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**The Health and Wellbeing of Homeless People:
Complexities around the Provision of Primary
Healthcare in New Zealand**

A thesis submitted in fulfilment
of the requirements for the degree

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Abstract

Homelessness is a pressing social issue, and people who are homeless, in particular those who sleep rough, often experience a confluence of physical and mental health issues. Health problems experienced by homeless people can be more severe than those experienced by domiciled people. Such problems can contribute to homelessness, and be exacerbated by homelessness. Previous research has found that for various reasons, primary healthcare services can be inaccessible for homeless populations. More recent research explores the growing availability of accessible, non-threatening health services targeting homeless people, with humanistic approaches to care. This thesis draws on a case study of an NGO clinic providing population-based primary healthcare to homeless and low-income people. The case study is informed by the perspectives of two groups of participants; homeless clinic patients and clinic staff. Ten semi-structured interviews were conducted with homeless clients, and six semi-structured interviews were undertaken with clinic personnel. Social representations theory informs the interpretation, analysis and discussion of the participants' conceptualisations of health and wellbeing, illness and disease, homelessness, health services and the NGO clinic. Social representations from both participant groups (micro perspectives) inform shared social representations (macro perspectives) of the NGO clinic. This determines whether participants conceptualise the clinic as an 'ideal' health service for homeless people.

NGO clinic staff responses reveal that clinic staff have a personal and professional ethos to work with people in need and those that may have been stigmatised from society. This shared ethos has shaped the development of the NGO clinic, into its current structure of a holistic, population based primary healthcare for homeless people integrated within a wider social service structure. In this setting, relationships are developed between practitioners and homeless clients to ensure homeless patients

healthcare needs are met. Also, practical needs are met as the clinic provides low-cost healthcare to homeless people within the context of an umbrella organisation that provides other much-needed social services. Collaboration is an important component to the efficacy of the NGO clinic, and meeting patient needs. However, clinic staff note that there are many dilemmas in providing healthcare to homeless people, and they can struggle to provide the service according to their vision, due to funding constraints. Nonetheless, NGO clinic personnel are committed to working with their patients, and find their jobs rewarding.

The responses from homeless clinic patients brought to mind a military metaphor, which was utilised to anchor the experiences of homeless people in a familiar concept – the military. Each homeless client that was interviewed at the NGO clinic is written about in the form of a health biography, which summarises current health issues, health histories, health related practices and conceptualisations of health. The severity of three major health issues experienced by the participants – addictions, mental health issues and foot problems – are then explored in terms of detailed perspectives from homeless participants, and clinic personnel conceptualisations of those particular health issues. Social networks are discussed as important to homeless people's health and wellbeing, particularly through resource and information sharing. The clinic setting is conceptualised by homeless participants as a caring, welcoming environment; which contrasts with some negative experiences reported by homeless participants in other health service settings.

This thesis explores the NGO clinic as a unique model for a health service that meets the various healthcare needs of homeless people. There is a need for more recognition from government organisations and policy makers of the impoverished life situations that many homeless people find themselves in – often without minimum standards of living, which jeopardises their ability to take care of their health. Appropriate health services need to be accessible to homeless people, in order for healthcare needs to be met.

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Chapter One: General Introduction

Homelessness is a societal issue of growing importance in New Zealand (Laurenson & Collins, 2006; Leggatt-Cook, 2007). It represents a diversity of human experience, and can be an all-encompassing life situation which is often characterised by a culmination of problems such as family breakdown, unemployment, lack of resources such as shelter, nutrition and transport, and poor physical and mental health (e.g. Reitz-Pustejovsky, 2002). Previous research suggests that homeless people are sicker and die quicker than the general population (Quine, Kendig, Russell & Touchard, 2004). However, research on the health experiences of homeless people and their access to health services is lacking. This thesis explores the health practices, experiences, and health service use of homeless people. It comprises a case study of a primary health care clinic provided in a Non-Governmental Organisation (NGO).

This research was carried out within a wider project on homelessness in New Zealand – the *More than bricks and mortar: Homelessness and social reintegration* research group (Hodgetts, Stolte, Chamberlain, Radley, Nikora, Nabalarua & Groot, 2008). This larger project began with conversations between the principal researchers in this project, and agencies that provide services to homeless people. The rationale for the research pertaining to this thesis grew out of communication and collaboration between the researchers and an NGO that is a stakeholder in the wider project on homelessness. The NGO approached the principal researchers with an idea for a research project to be carried out with their existing on-site medical clinic that provides much needed healthcare to homeless people. The NGO provides a range of services for homeless and other marginalised people, so it could be described as a wrap around service.

This research will explore issues arising in the provision of the clinic service, from the perspectives of NGO clinic personnel. The medical clinic

at the NGO provides a unique opportunity to understand the everyday healthcare needs of homeless people and the functions of service provision to this disadvantaged group. The focus on health related practices will complement the information gathered for the wider homelessness research project, it could provide a basis for informing service developments and may also have policy implications. This research aims to document the processes involved in providing a specialised healthcare service for homeless people in an urban CBD in New Zealand, to see whether it is 'ideal' or appropriate for a homeless client base. The research also aims to explore the use of healthcare services by homeless people in light of their everyday symptoms, treatment and perceptions of care. Health-related practices of homeless people who use the NGO clinic will be considered. Homeless people's conceptualisations and experiences of health and illness will also be contextualised in relation to their situations and social networks, and their healthcare will be discussed as an important component for their social integration in society.

The rationale for this study is a lack of discussion in the literature about how and when homeless people access health services. Earlier research in the 1980s around the issue of homelessness in New Zealand has centred on the lack of housing (Leggatt-Cook, 2007). Housing is seen as an important determinant of health (National Health Committee, 1998), and housing status as a significant factor that influences health status positively (Kidder, Wolitski, Campsmith & Nakamura, 2007). Although better housing status predicts greater health status, health care, emergency department use, and use of medications (Kidder et al., 2007), it is important to note that homelessness is more than just a 'bricks and mortar' issue and needs a broader focus. The health of homeless individuals is influenced by a variety of factors including social, economic, political and structural factors – not just the fact that individuals lack a roof over their heads (de Winter & Noom, 2003; Leggatt-Cook, 2007).

There is a wide range of research on homelessness and health that is quantitative in nature. Gelberg and Linn (1992) explored demographic differences in the health status of homeless adults. This is an example of research that seeks to standardise the homeless population into subgroups, made up of particular 'types' of homeless people who have particular physical ailments, in this case, by age group. While this type of research is relevant, it fails to recognise homeless people as individuals who have unique experiences with regards to their health status, health practices, health histories, and health service use. Other quantitative examples include research that focuses on differences in health between homeless and housed people, how many homeless people experience specific ailments and/or how many people utilise particular health services. Some research explores a variety of services utilised by homeless people, other research focuses on one specific service, like a particular drop-in centre or healthcare service. Quantitative research is certainly useful for identifying possible causes of health problems (Wright, 1990) and factors likely to contribute to the death of homeless people (Kerker, Bainbridg, Li, Kennedy, Bennani & Agerton, 2005). However, there is a need for more qualitative research exploring personal dimensions and experiences of homelessness and health. In this thesis I draw on international literature on the health experiences, practices, conceptualisations and health service use of homeless people and relate some key themes from the literature to a study of a specific health service operating in New Zealand.

In the remainder of this chapter, I will discuss three core concepts for this thesis: homelessness, health, illness and disease. Then I will review a variety of quantitative and qualitative studies around health issues experienced by homeless people, as well as issues around service use, access, and barriers to healthcare. An overview section on the various types of literature surrounding homelessness and health will be explored including: Illness and homelessness, health issues experienced, implications of being homeless and sick, comparisons between housed and homeless populations, health and social networks on the street, and survival. The following section considers literature on the health-related

practices of homeless people. Our attention then turns to the availability and accessibility of health services for homeless people, the types of services utilised by this population and barriers to healthcare. Homeless people's experiences of care while utilising health services will also be explored, as well as the experiences and perspectives of health service providers. The chapter ends with an overview of the present research.

Core concepts: Homelessness, health, illness and disease

Ideally, a thesis on homelessness and health sets out a clear definition of these core concepts. However, homelessness is a vague and slippery term, as it is a complex social issue that researchers have found difficult to pin down (Chamberlain & MacKenzie, 1992; Leggatt-Cook, 2007). For example, the viability of a concept of homelessness has been questioned due to a lack of consensus about what the term denotes (Watson, 1984). Regardless, several countries have definitions of homelessness. These include Australia, Great Britain, and the United States of America. Respective definitions serve to give governing bodies a basis for implementing social policy, and providing much needed services (Leggatt-Cook, 2007; Statistics New Zealand, 2009). However, the New Zealand Government does not have an official working definition of homelessness on which to base social policy and service provision (Leggatt-Cook, 2007; Statistics New Zealand, 2009). This is because 'degrees of homelessness' can vary from person to person – homeless people could be located on a continuum with regards to the 'severity' of their individual life worlds, rather than being placed into categories. Homelessness is a complex social issue and defining it might mean that when policy is created, it might further marginalise those that need support. On the other hand, having a definition could focus more attention on the various issues surrounding homelessness from the public, media, researchers, organisations and government representatives.

In New Zealand, a discussion document has been made available to various organisations and relevant people that are involved in work on issues around homelessness in an attempt to develop a working definition of homelessness (Statistics New Zealand, 2009). While there is consideration of temporal aspects of homelessness, regional and cultural diversity and social connectedness, the preliminary focus for this discussion document is housing and secure accommodation, or lack thereof. While housing is certainly important, it is not the only factor that determines whether a person is 'homeless' or not. It will be difficult to come up with a definition of homelessness that is all inclusive; however, having a definition can help to raise the profile of homelessness as a national public health issue to address. Even though there are issues with quantifying a number of people who are 'homeless', having some rough figures can be helpful in the creation of social policy, allocation of resources, and development of services based on the needs of the people who fit into this category.

For the purpose of clarification, rough sleeping homeless people who sleep under bridges, on park benches or in other public spaces were included in this research. I also included people in transition from the streets who were currently in boarding houses or supported accommodation and who had a history of sleeping on the streets. Sleeping rough poses particular risks in terms of health and ongoing marginalisation and poverty. Rough sleepers comprise the sharp edge of the wedge of homelessness.

Health is another term which can be difficult to conceptualise, as ideas around health can differ, and are often context-dependent (Williamson & Carr, 2009). Nevertheless, governing bodies and organisations must have definitions of health in order to create policy and public health systems. The World Health Organisation (WHO) defined health as physical, mental and social wellbeing (1946), which is regarded as the biopsychosocial model of health. Flick (2007) finds this to be a useful definition to use when researching the health of homeless people. In the Aotearoa/New

Zealand context for Māori in particular, health can also incorporate a spiritual dimension, *taha wairua*, as in Durie's (2001) *Te Whare Tapa Whā* model of health, alongside three other spheres: *taha hinengaro* (emotion), *taha whānau* (social), and *taha tinana* (physical).

Conceptualisations of 'health' appear to have moved towards ideas around health being a resource for everyday life, first introduced in the *Ottawa Charter for Health Promotion* (WHO, 1986). More recently, health has been conceptualised in an economic model, as a form of capital where good health requires investment, and means that individuals are better able to participate in society and fulfil their responsibilities (Williamson & Carr, 2009). Health can also be thought of as a relational process that is mediated through social dialogue and interaction (Cornish, 2004; Hodgetts, Radley, Chamberlain & Hodgetts, 2007), such as the way homeless people interact with each other, and with health.

Research into lay health beliefs show that health can be conceptualised on a continuum, from being purely physical or biomedical, as an absence of illness or disease, to an all-encompassing holistic notion of wellness (Herzlich, 1973). Health practitioners and policy makers, as well as lay people, are shown to have multiple, overlapping, and sometimes contradictory definitions of health (Williamson & Carr, 2009). This supports the notion that some medical practitioners can have more open-minded ideas about how health is conceptualised for different populations, such as homeless people. Likewise, we need to also be open minded when conceptualizing illness and related experiences among homeless people.

Research shows that when people are ill, they learn to develop their own coping strategies and methods to achieve wellbeing, either alongside a dominant paradigm or by themselves. As illustrated by Radley (1993): "...how people make sense of and respond to their disease or disability is a function of the everyday beliefs and practices according to their social groupings" (p.1). One of the issues explored in this research was whether

homeless people and health professionals hold different perspectives of health and illness as experienced by homeless people.

Illness and disease are two concepts that are often grouped together in the same category. However, one can argue that historically they have been utilised by the social science and medical disciplines separately, respectively. 'Disease' is defined in terms of biological occurrences that deplete a person's physical health, which is what health physicians typically treat, such as rheumatoid arthritis (e.g. Williams, 1993). 'Illness' is defined as the experience of being unwell, which can often be due to disease. The illness experience is never purely physical as it includes the experiences of the person, behaviour changes, the reality of the disease, lifestyle changes, and psychosocial effects (Herzlich, 1973).

These core concepts are combined in this thesis to explore homeless peoples' experiences of health and illness in relation to a particular healthcare setting. As the NGO clinic is a site for healthcare, it (and the staff that work there) will play a major role in how health and illness is experienced amongst the homeless population they serve. The following section outlines various research that has been completed in the areas of homelessness, illness and health.

Homelessness and health – an overview

Some of the main themes emerging from literature and research into homelessness and health include: the relationship between homelessness and illness; health issues experienced by homeless people; the implications of being homeless and sick; comparisons in health status between homeless and housed people; health and social networks on the street; and surviving homelessness.

In public deliberations regarding homelessness, it is often inferred that illness is a primary cause. A counter argument is that illness is a consequence. The arguments about whether illness is a cause or consequence of homelessness appear to be irresolvable. However, it can be argued that illness is a feature of homelessness whether stemming from one's life prior to homelessness or resulting from street life (e.g. Wright, 1990). A large body of research in healthcare in the United States synthesised in a report by their Institute of Medicine in 1988, confirms three major links between homelessness and illness: 1. poor health is often a cause of homelessness; 2. Illness is a consequence of homelessness; and 3. being homeless makes the path to receiving adequate health services and care difficult (Wright, 1990). Shinn, Gottlieb, Wett, Bahl, Cohen, and Ellis (2007) note that "... it is typically the confluence of multiple risk factors or a cascade of events that make someone homeless, rather than just one" (p.704). Although these findings are from the USA, they are comparable to the New Zealand situation where research also shows clear links between lower socio-economic status and increased chance of illness (National Health Committee, 1998).

Key results from the 2002-2003 New Zealand Health Survey show that people categorised as 'most deprived' according to the New Zealand Deprivation Index 2001¹, had higher incidences of chronic health problems such as heart disease, stroke, diabetes, arthritis and cancer (Ministry of Health, 2004). Furthermore, they participated more in activities that research has shown to lead to poor health such as smoking and drinking excessive amounts of alcohol, than people who were 'less deprived' (Ministry of Health, 2004). Those categorised as most deprived were also less likely to practice health enhancing behaviours, such as eating a nutritious diet, and engaging in regular exercise, than those categorised as less deprived (Ministry of Health, 2004). There was no specific category in

¹ The New Zealand Deprivation Index 2001 (NZDep2001) is the key indicator of socioeconomic status in the New Zealand Health Survey 2002-2003. It measures the level of deprivation based on a combination of variables taken from the 2001 New Zealand Census: income, transport (access to a car), living space, home ownership, employment status, qualifications, social support, and access to a telephone (Ministry of Health, 2004).

the results to show whether homeless people were included in the survey² but it is clear that they would in many cases appear in the 'most deprived' category.

