in the clinic.

Using a script (Appendix C), the research assistant completed the consent process with participants. This process involved an explanation of the nature and purpose of the study, expectations of participation, potential harms and benefits, confidentiality and privacy, and the option to withdraw at any time without penalty. Once completed, the research assistants offered a copy of the consent form to the participant (see Appendix D).

Following consent, each study participants completed a multi-item survey administered by a research assistant (see Appendix E). The survey was designed to illuminate demographic features of CLSC clients, including very general information about client utilization and perceptions of the helpfulness of the different aspects of care offered. However, the primary purpose of the survey was to provide anyone who was interested in doing so, with an opportunity to have her/his voice heard. Fifty-five clients participated in this portion of the research process. Clients who completed the questionnaire portion of data collection and who appeared to respond positively to the experience were then invited by a research assistant to take part in an audio-taped, in-depth interview.

3.4.1 Interviews

Twelve clients participated in face-to-face interviews. These interviews lasted from 30 to 50 minutes and were guided by a semi-structured interview guide to ensure that the same basic lines of inquiry were pursued (see Appendix F). Eleven of these interviews were audio-taped;

malfunction of equipment for the twelfth interview made it unusable. Open-ended questions “designed to reveal what is important to understand about the phenomenon under study” (Maykut & Morehouse, 1994, p. 81) were used to elicit participants’ perspectives. Probes were used when necessary to obtain greater depth and clarity of points being made. The major foci of the interview guide was to seek out client perceptions of the care they had received at the CLSC and the impact that they perceived that care as having had on their health and wellness.

At the conclusion of each interview the research assistants recorded their personal observations in the form of field notes before making themselves available to meet with another prospective participant. The act of recording field notes assisted in keeping the research assistants alert and responsive to the data collection process. No identifying information was recorded on the questionnaires or fieldnotes.

At the end of each day the completed consent forms, the audio-tapes, and the field notes were delivered by the research assistants to the School of Nursing office at the University of British Columbia Okanagan (UBCO). The audio-tapes continue to be kept in a password protected network. Back-up copies of all recordings were made to ensure that data was not lost prior to transcription.

3.5 Data Analysis

Digital recordings were transcribed verbatim, including pauses, pauses, laughter, and changes in voice. All identifying information was removed. The two transcribers were instructed on the importance of transcribing word for word and to include pauses, laughter, and changes in voice. Furthermore, the transcribers were also instructed to exclude any identifying information that was included in the recording. Field notes were also transferred into type written documents in preparation for data analysis.

With no mandate to produce anything other than a rich descriptive summary of the meaning that the CLSC had for clients, the analysis of the qualitative descriptive data collected in this study was open-ended and inductive. To allow for data analysis to occur simultaneously with data collection and “to mutually shape and be shaped by one another” (Patton, 2002, p. 436), the street nurse/co-researcher met with the research assistants at the close of each data collection day. Together they debriefed, explored meanings, and considered questions while discussing personal, methodological, and ethical challenges that were encountered during the research process. In addition, the street nurse/co-investigator spoke with the principle investigator/project faculty advisor regularly during the data collection period. Guidance, support, advice, and the sharing of insights came from these conversations. These initial activities of analysis during data collection were congruent with the principles of naturalistic inquiry (Lincoln & Guba, 1985).

The constant comparative method was used and well suited for analyzing the multiple forms of data collected during the research process (Lincoln & Guba, 1985; Maykut & Morehouse, 1994). The use of this method established a foundation which enabled the research team to identify multiple realities imbedded in the data. The process began with inductive open category coding and the simultaneous comparing of units of meaning across categories. An initial coding framework was developed and used to guide on-going analysis of data. Categories were refined to ensure that all data had been accounted for. Relationships and patterns were subsequently explored. The on-going process of returning to the original interview transcriptions and representing the data in the natural language of the participants enabled the investigators to develop deeper insight into the meaning the CLSC held for clients.

3.6 Ethical Considerations

The question of how the researcher affects what is being observed and what information participants' report, is prominent in the minds of qualitative researchers (Patton, 2002).

Assuming that context is critical in the naturalistic inquiry, the goal of this study was to uncover as much information as possible about “the who, what, and where of events or a situation” (Sandelowski, 2000, p. 338). Humans were the instrument of research and data was collected in the natural setting. However, these design elements presented ethical challenges that are distinct to qualitative research and naturalistic inquiries.

The practicalities of conducting qualitative research with people who are homeless and near homeless were formidable. Since the participants in this study were members of a vulnerable population who routinely experience exploitation (Canadian Institute of health Research, Natural Science and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010), special attention was taken to ensure that research would be conducted in a respectful manner with minimum risk of harm to them. While the protection of participant privacy, avoidance of possible coercion, participant safety, and mutual respect are uppermost considerations in any research design, they were even more salient within this particular research process.

There was significant concern that participants may naively disclose information that might potentially leave them vulnerable for exploitation (Appleton, 1997). For that reason there was careful consideration of ethical issues and investigators prepared for the possibility of unanticipated effects related to the research process. Flexibility and reflexivity were accounted for and incorporated into the research process (Crabtree & Miller, 1999). Pseudonyms were used to identify participants during audio-taped interviews, and fictitious names used in the reporting

and dissemination of data. Having taken these factors into consideration, NOYFSS granted approval for this research to be conducted on their site (see Appendix G). This study also received ethics approval from the University of British Columbia's Behavioral Ethics Review Board.

3.7 Ensuring Trustworthiness

Tobin and Begley (2004) describe trustworthiness as “the means by which we show integrity and competence” (p. 390). Within qualitative descriptive research that uses a naturalist inquiry approach, the concept of an objective reality validating knowledge is deemed impossible (Maykut & Morehouse, 1994). Rather than being a detached outsider, the researcher is an integral part of the research process (Tobin & Begley, 2004). Therefore, as asserted by Lincoln & Guba (1985), trustworthiness is ultimately developed through transparency, and its' criteria are (1) credibility through the use of multiple methods of data collection, (2) dependability by working with a research team and peer debriefing, (3) the transferability of finding through thick descriptions, and (4) confirmability through the building of an audit trail (Lincoln & Guba, 1985). Collectively, these measures served to document the direction and the progress of this final thesis product, and maintained the transparency of the research process and analysis of the study findings.

Several actions were taken to ensure accountability and trustworthiness throughout this research process. Data collection and analysis were multifaceted and collaborative. For example, data collection techniques included a quantitative questionnaire format as well as in-depth, semi-structured interviews. Novice investigators, novice data collectors, and novice transcribers worked alongside researchers with extensive experience and expertise. An audit trail that included the original questionnaires and audio-tapes, field notes, and journal entries,

was maintained throughout the study. Daily field notes kept by the research assistants spoke of their impressions of participant's verbal and non-verbal behavior and mannerisms. Furthermore, the street nurse/co-investigator kept a detailed journal. These have contributed to the depth and clarity of findings.

In attempts to ensure trustworthiness, Maykut & Morehouse (1994) have researchers consider how trustworthy their research findings will be to others by asking themselves what they could do, or what they should have done in designing, carrying out, and reporting. Researcher self-awareness is subsequently central to the process of naturalistic inquiry and must be acknowledged and accounted for (Patton, 2002). As recommended by Lincoln & Guba (1985), the street nurse/co-investigator kept a personal journal. As the primary care giver at the CLSC, her reflections were limited by her inability to be directly involved in the collection of data without jeopardizing ethical standards. However, it was essential that she know herself and how her perceptions, biases, and way of being could change or impact the inquiry process as well as the findings. In addition to holding a chronological report of the day-to-day activities, meetings, and methodological decisions made, her journal entries also reveal a continuous commentary of her personal thoughts, insights, reflections, and memories.

3.8 The Position of the Researcher(s)

The perspectives that researchers bring to qualitative research are part of the context of the findings. As previously mentioned, one of the co-investigators of this study was also the CLSC nurse (the author). Her ongoing professional relationship with clients had to be taken into account in the design of this research process. The research team was cognizant of the possible conflict between the street nurses' two roles. Boundaries could easily and unintentionally blur. As a result, incorporating supplementary team members into the design of this study was a

necessity to accommodate for the anticipated challenges that would inevitably arise because of her central role as the nurse in the street clinic.

To minimize the impact of the dual roles of the street nurse/co-investigator, the principle investigator/project faculty advisor and second co-investigator collaborated with her in the design of all aspects of the research process. Ensuring that rigor was embodied in each step, they constructed the consent process, the data collection tools (the questionnaire, the semi-structured interview, field notes, journals), and how the data were to be managed. The principal members of the research team also worked together in analyzing the data.

To avoid the possibility that clients would feel coerced or obligated to participate in the study because of the dual role of the street nurse, data collection took place on days when she was not on site. Although the two undergraduate University of British Columbia Okanagan (UBCO) students assumed the majority of the data collection responsibilities, the principle investigator/project faculty advisor and second co-investigator collected data on one day. The CLSC volunteers and the research assistants were asked to avoid discussing any details about study participants with the street nurse, clients, or other participants. The street nurse/co-investigator agreed that she would not discuss the research process with clients, listen to the tape recording, nor be involved in the transcribing of the interviews. Furthermore, no identifying information was to appear on any of the data sheets and each interview was to be numerically coded.

The steps taken to minimize any risk of harm to participants because of the relationship that the street nurse/co-investigator had with clients offered the UBCO nursing students the chance to be involved in a community-based research project as part of a practicum. Additionally, their orientation to the study and the research process included opportunities to

help them become familiar with other community resources accessed by this population group, develop their level of comfort working with this client group, to develop their awareness of the prominent health issues and concerns of those living with poverty, and expand their tacit knowledge in regards to marginalization and othering. Prior to data collection they volunteered at Vernon's Upper Room Mission, Vernon and District Women's Centre, and the House of Hope Homeless Shelter. They also spent three afternoons working with the CLSC volunteers where they met and greeted clients as they entered the clinic and worked alongside the street nurse in the provision of nursing care. It was anticipated that their familiarity with the client might impact the comfort of the participants during data collection.

Another measure taken to avoid the possibility that the street nurses role as a co-investigator did not cause distress for the study participants, was the employment of two undergraduate University of British Columbia Vancouver transcribers. The street nurse/co-investigator was concerned that she would recognize the audio-taped voices of participants, and that participants' would have a similar fear. It was possible that participants' perceptions would be subsequently influence by their knowledge that the street nurse would be listening to their interviews. Therefore the purpose of employing transcribers was to further ensure that participant confidentiality was respected and maintained. In addition, the transcribers were instructed to replace the names in their transcriptions with a pseudonym (made up name).

3.9 Summary

Qualitative research methodologies can provide people who are living homeless and near homeless with the opportunity to voice their insight into their health and wellness needs. Naturalist Inquiry using qualitative description as the research methodology was chosen for this study. Naturalistic inquiry and qualitative description rely upon the perceptions, the inclinations,

the sensitivities, and the sensibilities of study participants to inform the topic of interest. This methodology was chosen by the research team because it is congruent with the underlying beliefs and values that guided the care that was offered by the CLSC staff. As the purpose of this study was to discover and understand, naturalistic inquiry using qualitative description also met the methodological needs of this study.

CHAPTER 4: FINDINGS

4.0 Overview

The main research question guiding this qualitative descriptive study was “What are client perceptions of the health and social care services and programs offered by the Cammy LaFleur Street Clinic?” Using broad, open-ended questions, the interviewers offered participants the opportunity to disclose descriptions.