In a review of the literature of health and homelessness from the 1980s, Wright (1990) came to one basic conclusion: "Most if not all of the material and existential conditions of homelessness are, in one or another way, detrimental to physical well-being" (p.50). Health is one of the most significant issues in the life worlds of homeless people, particularly rough sleepers. Homelessness often results from, and can cause a confluence of various "ailments" – physical, social and mental, all of which can lead to psychosocial stress (Flick, 2007). These "ailments" all have an impact on how homeless people live their lives on a day-to-day basis, particularly when basic survival is a high priority (Flick & Röhsch, 2007).

Life on the street often means that physical health and wellbeing is at risk due to unhealthy temperatures, poor nutrition, possible exposure to violence, and insufficient treatment of health problems. In international literature, some of the more commonly reported health issues experienced by homeless people include skin infections and foot problems, respiratory infections such as tuberculosis, seizures, heart problems, trauma/injuries, hypertension, HIV/AIDS, sexually transmitted infections, substance abuse, dental problems and mental illness (e.g. Hwang, 2001; Wright, 1990; Hunter, Getty, Kemley & Skelly, 1991; D'Amore, Hung, Chiang & Goldfrank, 2001). Homeless people are affected by illnesses in different ways – in terms of severity, and how they affect quality of life.

Homeless people have very serious health issues that can manifest into a life experience of 'being sick'. In a United States study on homeless people's perceived satisfaction with health services; one participant poignantly summed up how homelessness is an all-encompassing factor that is detrimental to health: "Being homeless means being sick, sick in the

² It is less likely for homeless people to be included, as they do not have a dwelling and are therefore less likely to be visited by a Census enumerator, and less likely to have an opportunity to participate in a national Census.

head, sick in the body, and sick in the heart” (McCabe, Macnee & Anderson, 2001, p.82). For this person, the words ‘homelessness’ and ‘healthy’ did not even go together (McCabe et al., 2001); the hardships of the lifestyle seemed to have left them in a state of helplessness.

The following paragraph from the United States Institute of Medicines’ *Homelessness, health and human needs* (1988) publication outlines the life world of a homeless woman with chronic health problems. It highlights the potential extremity of a homeless person’s health issue, how their day-to-day life is affected, how and when services are utilised, and the stigma and potential loss of dignity associated with being sick and homeless.

Doris Foy’s varicose veins occasionally result in swollen ankles. When homeless, she sleeps upright, and her legs swell so severely that tissue breakdown develops into open lacerations. She covers these with cloth and stockings – enough to absorb the drainage but also to cause her to be repugnant to others because of the smell and the unsightly brown stains. She is eventually brought to a clinic by an outreach worker. When the cloth and the stockings are removed from the legs, there are maggots in the wounds. She is taken to the emergency room of a hospital, where her wounds are cleaned. (Institute of Medicine, 1988, p. 41)

Doris Foy’s issues with her legs and feet affected her physically, socially, and probably mentally, as she did not have the resources to seek care, transporting herself to healthcare is likely to be very painful, and she is isolated because people do not want to be around her. Although she did receive healthcare, one can only wonder what may have happened to Doris if an outreach worker had not noticed that she had a severe health problem.

Homeless people are stigmatised for being homeless, and when they have chronic health problems, this serves to increase their marginalisation in society (see above). In their research on HIV/AIDS and Homelessness, Douaihy, Stowell, Bui, Daley, and Salloum (2005) talk about the stigma or shame experienced by homeless people with health issues – particularly those who suffer from HIV/AIDS, have mental health issues, and/or engage in drug use. Homeless people with HIV/AIDs may conceal their condition and engage in risk-taking behaviour, which can exacerbate

existing conditions and induce further health problems, due to fear of denial of services, and fear of abuse in shelters (Douaihy, et al., 2005).

Earlier research on homelessness and health considers the implications of the general public coming into contact with homeless people who are ill. Wright (1990) argues that homeless people with infectious diseases are often constructed as a threat to public health due to the fact that they cannot isolate themselves from 'the healthy', because of their occupation of public spaces. Furthermore, Wright (1990) says that many homeless people make frequent contact with others, particularly other homeless people, which puts them at risk of developing health problems. This is a problematic assumption because some homeless people (particularly rough sleepers) may not seek contact with other people at all. However, because they do not have personal living spaces, they must often reside in public spaces. Wright (1990) constructs homelessness as a public health issue, but only in terms of protecting the domiciled, 'healthy' population from the 'poor' health of homeless people. Such discourse can serve to further marginalise homeless people from society. Social stigmatisation can worsen the physical and mental health of homeless people.

Chronic health issues can also impair homeless people when they attempt to undertake practical tasks, as Douglas, Torres, Surfus, Krinkie & Dale (1999) found in their United States study. Participants indicated that due to their physical health issues: lack of dental care, vision care, and problems with ambulation; they were unable to complete tasks that would enable them to function suitably in society, thus perpetuating their homelessness. These tasks included filling out application forms for jobs or housing, working in service and/or laborious employment, and travelling long distances on foot to possible employment opportunities (Douglas et al., 1999). This demonstrates that while some homeless people may have the goal of reintegrating into a domiciled life situation, poor health can impair this.

The reality is that homeless people are at a higher risk of illness and premature death than domiciled people (Hodgetts et al., 2007), and significant differences between the mental and physical health status of domiciled and homeless people are evident (e.g. Kidder et al., 2007; Weinreb, Goldberg, & Perloff, 1998). In Kidder and colleagues' (2007) research, homeless people's health was found to be poorer than that of housed respondents. Homeless respondents reported significantly more days in the past 30 days during which they were sick, did not have enough sleep or rest, and physical or mental health problems prevented them from engaging in usual activities (Kidder, et al., 2007). Similarly, in their Spanish study comparing the health status of homeless people with those at risk of becoming homeless, Munoz, Crespo, and Perez-Santos (2005) found that homeless people are more likely to experience illness due to exposure to more risk factors, and the fact that they have difficulties in accessing health services and receiving medical treatment. The only variable that distinguished the 'at risk' group from the 'homeless' group was that the at risk group was housed. However, the at-risk group still accessed a lot of resources provided for homeless people due to their socioeconomic situation.

Positive social interaction and participation in social networks have been found to be beneficial to health (Cattell, 2001). The relationship between poverty and ill health is thought to be affected by social capital (Cattell, 2001); for example, a homeless person may live in poverty, but their 'health' (or wellbeing) may be relatively better than other homeless people depending on the strength of their social networks and their relationships with people around them. Health protecting and/or health damaging attitudes and attributes are features of social networks (Cattell, 2001). Homelessness is associated with significantly higher rates of social isolation (D'Amore et al., 2001). However, this definition of social isolation – "having no meaningful social contacts with non-homeless persons on a weekly basis" (D'Amore et al., 2001, p.1053) – is problematic in that it excludes having meaningful contact with other homeless people. It assumes that when homeless people are in social situations together, it is

not a meaningful social contact (Groot, Hodgetts, Leggatt-Cook, Chamberlain, Nikora, Stolte, & Radley, under review).

Homeless people will often form social connections with other people who are homeless, but this is described as a double-edged sword (Grigsby, Bauman, Gregorich & Roberts-Gray 1990). Although there are positive psychosocial outcomes such as support, protection and a sense of belonging; when homeless people affiliate with each other this can lead to a prolonged existence of being homeless (Grigsby, et al., 1990). Some of these social ties may support risk taking and unhealthy behaviours, such as substance abuse and unsafe sex practices (Aidala & Sumartojo, 2007).

Grigsby and colleagues (1990) found that social impacts on homeless people's health are characterised by exclusion from former or regular social contacts such as family and friends, and little or no stability in social situations. This experience has been labelled by some as disaffiliation (Grigsby, et al., 1990). Mental wellbeing is affected by being socially excluded, and being discriminated against – this can manifest into having little expectation left for life beyond the street, which can then descend into other mental health issues. Grigsby and colleagues (1990) make a similar argument in that they assert that disaffiliation can be of detriment to health because the material assistance, advice, and information that a homeless person can call on from others in order to meet basic needs and ultimately find pathways to exit homelessness, is limited.

Wilkinson (1999, in Cattell, 2001) argues that poor people may experience negative health consequences due to interactions with people of higher social status. Depending on the nature of those interactions, poor people may experience shame, disrespect, social anxiety, and perceptions of inferiority which all have an effect on health and wellbeing (Cattell, 2001). In comparison, other research has found that regular, positive social interactions with domiciled people are important to homeless people's well-being (Hodgetts, Hodgetts & Radley, 2006). However, it is crucial to

acknowledge that some homeless people do not always seek such social interaction (Hodgetts, Stolte, Chamberlain, Radley, Groot & Nikora, 2009).

As an example of practices that enhance health and social capital, homeless youth in Canada pool together resources by sharing food, buying food for others, or providing others with money to buy food when they were able to: "Often a group of four would pool their money to buy two packets of a macaroni and cheese "dinner" mix... the group then prepared and ate the pasta at the drop-in centre" (Dachner & Tarasuk, 2002, p.1044). These kinds of practices in social networks enhanced social capital. Homeless youth not only look after their own health in the best way that they can, but through sharing with others they give sustenance and gain friendships, which are widely recognised as health promoting.

Government research on health and policy documents are demonstrating more awareness and acceptance of ideas around social capital, such as social connectedness and social cohesion, as being important for health and wellbeing in New Zealand (National Health Committee, 1998). Less social support and social cohesion is linked to poor health, and being homeless (Hodgetts et al., 2007). However, resourcefulness was seen as an important health protecting characteristic of being homeless, in that it entails social supports. For example, homeless individuals are able to be both a source of support, and a seeker of support from other people in the same situation as a survival strategy (Hodgetts et al., 2007, McCabe et al., 2001).

A basic level of health is crucial to one's survival on the streets. Homeless people often spend more time and energy on basic survival strategies such as obtaining shelter, food and a place to rest before considering other factors relating to their health (Capponi, 1997, in McCormack & MacIntosh, 2001) such as seeking healthcare services. They are at a disproportionate risk for negative health consequences due to poor living conditions, lack of nutrition and adequate healthcare. These are all

processes which can contribute to and can exacerbate illness for homeless people.

In their research on spatial, material and relational dimensions of the health of homeless people in the United Kingdom, Hodgetts and colleagues (2007) found evidence of 'embodied deprivation' with their participants - the realisation by homeless people of their inevitable bodily decline. This concept illustrates how the hardships of homelessness can lead to the gradual deterioration of the human body. This physical decline often 'sneaks up' on people and surprises them, particularly when it 'suddenly' manifests itself as a major chronic health problem (Hodgetts et al., 2007). Because homeless people can become more preoccupied with other situational factors such as survival, rather than maintaining their physical condition, they may not notice the gradual decline of their health.

In sum, homelessness is a life situation that is beset with physical and mental health problems; and causal factors for homelessness have been debated for a long time. These debates reflect broader discussions in public health and health psychology regarding links between poverty and illness. Health problems can be a causal factor for homelessness and are often intertwined with many life events and situations; but it is generally agreed upon that once homeless, a person's risk for developing poor health increases dramatically due to such things as poor living conditions, poor hygiene, and poor nutrition. Homeless people are hindered both practically and socially, and this can have consequences for health. However, social capital in social networks is seen as a protective factor for homeless people, as it is known to be beneficial for health and wellbeing.

Health-related practices among street homeless people

Research on the health practices of homeless people is limited, but is needed, because it helps to break down stereotypes, particularly that of

‘vagrants’ or ‘idle tramps’ that appear to do nothing with their day (Riley, Harding, Underwood & Carter, 2003). Despite such conceptualisations of homelessness, each day homeless people must engage in a range of strategies to ensure that ‘health’ and wellbeing is maintained on a day-to-day basis. Such strategies are influenced by an individual’s conceptualisation(s) or social representation(s) of health (see chapter two). For example, research on lay people’s health concepts has been found that some people may conceptualise ‘being healthy’ as being able to work or function in society (Hodgetts & Chamberlain, 2000). Individuals who hold this belief will undertake various strategies to maintain that functional capacity, dependent on the type of work they do, and how demanding it is.

As illustrated in the previous section, life is a struggle for homeless people, and maintaining health can be difficult due to material and social psychological circumstances. Practices to sustain dimensions of health and prevent health problems take on new meaning when applied to the context of homeless people’s lives. Hodgetts and colleagues (2007) found that homeless participants’ accounts on health and illness were centred on “the need to respond to and cope with adversity” (p.713). Due to a lack of resources such as money and transport, fundamental needs to ensure health is maintained are often difficult to come by including secure, safe shelter, bathing facilities, nutritious food, and adequate clothing (Quine et al., 2004).

The following paragraphs describe health-related practices that homeless people have been found to engage in. Many come as little or no surprise, as they are things we all need (shelter, food), and do (bathe, exercise, socialise with friends). However, these practices take on a different meaning when put into the context of the life world of a rough sleeper. It becomes harder to obtain life’s necessities and even if they are obtained, they can be substandard. The purpose of this section is to create an understanding of how homeless people might conceptualise health, by exploring their health-related practices.

Safe, secure shelter is one of the basic necessities of life, and is something that homeless people lack. Homeless older men in Australia mentioned having a warm place to sleep as a priority (Quine et al., 2004). In research carried out in the United Kingdom on homelessness and health, one participant talked about his experience of squatting in a flat for several weeks: the conditions were so damp in the building due to a leak in the ceiling, that he developed chronic pneumonia (Hodgetts et al., 2007). This demonstrates that some health-related practices can be contradictory. But although this person found shelter which had a serious effect on his health (Hodgetts, et al., 2007), if he had not found any shelter at all, he may have had worse health problems. For some homeless people, the health practice of finding any shelter is necessary to escape the hardships and issues around 'sleeping rough', such as being vulnerable to physical violence. Unfortunately, even though shelter is achieved, it may often not be enough to escape unseen threats to physical health that exist in the environment.

A suitable roof over one's head will often mean that there is at least running water, or a bathroom installed. Being able to have a bath or shower is something that is taken for granted by the domiciled population, as most will have these facilities installed in their private homes. Homeless women in Radley, Hodgetts and Cullens' (2006) study emphasise the importance of keeping clean. Some homeless people find creative ways to ensure that they are able to clean themselves in a comfortable environment, even if they do not live in a private residence. One man mentioned that he was going to join "the Uni [gymnasium] for \$40 for six months and then I can get in before the students and use the toilet, shower and bath" (Quine et al., 2004, p.162). Bathing is a very important health practice to maintain personal hygiene, as it helps to minimise the risk of getting various infections.

Having access to drinking water and nutritious food is also important to maintain health and prevent many health problems. Healthy food sources

are difficult to come by for homeless people (Evans & Dowler 1999; Quine et al., 2004), food is consumed mostly to curb hunger and there is a lack of nutritious food available. Meal centres are often the environment where homeless people eat and converse with their friends, thus increasing their social capital. However, it is difficult for homeless people to maintain healthy living habits.