This chapter begins with a brief description of the Cammy LaFleur Street Clinic (CLSC) and the study participants, followed by a description of the clients’ perceptions of the CLSC. The major themes that emerged are: (a) My place, (b) I matter, (c) Meeting my needs, and (d) I’m OK. A recurring thread that wove throughout the four themes and constituent subthemes was the contrast between the CLSC and other services and programs they accessed.

4.1 The Clinic Context

North Okanagan Youth and Family Services Society (NOYFSS) founded the Vernon Street Clinic (VSC) program in 1993. In 2003 the name of the VSC changed when Cammy LaFleur, who had been the street nurse for seven years, succumbed to complications of cystic fibrosis. In her memory the VSC was renamed the CLSC to honor the insight, expertise, and compassion she had shared.

The CLSC was contracted by the Interior Health Authority (IHA) to offer on-site needle exchange, condom distribution, adult vaccinations, and reproductive health services. Testing and counseling for the human immunodeficiency virus (HIV), hepatitis, and sexually transmitted infections (STIs) was also provided. The demand for these services grew as manifestations of poverty and social exclusion (substance use/abuse, mental illness, survival sex, street involvement, and homelessness) became increasingly visible in the North Okanagan. To meet the growing and expressed needs of the community, NOYFSS sought to offer access to a

comprehensive range of client-centered health and social care; care that extended beyond the individual to include broader community and societal interests. As a result the needle exchange program expanded to provide on-demand health assessments, nursing diagnosis, care for acute and chronic physical and mental health problems, health and wellness teaching, advocacy assistance, referrals, ancillary products and services.

The street nurse was frequently available to meet with clients by appointment or drop-in outside of the clinic hours. The street nurse's care also included home visits, street outreach, outreach to surrounding communities, the mentoring of undergraduate nursing and social work practicum students, giving health presentations as requested by community and professional groups, active involvement on committees, support to mainstream health professionals, and fundraising. Through the extensive formal and informal support and financial assistance acquired from many community individuals and organizations, the CLSC was able to provide care that stretched beyond the required outcomes of their contract with the IHA. The necessary medical supplies and educational resources were either donated directly to the street nurse or purchased from donated monies. In addition, a core group of dedicated volunteers evolved at the street clinic as an integral part of the program.

4.2 Description of Participant Sample

Twelve clients participated in the in-depth, semi-structured interviews. Clients were diverse in sex, age, ethnicity, length of time coming to the CLSC, usual sleeping distance from the street clinic, referral source, their experience with other street clinics, and their source of income. The ages of the six women and six men participants ranged from 23 to over 60 years of age; the majority (seven) were between 41 and 50 years of age. Nine participants self-identified as Caucasian and three as Aboriginal. Participant involvement with the CLSC ranged from less

than six months to 11 years; the majority had been coming to the CLSC between 5 to 10 years. The usual sleeping distance from the street clinic of participants was between 1 and 30 kilometers; the majority slept within a 6-kilometer radius. While participant referrals to the CLSC had come from varying sources, including service providers, acquaintances, and word of mouth, nine of the participants had been referred to the street clinic from others who had accessed it. One participant had previous experience with a similar style healthcare facility in another community. While two of the participants had sporadic employment income, the majority of participants received government social assistance or disability benefits.

4.3 Theme 1: My Place

Study findings revealed that participants perceived the CLSC as more than a physical space or a building. It was a place that participants associated with safety and inclusiveness; factors that enabled them to meet their physical, emotional, and social health needs. With the exception of one, all participants described their relationship with the street clinic in terms of years. It was a place that participants perceived as having become “their place”.

4.3.1 Safe

The theme of safety encompassed emotional, physical and social aspects. The clinic was described as a place to come when feeling alone and/or ‘down’, a place to connect with others, a welcoming place, a place free from the judgmental attitudes of the mainstream, and a place to access clean intravenous drug supplies without fear of injury or infection.

Participant experiences with the staff and other clients, translated into positive feelings associated with the place; expressed as “this is the place I feel safe”. Brady, who had been accessing the CLSC for 11 years, described the clinic as a sanctuary. He valued it as a safe place where he could get his emotional needs met:

It's (the CLSC) always been kind of a sanctuary see . . . always a place to come when you were down and out and you had no one to talk too . . . and here (at the CLSC) you always had someone to talk to.

Vanessa came to the CLSC every day it was open. In her forties and raising a family, she felt safe at the street clinic because she knew what and who to expect:

I know most of the people coming in here . . . and you know I say 'For the Grace of God'. . . I really enjoy it you know It's just I feel safe here and I don't feel safe in the other places.

Participants weighed anticipated personal risks of asking for assistance with the desired health and social benefits. While the risk(s) involved stayed at the forefront of their minds in deciding whether to return, they were offset by the social, welcoming, and safe aspects of the clinic. Positive anticipation of feeling safe was one of the factors that shaped their decision to access clinic services and programs. Previous experiences with having felt welcomed was an important part of the decision making process for Claire:

Walking into any door can be a challenge - but then when you see what's on the other side of the door you know whether you're going to come back or not you know I've always felt it (the CLSC) was comfortable . . . you know they're so pleasant . . . sometimes you say "Like man how can you do that every day?" I'm sure some of us can be difficult - and we are difficult sometimes when we come in here and we're totally stoned to (but) they always have the smile on you know . . . like - you're still just somebody - and it's nice see that.

Another participant, Michael, who in his sixty-plus years had frequently lived homeless, reiterated the importance of feeling welcomed: "as you went from place to place looking for

something – there was always somebody there (at the CLSC) that was friendly and there to help”.

Participants described the CLSC as a safe place that was free from the judgmental eyes of others. For example Claire, who was homeless and sleeping on a friend’s couch, explained the negative impact of stigmatization. The important role the street clinic played in providing a safe and confidential place for people using intravenous drugs (IVD) to access supplies was important to her:

You know when the people (mainstream) see you they see disgust . . . and you know it is disgusting when people are sitting in alleys and on corners with needles and stuff like that you know - it’s not very good for the soul . . . they (the prevalent societal group) don’t really want to see it and we don’t really want them to see us - so this (the street clinic) has provided this to me.

The CLSC also contributed to participants feeling safe in their ability to meet their physical health needs. Confidential access to condoms and other harm reduction supplies meant they could prevent the transmission of blood borne pathogens. Living in a small neighboring community, Claire was particularly articulate as she spoke of the potential danger(s) of having to search for clean IVD using equipment from other drug users. She perceived the street clinic as being a safe place that allowed her to access clean drug use equipment and avoid the physical threats of the street:

This (the CLSC) has helped where I’m not having to come downtown and having to hit the street stuff like that (clean IVD using supplies) . . . without this (the CLSC) I would be downtown trying to ask strangers for things . . . that part I like - I’m not downtown . . . it (the CLSC) means safety - it means that I don’t have to deal with downtown.

Participants expressed worry about risks to their health should the CLSC close. For example, Brady, a 48 year old man who was no longer using street drugs, explained that without the safe access to the needle exchange individuals may have to engage in behaviors that would increase their risk of blood borne pathogens and other infections: “. . . and if they don’t do that (obtain new and clean IVD using supplies) then they’re going to start reusing needles and that’s just not good”.

4.3.2 Inclusive

Participants described the inclusive nature of the CLSC as helpful in enabling them to meet their physical, emotional, and social needs. The street clinic was described as inclusive of people. The range of services found at the clinic promoted their sense of inclusivity. The street clinic also functioned as a gathering place. In addition, its’ existence was viewed as a sign of concern from mainstream society for the health needs of marginalized individuals.

Participants viewed the CLSC as a place that appreciated people regardless of their physical and emotional states, and/or lifestyles. Participants reported that the inclusive qualities of the street clinic made it comfortable for them to refer others to the clinic because they knew they would be treated well. Although study participants’ initial contact with the CLSC occurred through a variety of connections, the majority indicated that they had been directly referred by other clients. For example, Jerry who was in his fifties sought out the street clinic primarily for health information, but he referred others with communication and interpersonal challenges to the clinic knowing they would not be turned away:

When I meet people that have those social skills (avoid everyone) - or lack of social skills - or hurt experiences that cause them to avoid health (care) I try to encourage them to stop in . . . I walk (them to) the place - I point it out (to them) . . . if there wasn’t this

place I wouldn't have any place to encourage them to go . . . it's good to have a location where I can say this is the place.

Over time, the CLSC grew from a needle exchange program to include a variety of services that addressed a range of health needs and issues. Heather reflected on this growth and increased clientele:

(the CLSC is) different than (name of organization) because people who don't have drug problems come here too . . . I mean just 'cause it's the needle exchange doesn't mean that's the sole purpose . . . it's (the CLSC) not a drug place – you know what I mean? Like it's not where the junkies hang out and it never was . . . they (CLSC staff) always made it clear – just not for drugs.

The inclusivity of services she had experienced over the previous five years led Vanessa to change the name she called the street clinic: “Well other people call it the needle exchange – but I call it the nurse's stations because that is what it is to me”.

The sense of belonging took precedence over any negativity that the small space, poor lighting, and lack of seating may have brought. The CLSC was a gathering place “for chit chat and that”. Not only was the street clinic a place where members of the street community received support from the staff, but it was also a place where they supported one another. Even participants who visited the clinic infrequently highlighted the social aspect of the CLSC:

It was a kind of a meeting place you know . . . it was good - because sometimes I only come in like once a month or once every two months . . . and then I can hang around and talk to people for like an hour or so . . . you know I probably know like 75% of the people around so that's good - and some of these people I haven't seen for like months at a time (Brady).

The inclusivity clients experienced at the street clinic contrasted with participant accounts of being socially isolated because of material and environmental deprivation. Participants expressed having the opportunity to connect face-to-face as helpful in coping with social isolation; making a positive impact on their social and emotional needs. Brady spoke of not having seen many “of these people - I haven’t seen for like months at a time”. Claire expressed a similar experience:

It’s really good (to see old friends) like Sam . . . he did it (drugs) with me like 20-21 years ago . . . I haven’t seen him forever like . . and I wouldn’t have seen him if I didn’t come here.

Connecting at the clinic allowed participants to compare their appearance with others and recognize when others were making progress. This comparison made them feel better about themselves and not so alone in their struggle. For example Brady, a former substance user, shared the positive experience that social comparison held for him:

If they’re heavier (then the last time I saw them) then obviously you know they’re not doing their drugs - you know you can tell by their speech and stuff too . . . hey you know – I’m not the only one out there fighting addictions - there’s someone else out there too . . . it’s almost like a support.

Participants contrasted the inclusivity they experienced at the CLSC with their more exclusionary experiences at other community agencies. Vanessa depicted how it felt to be excluded from food security resources by another community agency, despite the fact that she was a recipient of social disability benefits and therefore a member of the service’s target population group:

You cannot walk into the (name of the agency) or the (name of a second agency) 'cause at the (name of the agency) you have to have ID . . . I've been going to the (name of the agency) for 5 years - they know me by name but I have to bring a picture with me and my friend because they won't believe who I am - even though they know who I am . . . and now you can't even eat lunch at (the name of the agency) without getting your picture taken . . . I don't want to be treated like that.

Even though participants talked of feeling judged by mainstream society, some perceived the help and support they received from the CLSC as reflective of the concern the mainstream community had for them. Jerry's perspective was that the existence of the street clinic:

Means that there is a community concern about reaching out to those that otherwise can't help themselves or have barriers to helping themselves – there is a system in place to deal with the risking and converging issues in street health.

The street clinic helped clients to feel included as members of the wider community.

4.4 Theme 2: I Matter

Participants' experiences of feeling that their physical, emotional, and social concerns mattered to the CLSC street nurse, volunteers, and administration staff, was a theme that was pervasive in all of the interviews. They often acknowledged challenges in engaging with health and social care professionals; especially mainstream service providers. However, participants did not perceive this to be a challenge at the street clinic because they believed themselves to have personal significance to the staff. Their perceptions' of mattering had evolved out of trusting relationships with the CLSC staff. So pivotal was trust to their relationships that participant's spoke of being unwilling to seek assistance if they had to deal with a new, unfamiliar staff member; preferring to return at another time. For example, having been treated

poorly or made to feel embarrassed because of their lifestyle in previous health and social care encounters, clients were initially cautious and sometimes resistant to developing relationships with the staff. Many would visit the CLSC several times in search of needed items, before they would talk to the staff. Taz shared the importance of trust in his interactions with the staff:

It's not easy for me to kind'a talk to somebody - I'm not that kind of a person that lets you talk to me sometimes . . . there are some people (at the CLSC) that try to get to know me a little better you know you know like I'm able to talk about a lot of things (with the street nurse) . . . sometimes I'm afraid to go and talk to someone else about it . . . so - like you say - everything comes from trust.

Participants' perceptions of mattering had evolved from the trust participants had in the street nurse and clinic staff. Participants detailed the elements of mattering in the health and social care relationship according to four subthemes: they will understand me, they will accept me, they will care for me, and they will be there for me.

4.4.1 They Will Understand Me

Participants felt the staff understood and appreciated the challenges they faced. The staff's ability to convey their understanding of the emotional pain and psychological distress of clients was paramount in cultivating mattering relationships. The nurse listened without judgment, sought information and clarified health issues the participants presented with, recognized strengths, and used touch as appropriate.

Participant experiences' of being understood minimized feelings of stigmatization and gave opportunity to explain the course of events and the causes of the situations they found themselves in. Taz explained his relationship with the street nurse:

It's hard you know - more like I have a hard time trying to explain myself to me and they understand better than I do . . . and now I'm here (the street clinic) . . . they (the street nurse) understands you . . and like - where you're coming from.

Reporting that she had come to the street nurse seeking help related to a lip burn from a crack pipe, Heather stated: "and I mean it wasn't like she was lecturing me either . . . she's just like - talked to me about it and made me feel good". Conversely, Vanessa illustrated her perceptions of what it felt like to be regularly scrutinized and judged by the mainstream community and to have her personhood minimized:

It's so hard because I get it (negative judgment) - and quite a few people who are here (are also dealing with constant judgment) you know . . . and the people are - you know down and hurt or out . . and they have quite enough bad judgment on their own . . and they don't need someone else telling them how bad they are.

Participants perceived that being assessed to ensure the legitimacy of their concerns reflected the street nurse's ability to identify with and understand their life circumstances. Clients were not automatically provided with the healthcare that they wanted or believed they required. Heather regarded this as a positive reflection that her needs were being attended to:

They (street nurses) make sure that you are not actually faking it - like that you're actually sick - so when you come in here they (the street nurse) would actually listen to what you're saying - figuring out what's wrong rather than just thinking you're on drugs - trying to get pills or whatever.

Participants described feeling humiliated by the ambivalent attitudes conveyed by service providers who disregarded their individual qualities and circumstances. Taz described his relationships with service providers who he perceived as having treated him with disdain:

Like sometimes I'm afraid to go and talk to someone else about it (what's bothering me) . . . like you know - I quit bothering about a lot of the programs I went through . . . I came out of there (the other program) . . . and now I'm here - they (staff at other programs) made me feel like a fool . . . if you (service providers) don't live it then you need to read about it and how to maybe talk to people who already know about it . . . you know you gotta understand the problem before you can see it.

Other participants expressed empathy for those who lacked insight into the challenges and barriers that the street and drug culture held for those who lived on or close to the street. Claire voiced her understanding of those that exhibited insensitivity because of their preconceived beliefs and attitudes about her:

And that's (members of the mainstream community lack of understanding) not their fault - they're ignorant - they just haven't seen it . . . and they see it because of media - they see it as good-bad, good-bad . . . they look down and you know - that doesn't bother me but you know they don't know what the hell they're talking about . . . you know we're no different (than the mainstream).

In addition to listening, touch was a non-verbal form of communication that made participants feel understood. Hugs were never in short supply at the CLSC. Vanessa provided an example of how staff members made her feel like she mattered:

I come (to the CLSC) twice a week . . . it's just having someone to talk to . . . who understands you when I am really upset they can see it in me now and they'll (CLSC staff) come and give me a hug and say "OK. Come on back and what's going on?" Then it's usually something or someone you know and it's just letting it out.

4.4.2 They Will Accept Me

Participants reflected on how the street nurses' acceptance of them nurtured feelings of mattering. Some participants spoke of trusting the street nurse's acceptance of them because of their shared life experiences. Although the street nurses had not 'lived the life', Claire explained: "No one can understand it (the life) until you've done it". Taz, who had known the street nurse for over seven years, shared his belief of the importance of working with a service provider who had learned the ways of the street experientially and questioned the value of healthcare providers who could not relate to clients: "You know that piece of paper or book or whatever it is? What good is that if you don't have experience? If you don't know what people go through?" Brady illustrated how people working at the CLSC knew about life on the street:

I was stuck with the old codes and (the street nurse) and these guys (CLSC staff) . . they realized that . . . I'd tell her some stories of course and she could relate to it . . . but you know it's like that with all those people (staff at the CLSC).

Because the street nurse conveyed an initial and ongoing attitude of acceptance, participants felt at ease discussing their health concerns. Taz described his experience when the street nurse assured him of acceptance:

Sometimes you know – I just get tunnel vision when a problem arises . . . I just shut myself right off . . . and when I hear that person (street nurse) say "I don't care about whatever" – you know I kind'a feel more relaxed about it (the problem).

Similarly, Heather described the street nurses' acceptance when she sought assistance for an acute health problem directly related to her drug use: "she didn't make me feel like a total leper or anything".

Participants described acceptance at the CLSC that made them feel comfortable in disclosing important health information. This was unlike their tendency to conceal such information from mainstream providers who they anticipated would deny them access to services and programs if they were to provide them with ‘too much’ information. For example, Claire trusted the relationship she had with the clinic staff in a way she did not with her doctor. She contrasted her fear of her doctors’ rejection with the acceptance she experienced at the CLSC:

My doctor’s good - I mean I have a good rapport with him . . . but I’d never tell him about this part of my life (substance use) because you know he’d freak - if he knew I wouldn’t get my prescription from him He (my doctor) doesn’t know this part of me . . . I’ve noticed (that) because of the access to this kind’ve of stuff (IVD supplies) I can go and not - you know - lie to him (my doctor) but be OK with the way my life is going . . so he will take care of that part - these guys (CLSC staff) take care of this part.

4.4.3 They Will Care For Me

Caring relationships were characterized by the staff showing genuine interest and concern in the participants’ health issues, taking time to listen and coming to know them, and doing the necessary follow up to ensure that health needs were met. Participants described the genuine interest and concern that the staff had for them as significant in cultivating trust and making them feel like they mattered.

Genuine concern was shown by taking health issues and requests for assistance seriously: “They (street nurses) deal with health issues when they come up rather than pretending it doesn’t matter or it’s not important” (Lana). Heather recalled the genuine interest and concern she experienced during her interactions with the street nurse, and how she did not have to be ashamed of her drug use when she sought care from the street nurse:

I feel like there (at the street clinic) it's like I didn't have to be embarrassed with anybody . . . I like how helpful everyone is (at the CLSC) . . . I'd show her (the street nurse) and she'd help me - and I like how they care about even druggies going through withdrawals - like me.

Participants compared their experience of being cared for, and feeling cared about, by the street nurse with the care they received from other providers who would ignore or dismiss their concerns and let "it get worse". They felt they were being blamed for their health issue(s) because "they know you're on drugs and they're like . . . oh whatever" (Heather). The clinic staff's attention to Heather's health concerns is contrasted with the dismissal she encountered with a mainstream doctor:

I almost died if it wasn't for (the street nurse) . . . the doctor was like 'oh you're fine - just go'. And if I would have been another week I would have been dead - like it was bad. . . and she got me to go back to the doctor and say 'like there's gotta be something wrong here'. . . so they (street clinic staff) brought me up to the hospital and they (the street clinic staff) got it better.

Participants expressed ease in talking to the staff, which shaped their experience of feeling cared about. In turn, feeling cared about built their confidence and willingness to ask for help. Michael called attention to the uncomplicated nature of his relationships with the street nurse and staff: "It was real easy to make a relationship with anybody that was in here . . . to talk to and to get help". Heather describes talking to the CLSC staff, but few others: "I don't have much contact anymore with people but I felt close to the people (staff) here all of the time . . . so I come here to chat with (the street nurse) - and I like that because they are easy to talk too".

Participants trusted that the street nurse would spend the time needed to care for them. Taking the time to listen communicated that the nurse took their health needs seriously and paid attention to their concerns. Lana explained how “they’ve (the street nurse) sat down and explained different processes with me when I’ve had different issues that have arisen . . . they take a look at them”. Vanessa reflected on how listening alone supported her to cope with a challenging family situation:

I’d come in here crying and someone would bring me back (into the treatment room to meet with the street nurse) – they’d (street nurse) let me go and bring it out – you know . . . and it really helped because they couldn’t change it . . . there wasn’t any like ‘kick your son out’ or ‘do this’ or ‘do that’.

The time the street nurse took was especially important for engaging participants involved in high-risk activities that carried a moral judgment and were not socially condoned. Fear of being treated negatively frequently resulted in lengthy conversations before participants trusted the street nurse to provide them with the care they sought. Brady remembered the needle exchange as having been the introductory link in a chain of ongoing and effortless conversations that had led to a trusting relationship with the street nurse:

At first you want to get out of there (the CLSC) and go get stoned (after using the needle exchange) . . . then after awhile it didn’t matter because I’d just sit there when the door was open - and I’d sit there and talk to her (the street nurse) . . . you know right off the bat things was working so I told her (street nurse) a lot of things that I’ve never told anyone - like even friends . . . so it was pretty good.

Participants trusted the street nurse to take the time to listen to their narratives and health history without their having to prove or justify it. Not having to repeat the same background

information each time she met with the street nurse, Vanessa knew that she could just add to her story: “They (the street nurse) keep a file for me here – and so when they do things and I just come in and tell them (stuff) they add it onto their file (on me)”.

Participants perceived themselves as being cared about in the follow-up care the street nurse provided for their acute and chronic health conditions as well as those of their family members. Vanessa recounted the street nurse’s personalized follow-up care of her son who she brought to the clinic after receiving unsatisfactory care by a doctor: “He broke his foot or toe – and they (the street nurse) got x-rays for him and made sure he got medication”. Heather also highlighted the importance of the ongoing follow-up care she received in resolving her acute health issues:

I was really sick with pneumonia - like I couldn’t even walk across the street without losing my breath . . I came in here (CLSC) and she (street nurse) listened to my chest and she called the doctor for me and all that stuff . . she (street nurse) just kept checkin’ – like getting me to come in all the time to check when . . . that was good ‘cause I was gunna keep just going like - you don’t want to really realize just how sick you are.