Drop-in centres, shelters, missions, and other services provided for homeless people will often have an equivalent of a soup kitchen. In such spaces, homeless people have access to food that has been donated by local businesses, or is made at a low-cost on site. Dachner and Tarasuk (2002) discussed access to food in relation to young homeless people in Canada, where it is a daily struggle. Often, a lot of the food is quite low in nutrients, and has a high fat and carbohydrate content, and lacks variety. Because many homeless people are opportunistic eaters, i.e. they eat in order to avoid starvation, their diet will be poor, and they will not gain sufficient nutrients from their food in order to maintain good health (Evans & Dowler, 1999). Even though homeless people are eating, they can still become malnourished. This can lead to a range of health problems, such as obesity, high cholesterol, high blood pressure, and heart disease.

Evans and Dowler (1999) note that food provision through services such as soup kitchens is not in the first instance aimed at promoting health through food (mainly due to financial issues in sourcing healthy, nutritious food). Seeking sponsorship from potential businesses (those that stock perishable food such as fruit and vegetables) would be a step forward in ensuring that homeless people have access to better nutrition and will therefore be healthier, and able to function better in society (Evans & Dowler, 1999) in terms of being well enough gain employment, and engage in more physical activity.

Gaining enough exercise is seen as a health protecting behaviour, and is a major theme in public health promotions. Homeless older men in Australia talked about practices in relation to their health that the authors

described as health promoting behaviours, and this included physical activity (predominantly walking) (Quine et al., 2004). Walking is a form of physical fitness and is a way to 'get around' and pass the time (Hodgetts et al., 2009), yet this is often impeded due to foot problems because of poor shoes, long periods of walking and standing, and poor foot hygiene practices.

Even though it is well known that everybody needs the above 'basic necessities to life', these are situated in the sphere of physical health and wellbeing. What about social and emotional wellbeing – being happy and enjoying life? A key question explored by Flick and Röhnisch (2007) in their research on homeless adolescents conceptualisations of health, was; how do homeless people's social representations of health inform their health practices? Homeless youth discussed the fact that because they do not believe that they can attain their concept of the 'pinnacle' of health and wellbeing because of their situation, they engage in risky behaviour such as substance abuse, because it makes life more enjoyable. Some homeless people even go so far as to take toxic substances not intended for drinking, such as mouth wash (O'Connell, Mattison, Judge, Strupp, & Koh, 2005), and other poisonous liquids such as methylated spirits. They are cheaper than consumable alcohol, and have the intended effect. Furthermore, O'Connell and colleagues (2005) say that the use of substances such as these could indicate end-stage alcoholism, and put users at risk of an early death. Hodgetts and colleagues (2007) argue that even though risky behaviours such as participation in 'drinking schools' have adverse consequences for the physical health of homeless people, positive psychological and relational health outcomes can be observed due to the social supports associated with participation in communal activities such as this – a sense of friendship, reciprocity and shared purpose. However, participants acknowledged that drinking excessive amounts of alcohol or taking drugs in order to 'escape' the reality of homelessness is an unhealthy practice. It can exacerbate health problems, and perpetuate a vicious cycle of poor health (Hodgetts, et al., 2007).

Briefly, fundamental health practices of homeless people such as having enough food to eat, getting enough exercise, bathing, and having shelter and clothing seem relatively unsurprising since these are activities that the domiciled population take part in as they are necessary to function as a healthy individual in society. Homeless people often have to come up with creative solutions to ensure that they are able to get access to these basic needs, but factors due to homeless life situations can mean that their health is compromised regardless of such initiatives. The health practices of homeless people are often not enough to protect and preserve health, and can promote illnesses because the pursuit of life enjoyment is sometimes seen as more important. In this thesis I set out to ascertain the kinds of health practices that homeless people undertake in New Zealand, with the aim of providing a better picture of their day-to-day struggles with maintaining health and wellbeing, in order to challenge stigmatising stereotypes. An important practice to protect or maintain health is to utilise health services. Examples from international research on homeless people's health service use is explored below, to give a picture of the types of services homeless people seek, and how often.

Health services for homeless people: Provision and utilisation

This section explores the availability and accessibility of healthcare for homeless people. While there is little New Zealand literature on this, it is necessary to explore research internationally to gain an insight into the potential patterns of homeless people's healthcare use in New Zealand. By reviewing literature on the New Zealand health system, I am able to gauge how the availability of a specialised clinic (such as the NGO clinic) affects homeless people's accessibility to healthcare. There is a vast array of international research on the types of services available to homeless people. In this section, international examples outline major themes found

in literature on service provision, utilisation patterns, and service needs for homeless people. This will help to give a picture of what services are actually used by homeless people, how often they seek them, and aspects of effective service delivery. Initiatives for specialised service provision for homeless healthcare will be covered at the end of this section.

A large amount of research on homelessness and health has been carried out in the United Kingdom or United States where the health services context is different to that of New Zealand. New Zealand's health system is two-tiered, in that there is subsidised public health care, and a partially subsidised private health care system (Dew & Kirkman, 2002). The 1938 Labour government first introduced universal access to healthcare in New Zealand with the Social Security Act; where "...people could be treated free of charge in any hospital maintained by a hospital board – whether they were rich or poor" (Dew & Kirkman, 2002, p.20). Health services in New Zealand have gone through several phases of restructure since (Dew & Kirkman, 2002). Presently, District Health Boards (DHBs) have a budget determined by a "population-based funding formula" so that "limited resources are used in the best way possible" (King, 2000, p.25). All New Zealanders are entitled to publicly funded healthcare (King, 2000), but some healthcare is only partially subsidised (Ministry of Health, 2009). This has implications for how and when homeless people in New Zealand utilise the health system, given they are entitled to publicly funded healthcare as well. But little research has explored health service accessibility issues for homeless people, or specific service provisions for them in New Zealand. In the absence of local studies, insights can be gained from international literature.

International research shows that homeless people are less likely than the general population to have stable sources of care, which further complicates their poorer health statuses (Kidder et al., 2007). Despite this, more homeless people report a need for health services, than those that actually use them (Padgett, Struening & Andrews, 1990). This is related to Hart's (1971) concept: 'The Inverse Care Law', where "...the

availability of good medical care tends to vary inversely with the need for the population served” (para.1). To be specific:

In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas; and hospital doctors shoulder heavier case-loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff. (Hart, 1971, para.46)

This ‘law’ is affected by exposure to market forces (Hart, 1971), and could explain findings in literature around homeless people’s lack of access to and use of health services. Homeless people amongst other poor population groups have less access to appropriate medical care, yet higher income populations have better access (Hart, 1971).

Homeless people need different types of services to be able to function in society, and certain services are perceived by this population as more important than others. In a needs assessment study conducted by Acosta and Toro (2000), homeless people ranked access to medical and dental treatment and healthcare information fifth behind physical safety, further education, transportation and affordable housing. Although health issues are a concern for homeless people, the research illustrated that health concerns can be eclipsed by other more pressing concerns. This could be due to a range of factors, such as a perception of health services as inaccessible. Gelberg, Gallagher, Andersen and Koegel (1997) found that ‘competing priorities’ such as finding food, shelter and safety may impede homeless people’s utilisation of health services.

While homeless people appear to utilise health services less than they need to, there seem to be a reasonable amount of services available in certain areas. In a study of 165 day centres in the United Kingdom, Johnsen, Cloke and May (2005) found that 36% provided primary medical care, and 30% provided specialist medical care. Day centres in the United Kingdom ranged from being faith-based organisations which rely primarily on volunteers and donations that provide only a basic level of service to impoverished populations, to more professionalised organisations,

providing a greater range of facilities and services, and taking a more secular approach to secure funding from government (Johnsen, et al., 2005). What has grown from this is recognition that not all of these types of services reach everybody that needs them. Therefore, some groups have developed organisations to address gaps in services and offer intensive support to service users. Douaihy and colleagues (2005) have identified that in the US, it is difficult for homeless populations to receive integrated care due to a myriad of problems to do with their health. For example, separate agencies on separate levels of government fund different types of services, all with varying approaches to care and different eligibility requirements. There is little collaboration between these services, resulting in a disjointed system of care (Douaihy et al., 2005). More wrap-around services are needed for homeless people because they need to seek a wide array of social services (e.g. Acosta & Toro, 2000), as their situations do not just fall into one 'category'. This could include being unemployed and having chronic health problems, as well as not having a place to live.

Homeless people in Amsterdam reported little contact with medical and social services, fewer with general practitioners in particular (van Laere, de Wit, & Klazinga, 2009). In their United States study of homeless people's emergency department use, Kushel, Perry, Bangsberg, Clark and Moss (2002) found that the majority of the homeless participants used emergency departments for health care at least once in the previous year. Sachs-Ericsson, Wise, Debrody and Paniucki (1999) observed that most homeless people who utilised health services sought treatment for medical problems they had received treatment for in the past, which were ongoing, recurring problems.

The most frequent sites that O'Toole, Gibbon, Hanusa & Fine (1999) found homeless and housed poor people sought for care were traditional ambulatory care settings that included hospital based clinics, private physician's offices, and community clinics. Emergency departments and free shelter clinics were less sought after (O'Toole et al., 1999). However,

a British study concluded from reports that homeless people seek care from emergency departments more often than any other services, and that these visits were more often focused on acute needs, rather than illness prevention or health promotion (Power, French, Connelly, George, Hawes, Hinton, Klee, Robinson, Senior, Timms & Warner, 1999).

Homeless people's use of emergency rooms in hospitals for primary health care is a major issue, in that it is high-cost, non preventative, and not sensitive to homeless people's needs (Sachs-Ericsson et al., 1999).

"Funding opportunities [for primary health care clinics that offer services specific to homeless people's needs] may be enhanced when providers can document that the lack of available services for the homeless ultimately leads to not only more suffering for the homeless, but also a greater financial burden for the community" (Sachs-Ericsson et al., 1999, p.451).

Homeless people often delay presentation to health services, and many will only seek healthcare once ailments, injuries or illnesses become severe (Gelberg et al., 1997; Power et al., 1999). An unfortunate finding from Stein, Anderson and Gelberg's (2007) research, is that homeless women in more severe homeless situations were less likely to utilise health services, even if their health statuses were worse (compared with that of other participants). These women were more likely to utilise acute care services, such as hospital emergency rooms, which was seen as better than no care (Stein et al., 2007).

If homeless people actively sought healthcare before health issues become acute, their need to utilise secondary specialised health services will be reduced. Reilly, Grier and Blomquist (1992) found that homeless clients at a nurse managed clinic in the USA gained effective treatment for mildly to moderately severe problems, which meant that they did not need to be referred to other services. Reilly and colleagues (1992) inferred that service users could be identifying problems that are treatable at the clinic,

seeking treatment before health problems become more severe, and only using secondary or specialised health services for more severe illnesses.

The amount of time a homeless person has to wait for healthcare is an important factor in its accessibility. It is well known that waiting times are often long in hospital emergency departments and other health services when primary health care is sought. Homeless youth in Ensign and Gittelsohn's (1998) research identified emergency rooms (ERs) as convenient places to seek healthcare because they were always open: "...you may have to wait forever, but eventually you will get seen" (p.2095). In their study of homeless people's perceived satisfaction of care, McCabe and colleagues (2001) found that when participants knew that they required healthcare, they would seek it immediately. When they sought care, and knew that they would be responded to, time became relatively unimportant, because of the fact that participants knew that they would eventually be seen by a healthcare professional. In these cases, homeless people would ensure that their health care needs were understood, and needed to know that they were guaranteed to get the healthcare they needed, so would be prepared to wait a long time (McCabe et al., 2001).

There are a number of recommendations that have come from research with health services for homeless people. Reilly and colleagues (1992) believe that rather than treating chronic illnesses episodically, health services for homeless people could develop support groups for the management of chronic health problems, and provide such services as respite care when homeless people experience exacerbations of chronic illnesses; such as being able to stay in a bed at a shelter outside usual operating hours. Power and colleagues (1999) argue that health promotion and disease prevention for homeless populations is lacking, although it is a difficult issue to address i.e. one can tell a person that they should eat a balanced diet, or to ensure that they brush their teeth – but that information is impractical in many cases due to the lack of resources homeless people have. Some other health promotion efforts have been

documented such as condom distribution and vaccination programmes. Power and colleagues (1999) believe that practical help is more useful to homeless people, and suggest that sunhats, sunscreen, clean socks, and washing facilities should be made available, as well as information on general hygiene practices and avoiding conditions such as hypothermia and sunstroke.

Advice and information is important to ensure that young homeless people utilise services. Younger homeless people in Baltimore City, US, said that they would seek advice about health issues from friends and trusted adult figures such as extended family members, because they knew they would not be judged (Ensign & Gittelsohn, 1998). They also gain information on health issues through education programmes (Ensign & Gittelsohn, 1998). Another factor that has been found to increase service utilisation among homeless people is when specialised outpatient health services are located close to other services that homeless people frequent, such as shelters and drop-in centres (Sachs-Ericsson et al., 1999). Outreach services were another way to increase service accessibility and utilisation (Sachs-Ericsson et al., 1999). It was found that “a substantial portion of homeless individuals will choose to use medical services sensitive to the needs of the homeless when such services are available” (Sachs-Ericsson et al., 1999, p.451).

In sum, the literature reviewed in this section on health service use was primarily quantitative and based internationally, but it highlights the fact that most homeless people seek healthcare for acute conditions – mainly in hospital emergency departments. However it was found that when homeless people utilised primary healthcare before easily treatable health issues became acute, their likelihood of being referred to secondary treatment was minimised. There are a lot of examples of health services that homeless people are more likely to frequent, particularly those that are closer to specialised services already provided for them.

Homeless people report both positive and negative experiences with health services, which are reflected in the fact that different services are sought out for different needs. Some homeless people utilise a variety of services, some refuse to use certain services based on their own experiences, and knowledge of other people's experiences. The next section highlights some of the barriers homeless people experience when seeking and utilising health services, as well as various experiences within health services.

Necessary spaces for care: Barriers to access and experiences of health service use

While there are a range of health services that may meet the needs of homeless people, access to these services is still a major issue. Problems with access stem from a lack of financial and material resources, sometimes an uneasiness about the settings of some services, or a general distrust of medical professionals. Once again, research reviewed in this section is predominantly from international sources, but can be related to homeless people's life situations in New Zealand.

Geber (1997) found that for a sample of homeless youth in a United States city, the most significant barriers to health care service use were: lack of financial resources to pay for care, problems in accessing care, and fearing that medical professionals might be prejudiced. In their review of Canadian literature on the health of homeless youth, Kelly and Caputo (2007) found that one of the main problems for street youth in terms of accessing health care is being underage. Street youth tend to be wary of mainstream medical clinics and health services due to fear of being picked up by the police and/or social service agencies. "Making contact with someone in the system they can trust is an important first step" to improving health issues (Kelly & Caputo, 2007, p.735). Developing trust

between service providers and homeless clients is important for continuity of care (Wright, 1990).

Stein and colleagues (2007) argue that homeless people with barriers to healthcare will experience poorer health than others because they lack preventive care and do not attend to chronic, longitudinal health issues. Lack of transportation is a very important issue in homeless people's life worlds that hinders their access to health services (Douglas et al., 1999). Financial problems are indicated as another barrier to accessing healthcare (Stein et al., 2007). Also, homeless people may not seek healthcare due to perceptions of particular illnesses such as shame, which can be associated with sexually transmitted infections (Stein et al., 2007). This could be because they are afraid of being misjudged by health practitioners. This has a threefold effect: worse illness amongst homeless populations, which can lead to a greater cost to society and therefore a greater cost to the individual taxpayer (Stein, et al., 2007).

Another barrier to healthcare for homeless people is when some practitioners are less likely to prescribe particular medications to homeless people because there are concerns that their ability to take them will be impaired (Douaihy et al., 2005). This is often due to storage issues – some medicines need to be refrigerated, and if they are not, they are unlikely to be effective (Douaihy, et al., 2005). However, findings from Waldrop-Valverde and Valverde (2005) suggest that while it is true that medical practitioners may assume that homeless people may not adhere to drug treatments, they found that a substantial number of homeless people in their study were able to adhere to and manage medications. McCormack and MacIntosh (2001) discussed medication management as a particular practice that homeless people engaged in to prevent illness and preserve their health. For example, one homeless man chose to not disclose his insulin and needles to the staff at the shelter where he was staying so that he could manage his own health. He kept his medication with him all the time and he believed that this practice suited him, despite the shelter rule that all medications were to be held by staff (McCormack & MacIntosh,

2001). This links back to experiences of services and the appropriateness of those services for the homeless population – the fact that there are shelter ‘rules’ such as this might not function well for those who need the service, yet feel as though they are capable of managing their own medications.

Briefly, there are many barriers to health services that homeless people experience. Resource availability to ensure access to services is a concern, as well as issues around age for young people, and uneasiness about healthcare professionals. One of the most worrying barriers is the fact that homeless people often have debilitating chronic illnesses, which further impede their ability to access health services, and living situations often means that storing particular medications is problematic. The next section explores homeless people’s experiences in healthcare settings.

The serious nature of physical and psychological health issues affecting homeless people and complications of living on the streets means providing effective health interventions is not a straightforward task. Do (health) services provided for homeless people benefit their health, and/or life worlds? McCormack and MacIntosh (2001) found that homeless people’s experiences with health care providers were mixed:

...providers imposed social distance through their use of language, lack of trust and disrespect for age, which forced these participants into isolation from society... social distance was reduced when providers accepted and respected the homeless person, making navigation through the sector accessible. (p.687)

According to McCormack and MacIntosh (2001), homeless participants identified many health services that had the potential to help them achieve better health; but there were also many inappropriate strategies that did not help at all. The participants indicated that an effective system of help in terms of health care requires collaboration across sectors, which is currently not happening at the extent that it should (McCormack & MacIntosh, 2001). The following excerpts from literature provide examples of positive experiences within services, as well as negative.

Social and cultural geographical work on health and place has led to the development of the concept of 'spaces of care' in homeless services (Johnsen et al., 2005). Gesler and Kearns (2002) argue that "If a person identifies in a positive way with the *place* in which care is being provided, indications are that the treatment will be more successful", and also, "It is important for health care personnel to have positive feelings about the places in which they work as well" (p.61). This leads to the idea that places and spaces of health care provision cannot just be places to go where one is sick, in order to come out the other end with some treatment or medication that will hopefully 'fix' the health problem. Places of health care provision need to be seen as accessible and comfortable places to be in by their target populations, in order for health 'care' to be practiced and received accordingly.

In his research on health in place in Hokianga New Zealand, Robin Kearns (1991) found that local medical centres were seen as more than somewhere to seek health care. Because the medical centres were located within such tight-knit communities, they were more like public places for community members "...which are used – to varying degrees – to gather, interact and exchange information as well as to be treated by doctors and PHNs [public health nurses]" (Kearns, 1991, p.529). This example parallels with day-centres in the United Kingdom for homeless people, in that they offer a space for people to have basic physical and material needs met, including healthcare, while experiencing a sense of belonging, comfort, and social support within those settings (Hodgetts et al., 2007). The focus is not just simply on providing health care to homeless people, but developing relationships with them to ensure that utilisation of healthcare continues (Johnsen et al., 2005).

For homeless people, spaces for care can include more specific settings such as day centres or medical clinics, but also a range of other spaces which can include libraries, churches, and even friends' houses (Hodgetts et al., 2007; Johnsen et al., 2005). Spaces for care can be places to gain

social support and personal strength, places to get away from the hardships of homelessness, and where people can gain access to basic needs such as clothing, food and medical care (Hodgetts, et al., 2007).

In research that explored homeless people's experiences of health services, participants talked around several themes that described positive aspects of health care they had received in the past, and what gave them 'satisfaction' with service providers (McCabe et al., 2001). The themes that best described these positive experiences were: the committed nature of staff in health services; respectful engagement with clients; creation of trust between clients and staff; staff who held no assumptions and did not prejudge their clients; and inclusive care practices by service providers (McCabe et al., 2001). Experiencing 'welcomeness' within services is important to homeless people: "they made me feel like I was a person, not just some derelict that, you know, shouldn't be breathing" (Wen, Hudack & Hwang, 2007, p.1013). All of these factors contribute to a better structure for health service delivery for homeless people, particularly in terms of client-professional relationships.

A number of day centre settings for homeless people were conceptualised as spaces of 'fear' by participants in Johnsen and colleague's (2005) study. Some day centres were considered to be inappropriate, as they were within substandard buildings – some were reported to be quite overcrowded, dark, cramped and smelly (Johnsen, et al., 2005). These centres are supposed to be places where vulnerable populations come for support, and are intended as such; but there is a stigma associated with using these services – some people avoid these centres because they do not wish to identify with homelessness (Johnsen et al., 2005).

Maintaining a sense of dignity while using services is important to homeless people. Responses from homeless participants in Hoffman and Coffey's (2008) study suggested that "they did not feel that they were treated as fully recognised adults or respected as equal citizens, but rather as numbers and children" so many homeless people decided not to use

services in order to “maintain a sense of dignity and self respect” (Hoffman & Coffey, 2008, p.208). An example of a person who has felt unwelcome in various healthcare situations and tries to avoid them is Luke: “I get to the point where I don’t really, I don’t know, trust or like physicians. More and more I see it as almost they would sooner deal with rich people, people with good insurance, and everything else” (Wen et al., 2007, p.1013).

An earlier study carried out in the late 1980s in the United States on the implementation of a new programme to aid homeless people, found that some traditional services that were available to the homeless were not very welcoming:

Medical clinics were not eager to serve people who smelled bad or were lice-infested, and in many subtle and overt ways made homeless people feel unwelcome. Mental health programs served only those who could make and keep regularly scheduled appointments and refused to see anyone who smelled of alcohol. Substance abuse services served only those who were able to remain completely abstinent. Even a minor relapse resulted in immediate dismissal from many programs. Substance abuse services also refused to serve anyone who used psychotropic medications for mental illness (Surber, Dwyer, Ryan, Goldfinger & Kelly, 1988, p.118).

While Surber and colleagues’ (1988) research is more historical, it cannot be ignored. Some organisations may have improved their services considerably, but others might not have. This is illustrated in Quine and colleagues’ (2004) Australian study, where homeless people reported that they had received inappropriate and impractical advice from health professionals. For example one man who was living on the street was diagnosed with pneumonia – as a result, his doctor had advised him to stay in bed and keep warm (Quine et al., 2004). While this is the right advice to give to a domiciled person who has access to a warm bed, it is potentially offensive to a homeless person. Other participants had reported not being taken seriously by doctors, and believed that the treatment they had received from medical professionals had caused further health problems (Quine et al., 2004). Results from Kidder and colleague’s (2007) study indicate that “many homeless people living with HIV/AIDS do not receive the quality of care that is optimal for managing HIV” (p.2244). One

could argue that this is a similar experience for other homeless people who suffer from any sort of chronic illness – consequently, access and adherence to satisfactory health care is impeded by the condition of being homeless.

Utilisation of health services is also affected by the interactions homeless people have with service providers. Relationships between homeless young people and social workers in service providers are often tenuous in terms of the different needs homeless youths have (de Winter & Noom, 2003). Some need more support in some areas and more independence in others, and communication between social workers and homeless youth is important to ensure that services will be utilised effectively (de Winter & Noom, 2003). Such issues can apply to the homeless population in general and will be relevant to health services – individuals will utilise services that actually provide for their needs.

To recap, homeless people have both positive and negative experiences with health service providers. Depending on the types of services they have received in the past, homeless people will make healthcare choices based on their perceptions of those services like any other lay person. Homeless people's perspectives and voices need to be heard and considered alongside wider population health needs. It is evident that creating a 'space of care' (or an environment where homeless people feel comfortable, welcome, and open to developing relationships with staff and health professionals) is imperative to ensure regular use of services, and better health outcomes for this population. Collaboration across health and service sectors is seen as important to ensure that homeless people receive appropriate healthcare where necessary. Health service provider perspectives of caring for homeless people will be explored next, to gain a picture of how the task of treating homeless people's health problems is perceived by health professionals, in international literature.

Provider perspectives of service provision

There is limited research on the experiences and dilemmas faced by professionals providing health services to homeless people. However, what is available is insightful. In a study in the United Kingdom, Masson and Lester (2003) explored the perceptions of medical students towards homeless people, using the *Attitudes Towards the Homeless Questionnaire* (ATHQ). The research was rationalised because there is evidence to suggest that the perceptions of healthcare professionals can create major barriers to health care for homeless people (e.g. Wen et al., 2007). What was found is that medical students recorded both positive and negative incidents during their training with homeless people. Those who had experienced positive encounters with homeless people reported that they would treat a homeless patient as an equal. The majority of medical students reported that they had experienced negative encounters. These students viewed homeless people as less worthy of medical care than other patients (Masson & Lester, 2003). An explanation for this was offered, in that medical students would learn via role-modelling of senior staff. "A negative attitude might be transmitted either through derogatory comments made by senior staff or through the student's observations of the way in which patients were treated [by senior staff]" (Masson & Lester, 2003, p.870).

Although some organisations strive to offer homeless people the best possible treatment, this can be challenging when the service must operate within a small budget. It is argued that the knowledge production of some professionals working with homeless people is shaped by perspectives from the public state-controlled sector, as well as the voluntary sector, and these competing approaches can shape the context of health service provision for homeless people (Renedo & Jovchelovitch, 2007). In their United Kingdom study, Renedo and Jovchelovitch (2007) discussed the concept of 'Cognitive polyphasia' in people who work with the homeless in a variety of services. Cognitive polyphasia is marked by one person, institution, group or community receiving a plurality of representations or

ideas about a particular phenomenon. These perspectives may create conflict in terms of thinking patterns. However even though they differ, such perspectives regarding specific issues must be taken into account (Renedo & Jovchelovitch, 2007).

The most essential feature of HP's [Homeless Professionals] way of thinking is the coexistence of internal dilemmas and contradiction, which speak about the complexity of the phenomenon of homelessness and point to the need to take into account the intricacy of this issue when designing policy. (Renedo & Jovchelovitch, 2007, p.789)

At the heart of these internal dilemmas is the struggle to take a humanistic approach when interacting with homeless people, while taking into account and resisting pressures associated with state agendas that may undermine the wellbeing of this population (Renedo & Jovchelovitch, 2007). This could very well be a feature of many organisations that deal with homelessness in New Zealand.

The representations and discourses surrounding homelessness held by HPs' and the services they work for (however conflicting), could affect the way homeless people perceive specialised services (Renedo & Jovchelovich, 2007) – in particular health service provision and access, thus affecting their wellbeing. Depending on HP's representations of homelessness, knowledge of the above assertion could serve to increase cognitive polyphasia, as they try to make sense of conflicting perspectives, in order to apply these in professional practice.

Johnsen and colleagues (2005) also emphasise the challenges of having a humanistic approach while working with homeless people. They found that the responsibility to create an environment where homeless people feel comfortable, welcome and non-judged is often placed on staff in such services (Johnsen et al., 2005). It is acknowledged that "the ability of staff to foster these relationships in an atmosphere of refuge and freedom from 'othering' is often fundamentally compromised by the realities of working in an under-resourced sector involving direct contact with desperate people" (Johnsen et al., 2005, p.799). However, in terms of health services for

homeless people, the idea of spaces of care is hugely important because if one identifies positively with a place in which healthcare is provided, their treatment is more likely to be successful, and patients are more likely to come back to that place for further care (Gesler and Kearns, 2002).

In a study conducted by Hunter and colleagues (1991), health service providers in the United States believed that structural issues were the most significant barriers to service access – cost/financing, interagency referral, and lack of safe places for discharge. These providers were generally found to be quite sympathetic towards the social and health care needs of homeless people, coming from the viewpoint that they are entitled to the same services as the general population. However, characteristics of the client group were also seen to be barriers, including a lack of motivation for self-care, and inability to follow through with recommended treatment by service providers (Hunter et al., 1991).

Dealing with a confluence of health problems, and trying to collaborate with services is a challenge for some doctors who provide medical care to homeless people. Van Laere (2008) outlines the difficulties experienced, and how these affect those that work for homeless people:

We find pathways to deal with multiple and interacting problems. We wrestle with the consequences of fragmented and disconnected services. We become cross about the lack of information sharing. What is social care about? We flounder. A high morbidity pattern among our homeless patients affects health workers ourselves. We feel paralysed, excluded, and ignorant, overlooked by the rest of the system. (p.367)

Van Laere (2008) asserts that doctors should be able to make a difference in the medical and social lives of homeless people, and warns that “medical professionals need to be aware of the red tape pathways the poor and homeless have to take along public services and their ever-changing rules, in order to obtain basic care” (p.367).

In New Zealand, people who worked with high needs populations in the health sector found that some clients experienced shame associated with visiting health services, and some even feared health services (Bennett,

Ryder, Governor, James, Simcox, & Ormsby, 2008). Professionals found that developing relationships, relating to clients, working with clients, patience, perseverance, co-operation, humility, respecting cultural differences and creating trust were all important to ensure high-needs populations received the best possible healthcare (Bennett et al., 2008).

It is essential to look at service provider experiences in providing healthcare as well as their perceptions of homeless people, in order to understand the dynamics of healthcare professional and homeless client relationships. Homeless people have higher incidence and severity of illness, and can be dependent on health services to provide them with adequate healthcare. This becomes problematic when medical students who could potentially be working with homeless clients, develop perceptions of them as 'unworthy' of care. If homeless people receive poor treatment from a service, it is unlikely they will return. However there is evidence that there are many services that work hard to ensure that homeless people receive the healthcare that they need. Often there is conflict between what services are funded for and what they actually (need to) provide, and policy developers should take this into account.

The present study

As described earlier, the present study is exploring health and illness experiences and health service use amongst a group of homeless people who make use of a particular medical clinic provided by an NGO (the NGO clinic). This research will also look at NGO clinic staff perspectives and experiences of working with homeless people, as illness is a significant factor in the lives of many homeless people. The literature summarised in this chapter provides a guide for what to expect in an exploration of homeless people's conceptualisations of health and illness, their health practices, services utilisation and barriers to healthcare services, and experiences of care in service use. NGO clinic personnel experiences in

consulting with and treating homeless people will also be explored. This collection of research on these topics helps to justify the importance of carrying out this project in New Zealand, where homelessness and ensuring appropriate healthcare provision for this population is becoming a significant issue.