4.4.4 They Will Be There For Me

Mattering evolved from relationships of trust that were fostered by the staff’s demonstrated willingness and ability to accommodate. They could be depended upon to provide a variety of health and social care services such as assisting with child welfare issues or phoning clients if they were incarcerated. For example Lana remembered the staff as being there for her: “They go out of their way to try and help for everything I’ve needed”. Heather recounted how the street nurse made appointments to meet her “even outside of the clinic time . . . she was good for that and if I forgot them she’d call me”. Study participants perceived themselves as having

received both emotional and physical support from the CLSC that went beyond their expectations.

When health and/or lifestyles changed and visits to the CLSC were infrequent, participants expressed a sense of security in knowing that the street nurse and staff could be relied upon to still be there for them. Jerry explained: “the really helpful thing is just knowing that they’re present - and available and that they’re here . . . it’s kind of a reassurance”. Living in Vernon’s downtown area, Anya, who had been coming to the street clinic for over seven years, stated: “they’ve always been very helpful and aware or whatever . . . they’ve all been there when I’ve needed them . . . (for example when) I said ‘I need help’ she (the street nurse) was there”. Secure in the knowledge that the staff would be there; Claire described the street clinic as being part of her action plan:

I don’t have a nickname or an AKA you know – my name is Claire and when I come in here I give them my name – not something like ‘princess’ or ‘dirt devil’ . . . because if I go missing how are they going to know me as ‘princess’?

Participants, including Claire, compared their relationship with the CLSC with that of family:

They’re (CLSC staff) always there . . . I could come here and they would help me - no matter how big or how small . . . and I just know they’re always there . . . Yeah Yeah . .

I’m losing a part of my family.

4.5 Theme 3: Meeting My Needs

Participants perceived that the health and nursing services and programs they found at the CLSC provided them with the assistance they needed to meet their health and social needs. The support they received that was most significant to the participants is grouped under the following

subthemes: obtaining information, receiving basic supplies, and being pointed in the right direction.

4.5.1 Obtaining Information

Participants described the CLSC staff as sources of health information that empowered them to recognize the options that were available to them. Clients relied on the staff as their primary source of information in the promotion of good health and the prevention of illness, infection, and disease. Many also came to the street clinic seeking information about societal and community resources. For example, Jerry articulated how he had found the street nurse to be of help to those clients “(who) are unable to do it on their own without some kind of guidance or direction or encouragement”.

Participants perceived the teaching and learning they accessed with the help of the street nurse as increasing their control over their health and well-being. Taz reported that one of his reasons for coming to the street clinic was to “get information sometimes that I need - and to learn a goal”. Claire stated:

You know education - a few things like that has helped people with their kids . . . and you know (with) their (my son’s) friends “Mom can I get a (condom)” – “You know where the bowl is - help yourself” . . . education is . . . yes - is for everybody - ‘cause hell if we had education I wouldn’t have Hep (hepatitis) C . . . which isn’t a bad thing you know - I’m not going to die . . . there’s pamphlets everywhere (at the CLSC) and I always grab pamphlets and stuff like that . . . without all of it I wouldn’t have the knowledge I have today.

Anya, a mother of teenaged children, had been accessing the CLSC for over 5 years. She recalled: “They’ve (street nurse) taught me how to keep myself clean - and if I have open sores

(how) to keep them clean and covered”. Avery, who stated that she was awaiting a cholecystectomy, described the street nurse as having collaborated with her in the development of strategies that would improve her long-term health:

(the street nurse has) given me information on what type of food I should be eating due to my medical problems - in terms of things I need to do to change my diet and everything . . . I’ve stopped eating the junk food and fried food and things with high cholesterol and I’ve started eating more fresh vegetables and more fruits.

4.5.2 Receiving Basic Supplies

Participants described the CLSC as a place where they could have their physical health and basic survival needs met. This help often took the form of health and social care items that were offered unconditionally. Clothing and foot wear, food, medical and hygiene items, bus tickets, and swim passes for showering, were freely accessible at the CLSC. Renn described how the ‘no-questions asked’ access to resources met his physical need for warmth and comfort:

If you needed clothes or whatever like layers or jackets or . . . (you can) just come here and get it- and that helped a bit because I had no jacket for the winter . . . and for stuff I forgot to get at the store . . . like maybe I didn’t have any (money) to get it – like soaps and shampoos and lotions – so I got it here.

Vanessa had been coming to the CLSC for over five years. She also focused on the easy access to needed supplies:

No one (street clinic staff) asks you why you need the same thing twice . . . or like look at Sally – she’s living on the street and every day she comes in and probably asks for the same thing because yesterday she lost it . . . and there’s no condemnation with like “What did you do with the toothbrush I gave you yesterday?”

Other participants accessed medical and first aid supplies such as vitamins, over-the-counter medications, wound care supplies, and water at the street clinic. Participants also described having received financial help to purchase prescription medications, either for themselves or for family members. Vanessa gave an account of when she came to the street clinic seeking assistance on behalf of her adult son: “I didn’t have any money and we needed medication for him and they (street nurse) phoned the pharmacy for it – I believe otherwise I would have had to wait 8 days”.

4.5.3 Pointing Me in the Right Direction

Participants described the difficulties they had in attempting to access resources and healthcare in the wider community for themselves and for others they knew. Participants identified the street nurse as someone who facilitated their access to professional health and social care as well as a variety of community-based helping initiatives. These included applications for birth certificates, health and medication insurance, child benefits, and disability services. Claire expressed her frustrations with having been given wrong or inappropriate information by service providers: “because you probably go to the wrong place and not get the proper care and - we don’t know that you know . . . it’s not helping us”. In her search for access to dental care, Vanessa illustrated the hardship she continued to endure after having been given poor direction:

Like I had my teeth - I talked to them (mainstream service provider) about my teeth because of that tooth there . . I paid 700 dollars to have a root canal and then three months later the tooth broke - and now I’m still paying for the root canal where there’s no tooth.

Participants also described the CLSC as giving them access to services, programs, and resources of which they were unaware. Claire reflected: “(And) where I wouldn’t (have) known (of) that (place) before - they would show me a door that I could take that I didn’t know was there before”.

Participants described the street nurse as mobilizing resources on their behalf and providing them with individual personalized direction which facilitated the accessibility of societal, and community resources. Participants recalled this accessibility to resources as turning points in their lives. Anya remembered: “. . . at one point I didn’t believe that there was anything out there . . . but it was (the street nurse) who set things in motion (for me)”. Michael elaborated on the facilitated access to needed health care he received: “She (street nurse) put me in touch with the team (Crisis Response Team) to get me in the psych ward - because I was having problems . . . then I met people”.

Participants spoke of advocacy as playing an important role in their ability to access limited resources, services, and programs. Participants credited the street nurse with advocating on their behalf to secure housing and admission to programs with limited space. For example Michael illustrated how the street nurses’ advocacy efforts pointed him in a direction which had given him access to a new start:

They (the street nurse) will point me in the right direction I was living on the street - and I just didn’t have it within me to go ahead and call these places - and she (the street nurse) grabbed the paper - went through the list with me . . (and) called a place for me . . and from there my life started turning around . . . I got a place to live - I’ve got my fifth wheel back - I got my truck back - I got married.

When the healthcare, service, or the assessed need sought by clients was beyond the scope of practice or resources of the street nurse, clients were referred to the appropriate program and provider. Lana pictured the street nurse as being a hub in her desire to improve her health: “It’s (the CLSC) a connection to help take care of myself for - I’d say health issues . . . it’s always been good . . . (they) try and resolve the issue or send me where else I needed to go”. For example Renn had turned to the street nurse in his search for affordable dental care: “I asked her (street nurse) about these bad teeth - this here tooth . . and she said I needed to go to (a non-profit community organization) - for people that only come for dental”. Additionally, participants described help received from volunteer staff members and the administration assistant in their search to access community resources. Vanessa recalled: “(the CLSC administrative assistant) has done so much for me . . like my income tax this year . . she helped me get that (and) she talked to the welfare for me this year”.

4.6 I’m OK

Through their experiences of gathering information, receiving basic supplies and accessing community services, some participants began to find a new way of living and to feel that they were okay. The support they had received at the CLSC had prompted participants to create a new vision for their future health and well being by making positive changes and giving back to others.

4.6.1 Positive Changes

As a result of the help received at the street clinic, participants identified that they had developed capacities that enabled them to break away from self-destructive patterns of behavior. With the support of the staff, participants spoke of having developed greater self-awareness and an increased ability and willingness to discuss their feelings and experiences. Anya spoke of

having come to understand herself better and change for the benefit of her children: “ I’m trying to straighten my life out . . . my daughter is going to be 18 and I’d like her to be able to come home and live with her mom – ‘cause her brother’s at home now”.

Participants acknowledged that they were responsible for having done the difficult work of change. Participants discussed a variety of positive changes that they had made in their lives. While these positive changes were personal and not applicable to all, they included getting off the street, overcoming addictions, getting back custody of children, being more open about feelings, willingly seeking support, and improving chronic disease self-care management regimes. Heather spoke of the significant impact she perceived the services provided by the CLSC had had on her life:

I wasn’t doing it ‘cause I like drugs - I was doing it ‘cause I didn’t like myself . . . sometimes you know like you get really sad or like whatever – it (the CLSC) just made me realize that I had to change . . . like that wasn’t the life (street life) I wanted . . . “(If it wasn’t for the CLSC) I’d probably still be on the street right I hate to say that but – I would be if they weren’t around for sure I’m thinking of going back to school.

Several participants spoke of how the support they received at the CLSC helped them overcome addictions. Brady shared the insight that the support of the street nurse had helped him become the master of his addiction:

Over the years (I’ve learned that) a lot of it I think is that you really want it (the drugs) when you look at it . . . (and) in the old days it was the drugs (first) and then you’d think . . . what I’ve learnt is (that) you can control all of that (drug cravings) through your mind - that’s what (the street nurse) always told me how do you say it – I guess – your

mind has a lot of power inside of it I guess you know you can talk your way out of anything - and I can do that now but then that's what they (street nurse) taught me.

As a result of stopping her use of heroin Anya was able to regain custody of her children:

I don't do heroin (any more) . . . the only thing that I do is my pain medication - besides my every day (prescribed methadone) . . I don't use anymore thanks to the street clinic - I can go home now - I'm not helping out the ones (that are still using) . . . my home is my safe haven now . . I mean yeah I'm still tempted - but I just think of my kids.

While Jerry recalled the support offered to him by the street nurse as having: “help(ed) me creatively to think of what other kind of solutions there might be that could be added to the mix”, other participants had reflected on their lives and decided they were fine with where they were currently at. For example Claire stated: “You know I'm fine with me doing drugs you know – I'm OK with that . . . they (substance users) just want to do their drugs and be left alone”.

Participants also discussed how with the support of the CLSC they had become better able to follow self-care regimes for chronic disease management. Lana asserted: “I'm taking better care of myself . . . by following up on doctor's appointments – medications – by monitoring my blood pressure . . . that kind've thing”. While others, such as Taz, explained how being more open about feelings improved one's ability to manage health and social needs:

I changed my lifestyle from what I've been doing in the past . . . I didn't know how to deal with it before . . I wouldn't even talk to anyone else - like you know about my feelings and past experiences . . like it's a lot easier for me to deal with my problems now than I did before the street clinic opened up . . . I'm more able to be more open about how I feel . . . 'cause that's what gets me in trouble when stuff gets in and (I) keep it in.