This research is set in a specific medical clinic. The NGO that provides the medical clinic on their premises is a drop-in centre, and has a long history of providing much needed services to homeless people and other groups that experience poverty in this particular region. It is open Mondays, Tuesdays, Wednesdays and Fridays, and was intending to open on Thursdays in mid-2009. There are generally three or four clinic staff members working each of these days. The receptionist and manager work each day, as well as one or two health practitioners.

The clinic had been running for 2-3 years as a 'suitcase clinic', where a General Practitioner (GP) volunteered their time for a few hours a week, and homeless people could seek free healthcare for acute primary health needs. Then, the clinic grew to have another GP volunteer their time which increased service availability for homeless people, and in the last year or two decisions were made to restructure the clinic as an official primary health care provider under a Primary Health Organisation (PHO), funded through the regional District Health Board (DHB). By structuring the clinic in this way, primary health care will be delivered to homeless people in line with the vision of *The Primary Health Care Strategy* (King, 2001).

This thesis documents the implications of having this sort of medical clinic situated within a site where homeless people seek services. It is hoped that an understanding will be gained of whether the clinic is an 'ideal' or appropriate health service for homeless people, and if it is closely aligned to meet the needs of this client group. The research will be achieved through field research and interviews with homeless people who use the clinic service, and staff members who work within the clinic and the wider NGO. Attention is also given to studies using Social Representations

Theory (SRT), which has been used extensively in qualitative health research, and provides the conceptual basis for the present study.

Chapter two covers the methodology considered and utilised in this research. Ontological and epistemological assumptions – critical realism and social constructionism respectively – will be described in terms of their relevance to this research. To follow, social representations theory will be outlined and discussed in terms of previous research on homelessness and health, and how it will be applied in the research. The collaborative nature of the research will be discussed, as well as how this research can be defined as ‘abductive’. The research design and methodology will then be outlined, and the research setting and process will be discussed. Finally, the method of analysis will be outlined.

Chapter three is an analysis of clinic staff responses, and is titled ‘The Clinic’. This chapter will look at the functions, limitations, and issues for the staff and NGO in offering a specific primary healthcare service to homeless people. I will cover the day-to-day running of the NGO clinic in terms of: staff backgrounds and approaches to treatment; clinic structure and development; an ideal vision for the clinic as an integrated service, while meeting patient needs and developing relationships with clients; and the various constraints, dilemmas, and challenges staff face on an everyday basis.

Chapter four will analyse the responses of homeless clients. First of all, their health experiences, social representations, conceptualisations, histories, and current health issues will be explored through the use of health biographies. Clinic staff and homeless client perspectives on three health issues will then be explored in depth – mental illness, drug and alcohol addictions, and foot problems. To follow, the influence that social networks have on homeless people’s health will be explored. Finally, homeless patients’ perspectives on health services and the NGO clinic will be discussed. A military metaphor will be woven throughout the chapter to highlight the uniqueness of the NGO clinic.

Chapter five brings together the perspectives of both NGO clinic staff and homeless participants into a discussion. This chapter looks at how social representations of health, illness, homelessness, and (the NGO clinic) health services can both overlap and differ between diverse groups of people. The overarching themes from chapters three and four will be discussed in relation to research explored in the literature review in this chapter, and will be brought to a conclusion.

Chapter Two: Methodology

It is important in any research project to have methodological processes that fit the purpose of the particular research being undertaken. This chapter outlines the philosophical underpinnings of this study, the theoretical standpoint for this research – social representations theory (SRT), the consultation process with the Non-Governmental Organisation (NGO), the methods used and the research process.

Philosophical assumptions

Ontological assumptions concern what the form and nature of reality is, and what can be known about reality (Nelson & Prilleltensky, 2005). The ontological assumption followed in this research is that of critical realism, where a realist stance is taken, but that stance is informed by critique on the traditional philosophical discourse of modernity, and classic pre-modern discourses (Hartwig, 2007). Reality is espoused to exist outside the mind, that is, there is a physical, material reality – a ‘world’ that exists outside the minds of people (Crotty, 1998). However, we can never fully know the reality of people’s experiences. Critical realism asserts that the world is out there, but we can never access it directly, and we can never know everything about it, hence the category of ‘absence’ of knowledge being important to this ‘critical’ ontology (Hartwig, 2007). For example, if a research participant were to describe how they dealt with an injury or illness on the street, that construction of their experience in reality would inform my interpretation of that experience, because I cannot have access to it. This illustrates why critical realism informs this research, and links in the importance of a constructionist epistemology.

An epistemological assumption explains the nature of knowing reality, i.e. a way in how we know what we know (Crotty, 1998). Constructionism is

the assumption that “Truth, or meaning, comes into existence in and out of our engagement with the realities in our world... Meaning is not discovered, but constructed” (Crotty, 1998, p.8-9). The meaning ascribed to a single phenomenon can vary from one individual (or group of people) to another, in terms of many context variables.

The meaning that a homeless person ascribes to dealing with illness or injury could be completely different to that of a wealthy, housed person. This is because their life situations can vary enormously, and diverse contexts will mean that injury and illness experiences will be constructed differently. For example, people of higher socio-economic status (SES) can often access healthcare more easily, and faster. This is due to ease of communication, transport availability and better ability to pay medical fees. Lower SES, whether a person is homeless or not, will often mean more difficulty with access to appropriate healthcare due to a lack of resources that higher SES groups have in comparison (e.g. Stein et al., 2007).

People from different SES groups construct meaning about health and health services in different ways because of social experience, and varied interactions with the physical world and social experience (Chamberlain, 1997). Some knowledge constructions have developed over time throughout many generations, are culturally and socially specific, and they govern how each of us know the things we know, and how we see the world. Often, these knowledge constructions or social representations are socially located, for example, in books and other cultural artefacts that people have access to (Farr, 1998). Constructionist epistemology informs the theoretical perspective of this research – social representations theory (SRT).

Theoretical perspective: Social representations

The study of social representations is derived from Durkheim's (1898/1965) classic essay on the differences between individual and collective representations. This essay differentiated the study of psychology (individual representations) from the study of sociology (collective representations). Individual representations were theorised as the interrelationship between the mind and the physiological structure of the brain; whereas collective representations are theorised as exterior from individual minds, and are created from the association of minds in society (Durkheim, 1898/1965). The distinction between individual and collective representations is not realistic, in terms of the way people think, act, and interact socially. It was sought to be overcome by Moscovici (1961/1976, in Farr, 1998), who espoused that social psychology *is* the study of social representations – an interrelationship between individual and collective representations. People are inherently thinking and social beings, and to separate the two spheres is not a useful approach when we look to study people's individual experiences within society.

Social representations theory (SRT) informs this research. By using this framework, I seek to gain an insight into homeless people's social representations of health services and their own health situations in relation to their life worlds; as well as social representations held by NGO personnel of the healthcare service they provide, and that of homeless clients and their health issues.

SRT addresses the social nature of knowledge. The theory asserts that people have representations of physical objects, abstract ideas, actions, beliefs and information (things in the world) that are mediated socially. Therefore, this assumes that there are multiple dynamic and complex knowledge systems in the world (Howarth, Foster, & Dorrer, 2004) that may often go unrecognised in society.

Social representations... concern the contents of everyday thinking and the stock of ideas that gives coherence to our religious beliefs, political ideas and the connections we create as spontaneously as we breathe. They make it possible for us to classify persons and objects, to compare and explain behaviours and to objectify them as parts of our social setting. (Moscovici, 1998, p.214)

Prominent contemporary social cognitive perspectives in Western psychology offer sophisticated understandings of the knowledge contained within people's heads. However, these perspectives provide limited understanding of the social, dialogical nature of human knowledge and often presume that people are rational and independent beings who think alone (Howarth, et al., 2004). Social representations that are held by a particular group can be conceptualised as *processes*, that is, social representations are never complete – as people learn more about different phenomena, they engage in an ongoing process of meaning-making that is fluid, as opposed to the idea that social representations, once learned, are fixed. SRT conceptualises knowledge as context-dependent; where knowledge systems are interlinked between persons, communities, cultures and histories (Jovchelovich, 2007).

Moscovici (1984a, p.24, in Flick, 1998, p.7) asserts that the aim of every social representation is "...to make something unfamiliar, or unfamiliarity itself, familiar". Two concepts, anchoring and objectification, are seen as central to the process of social representations. Anchoring means to set strange ideas in a familiar context by reducing them to ordinary categories and images, or to link new ideas to existing social representations (Moscovici, 1988). Objectification means to link abstractions with concrete objects, or to translate abstract ideas and concepts into concrete images (Moscovici, 1988).

An individual's social representations develop from their communities of origin, such as their immediate family and/or where that person grew up. While these representations are subject to change based on how a person's life story pans out, if a person situates themselves within the same context for their whole life, their social representations are less likely

to shift far from the fundamental values and morals based within those representations.

Because social representations can develop and evolve over generations and become entrenched in social practices, they may serve to sustain boundaries between social groups (Howarth, 2001). “Dominant groups such as the media and political elites... dispense and impose particular representations which support their own interests and their own construction of the world” (Howarth, 2001, p.232), and this can marginalise certain sectors of society, such as people experiencing homelessness. While mainstream representations can marginalise, it also must be noted that marginalised community representations are often constructed in the context of dominant community representations.

Homeless people may often have negative representations of health systems because mainstream health services were created for a dominant, ‘mainstream’, housed population. When someone ‘different’ i.e. a homeless person, walks through the door of a mainstream service, they might feel as though they do not fit in, even though the healthcare they receive is similar. Hence, the homeless person might make an alternative social representation to what most of the mainstream community would make of mainstream health services. It is important to think about institutions in this way, as while they espouse to provide for a whole population (King, 2001), populations are not homogeneous but are often homogenised by dominant narratives: “One size does not fit all, as mainstream services assume” (Bennett et al., 2008, p.204). Furthermore, there is often little understanding of some healthcare services by people who are ‘outside the mainstream’ (Bennett et al., 2008). If non-dominant narratives about public healthcare were explored more readily and taken into consideration, steps could be taken to ensure that public health services really do provide for the whole population. This relates to Rappaport’s (2000) article describing ‘tales of terror and joy’ in community narratives, in the way that we often hear ‘one side of the story’, such as what we see and hear in mainstream media. Non-dominant narratives help

to reframe these perspectives on things we take for granted (Rappaport, 2000) like public health services, so that we can understand what works well for us, may not work well for others.

Classic research on lay people's social representations of health in France found that health is conceptualised in many different ways, from an 'absence of illness', where a person is unaware of being healthy because their focus is on other aspects of life when health is good; to the idea of health being an 'equilibrium', where equilibrium is a holistic concept, and is determined by the individual who experiences it (Herzlich, 1973). In their research with people of lower socioeconomic status in New Zealand, Hodgetts and Chamberlain (2000) found that participants have multiple, diverse representations and constructions of health and illness:

"...explanations are intertwined in a causal web of biological lifestyle and structural influences" (p.328). It is likely that talking with homeless people in New Zealand about health will generate similar responses, and participants will have their own unique, subjective conceptualisations and representations of health and illness.

For homeless adolescents in Germany, ideals of health depend on structural and social circumstances: if living conditions are impaired due to the everyday pressures of being homeless, youth will strive to cover their basic needs such as food, shelter and clothing, before addressing health issues (Flick & Röhsch, 2007). Participants "see the value of health as secondary and long term investments on health as too 'costly'" (Flick & Röhsch, 2007, p.738). Furthermore, youth argue that health and wellbeing can be achieved as long as they have a positive outlook on life (Flick & Röhsch, 2007). Likewise, research on homeless people in Canada uncovered a model of health through discussing conceptualisations and representations of health with participants (McCormack & MacIntosh, 2001). The model consisted of three pathways to health: the first contained the mediating factor of lifestyle behaviours (such as health promoting and illness preventing behaviours); the second contained the mediating factor of sector services (formal services

designed to assist in obtaining, preserving and regaining health); the third contains both mediating factors. The two components of 'person' and 'health' are central to this model. "The person is an active participant directly influenced by family values and beliefs, and both directly and indirectly, by societal values and beliefs. [A] person selects to move toward health through at least one of the two mediating factors, lifestyle behaviours and sector services" (McCormack & MacIntosh, 2001, p.684). While the diagram of this model is quite complex (McCormack & MacIntosh, 2001, p.689), the description brings to mind the Ecological Model, in terms of the individual person that experiences health and illness, being situated within micro, meso and macro societal systems (Nelson & Prilleltensky, 2005, p.71).

The aforementioned studies are directly relevant to this thesis in that it explores homeless people's social representations of health and illness. These conceptions range from being purely physical, to integration and/or separation of physical, mental, spiritual and emotional health. Representations of health are influenced by personal experiences of chronic illnesses and personal challenges not only to health status but to lifestyle status. The importance of lifestyle factors is highlighted in research by McCormack and MacIntosh (2001) where 'Jane', a homeless woman staying in a shelter had just found out that she was pregnant, and anticipated that the experience would be a challenge because she did not feel as though she would be able to take care of herself and her baby, due to her health and living situation.

Three themes were identified from homeless people's conceptualisations of health in McCabe and colleagues' (2001) research: Ableness, self-knowing and well-being. Ableness was defined as the extent to which a person has the capacity to function or not in society. Self-knowing is a concept to describe how homeless participants know what is going on with their own bodies when they are ill or healthy, who will be able to assist them if in need, and knowing what they do need in terms of their healthcare should something be wrong. Well-being is defined as health

beyond the experience of physical wellness – a more holistic concept, which includes mental and social factors (McCabe et al., 2001).

Challenging mainstream representations can be a source of empowerment for social groups in terms of affirming positive identities (Howarth, et al., 2004). “When other’s representations of us are negative...we find strategies to protect our sense of self and defend our esteem” (Howarth, et al., 2004, p.237). For example, if a group of ‘housed’ people were to have a social representation of homeless people as mentally ill, sick, dirty, and hosts of contagious diseases, they may be correct in some cases, but they cannot generalise this representation across a homeless community, and cannot claim that all people who are housed think about homeless people in this way. Many homeless people are not visibly homeless, or noticeably sick for that matter. If they are in either case, they could very well be in control of their situation. But due to their invisibility and the fact that there is a stigma associated with the label – “homeless”, the stereotypes still exist. These stereotypes, that can be pervasive, have been challenged in recent years through mainstream media in the form of newspaper articles (Hodgetts et al., 2008) and television documentaries (Laurenson & Collins, 2006). These are examples of homeless people being given more opportunity to be able to tell their stories and explain their situations in the public eye. The ways in which homeless people conceptualise their worldviews about health and illness is important to research such as this, as it could well inform developments in service provision. Homeless people need to be given a voice in order to challenge common misrepresentations, and access the services that they need.

While it is limited, the research in this section shows that social representations theory provides a useful framework for exploring conceptualisations of health, and accounts of illness among homeless people. It is important to have an understanding of the complex life worlds of homeless people in relation to health and illness, as people’s social representations of these are often interlinked with concepts of

relationships between family and friends, and services that help them (Radley, 1997). There is a significant gap in research literature about health professionals' social representations of their roles in dealing with homeless clients, and their perspectives on the health issues experienced by homeless people.

SRT provides an explanation for why and what people think, know and do; and how this can vary from one person to another – sometimes slightly, sometimes greatly. It is a useful conceptual tool for this research because it acknowledges different worldviews and how these perspectives can be legitimised within different societies, communities and groups – namely homeless people and professional/medical groups. By exploring this, we can better understand why homeless people behave in the way that they do in relation to their health needs, and find ways to improve health service provision and access for homeless people.

Collaboration with stakeholders in the research process

This thesis is one component of the action research occurring between the *More than bricks and mortar* research team, and the NGO. Participatory Action Research (PAR) informed this research and guided the formation of the proposal, data collection, and the dissemination of findings. Action research is generally thought of as a cyclical process, without fixed ideas as to how research partnerships between researchers and stakeholders will pan out. Research relationships are negotiated and renegotiated between parties, in order to gain the best possible research process for the purpose (Brydon-Miller, Greenwood & Maguire, 2003).

The idea for this project grew out of communication and collaboration between the researchers and the NGO as major stakeholders in the research. A long standing relationship between researchers in the homelessness project and personnel at the NGO has developed over the

time this project has been planned and carried out, that predates the research for this thesis. The NGO personnel approached the researchers with an idea to do a piece of research on their existing medical clinic. This was then discussed between both parties, and three investigators in the project drafted a proposal with input from the NGO staff. An on-site assessment was conducted in the NGO clinic by its CEO before the ethics application was submitted by the research team to the regional District Health Board, where an NGO staff member assisted the research team in presenting the ethics application to the ethics committee. Throughout the research process there has been constant dialogue between the research team and the NGO to discuss issues such as data collection and progress. These are characteristics of a healthy research partnership (Nelson & Prilleltensky, 2005).

Although this research within the NGO clinic does have similar attributes to participatory action research, this thesis in itself does not really qualify as PAR because its content will be limited to information gathered at discrete points in time, rather than ongoing information gathering that is a characteristic of PAR. Nonetheless, this thesis is part of a larger action research project that has been going on for several years, and it is part of the ongoing dialogue between researchers, homeless people and service providers.

Abductive research

This research process can be described as abductive; influenced by both inductive and deductive assumptions, because it works in two ways. Firstly, participants are able to raise issues and give perspectives (inductive). Secondly, social representations theory and literature on homelessness and health informs this research (deductive). Inductive and deductive assumptions are combined through the process of abduction when theory and previous research is used to make sense of participant

responses and narratives (Rennie, 1999). More specifically, induction is used to 'search' for knowledge in this area, particularly in terms of the fact that the NGO clinic is being researched as a case study, informed by the perspectives of health professionals and service users to demonstrate the role of such a service in homeless people's lives. This type of research has not been done before in the New Zealand context, so could serve as a foundation for further research in similar areas (Flick, 2006). Deduction is often thought to epitomise hypothesis testing, but it is evident in this research as social representations theory is used as an underlying framework for knowledge production. There is a variety of research exploring homeless people's social representations and conceptualisations of health and illness. This body of literature helps to create an argument for similar research in the New Zealand context, and also informs this research (Flick, 2006).

Research design and methodology

Essentially, this thesis is a focused case study of the NGO clinic's service provision, and the health and illness experiences of those who utilise the service. By looking at several homeless people's health and illness stories within the context of the clinic, we can begin to understand how a clinic such as this one has an impact on these people's lives.

A case study is defined by an interest in an individual 'case' – not by the methods of enquiry used (Stake, 2000). However, methods of enquiry will determine how simple or complex the description of a case is. A case could be one person, an organisation, or a health service, such as the clinic based within the NGO. An individual person's case, depending on the context of the research involved, can be very complex, but for the purpose of this research, individual 'cases' - homeless and transient people's health biographies, will inform the wider case study on the NGO clinic.

This case study will be both instrumental and intrinsic – instrumental in the way that this case will be examined to provide insight into an issue, and intrinsic in the way that we, the researchers, want to gain a better understanding of this particular case (Stake, 2000). The nature of this case study research is interesting in terms of understanding the medical clinic as a ‘case’, as it is often a label used for an individual patient who utilises health services. However, I will not be labelling the participants as ‘cases’. Homeless and transient NGO clinic service user responses and perspectives will be analysed separately to clinic staff, and then analysed together to inform the overarching case study that is this thesis.

Interviews are a common methodological tool, often used in carrying out qualitative research. Qualitative methods such as semi-structured interviews have the potential to elicit in-depth description of issues, phenomenon or behaviour within certain contexts (Flick, 2006). “This rich description allows us to capture both this diversity and the specificity of human experience” (Banyard & Miller, 1998, p.490). Qualitative research calls for a methodology that explores the depth of certain issues, often including fewer participants because of the time taken to conduct interviews and transcribe them. In this case, a semi-structured interview has advantages over structured interviews in that they allow for the interviewer to ask for explanations of answers to questions, as well as clarification of opinions, and there is space for participants to tell stories or narratives about their experiences in relation to the interview topics. This is in contrast to a more rigid question and answer format where the interviewer asks the question, the participant responds, and this pattern continues. Semi-structured interviews are a useful method in social representations research, as there is more room for narrative responses and dialogue between the researcher and the participant.

Semi-structured interviews can take on several forms, and different ‘types’ of questions are sometimes asked within this format. Questions are usually open-ended, interviewers can prompt from cues that lead to more

relevant information that may or may not have been reported otherwise, and narrative questions are often integrated as an element in these types of interviews (Flick, 2006). An example of a general narrative question that can be used at the beginning of an interview, is one that relates to background or life story; 'how did you get to where you are today' in relation to the topic at hand (Flick, 2006). This can be a good note to begin with, especially for participants coming from disadvantaged backgrounds as the opportunity to tell one's story may not arise very often in a research situation.

The use of individual semi-structured interviews was determined as appropriate for both homeless participants, and the NGO clinic staff. Interviews allow each person to speak about their perspectives on the interview topics and issues raised as the interviews progressed. The two participant groups had different interview schedules/guidelines. Both sets of interviews were conducted in a face-to-face situation in a setting that was comfortable for the participant to allow for a more personable exchange. In this way, interviewers can take cues from body language, and meaning or clarification can be easily sought between parties. The use of an audio-recording device is necessary with semi-structured interviewing, as then the interviewer can focus more on the conversation and dialogue with the participant, rather than taking notes. Audio recordings give the researcher accurate data to analyse and report from, which is particularly important in terms of stories elicited from more narrative-oriented questions.

Anonymity and confidentiality are very important issues to consider when approaching potential participants for any research, and have already been outlined in the research ethics process preceding the research. For the people who participated in this research, important ethical concerns include audio recordings and the relatively small size of the NGO. To ensure confidentiality and anonymity, pseudonyms are used at all times when writing health biographies for homeless and transient participants, and when quoting homeless/transient participants and the NGO personnel

and clinic staff in the findings. However in saying this, it can be problematic as the NGO clinic staff may be able to be identified since there are only a handful of people who work there. Other people who work within the NGO, even some service users who are quite familiar with the staff, may be able to guess who made certain comments, due to their familiarity. This is also relevant for homeless and transient participants, as certain health issues and injuries recorded in their health biographies may identify them to people who know them.

All data, including the original interview recordings, transcripts, and background sheets, were held by the research officer for the homelessness project at the University of Waikato. These were collected by the author and the research officer together with raw background sheets, consent forms, and participant reimbursements forms, and stored in secure archives.

The research setting and process

In the research process, two phases of semi-structured individual interviews were undertaken. The first phase of interviews was conducted with ten homeless and transient people who were using the NGO medical clinic for their health care needs, in July of 2008. These were completed over two weeks of field research at the NGO.

I had previously travelled to the NGO a week before my field research with three other researchers – a PhD candidate, a fellow Masters student, and the principal researcher within the homelessness project. The object of this visit was to orientate myself within the NGO, to meet and familiarise with staff members, to participate in morning drop-in and to meet and talk with potential participants to develop some rapport.

The first four interviews with homeless clients were conducted in the first week of field research; where I stayed in the city which was the site of the research for a working week with the two students that had visited the NGO with me the week before. I spent most of each day at the NGO, volunteering in the morning and evening drop-in, talking to potential participants, the NGO staff and fellow students within the project, carrying out interviews, and doing other work on the thesis. Morning 'drop-in' is where the NGO is opened at about 8AM, service users can line up and sign in, and volunteers provide cups of coffee, tea, and hot chocolate. Drop-in is open for about an hour every morning, and gives people a chance to sit in a relatively warm, comfortable environment, have a hot drink, have conversations with friends, and participate in other activities such as reading books and the newspaper, and even knitting.

Evening drop-in is similar to the morning drop-in. Volunteers make hot drinks for the people coming in, but also serve up food that had been donated by local businesses and other people. Drop in opens at 6PM and finishes at 9PM. The rest of the day between the drop-in hours (9AM and 5PM), if the clinic was open, people could make appointments with a doctor and wait inside the NGO building until the doctor was ready to see them. People could also come in and request food parcels, clothing and blankets if needed.

Being in the space of the NGO provided excellent opportunities to have conversations with homeless people about their lives and the research, and to recruit participants. I was initially quite nervous about how to begin interacting with people at the NGO, but after a day or two I relaxed and felt more comfortable having casual conversations and interactions.

The first individual interviews in the initial week of fieldwork were conducted by myself, inside consultation rooms at the NGO, with four homeless people that I had talked to at drop-in. These interviews occurred while homeless participants waited for their doctor's appointments. Care had to be taken to ensure that there would be enough time before an

appointment for the interview to take place so that participants would not miss their appointments; otherwise interviews took place after a doctor's appointment. The setting in which the interview took place, inside the NGO in their consultation rooms, was important in this first week of field research. The participants were in an environment they were familiar and comfortable with, the NGO staff whom the participants were familiar with were on-site, and I was sensitive to participants' moods and behaviours. Should any issues have arisen during interviews, they would have been able to be addressed immediately, ensuring participant and researcher safety.

I took the following paperwork into the interviews: An information sheet for the participant (Appendix A), consent forms (one for the researcher and one for the participant) (Appendix B), reimbursement forms (for recording who had been reimbursed for their participation in the interview) (Appendix C), a sheet of questions as an interview guide (Appendix D), and a background sheet for recording demographic information and the researcher's thoughts about the interview process (Appendix E). These documents had been generated by researchers leading the larger homelessness research project. Topics covered in the interviews were the background and biography of the participants, their health care and prevention practices, their current perceived health status, and their current consultations. Participants were then given \$20.00 reimbursement for their time. Interviews were recorded with an mp3 digital voice recording device, and transcribed at a later date.

The first round of interviews ranged from 10 to 25 minutes each. This was puzzling to me, as although I was a novice at facilitating interviews with research participants, it had been mentioned by supervisors that interviews should be expected to take between 30 and 45 minutes. In this first week, I was unknown to the homeless community, and thus was not particularly successful in carrying out interviews that were supposed to be 'in depth' – although three participants that I interviewed during this week had been involved in the homelessness project in the months beforehand

and were very helpful. In the week after the first round of interviews, I discussed the situation concerned with the first four interviews with my supervisors to search for ways that we might revise our strategy for the next six interviews.

A week after the first interviews took place, I once again travelled to the research site with one of my supervisors to do a second week of field research. The goal was to complete the ten interviews with homeless people who utilise the NGO clinic. On the Monday afternoon of this second week, I was introduced to a committee of homeless people who were 'regulars' at the NGO, by a staff member who facilitated the meeting. This was an opportunity to introduce myself more directly to the people who utilised the various services provided by the NGO. As well as that, members of the committee were encouraged by the staff member to participate in interviews, and to tell their friends that I was seeking participants. That week, I interviewed six people with assistance from either my supervisor, or another researcher in the homelessness project. Both had considerable experience in facilitating interviews with homeless people due to their work over the previous months in the project. This helped considerably in creating an environment where both researchers and participants were comfortable in having a conversational style of interview, and the data collected was more narrative in content.

Four interviews took place in the NGO's consultation rooms, one took place at the NGO's detox facility, and one took place in a city square, not far from the NGO. The same protocol as the first round of interviews was followed, however, using a different style enabled me to have more of a casual conversational interview with participants. These changes were very effective, as the second round of interviews with clinic users generated more narrative responses, and were between 45 minutes and one hour and 20 minutes. Table 1 shows demographic information for all clinic patients interviewed.

Table 1: Homeless/low income clients of NGO clinic - demographic information

Pseudonym	Age	Sex	Ethnicity	Housing status
Robert	43	Male	Māori	Boarding house
Thomas	56	Male	Tongan/NZ	Homeless
Howard	48	Male	NZ European	Boarding house
Sarah	41	Female	Māori	Homeless
Arthur	40s	Male	Māori	Housing NZ
Pete	40	Male	Chilean	Homeless
Sean	45	Male	Māori	Homeless
William	35	Male	Māori	Detox
Liz	50	Female	Fijian/NZ	Housing NZ
Clinton	47	Male	Pākehā	Homeless

Because this was the first time that I had done several interviews within the space of a couple of weeks, developing an interview style was a 'learn-as-you-go' experience. Not being sure how to approach interviews, in the first week of field research I tended to approach them in a reasonably controlled way, trying to follow interview procedures as accurately as possible. On reflection, this seemed to create a distance between myself, the researcher and participants, which was not particularly conducive to a more relaxed conversational style of interviewing, which was achieved in the second week of interviews.

Another issue in this research process was how to tell whether we would be recruiting the 'right' participants, as in those who were homeless at the time. This is why there are interviews done with homeless, as well as other low-income people who utilised the clinic service. This is something that I could have thought about and planned a bit more before going into the field. However in terms of the amount of time I had spent at the NGO these results might have been expected. Someone who had been volunteering there on a more regular basis would have a clearer idea of who is or is not homeless, due to familiarity and communication with the people who visit the NGO.

Because this research was situated within an organisation and I could only interview people who were clients, I did not gain any perspectives of homeless people who did not seek the assistance of services such as the NGO I worked within. This was beyond the scope of this thesis, however, there could be homeless people who do not visit any form of service, or do not interact with outreach workers unless they are desperate – and it would be interesting to learn why they may choose not to use such services. A person I had a conversation with during field research referred me to a friend of his, whom he thought would be a great participant for this research – except he did not use the service as he did not like to. It is easy to understand why some homeless people would refuse to use health services – given the past experiences of some participants, explored in chapter four.

I wrote field notes throughout the time I took part in field research and conducted interviews. The notes contain information and observations made during field research that will have some relevance to the findings reported in the analysis and discussion sections, and are referenced, if relevant, there. Most of the observations recorded were for the purpose of reflecting on the process of doing field research at a grassroots level, and if relevant, are discussed throughout this section.

The second phase of semi-structured interviews was undertaken with the NGO personnel and clinic staff. These interviews took place from September to October 2008 and March 2009, and were conducted by more experienced researchers in the homelessness project. The reason I did not facilitate these interviews is because of my relatively 'new' status within the homelessness project, as opposed to the more experienced researchers who have engaged in more dialogue with the NGO clinic staff and personnel over the course of the project. One of these researchers is based in the city where field research took place, and organised and facilitated interviews with four NGO clinic staff and personnel from September to October 2008. Due to difficulties with arranging interviews;

time constraints and various other commitments, the final two interviews were unable to be completed by the end of 2008, and so two of the Hamilton based researchers in the project conducted these interviews in March 2009.