4.6.2 Giving Back

As clients who were living homeless and near homeless became increasingly self-reliant as a result of the positive changes they had made, the world around them became more visible. No longer needing to focus only on the struggles of daily survival, participants described having discovered inherent skills and abilities that could be of help to others. Brady's narrative portrays the impact that one's sense of self can have on how one thinks, perceives, and acts in the world:

There's the other guy there - he's maybe not quite in as good a place as me. .but you know I bring him things . . and people will say 'You know you're crazy for doing this' - but you know I was there in my past . . I'm only one day ahead . . you forget about that past and you know . . . I know better than that - I'm only one day ahead.

He also shared his dreams of giving back by helping young people who he could see were traveling down the same path he had once taken:

I've always said that if I could I would love to do what you guys do because you know if maybe I was able to talk to maybe three or four of them (young kids) maybe I could help one of them . . . you know if somebody comes to tell them they're not going to listen to them - maybe if somebody like me - with a few tattoos and the marks (track marks) - goes and talks to them . . and (I) tell them stories about what I've (done) right . . and hopefully they'll say 'Hey maybe this guy is right - Maybe I should listen to him'.

By giving back what they had received, participants called attention to their desire to be positive contributing members of their community. Some participants described how they were now providing assistance to agencies that had supported them. Michael explained how his concern for the safety of others was a motivating factor in his desire to assist the CLSC in keeping the community free from randomly discarded used syringes:

The thing I like to do is to walk around in the park - my wife and I both enjoy it . . we like to walk in there (the park) and as we do it we always carry a bag for beer cans and pop bottles and that - but we also pick up the broken ones (discarded needles) . . . I collect them (discarded needles) whenever I get a chance I'm always scared of kids getting hurt - getting hit by one of the needles . . . and that would be a tragedy.

Others spoke of giving back by assisting individuals who they could see were struggling.

Because of his life experiences, Taz expressed confidence in his ability to help others take the right road:

Like you know sometimes they (others with similar life experiences) don't know how to deal with it (feelings, past experiences, pain) like I do . . . I tell them 'Well it's OK - you know it's not going to hurt you anymore than you are (hurting) now' - so they understand . . . they learn to trust me 'cause you know I've been through it.

4.7 Summary

The CLSC was a healthcare service specifically targeting people who were living homeless and near homeless in the community and surrounding area. This study provided participants the opportunity to describe their perceptions of the help and support they received from the staff. The participants explained that the staff created a service that cared for the physical, emotional, and social health of all clients. Their perceptions illuminated the importance clients placed on (a) place, (b) mattering, (c) meeting their needs, and (d) feeling OK about themselves.

The meaning of having a safe and inclusive place, where participants found providers who made them feel like they mattered and supported them in their ability to meet their emotional and physical healthcare needs, was important. Participants' perceptions of mattering

were embedded in the trust they had that the CLSC staff would be understanding, accepting, caring, and could be relied upon to be in time of need. Participants described the informational, material, and health and social care referrals and advocacy, they found at the street clinic as motivational for self-care. Participants recognized that their personal challenges had led to the acquisition of life lessons and skills that would be of value to others in their community.

CHAPTER 5: DISCUSSION, IMPLICATIONS, AND CONCLUSION

5.0 Overview

The purpose of this study was to discover and understand client perceptions of the Cammy LaFleur Street Clinic (CLSC) program. Client perceptions of the street clinic were grouped into four distinct, yet interdependent themes: ‘My Place’, ‘I Matter’, ‘Meeting My Needs’, and ‘I’m OK’, with accompanying subthemes. These themes will be discussed in connection with relevant research and field observations, followed by a discussion of the implications of findings and the study’s strengths and limitations.

5.1 Client Perceptions of Street Clinic Services

The perceptions that clients had of street clinic services exist within a larger healthcare context shaped by economics and policies. The street clinic which served a largely homeless or near homeless population, mirrored societal perceptions of who is deserving of health and wellness resources and who is not.

North Okanagan Youth and Family Services Society (NOYFSS) received contract-based funding from the Interior Health Authority (IHA). The financial constraints imposed by government during the past two decades had led to fewer services and programs, and reduced access to benefits by people who were poor in the community (Canadian Public Health Association, 1997; Cutting Services Not Poverty, 2005; Wilton, 2004). Although the CLSC staff worked to improve health and wellness, they were unable to change the policies, laws, and economic systems that contributed to poverty and homelessness in the community. As a result, the street clinic had to rely heavily on donations and volunteers. Despite these structural and organizational challenges, findings suggest that clients did not perceive the quality of care received at the CLSC to be less than that received by people who were not homeless or at risk of

becoming homeless. Clients in this study made few complaints and were overwhelmingly positive in their perception of the clinic.

Political, economical, and legal policies that are focused on the health related behaviors, choices, and lifestyles of the individual (Labonte, Schrecker, & Gupta, 2005; Raphael, 2007), have succeeded in making people feel guilty for being poor (Swanson, 2001). Perhaps it is for this reason that people who are homeless and near homeless often feel that they have no right to complain (McCabe, Macnee, & Anderson, 2001; Smye, Browne, Varcoe, & Josewski, 2011; Swanson, 2001). It is conceivable that in this study the lack of negative comments was because participants felt that the system was justified in providing them with inadequate resources. Collectively, the IHA, British Columbia's Ministry of Health and Provincial Health Services Authority, and clients of the CLSC, might have felt it was acceptable to provide people who were homeless and near homeless with less. Yet in contrasting the CLSC with other services and programs they accessed, participants described provider-client experiences they perceived negatively. The attitudes and behaviors of other providers had caused them to feel powerless and vulnerable.

Nonetheless, as a non-profit community-based organization, NOYFSS and the CLSC were excluded from the traditional health care system. However, freedom from over-regulation by hierarchical levels of authority had provided the staff with the autonomy to cultivate a wide range of no-cost resources and services for clients. The positioning of the clinic within the traditional healthcare system was instrumental in the street clinic program having evolved from a needle exchange program to one that was capable of offering both health and social care services. The independent nature of the CLSC's alliance with the IHA served to forge a fundamentally positive relationship between CLSC staff and the community, service providers

and business owners, on behalf of clients. On the down side, the efforts of NOYFSS and the CLSC staff took the onus off of the government to provide the necessary health and social care to meet the needs of community members who were poor and homeless, or near homeless.

5.2 My Place: There's a Place for Me

Collectively, participants' experienced attachment to the CLSC as a place of safety and inclusivity. It had become a sanctuary from the chaos of street life. Place attachment characterizes the multifaceted bond that commonly occurs between people and the places that are meaningful to them (Scannell & Gifford, 2010). Scannell & Gifford's (2010) three-dimensional framework of 'person - psychological processes – place' serves to clarify understanding of how elements of the CLSC had interconnected to shape participants' perceptions of safety and inclusivity. Person, or the connections that people have for a place, refers to personal and cultural bonds. The psychological process dimension of place attachment highlights the way in which people relate to a place. The third element, place, signifies the social and physical dimensions of place attachment.

The 'person' dimension was evident in participants' references to patterns of behavior and thought that pointed to the CLSC as symbolic in the lives and minds of people living homeless and near homeless. As it evoked positive personal and shared memories of safety, the street clinic had contributed to a stable sense of self having offered invisibility and refuge from biased attitudes and condemnation. It was a place where clients felt comfortable being in their 'own skin'. The CLSC was a place where participants did not feel inferior and could escape the blame and shame of poverty. This is similar to other researchers who also found that people who are poor feel ashamed because they are poor (Lyon-Callo, 2000; Reutter et al., 2009).

The relationship participants had with the clinic, or the emotional attachment to place (psychological dimension), was not one of dependence, despite its' role in helping them survive poverty and improve their access to health and social care. Visually, the street clinic might have given the impression to 'outsiders' that people who are poor and homeless were less deserving of quality health and social care. However, the CLSC had created a safe environment where clients perceived themselves a 'fitting in' (Scannell & Gifford, 2010). The health and wellness care, support, and resources, found at the street clinic were practical and matched clients' everyday realities. This finding adds support to those of other researchers regarding the positive impact that emotional safety can have on willingness and motivation to seek out health and social care (Gessier & Maes, 2011; Khandor & Mason, 2007; MacNeil & Pauly, 2010; Wen, Hudak, & Hwang, 2007; Worthington et al., 2008).

The place dimension of Scannell & Gifford's (2010) place attachment framework has highlighted the social and physical characteristics of the CLSC. They propose that people become attached to places that facilitate social relationships and a sense of community. In the current study, participants found the street clinic to be a place that housed many of their social ties and networks, and where they were able to integrate their own experiences with those of others. In contrast to other health care settings where they were often looked down upon, at the street clinic the clients felt no cause for embarrassment because of their health and social issues. Participants perceived the comfort and companionship found at the street clinic as having helped them to reframe their health and social problems more positively. Similarly, Fast, Small, Wood, & Kerr (2008) and MacNeil & Pauly (2010) discovered fixed-site needle exchanges to be described by clients as a 'socially positive' environment. The findings of this study demonstrate

that the multiple processes involved in person-psychological-place bonding are pertinent to homeless and near homeless people in accessing health and social care.

5.3 I Matter: Someone Cares About Me

This is one of the few studies to identify the importance of mattering for people who are homeless and near homeless (DeForge & Barclay, 1997; DeForge, Belcher, O'Rourke, & Lindsey, 2008) and unique in revealing how mattering influences their perceptions of health and social care. Perceptions of mattering are shaped by the belief that one is important and significant to the world in which one lives (Elliott, Kao, & Grant, 2004). In this study, mattering evolved out of trusting relationships with the street nurse and volunteers. Rather than the cumulative negative impacts of feeling that others do not pay attention, listen to, or believe you, which make homeless and near homeless individuals begin to feel like 'non-persons' (Elliott et al., 2004; Lyon-Callo, 2000; Geanellos, 2002), participants felt like they mattered to the street clinic staff.

The presence of regular providers who were trusted to be available and responsive to their needs and interests had a central role in cultivating participants' sense of mattering. Adding support to the findings of Elliott et al. (2004), the current study found that feeling understood, accepted, cared about, and being able to rely on the staff to be available and responsive during times of need, was reassuring. This finding is also consistent with the findings of Carter, McSweeney, Storey, & Stockman (2001), who found that repeated exposure to providers who were compassionate, who understood them, and who had accepted their strengths and challenges during previous clinic encounters, shaped participants' perceptions of trust.

Feeling that one matters is positively associated with self-esteem (Elliott et al., 2004; Raque-Bogdan, Ericson, Jackson, Martin, & Bryan, 2011; Taylor & Turner's (2001).

Participants' experiences of feeling understood fostered self-worth, self-esteem, and self-efficacy, resonates with the findings of other researchers who found that homeless and near homeless people were more willing to return for further care when they perceived that the provider(s) cared about them (Barry, Ensign, & Lippek, 2002; Cunningham, Sanchez, Heller, & Sohler, 2007; Exner et al., 2009; Fast et al., 2008; Hudson et al., 2010; MacNeil & Pauly, 2010; Rogers & Ruefli, 2004; Shiner, 1995; Woods et al., 1998). Repeat exposure to providers opens opportunities for the processing of health and social care information. Mattering affirmed deservingness of health and wellness and prompted greater self-care and the desire to seek out health and social care.