Interviewers for all clinic staff and NGO personnel interviews had with them the following paperwork: An information sheet for participants (Appendix F), consent forms for both researchers and participants (Appendix G), an interview guide (Appendix H) that listed the topics that were to be discussed, that would cover the history, aims, and functions of the NGO clinic, and a background sheet for recording demographic information and the researcher's thoughts about the interview process (Appendix I). The interview guide did not set out specific questions, but rather general topics, as clinic staff and personnel needed to be given the opportunity to raise issues that they felt were salient to the research, in a confidential environment. All of the interviews took place in the NGO's consultation rooms, and took between 20 and 40 minutes.

Analysis

Overall, 16 interviews were completed. They were all transcribed by the author, to be analysed qualitatively using social representations theory as an orientating framework. "Different knowledge systems are examined on their own terms, in their own contexts: differences are seen as consequences of the value and purpose of knowledge systems for different social groups" (Howarth, et al., 2004, p.232). This demonstrates the value of doing research in this manner, with two different knowledge systems, that of homeless and transient people, and health professionals. This is similar to research described by Uwe Flick at his conference presentation on 5 June 2008 in Lisbon, Portugal, where 'micro' perspectives (e.g. homeless participant and professional interviews) are analysed separately, and then together, in order to create a 'macro'

perspective on a community issue, such as how health and homelessness are interrelated. Not one perspective is favoured over the other, both are valid, and both inform the macro perspective (Flick, 2008).

Initially, the data analysis was going to follow the framework of a generic thematic analysis. This is where each interview would be coded into themes for each participant group to be analysed in separate chapters, while providing a discussion chapter that ties the two participant group perspectives together. However, after discussing this structure with supervisors, it was agreed that it would be better to do two analysis chapters, one for each participant group, with each chapter using previous research and SRT to analyse and interpret the information. The perspectives gained from both participant groups will be brought together in the discussion chapter, where conclusions will then be drawn (see chapter one for an outline of the analysis and discussion chapters). The analysis will help to ascertain how social representations of the NGO clinic, health, health practices, and health services are shared and are different in terms of homeless client and NGO staff perspectives.

Chapter Summary

This chapter outlines the various methodological considerations for this research. The philosophical assumptions of critical realism and social constructionism were explored, in order to give an understanding of where the idea and background of the theoretical perspective, social representations theory (SRT) emerged from. SRT was then explored in terms of its definition, and with examples of how it is applied to research with homeless people. Collaboration with stakeholders was then discussed, as it is recognised as being an important issue in this research process. The research was described as being abductive, thus incorporating elements of inductive and deductive research processes. Then, the research methodology was covered: the case study of the NGO

clinic incorporating semi-structured interviews, ethical considerations, and data storage. To follow, the research setting and process was described. Finally, methods of analysing information gathered from interviews and field research was discussed, and a structure for the analysis was outlined. The following two chapters will present the analysis regarding the data first from clinic staff interviews, and second homeless patient interviews.

Chapter Three: The Clinic

This chapter looks at the NGO clinic as a medical centre for a low-income urban population, managed under a 'domiciled' health clinic framework. The purpose of this chapter is to explore the day-to-day functions of the NGO clinic through the analysis of clinic staff responses, and consider the various challenges and issues experienced by the staff in offering this type of service to a homeless population. This will determine whether clinic personnel believe that the NGO clinic has an 'ideal' model of health service provision for their homeless clients. Through their accounts, NGO clinic staff constructed the clinic and their experiences of working in the setting. These constructions can be considered as social representations (see chapter two), and are a version of events articulated by staff of their everyday experiences of working in the NGO clinic. The quote below is an example of a client consultation experienced by an NGO clinic practitioner.

NGO personnel 5: ...I will see a person who comes in the door drunk and wants me to sign a sickness benefit. That will be my usual scenario. And while I am signing his sickness benefit I will discover that... he's just out of jail... he's actually got schizophrenia and he's got a major P addiction, his feet are in appalling condition... and he's got rotten teeth that are making him feel crook all the time. And he's got out of control asthma.... It's a pretty routine consult, 15 minutes. Now if I saw that guy as a one off there's no way I can deal with all of that. But if I tie him in and develop a relationship... [so] that he comes back and sees us regularly, then bit by bit I can start chipping it off. 'Cos his immediate need is 'sign my sickness benefit so I can get money', so I will always deal with that... He's out of jail he's got no money, he needs a sickness benefit. But his longer term needs are enormous, and if I can establish a relationship with him that he'll like to come back... we're not going to put barriers in his way.

This quotation exemplifies the purpose of this chapter. It highlights the potential challenges associated with consulting with homeless patients in a clinic setting (Johnsen et al., 2005; Renedo & Jovchelovich, 2007; van Laere; 2008). Homeless people often have multiple and complex physical, mental and social issues that practitioners address through their own medical practice, and through collaboration with the wider NGO service. The quote also illustrates the dilemmas experienced by practitioners in their consultations with this population, and the constraints in dealing with

those dilemmas. It is crucial for clinic staff to develop relationships with patients, and take on multi-faceted roles in order for homeless patients' needs to be met, as meeting these needs can take time.

The chapter is divided into five parts. The first discusses the development and aims of the clinic, as well as the structure for the day-to-day running of the clinic under a PHO model. Clinic staff's work backgrounds, social representations of the clinic and their clients, and roles within the clinic will be explored. Second, the vision held by the clinic staff, holistic population-based healthcare and the integration of the clinic within the wider NGO service will then be explored including the importance of meeting patient needs, and developing doctor-patient relationships. Third, examples of collaboration within the NGO service and with other services and organisations which are important to the vision articulated by the people that work in the clinic will be outlined. Fourth, everyday dilemmas around working in the clinic will be covered. Personnel at the clinic encounter many challenges in providing healthcare to homeless people in terms of treatment and follow-up compliance, and medication use/misuse. Fifth, funding constraints with regards to meeting the vision of the clinic will be explored. NGO clinic staff attempt to resolve dilemmas and work within constraints, and are motivated in the belief that they are 'making a difference' in the lives of these people.

Development and current structure

Research has shown that there is a need for appropriate health services to be developed in order to meet the needs of homeless people (Sachs-Ericsson et al., 1999). The NGO clinic has been operating for nearly three years within an organisation that provides services to homeless people in their region. It began as a small 'suitcase clinic', where a GP volunteered their time for a few hours per week, so that homeless people could seek free healthcare for acute, primary health needs on a casual basis. The

NGO service staff recognised the clinic as a valuable addition to their organisation – as well as addressing a gap in service provision for homeless people, so a manager and another GP were hired to expand service availability. However, it was recognised that casual homeless clients were not necessarily having all of their primary health needs met by the ‘suitcase’ model.

NGO personnel 5: ...my concept of what [a] proper Primary Health Care service [is]... around a population-based approach is to offer them a sort of a full population-based perspective... [the GP who developed the old clinic structure] was certainly doing... a little bit of global stuff, but really it wasn't a systematic approach to all their health needs... they [patients] walk in, they have this need that gets treated, you know that's much more like an A&M service, so I think that actually makes it even more unsafe for them, because you get the immediate acute needs serviced, which may actually put them off enrolling properly and getting their full needs met.

It was recognised that while having an on-site medical service for homeless people was a great initiative, more could be done to ensure that they were able to receive healthcare in a broader sense rather than just having their acute needs met. In mentioning ‘global’ health needs, this practitioner is referring to all of the health needs of any particular client. Providing integrated healthcare to homeless people has been described as a necessary, albeit difficult task (Douaihy et al., 2005). It “requires a systematic approach by dedicated homeless health care professionals” who need to simultaneously address social and medical care (van Laere & Withers, 2008, p.5). Clinic personnel recognise that homeless people are going to have many health issues that will require care beyond immediate needs. If homeless people do not have their primary health needs met, they will suffer more on the street from more severe illnesses.

As discussed in chapter one, international research has shown that homeless people have difficulty accessing suitable primary healthcare, therefore many homeless people’s primary health needs are often not addressed in full (Stein et al., 2007; van Laere et al., 2008). To increase the likelihood that their healthcare needs would be met in the NGO clinic, measures were put in place to restructure the clinic as a primary healthcare provider under a Primary Health Organisation (PHO), where

primary health services are provided around the needs of a defined population. Because in New Zealand 'homeless' populations do not have a national definition, the defined, targeted population is 'low-income', therefore includes homeless people. This initiative, proposed by a GP who had worked in the suitcase clinic, was met with support and positive feedback from the CEO, and wider NGO service staff. Clinic personnel acquired funding from the regional district health board (DHB) through an application process, so that the clinic could be restructured to accommodate a population-based health perspective, in line with *The Primary Health Care Strategy* (King, 2001). The vision articulated in this policy document is that:

- People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care
- Primary health care services will focus on better health for a population, and actively work to reduce health inequalities. (King, 2001, p.vii)

In the context of the NGO clinic, the goal is to provide a population of low income earners, particularly homeless people, with health services based around their specific needs.

The restructuring of the clinic began in March 2008 and over the course of 12 months, several people have been employed as staff members in the NGO clinic. All of the clinic personnel interviewed talked about dilemmas and constraints around being a staff member in a service that was in the process of being restructured and redeveloped under a new primary health care perspective and funding structure. Difficulties around the restructuring of clinic processes were minimised as being 'teething problems', seen more as challenges rather than frustrations, and rationalised as taking steps forward in the process of creating a health service with enormous potential for the population that it serves.

The staff

Some of the staff were interviewed only a short time after their employment commenced at the NGO clinic. Other personnel had been there longer, as interviews were conducted over an eight month period. The clinic staff consists of two groups: The first is the CEO and a GP who can be counted as the instigators of the vision for the NGO clinic as a primary healthcare service that provides holistic care under a PHO. The second group consists of those who began their employment after the NGO clinic shifted from a 'suitcase' to a PHO model. These staff members fully support the vision and extend it through to their work with their clients. This section will provide a general overview of the backgrounds of the staff involved with the NGO clinic, how they came to work at the clinic, and why. Staff social representations of the clinic and their clients will be discussed; as well as the roles that clinic staff occupy in the clinic setting.

The clinic itself has six staff members (not including staff who locum for the clinic): two general practitioners (GPs), a nurse practitioner, a practice nurse, a receptionist and a team leader/clinic manager. Staff interviewed include the CEO of the NGO service, and all of the clinic staff mentioned above excluding the receptionist. Their work histories vary, but are linked in terms of their interest in working for lower SES populations, and their care and compassion for people.

Work backgrounds³

The CEO of the NGO service has been in the position for a number of years, and has overseen the development of the clinic from a 'suitcase' model to a PHO model, as well as the many other services and initiatives run by the NGO. The CEO has background experience in running a community hospital, and has worked in counselling.

³ In this section, pseudonyms are not used as NGO clinic staff are easily identifiable by their roles within the organisation (see chapter two). The quality of written language in this section has been compromised to protect the anonymity of participants.

One of the GPs trained as a doctor in New Zealand. This GP has set up health services for another organisation that provides health services for low-income populations in a different regional area, as well as being instrumental in the establishment of the NGO clinic as a fully operating population-based clinic under a PHO. This GP works at many different levels within these and other organisations; including grassroots healthcare, clinic management, funding applications, policy work, fulfilling academic roles of researcher/lecturer, as chair of a medical department, and as a member of health committees and advocacy groups.

The other GP at the NGO clinic had trained as a medical doctor in England, and had worked in student health. In terms of work in New Zealand, this GP took up the job in the organisation with the GP mentioned above. This GP came to the NGO clinic because of this contact, and because they find working with lower socio-economic groups rewarding.

The team leader/clinic manager trained as a psychiatrist in Europe and was involved in managing another service in the NGO, before taking on their role within the clinic. The team leader has experience and an ongoing interest in mental health issues due to a background in psychiatry.

The nurse practitioner trained in the United States 15 years ago, and had a clinic practice there. The practitioner worked for the United States Army, and while working for an emergency department at a hospital in California, started a mobile clinic with a colleague. During their three years living in New Zealand, this practitioner has worked for a Māori PHO, and now works as a nursing lecturer in a tertiary educational institution. Working for the NGO clinic is part of the nurse practitioner's contract with the institution, in that they will continue to practise in a clinical setting. Through their networks within the tertiary institution, they have been able to introduce new services to the NGO clinic, such as podiatry.

The practice nurse trained in England, and has over 40 years of nursing experience. This nurse was involved with surgical nursing on arrival in New Zealand in 1971, but has worked as a practice nurse since 1978 in New Zealand, and overseas. Part of this overseas experience included working for a volunteer organisation in South Africa for two years. The reason this nurse came to work at the NGO clinic was because they experienced little job satisfaction working in a more affluent community, and felt as though this job fitted better with their work experience and interests.

Staff constructions of working in the clinic

Staff constructions, conceptualisations, or social representations of working in the NGO clinic will be covered in this section. Throughout the interviews, practitioners compared and contrasted the clinic with other clinic settings. During their employment with the NGO clinic, some staff members have observed differences with this clinic in comparison to domiciled health services that they had previously worked in.

NGO personnel 3: ...it's very different, it's not like normal general practice... so [it's a] learning curve for me too. I'm coming across totally different problems than I did [in another general practice]... The feet, and certainly the... psychiatric illness is something I haven't dealt with to such a huge degree here, but, a lot of the homeless people have also got a psychiatric problem... and of course addiction problems.

Staff social representations of the uniqueness of the NGO clinic was expressed in accounts such as the one above, in terms of: the client group range, types of ailments seen, and other social-structural issues experienced by the clients. The frequency of mental illness and addiction problems was one of the main points of difference to other GP services noted by the practitioners who have had to learn how to deal with cases like these every day. One staff member preferred working in this clinic to the idea of working in a 'typical' domiciled clinic as they liked the challenge of treating various ailments, while dealing with a population group that is often marginalised from mainstream health services.

NGO personnel 6: ...I want to work places where patients either don't pay or pay as little as possible, because then I don't feel so uncomfortable about it... I'd prefer the sort of people at the lower income end... I enjoy the work better here, than somewhere in [an affluent suburb] where I might just be spotting, you know, sorting out white spots on fingernails, or... you know... trivial [chuckles].

This practitioner's preference for working with low income people and within this particular NGO clinic reflects their commitment towards a humanistic motivation and helping others – making a large salary does not appear to be a prime motivation for working at the clinic. This is reflected in Renedo and Jovchelovich's (2007) finding that homeless professionals working at the 'front line' of care held humanistic social representations of how they should work with homeless people. An altruistic worldview appears to be an important platform for the orientation of the NGO clinic; where practitioners espouse a vision of caring for patients in a way that is holistic, takes their needs and context into consideration and values them as human beings (Fagermoen, 2006). This particular practitioner constructed the day-to-day work at affluent clinics to be less interesting and 'trivial' in comparison to the challenges they are faced with every day at the NGO clinic. This is perhaps linked to the practitioner's ideal of working with a population who have considerably less access to healthcare than domiciled people, and often are in poorer health⁴.

The NGO clinic has a relatively atypical patient population. According to NGO clinic staff, patients are mostly men of Māori descent, sleep rough and are of lower socio-economic status. Personnel at the NGO clinic see around 20-24 patients on a full day, and 6-10 on a half day. 230 patients were enrolled in the practice at the beginning of August 2008.