In this study, mattering positively influenced participants' sense of self, and turned their attention towards their personal health and wellbeing. Participants perceived the staff as seeing the good side of them as the communication of successes was integrated into the care process. Clients perceived that they mattered as they were treated as experts and partners in the creation of realistic and achievable health and wellness strategies. They were encouraged and supported to take ownership over their health and wellness. Rather than perceiving themselves as being pitied or feeling stressed by demands and expectations, they found collaboration. This finding is similar with what other researchers (Fast et al., 2008; Geanellos, 2002; Hilton, Thompson, & Moore-Dempsey, 2000; MacNeil & Pauly, 2010; Ribner & Knei-Paz, 2002; Wen et al., 2007) have found, and contrasts with other settings in which people who are visibly poor are often discounted by service providers as well as by members of the general populace (Davis 1996; Hudson et al., 2010; Raphael, 2007; Reutter et al., 2009; Sayles, Ryan, Silver, Sarkisian & Cunningham, 2007; Swanson, 2001). The experience of collaborating with the provider(s) was an important dimension of mattering and heightened participants' awareness of the consequences

of delayed health and social care. It also promoted the interest of participants about issues they perceived as being non-urgent or trivial and their willingness to return to the street clinic for assistance in addressing these issues.

5.4 Meeting My Needs: I Know What I Need

People do not choose to be homeless. Nor do they choose dependence on others to have their needs met (Davis, 1996; Flaskerud & Strehlow, 2008; Goodman, Saxe, & Harvey, 1991). Nevertheless, health care interactions in traditional settings make them feel guilty, ashamed, and humiliated because they do not have enough money (Raphael, 2007; Swanson, 2001). Having to always rely upon individuals, non-profit organizations and charities, and/or government agencies for survival can create relationships “of power and dependence” (Swanson, 2001, p. 135). Over the long term, feelings of inadequacy are often accompanied by behaviors reflective of learned helplessness (Flaskerud & Strehlow, 2008; Goodman et al, 1991). These behaviors include resentment, anger, passivity, and/or depression. However in this study, participants perceived the CLSC as having supported their independence. They spoke of the staff as having helped them find what it was they needed, rather than telling them what it was they needed. Promoting the sense that they were not alone in the daily challenge of meeting basic needs supported clients to become accountable for the meeting of their needs.

Offering free access to resources was found to have normalized the needs and survival practices of the client group. Rather than framing their needs, or difficulties in meeting needs, as unique or failures, findings suggest that programs and providers who structure supportive resources in the context of common humanity promote self-care. Models of care that offer free ancillary services alongside healthcare (Barry et al., 2002; Cunningham, Sanchez, Li, Heller, & Sohler, 2008; Exner et al, 2009; MacNeil & Pauly, 2010; Manning-Walsh et al., 2004; Rogers &

Ruefli, 2004; Tresolini & Shugars, 1994) serve to broaden the definition of health and healthcare to include physical, mental, and social well-being. Similar findings have also been noted by others examining comparable models of care (Benoit, Carroll, & Chaudhry, 2003; Conviser & Pounds, 2002; Cunningham et al., 2007; Cunningham, et al., 2008; Rogers & Ruefli, 2004; Woods et al., 1998). Healthcare programs such as the CLSC that encompass a wide variety of strategies empower clients to cope with their health and social needs. In addition, requests for donations can strengthen community consciousness of the link between social determinants and health.

This study also found that free access to resources facilitated the entry and retention of clients into primary care. Client motivation for self-care was nurtured with the tangible, informational, and directional resources found at the CLSC. Similar to the findings of others (Jones, 2004; McMaster, 2004; Roe, 2005; Van Beek, 2007), helping people to re-examine their situation through the development of new knowledge and skills, role modeling, and rehearsal, encouraged the reduction of risk taking behaviors. This is consistent with the pragmatic and humanistic attitude, philosophy, and approaches of harm reduction (British Columbia Ministry of Health, 2005; Pauly, 2008; The Government & Public Awareness Task Group of NPNU Consortium, 2000). The findings of the current study suggest that supporting people to meet their needs without self-condemnation increases self-awareness and personal health. Health and social care providers and organizations that present people who are homeless and near homeless with individual choice, dignity, opportunities, and community, support people towards independence (Swanson, 2001).

5.5 I'm OK: I Am OK

People who are homeless or near homeless must be able to solve problems and find meaning in life without the usual tools of income and stable support. Some of the strength(s) and insight(s) needed to survive poverty are obvious. However the hidden social and human costs of feeling that no one cares are telling. Anxiety, depression, and avoidance of potentially stressful situations despite the longer term consequences to their health and wellness, are frequent outcomes (Davis 1996; Hudson et al., 2010; Reutter et al., 2009; Sayles et al., 2007; Wen et al., 2007). In this study, the varying dimensions of support and nurturance received from the CLSC staff appear to be linked to the participants' increased sense of self-determination and agency. Participants became more optimistic about themselves and their futures as they came to realize that their worth was not hinged on their being homeless, near homeless, or housed.

Participants' perceptions of themselves as being "Okay" grew out of self-acceptance as effective decision makers with skills and insights. The negative attitudes that some participants had previously had about themselves had been transformed for the better. Participants began to understand, accept, and rely upon their strengths and capacities. They began to regard themselves with greater kindness. Saleebey (1996) explains that understanding one's responses to adverse life circumstances lies in one's ability to discover where one's strengths lie. Neff's (2003) construct of self-compassion has relevance to CLSC clients given that self-compassion promotes a growing mindfulness of the risk(s) of becoming trapped in self-pity and awareness of the challenges of others. In this study, self-acceptance and self-compassion evolved into a growing acceptance and compassion for others. Survival-based behaviors and knowledge such as bottle-picking were admired and described by clients as recycling, environmentally responsible, and resourceful. The ability to stay alive despite the hazards presented by the drug

and sex trade was viewed as ingenuity. This study's findings imply that being supported by providers who nurture positive self-perceptions is foundational in establishing a sense of common humanity. A positive perception of self transformed how participants dealt with their own future challenges and their perceptions of others who were struggling.

While client awareness and understanding of their potential developed, their desire to increase their good qualities and reduce the negative ones grew. Supporting the assertions of Olsson, Bond, Burns, Vella-Brodrick, & Sawyer (2003) and Saleebey (1996), the findings of this study suggest that the development of personal goals can serve as a protective coping strategy. Similarly, Connor, Gaines Ling, Tuttle, & Brown-Tezera (1999) found that working with people who were homeless or street involved, helped previously homeless people avoid the call of the street. As the participants of this study became honest and knowledgeable about their strengths and vulnerabilities, they began to plan for a life that did not include instability and homelessness. Having goals reminded participants that they had the potential, the capacities, and the resilience to achieve health and wellness. Having goals helped to keep their awareness of their own significance and their deservingness of health and happiness, in the forefront. Collectively, the health and social care provided by the CLSC positively impacted client perceptions of self and fostered a sense of I'm OK.

As participants became more self-compassionate they were less self-critical, became more resilient, and were more fully able to express their humanity. This is consistent with previous studies that have shown that self-compassion is positively associated with optimism (Neff, Kirkpatrick, & Rude, 2007), social connectedness, emotional intelligence, and self-acceptance (Neff, 2003). Some of the participants in this current study were no longer focusing only on their personal challenges. As they gained new perspectives they reflected upon their past

to understand their present circumstances as well as the challenges of others. In response, they perceived it to be their responsibility as a community member to protect and support others. The CLSC as a program and a service served to dismantle and undermine societal voices that clients had internalized, and change their inner voice from one of self-blame to one of affirmation. Learning to control self-criticism through understanding and supporting others in confronting common problems, is working towards the improvement of health and wellness for all (Swanson, 2001). Giving back can challenge self-criticism and patterns of blaming.

5.6 Implications of Findings

This study has highlighted the meaning that the CLSC had for clients and the impact the care received had on their health and wellness. The implications of these findings for nursing practice, nursing education, and nursing inquiry are discussed below.

5.6.1 Implications for Nursing Practice

The number of people in British Columbia living homeless and near homeless continues to grow (Eberle Planning & Research et al., 2010; Khandor & Mason, 2007; Social Planning & Research Council of British Columbia, 2011; Worthington et al., 2008) and this trend has serious ramifications for nursing practice. As the largest group of paid healthcare workers within the Canadian healthcare system, nurses are often the first point of contact for prospective patients and clients. They are the primary gatekeepers and have a duty to provide safe, compassionate, competent, ethical, and moral health and social care for all, including those who are poor and homeless, or at risk of becoming homeless (Canadian Nurses Association, 2008).

On the broad economic and political fronts, individuals are encouraged to identify and deal with health and social issues on their own (Raphael, 2004; Raphael, 2007; Swanson, 2001). As a result, front-line nurses may falsely perceive themselves as having limited responsibility in

minimizing or eliminating societal inequities that prevent people from accessing health and wellness (Douglas, 2012). Nurses have a responsibility within their worksites to change the way that primary health care is experienced by people who are homeless and near homeless. Through the caring practice of listening, nurses can help clients avoid the pitfalls of fear and self-blame by supporting their perceptions' of mattering. Nurses who value the experiences and insights that clients bring to the health and social care encounter learn from the experts the realities of being homeless or near homeless. Listening to client stories lays the groundwork for shifting the focus of nurses' from individual behaviors towards organizational policy and procedural changes that can enhance the capacities of clients to reach their health and wellness potential. As nurses listen to how people who are poor feel discriminated against in health and social care encounters, they can become knowledgeable about elements of care that can support vulnerable groups of people to successfully move through the delivery systems of care in their communities. Nurses who integrate their knowledge of these elements of care with their knowledge of organizational and structural factors, have the tools to support people who are homeless and near homeless to receive care they are entitled to.

Collaboration is an important element of mattering. Homeless and near homeless client experiences of collaboration come to fruition when they perceive the power that comes with knowledge and knowing, as having been shared. Nonetheless, despite clients' perceptions of power sharing within the helping relationship, nurses' ultimately wield more power with greater access to information, specialized knowledge, skills, and resources. It is for this reason that nurses have a responsibility to ensure that their use of power is always to the benefit of the client, and the needs of the client are the priority (CRNBC, 2006). Their efforts positively impact client perceptions of need and willingness to seek care in the early stages of illness and poor health. In

contrast, nurses who allow negative attitudes, beliefs, and behaviors to enter into the nurse-client encounter, misuse their power and make the homeless and near homeless client feel vulnerable and powerless.

Working with, and learning from, clients who are struggling with both health and social issues will help nurses stay grounded and connected to what is really important in life (Neff, 2003). Mattering helps to eliminate psychosocial barriers which prevent homeless and near homeless clients from realizing their self-worth, their capacities, and their health and wellness. Believing themselves to matter gives clients the confidence to use their voices. Nurses who support client perceptions of mattering can support the development of client resilience, and can help avert previously homeless people from slipping back into harmful patterns of thought, feelings, and behaviors, when life becomes easy or too difficult. Nurses have the power to support the clients' sense of mattering. As explained by Michele Forest, "(w)e need to get back to the concept that we are part of a community" (Swanson, 2001, p. 150) in which everyone perceives themselves as mattering and equally deserving of food, clothing, shelter, and health.

5.6.2 Implications for Nursing Education

This study's findings have illuminated aspects of caring for vulnerable populations that need to be emphasized in nursing education. The nurse-client encounter is inherently unequal and this imbalance in power is promoted by nursing interventions that are focused on a deficit approach to care (Sousa, Ribeiro, & Rodrigues, 2006). Many nursing students graduate from their educational programs believing themselves to be experts about health and social care needs (Sousa, Ribeiro, & Rodrigues, 2006). However, they either forget or have a lack of awareness that such expertise is achieved only by collaborating with patients during the provision of care.

Nurses do not necessarily need to have walked in the footsteps of their clients in order to provide them with meaningful and effective care. Relational practice courses provide knowledge and skills to care for vulnerable populations. However many nursing students come from a context in which they have little understanding of the social determinants of health, especially socioeconomics. The participants in this study described providers, including nurses, who gave little weight to their lived experiences and expertise. They felt patronized and humiliated because they felt misunderstood, judged, and not cared about. As a result, they were reluctant to return for further care. However, participants also described the actions of providers who made them feel like they mattered. It is for this reason that the findings of this study challenge nursing educators to develop competency-based curricula that will broaden the view(s) that nurses have of what they want to accomplish during the provision of care. Focusing on who people are and what they have during the provision of care, promotes self-compassion, self-forgiveness, and resilience.

The intention of this new curriculum would be to support and nurture nursing students in their ability to help clients perceived themselves as mattering within the provider-client encounter, and change the perceptions of both nurses and clients of who is worthy of health and wellness. Nursing curricula that promotes the adaptation of biomedical practices to the realities and circumstances of individual clients endorses competency based health and social care. The art of nursing can be realized when self-compassion, self-worth, and the self-confidence of the client is promoted within the nurse-client encounter.

5.6.3 Implications for Nursing Inquiry

The findings of this study challenge nursing researchers to investigate elements of care that promote perceptions of mattering in the homeless and near homeless population. There is a

lack of nursing inquiry investigating the homeless and near homeless person's perception of self and the factors that serve to shape, support, and discount, these perceptions. The current study stands alone in bringing to the forefront the cumulative impact that place, being supported in the ability to meet one's own needs, and trust in providers, has on perceptions of mattering and of self, and subsequent health and health seeking behaviors.

The importance of relational and client-centred care appears frequently in nursing literature. However, the concept of mattering appears to have been overlooked. This gap in research has contributed to a lack of understanding of the importance of mattering in the helping relationship. Participants in this study have identified definitive yet interdependent factors of care that evolved into perceptions of mattering and positive perceptions of self. Collectively these factors were perceived by participants as having focused on their strengths rather than deficits. They supported and promoted self-reliance, resilience and a sense of optimism. The perceptions of the participants of this study can assist nursing researchers to develop a strengths perspective that focuses on mattering. A strengths perspective such as this would be unique and specific to the lens of nursing.

5.7 Limitations and Strengths of the Study

The perceptions of the participants in this study provided a very positive profile of the CLSC. Their positive perceptions imply that participants may have become protective of the street clinic. Therefore the limitations and strengths of this study must be considered in relation to the positioning of participants as members of a vulnerable population.

The findings of this study are context specific and not generalizable (Maykut & Morehouse, 1994). The complete lack of negative perceptions expressed by participants in this study may have been based in fear related to the circumstances and context of when the study

was conducted. The CLSC was closing. As a socially excluded group struggling to survive, meeting basic needs might have taken priority over honesty. Participants may have purposely chosen to omit any negative perceptions in relation to the street clinic, hoping that positive perceptions and appreciation would prevent the loss of one of their programs. This is similar to the findings of many other researchers who have also found the perceptions of homeless and near homeless clients to be idealistically positive in relation to a specific program or service they accessed (Attala & Warmington, 1996; Bhui, Shanahan, & Harding, 2006; Daiski, 2005; Fast et al., 2008; Hilton, Thomason, Moore-Dempsey, & Hutchinson, 2001; Janssen, Gibson, Bowen, Spittal, & Petersen, 2009; MacNeil & Pauly, 2010; Magee & Hurliaux, 2008). For example Bhui et al. (2006) found that participants downplayed negative experiences by asserting that it would be unreasonable of them to expect any service to be perfect. This implies that perhaps they believed themselves to be undeserving of high quality care because they were poor and homeless.

Lack of trust and fear of being identified may have limited the depth and breadth of findings. Although participants were assured that their confidentiality would be maintained, they might not have wanted to be critical because of the prospect that the staff would seek out employment at other places they frequented. Participants might have been fearful that any expressed criticism would threaten their relationships with the staff, negatively impacting the staffs' willingness to provide them with care. Bhui et al. (2006) and Neale et al. (2007) also thought that the participants in their respective studies might have been reluctant to be critical of services because they continued to need support. However, Smye et al. (2001) noted that street involved, urban Aboriginal clients spoke of deeply embedded negative experiences that interfered with patient-client relationship building at the sites they frequented. Nevertheless, the

service providers who work with people who are homeless or near homeless in Vernon, British Columbia make up a small group. Participants might have been afraid that talking about any negative experiences would threaten their access to other services and programs.

Time was a precious commodity in the data collection portion of this study. The environmental, physical, and financial limitations of the CLSC also contributed to the logistical difficulties of conducting this study. On account of these limitations, research assistants were unable to speak to participants a second time or seek out the perspectives of clients who no longer accessed the street clinic. Attempts at member checking were unsuccessful as participants invited to return for correction, clarification, or verification of their descriptions, did not. In addition, people who had been unhappy with street clinic services might have stopped coming. Their voices could only have been captured in this study if resources had been available to seek out prospective participants at other locations. Those who did participate in this study did not have 24 hours advanced notice to decide if they wanted to participate. Other researchers trying to connect with people living in conditions of extreme poverty have also considered the possibility that their study findings were limited by having been based on a small convenience sample (Davis-Berman, 2011; Dzul-Church, Cimino, Adler, Wong, & Anderson, 2010; Nokes & Nwakeze, 2007). Although the measures used in this study to ensure trustworthiness were multiple, it is acknowledged that the clients who participated in this research study may have been a biased group.

In spite of these limitations, this study's data has important strengths. The informal atmosphere of the semi-structured interview format and the distinction between research assistants and street clinic staff enabled participants to be open and reflective. As well, the independence of the primary investigator and second co-investigator from the street clinic was an

additional strength in the analysis of data. They raised questions that helped lift the awareness of the street nurse/co-investigator of her biases and illuminated the need for on-going explanation and clarification for those with no experience working in non-traditional health care settings. The team approach allowed members to provide one another with emotional support. And while qualitative descriptive researchers seek in-depth, context specific information from a relatively small sample size, the participants in this study were all current residents of the North Okanagan, clients of the CLSC, and were diverse in age, sex, and the length of time they had been accessing the street clinic. In addition, the relationship-based organizational structure of NOYFSS allowed for the flexibility and re-flexibility required for research to be conducted on site with few resources.

5.8 Summary

This study examined the perceptions of clients who accessed the CLSC concerning the health and social care they had received there. Protected by the non-profit status of a small non-governmental organization, NOYFSS and the CLSC staff had developed creative strategies to stretch limited resources to meet real needs. Over time the street clinic had evolved from a needle exchange program to one that offered both health and social care.

The six women and six men who participated in this study were diverse in regards to age, ethnicity, length of time they had been accessing the clinic, sleeping distance from the clinic, referral source, and source of income. The major focus of the in-depth semi-structured interviews was to seek out both negative and positive perceptions. Furthermore, in keeping with qualitative description methodology, this naturalistic study's findings were analyzed using a constant comparative method. While the diverse local conditions of non-traditional healthcare

services makes generalizability impossible, study findings revealed that client perceptions were shaped by place, mattering, ability to meet ones' own needs, and feeling 'OK' about themselves .

The findings of this study go beyond participant perceptions of the health, healing, and wellness outcomes they experienced, adding to what is already know about the perceptions of people who are living homeless and near homeless. The four distinct yet interdependent elements of care and accompanying subthemes altered participants' perceptions of self. This study's findings have highlighted the accumulative impact that a place, mattering, and being supported to meet ones' own needs, can have on perceptions of health, wellness, and self-worth. The perceptions of CLSC clients have revealed the importance of mattering in the delivery of health and social care for people who are homeless and near homeless, and the elements of care that can support this perception. Their perceptions have also brought to the forefront the need for further nursing research on the subject of mattering and a strengths perspective that is specific to the lens of nursing.

5.9 Conclusion

Despite the commitment of the staff, inadequate and unstable core funding meant that CLSC was an unsustainable band-aid solution to the delivery of primary health care. However the efforts of NOYFSS and the street clinic had created the illusion that the IHA was deeply concerned about the health and wellness of homeless and near homeless people in the community.

Participant perceptions of the street clinic were overwhelmingly positive and revealed four distinct, yet interdependent elements of care found at the CLSC: place, mattering, ability to meet ones' own needs, and feeling 'OK'. Emotions linked to knowing that they had a place to go where they would feel safe and included, with providers who could be trusted to understand

them, accept them, care for them, and be there for them, led to participant perceptions that they mattered. On a practical level, the street clinic was perceived by clients as having supported them in their ability to meet their needs. Collectively, the participants of this study perceived the CLSC to be a model of care that transformed perceptions of self and promoted aspirations to increase positive qualities and reduce negative thoughts and behaviors. Their desire and ability to care about themselves and for themselves improved because they perceived themselves as mattering.

Nurses who do more listening and less assuming lay the groundwork for homeless and near homeless clients to feel that they matter. Be that as it may, there is a lack of research that speaks to the role of mattering on the health and well-being of vulnerable populations. If the voices of the clients in this study are listened too, their expertise can provide academia with a starting point for inquiry. Participants have shared how a focus on strengths and capacity can lead to collaboration and the co-creation of strategies that promote self-compassion and healthier attitudes towards, and about, the self. They have identified a strengths-based model of care to be one that would focus on mattering and strength-based elements of care that support that perception. A nursing perspective that is centred on mattering in conjunction with evidence-based practices is the place where peace and power can be realized by the client within the provider-client experience. The perceptions of the clients of the CLSC have identified this to be the place where they support nurses to discover, understand, and craft their art as professionals.

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APPENDICES

Appendix A: Script for the Clinic Volunteer to Discuss Study with Street Clinic Client

Hello _____ (Name of the Street Clinic Client)

My name is _____ and I am one of the volunteers here at the street clinic. I would like to request your help in discussing the usefulness of the street clinic services. We believe that the only way we can really learn about this is by asking people who actually use the clinic. We don't want to do the asking though, because we understand that people might not feel comfortable giving their honest opinions to those of us who work or volunteer at the clinic; or they may worry that their answer(s) may offend the staff and/or volunteers and negatively effect their access to the clinic services or nursing care in the future. So we have asked two third year nursing students from UBCO in Kelowna to talk to people and ensure that your identity is not revealed to the street nurse, the reception staff or the volunteers through the study.

To learn more about your ideas about the street clinic's services, we would like to ask you to complete a short questionnaire. You can complete the questionnaire in one of the private rooms behind this reception area with one of the nursing students. If you agree to participate, you will be asked to sign a consent form. The questionnaire will take approximately 20 minutes and the questions will be asked by a third year nursing student from UBC Okanagan. You will be asked about what services you have used at the clinic, how helpful you thought the services were to you, what additional services would be helpful to you, and some background information.

After completing the short questionnaire, the nursing student may invite you to participate in an interview. This interview will take an additional 40 minutes. During this interview, you will be asked about your experiences with street clinic staff, how the nurses may have assisted you with your health concerns and how the street nurse program could be more helpful to you.

Your participation is totally voluntary and your answers will all be kept confidential. If you do not wish to participate, your access to clinic services or nursing care will in no way be affected, now or in the future. If you are unsure, please take some time to think about it and let us know later if you are interested in participating. We would really appreciate your talking with the nursing students. Do you think this would be a possibility for you? Do you have any questions or concerns?

Thank you

Appendix B: Recruitment Brochure

Title: Client Perceptions of Street Clinic Healthcare Services

Principal Investigator (Contact Person):

Dr. Kathy Rush – Associate Professor, UBC Okanagan School of Nursing
Contact Phone: (250) 807-9959; Email: Kathy.rush@ubc.ca

Co-Investigators:

Ms Wilda Watts – Instructor, UBC Okanagan School of Nursing
Contact Phone: (250) 807-9913; Email: Wilda.watts@ubc.ca

Rhodina Hobbs, RN, BSN –UBCO MSN student. Contact Phone: (250)545-3572;
Email: rhodina@noyfss.org.

What is This Study About?

The purpose of this study is to understand clients' perceptions of the healthcare and nursing services provided by the Cammy LaFleur Street Clinic. There is little known about how clients perceive the nursing care they receive at the street clinic. Understanding client experiences and perspectives is important as a basis for developing program improvements that not only achieve strategic objectives, but will assist in improving the health of those persons living in the North Okanagan and using the services provided by the nurses at the Cammy LaFleur Street Clinic.

Who Can Participate?

To participate in this study:

- You must have had direct contact with a street nurse in her/his professional capacity at the Cammy LaFleur Street Clinic
- Be 19 years of age or older
- Speak English

What Will I Be Asked to Do?

1. Complete a questionnaire with a research assistant (third year nursing student from UBC Okanagan). The questionnaire will take about 20 minutes to complete.
2. Following completion of the questionnaire, you may also be asked to participate in a recorded interview with the research assistant. The audio-taped interview will take another 40 minutes of your time.
3. Answer questions about yourself such as your age, your primary mode of transportation, the role the street nurse plays in helping you meet your healthcare needs and how the street clinic be more helpful for you

4. Agree to have your answers and perspectives analyzed in combination with those of others who have participated in the study

What Do I Do If I Am Interested in Participating?

Please let me know if you are interested in participating. You can complete the questionnaire and the taped interview today or on another day, when one of the nursing students is available to meet with you.

We appreciate your taking the time to share your opinions with us about how the nursing care at the clinic has helped you or not helped you, what the nurses are doing well, and what they could perhaps be doing better.

Thank-you so much for your time!!

Appendix C: Script for Research Assistants

Hello _____ (Name of the Street Clinic Client).

My name is _____. I am a third year nursing student at UBC Okanagan in Kelowna. As explained by (name of clinic reception staff member), the Cammy LaFleur Street Clinic Program is interested in hearing your perspectives about the helpfulness of the street clinic nursing services. As part of my studies I am working with the street clinic in helping them learn about your perceptions of these services. By getting an understanding of what people who come to the street clinic think of the services they receive, it is hoped that changes may be made that will improve the health care that you receive.

As has been explained to you by the clinic volunteer and the information sheet about the study, I will be taking approximately 20 minutes of your time to complete a questionnaire. I may also invite you to participate in a more in-depth interview that will be taped. The taped interview would take an additional 40 minutes. Consenting to completing the questionnaire does not commit you to the taped interview. How do you feel about this process? Do you think you would be interested in participating?

Before we begin I will review the consent form with you and then ask you to sign it if you still feel comfortable to continue participating in the study. The consent form will provide additional information about the study, the risks and benefits of participating, how confidentiality will be provided for you and contact information if you have further questions you would like answered. Your participation is strictly voluntary and you may refuse or withdraw from the study at any time. If you decide to not participate or choose to withdraw from the study during the questionnaire or interview process, your access to the services or nursing care provided at the Cammy LaFleur Street Clinic will not be affected now, or in the future. I will also give you a copy of the signed consent form for you to keep.

Are you still interested in participating? Do have any questions or concerns before we begin?

Appendix D: Information and Consent Form

Title: Client Perceptions of Street Clinic Healthcare Services

Principal Investigator (Contact Person):

Dr. Kathy Rush – Associate Professor, UBC Okanagan School of Nursing
Contact Phone: (250) 807-9959; Email: kathy.rush@ubc.ca

Co-Investigators:

Ms Wilda Watts – Instructor, UBC Okanagan School of Nursing
Contact Phone: (250) 807-9913; Email: wilda.watts@ubc.ca

Rhodina Hobbs, RN, BSN –UBCO MSN student. Contact Phone: (250)545-3572;
Email: rhodina@noyfss.org.

Study Information and Purpose

The purpose of this study is to understand client perceptions of the healthcare and nursing services offered by the nurses of the Cammy LaFleur Street Clinic program. Understanding your experiences and perspectives of the healthcare and nursing services offered by the clinic is important for making changes to improve the care you receive.

Who Can Participate?

To participate in this study, you must have had direct contact with a street nurse in her/his professional capacity at the Cammy LaFleur Street Clinic, be 19 years of age or older, and be able to speak English.

What Does the Study Involve?

You will be asked some general questions by the research assistant about your experiences in coming to the street clinic. Answering these questions will take approximately 20 minutes and your answers will be written down. It is important that we get a range of opinions, and for that reason you may also be asked to participate in an interview based on your responses to some of these initial questions. The interview will take approximately another 40 minutes of your time and will be tape-recorded.

Potential Harms (Injury, Discomforts or Inconvenience)

There are no known harms associated with your participation in this study. However talking about some of your experiences may make you feel mildly distressed. Should this happen, you can take a break and continue after you feel better. If you feel that you need counseling or support services as a result of our interview, information on where to obtain these services will be provided. Remember that you are under no obligation to participate in this study and you can withdraw from this study at anytime without consequence.

Potential Benefits

You may not benefit directly from participating in this study. However this is an opportunity for you to assist the nurses at the Cammy LaFleur Street Clinic to understand what services have been helpful to you and how services could be improved.

Confidentiality and Privacy

A number of measures will be used to ensure that your identity is not connected to the information you provide. We will not record your name anywhere on the questionnaire. If you are involved in a tape-recorded interview, the research assistant will use a made-up name of your choosing to call you by during the interview. There will be nothing recorded on the questionnaire or the transcriptions that will make it possible for anyone to identify who you are.

All interviews will be typed out (also called “transcripts”). The street nurses will not listen to the tape recordings and will not be involved in transcribing the interviews. There is a risk that the details you provide in answering a question may make it possible for you to be identified. Therefore we encourage you to carefully consider this possibility when you are deciding how to respond to each question. Your interview will be identified by a code number only. We are collecting the data for this study on days in which the regular street nurse is not working and we will not be sharing any information about who participated in the study. The clinic reception staff has agreed not to discuss any details about study participants with the street nurse, clients or other participants.

The data you share will be collected and analyzed, and the opinions studied in combination with those of others who have agreed to participate in the study. This will also further protect your identity. During the study all interview material on tape and in written form, including the consent form that you will be asked to sign will be stored in a separately locked cabinet at UBCO, to which only the principal investigator will have access. When the study is completely finished, all the questionnaires and taped interviews will be destroyed.

Contact for Information about the Study

If I have any other questions, concerns or would like further information about the study, you may contact Dr. Kathy Rush at (250) 807-9959.

Research Ethics Board Contact

If you have any concerns about your treatment or rights as a research participant, you may contact the ‘Research Subject Information Line’ in the UBC office of Research Services at (604) 822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

Consent

Your participation in this study is strictly voluntary and you may choose not to participate or to withdraw at any time during the course of this study without any effect on your access to the clinic services or nursing care provided at the Cammy LaFleur Street Clinic, now or in the future. In no way does signing this form waive your legal rights nor relieve the investigator or involved institutions from their legal and professional responsibility. If you withdraw from the study, any data collected up to that point will be kept in the study.

By signing below I acknowledge that I have read the information sheet myself or the research assistant has read the information sheet to me, my questions about the study have been answered to my satisfaction.

I agree to participate in this study, and I have been given a copy of this informed consent form.

_____	_____	_____
Subject’s Name (Please print)	Subject’s Signature	Date
_____	_____	_____
Interviewer’s Name (Please print)	Interviewer’s Signature	Date
_____	_____	_____
Witness’s Name (Please print)	Witness’s Signature	Date

Appendix E: Questionnaire

1. Age: 19 20 – 30 31 – 40 41 – 50 >50
2. Sex: Female Male Transgender
3. Ethnicity: Caucasian First Nations Indian Asian Other
4. How far from the street clinic do you normally live/sleep?
 Vernon's downtown area East Hill Mission Hill South Vernon
 Alexis Park Harwood Okanagan Landing Coldstream BX
 Lavington Lumby Armstrong Enderby Falkland
 Cherryville Other
5. How do you get to the street clinic? foot bicycle car/truck bus
 other
6. How did you first hear about the street clinic?
 acquaintance friend family member
 my doctor, the walk-in clinic or emergency department
 another service provider other
7. How long have you been coming to the street clinic for?
 less than 1 month 1 – 6 months 6 – 12 months
 1 – 2 years more than 2 years
8. Have you been to street clinics in other communities? Yes No
9. How do you financially support yourself?
 Criminal Activity STW Recycling MEIA recipient
 PWMB PWD CPP Disability ICBC Old Age Pension
 Employment Other
10. Rate each of the following healthcare services provided directly by the street nurses according to how helpful they have been in assisting you to meet your healthcare

needs?

0 = not accessed 1 = not helpful 2 = slightly helpful 3 = fairly helpful

4 = very helpful

income

housing

food

vitamins, ibuprofen, gravol

clothing and/or hygiene products

family/friend relationship issues

self improvement

connectedness to services/benefits/programs

dealing with negative feelings (mental health)

drug use problems

physical health problems

legal problems

11. Has your contacts/visits with the street nurse changed which community services, including healthcare services that you utilize?

no contact with nurse yes no

If yes, which services:

healthcare services food programs housing/shelter advocacy

mental health addictions MEIA other

Appendix F: Semi-Structured Interview Guide

1. What does the street clinic mean to you?
2. Talk about what your experiences with the street clinic staff have been like.
3. On the following scale, how would you rate your health?

O _____ 10

Terrible

Awesome

4. How have the nurses at the street clinic assisted you with your health issue(s)?
5. Can you describe a particular situation with the street nurse that you remember as being really helpful for you? Not being helpful to you?
6. What health information and/or health strategies have you learned from the street nurses?
7. Talk about what you have done with that information.
8. What has changed for you/what do you do differently (if anything) as a result of your work with the street nurses?
9. Which of your health needs remain unmet?
10. What do you think would make the street nurse program more helpful in meeting your healthcare needs and the healthcare needs of those you know?

Appendix G: Approval to Conduct Research on Site: NOYFSS

- Community Based Services - (250) 545-3572
- Residential Services:
 - Mara House - (250) 545-3395
 - Intensive Support Program
 - Residential Clinical Consultant - (250) 545-4908
- Administration - (250) 545-3262
- Fax (250) 545-1510
- e-mail: reception@noyfss.org

NORTH OKANAGAN YOUTH AND FAMILY SERVICES SOCIETY

Counseling and Support Services to Children and Families since 1974

3100-32nd Avenue, Vernon, B.C. V1T 2L9

January 18, 2008

The University of British Columbia
Behavioral Research Ethics Board
Office of Research Studies
Suite 102, 6190 Agronomy Rd.
Vancouver, BC V6T 1Z3

Attention: UBC Research Ethics Board

To Whom It May Concern:

North Okanagan Youth and Family Services Society has reviewed the proposal research plan as required by our Research Policy (attached) and gives its permission to Rhodina Hobbs and her co-investigators to conduct a research project adhering to these criteria in The Cammy LaFleur Street Clinic at 3100-32nd Avenue, Vernon, BC V1T 2L9 during the Spring of 2008.

Sincerely,

John Belfie
Executive Director
North Okanagan Youth and Family Services Society

JB/cb