Clinic staff raised important issues in terms of how to approach a patient who may have a treatable physical medical condition; but also social, structural, and environmental conditions in their lives that they are unable to treat. Addressing such contextual, non-physical factors can reduce the

⁴ This is not in any way an attempt to trivialise the health needs of the domiciled public. Many domiciled people have significant health issues that they struggle with on a daily basis.

impact of physical and mental health issues (National Health Committee, 1998). Given the wide ranging and serious nature of the needs of the homeless clients, staff are frequently constrained in what they can do due to limitations of resources, time and sometimes specific expertise. However, it is important that potential contributing factors are recognised by medical practitioners in relation to specific health issues. Research has shown that professionals who work with homeless people realise that their approach to working with this population must be within a discourse of understanding, holistic healing, and moral commitment (Renedo & Jovchelovich, 2007). This is in contrast to rhetoric of victimisation, “anchored in images of deficiency and incompleteness of the homeless and is expressed in practices of judging and curing” (Renedo & Jovchelovich, 2007, p.784). While practitioners identify some significant health problems they see with homeless patients, it is important to note that staff social representations of these patients are not limited to their health issues, as that could reinforce victimising rhetoric of homeless people. Later in the chapter, clinic personnel discuss the importance of meeting patient needs and developing relationships to ensure the holistic care of patients.

Clinic personnel were asked to outline a typical homeless client presentation at the clinic. These ‘typical presentations’ were all different, but displayed some important similarities. As is identified in the next quote, drug and alcohol addiction and mental illness were identified as the most common health issues that homeless people present with. The most common physical health presentations are skin infections, particularly foot problems. Homeless people’s experiences of these health issues will be explored in depth in chapter four.

NGO personnel 5: [We see] drug and alcohol and mental health [issues] overwhelmingly, um, and then in terms of the physical problems, skin infections, teeth – nightmare, feet, you don’t take shoes off unless you’re desperate. Um, so they’re real biggies.

Similarly, United States research found that mental health and substance abuse services were identified as two of homeless clients' top three service needs, identified by service providers (Rosenheck & Lam, 1997). The practitioner also makes the important point that homeless clients present with the same everyday illnesses and ailments as domiciled people. However, these are exacerbated because of homeless life situations (McCabe et al., 2001; Wright, 1990) – the lack of basic necessities and possibly a focus on survival over and above 'health' associated with sleeping rough.

NGO personnel 5: ...the usual routine stuff that goes wrong for everybody, it goes wrong for these guys more often. So you'll see lots of coughs and colds... lots of out of control asthma, lots of bad eczema, eyes, you know they can't get eye attention. So the usual stuff that goes wrong for everybody, it's just accentuated.

Clinic personnel recognise the various issues associated with being a homeless person with a chronic health condition that any domiciled person could have, such as diabetes. A homeless life world is perceived as hard, while being housed is constructed as 'easy'. Having to manage diabetes and experience the type of poverty that a homeless person lives in makes life that much harder, whereas living in a warm house with access to the right type of food, makes managing diabetes easier.

NGO personnel 6: ...so you've got an easy diabetes case, but you can't treat it as an easy diabetes case because the patient might... not [be] able to take tablets or [are] not able to store them or loses them the minute they come out of the chemist 'cos somebody pinches them or... yeah. So, so even just on a compliance issue things are different and, you know if you're diabetic and you're living in a nice warm home with easy food then you're not likely to get the foot ulcers or the chest infections, and stuff, yeah. It just magnifies everything.

Like domiciled people, homeless people can often have very serious health conditions which require emergency services. However, clinic staff recognise that assistance can be delayed because rough sleepers in particular can lack access to communication services, particularly if there is no public phone in the area. They may also lack transport, so they must walk to where they know they will receive appropriate assistance.

NGO personnel 3: ...we've had people just [inaudible] where it has been a really serious situation and we have to get them off to hospital, but that's like any medical centre ... We had a um, person who was seen before walked in, 38 year old man sleeping down in [a park] and just said 'oh I woke up with this pain in my chest and it goes into both arms, but when I drink water it goes away'. He'd walked up the hill but he just looked so unwell and that's something I recognised and he'd had an MI (Myocardial infarction – heart attack). So, but had walked from [a park about 0.6km away].

This emphasises some of the difficulties faced by homeless people who need emergency treatment. If a domiciled person had a heart attack, they probably would not walk half a kilometre to the nearest medical centre. They would use the nearest phone and call for an ambulance. This homeless person did not appear to have access to one. The practitioner goes on to attribute the frequency of serious cases to a social representation of delayed presentation to medical services in the homeless community (e.g. Gelberg et al., 1997).

NGO personnel 3: ...a lot of these men are notorious to be known throughout society in general not to access medical care anyway.

Interviewer: Unless they're at death's door.

NGO personnel 3: That's right, so we tend to... a lot of situations do tend to be reasonably serious.

Delayed presentation could be for many reasons. One could argue that Maslow's (1970) hierarchy of needs, which demonstrates that having basic needs met (i.e. food, water, shelter, clothing); is a more understandable priority for a rough sleeper before worrying about one's feet or asthma for example. But when health issues become acute, they become the priority.

In the above excerpts, clinic personnel provide social representations of: working in the NGO clinic, homeless people's life situations, and the health issues they see on a day-to-day basis. These issues can differ enormously to the general health issues seen in domiciled clinics around New Zealand where patients will most often see a GP for a short term condition, or routine check-up for chronic illness or disability (Ministry of Health, 2004). Chronic health issues that domiciled people have such as diabetes or heart conditions are exacerbated for homeless people in terms of their living environments. Competing priorities such as ensuring basic needs

are met will affect the likelihood of homeless people accessing the clinic for healthcare. The roles of clinic staff are important to ensure that those who do present to the clinic receive the best possible healthcare.

Roles in the clinic

Four (of six) personnel described their roles in the clinic purely in terms of their medical or management speciality – such as keeping records, diagnosing illness, prescribing medication, signing medical forms, doing medical examinations, and treating injuries. Some personnel try to be ‘realistic’, and see their role in the clinic in relation to the people they serve, who are well below the poverty line. Clinic personnel see their provision of healthcare to homeless people not as a panacea (e.g. Lester, Wright & Heath, 2002) but as a step forward for this population to potentially move forward in their lives.

NGO personnel 5: I’m not in that clinic ‘cos I’m going to fix up these guy’s lives, there’s no way we can fix up those guys lives. You know we’re just there to help them a bit because... their life is a trajectory that’s happened right from the start...the... child poverty stuff and the early developmental stuff. That’s what’ll make the difference, you know not the general practice. You know we’re just there with a pile of guys who’ve had a shit life that’s really impacting on them now that you can’t undo. You know just sort of, ease it a bit for them.

While this clinic staff member explains their role in the clinic as ‘making life easier’ for their clients, they discuss the wider social and structural issues associated with homelessness. They acknowledge that the NGO clinic is an ‘ambulance at the bottom of the cliff’ strategy, a service that aims to assist people who are already homeless, to ‘recover’ and hopefully reintegrate into society. Health is one step in this process. However, prevention strategies are crucial in early childhood development (Koegel, Melamid & Burnam, 1995). As is well documented (Reitz-Pustejovsky, 2002; Shinn et al., 2007), rough sleeping homelessness is caused by a confluence of social, physical and mental issues, and prevention strategies cannot single out a way to prevent homelessness.

Another clinic staff member talked about their role in the NGO clinic in relation to the NGO services as a whole; to ensure that they collaborate with other staff and ensure integrated service provision.

NGO personnel 3: I think we're very much here trying to work as a team, with the social workers and I think that's very important, they refer people to us and we refer people to them if we can.

While collaborating with colleagues is imperative, it is clear that clinic staff work with clients to ensure the best possible healthcare service. When I made a site visit to the NGO clinic the week before I carried out interviews with clients, I recorded the following observation in my field notes of an interaction between the GP and one of the homeless clients.

[The GP] provided a very welcoming, warm, helpful atmosphere to the homeless client [who had come for an] appointment. [The GP] made the client feel that they were the most important person and that [their] priorities were with them – helping them with their healthcare... [a] very humanistic way of working with people (Field notes, 2 July 2008).

When clinic personnel are helpful in this way, homeless clients will feel cared for and comfortable in the setting (Wen et al., 2007). The NGO clinic can thus be conceptualised as a 'space for care' (Johnsen et al., 2005). This is in considerable contrast to accounts from homeless participants that described how they had been treated negatively by practitioners from other health services (see chapter four).

The roles of clinic personnel are not just limited to their 'label' or profession. Roles within the NGO clinic seem to be fluid, and this fluidity is necessary to ensure that patients are treated in a holistic manner (see section on doctor-patient relationships, this chapter). Clinic personnel adopt approaches to treatment that fit in with this ideal; they are not just operating as a general practitioner (GP) in medical matters only.

NGO personnel 6: ...most of what I'm treating probably isn't typical medical illness, yeah, a lot of it is either writing sickness benefit notes or being an ear, or, being a direction to somewhere else.

Interviewer: Yeah, so you're actually dealing with social structural problems...

NGO personnel 6: I'm a social worker, a psychologist, a psychiatrist, a GP, yeah. But I think a GP is all of those things.

This practitioner described their role as being more of a holistic helper with a specialisation in medicine, as consultations with clients are not necessarily about medical illnesses. However, the excerpt above shows that the health practitioner is often called upon, and feels that they need to fulfil several roles in this context. This could be true for many GPs but is especially the case in this, and other clinics that are trying to help lower SES people.

The roles of the practitioners working in the clinic are largely determined by the clients that they see. Because of the setting of the clinic and the diverse knowledge and compassion of the staff, approaches to treatment are holistic, and practitioners aim to treat patients in ways that do not exacerbate current health problems (i.e. drug addiction). The NGO clinic itself is not a panacea, but is one part of the many services that the NGO service as a whole provides, and hopes to continue to provide in the future for homeless people.

An integrated, holistic medical service

This clinic operates as a not-for-profit holistic medical service, integrated and linked with other services under the umbrella structure of an NGO. Business objectives include balancing the books so that the clinic service remains viable while being low cost, as well as meeting patient needs. This is distinct from an independent practitioner service business model where medical fees may not be subsidised as much by the Ministry of Health (CBG Health Research Limited, 2004). If a person cannot afford to pay doctors fees, they are less likely to have access to more standard practitioner services.

This section focuses on the day-to-day operation of this clinic as integrated within the NGO, the needs of homeless patients and the capacity of the service to meet those needs, and issues around doctor-patient relationships. The vision espoused by NGO clinic staff is to provide low-cost, holistic, population based healthcare to homeless and low-income people in accordance with *The Primary Health Care Strategy* (King, 2001), within a specialised service structure developed to assist homeless people.

NGO personnel 2: [The medical clinic] is closely related to the social work services... so our goal is to have [a] one stop shop... client comes here, doesn't matter for what problem, [they] can access other services we will provide...

Sachs-Ericsson and colleagues (1999) found that homeless people were more likely to use health services that were close to other services that they frequent. The clinic is already situated within an NGO service that is visited by a large number of homeless people, therefore more homeless people will be likely to utilise that clinic as it is already located within a trusted service provider. Other research has found that wrap-around services are vital to ensure homeless people receive appropriate support for the range of issues they experience (e.g. Sisters Inside, 2008; Crisis UK, 2005).

Meeting patient needs

As part of the integrated service structure, the NGO has a process to ensure that patients at the clinic are aware of, and have access to other services they need. If people come into the NGO wanting to see a doctor but are not currently enrolled in the clinic, they will have an interview with a social worker to determine the reasons behind seeking out this particular clinic, their ability to pay doctors fees, and their current socio-economic situation.

NGO personnel 4: ...basically the criteria is that it's low income. So well, really that needs to be ascertained, because if you just walked in and said 'well I don't have any money can I go [to the doctor]?' ... we need to check that out and quite frankly, if you're coming here to see the doctor you've probably got other needs as well.

Creating an affordable clinic service within a specialised service for homeless people has positive implications for this population. Homeless people who come to the NGO clinic for healthcare are likely to have other needs, such as employment, food, and assistance with addictions, or housing. Determining the needs of clients on a case-by-case basis and enrolling them when they first present to the clinic means that not only can health issues be addressed, but wider life issues.

This clinic staff member is clearly enthusiastic about the fact that they are able to provide a service that provides for the needs of the enrolled population, while keeping doctor's fees affordable.

NGO personnel 2: We're not a commercial medical centre, we're not pushing commercialisation, we're not business based, we're just looking at our accounts and making sure we can run it as it is and subsidise it so it's very low cost and free for the clientele, the greater reward is to see that it's not commercial, and provides good quality medical care to the [clients].

They enforce the ideal that the NGO clinic is not a commercial enterprise. It is truly population-based, not-for-profit healthcare which is of great benefit to those that utilise it. Being low-cost is clearly an important objective of the NGO clinic, so that it will be more accessible to homeless people and other low-income groups.

Homeless people often experience a confluence of physical, mental and social problems (Flick, 2007) that are complex to treat within a medical setting. However, because the clinic is located within an NGO that provides a range of social services, some of these non-physical needs are able to be met.

NGO personnel 2: Well, the complex of mental health, addiction problems and physical problems... There's a lot of co-morbidity and co-existing conditions all together, complex issues presented by these patients... Oh, like patients with traumatic brain disease having had severe brain injuries in the past, they have... memory lapse[s], anger management issues, addiction issues... plus they have a partner and having babies they need to care [for], and all this shit's balled together... gang affiliations... the culture, sub-culture of the gang and the day-to-day violent relationship with their partners.

This staff member appears to describe a social representation of homeless people as those who have borne the brunt of many societal 'evils', and by seeking assistance, they are attempting to make a better life for themselves. The combination of these issues makes consulting with some clients more complicated and sometimes difficult for practitioners, especially in terms of the life histories that clients may share in a consultation.

NGO personnel 1: Uh, that comes out quite a bit [in consultations] in that people had been abused, um, as children. Um, and it surfaces um, pretty quickly, it seems like in conversations, where folks will go right back, way back years, and bring that up as a source of problems... Partner abuse, child abuse, um... [long pause] It's shocking to me really. Um, to see all the abuse... and how um, that part is so hard to treat, and to try to get that addressed, I mean it's, to me it's becoming clearer and clearer how, in a way how ridiculous it would be, you know to just throw superficial things out at trying to help homeless people because it is so deep. And that seems to be such a heavy pattern with all this, with all the folks that are coming in here...

This clinic staff member noticed that personal, family and social issues were commonly brought up in consultations with homeless clients. Medical or physical treatments seem almost insignificant in that context, as some people are deeply injured and hurt by life itself. Treating the physical injuries and health issues is important, but healing the personal, social and emotional hurt is still fundamental to ensure holistic wellbeing. This is why the clinic is integrated within a wider NGO service structure, with collaboration as an important part of its philosophy.

Doctor-patient relationships

Meeting homeless patient needs at the NGO clinic requires relationships between clinic staff and homeless clients, as an important part of the holistic primary healthcare vision espoused by staff. Having homeless and

low-income clients enrolled with a primary health care provider ensures that they have a source of primary healthcare, and an opportunity to see the same doctor on a regular basis. Part of the vision and the clinic staff's holistic approach to healthcare is ensuring that they develop ongoing relationships with patients based on honesty, trust and respect.

One clinic practitioner talked about their label as 'the doctor' in the patient-professional relationship they have with their patients. While this person seems to be aware that the professional label has been used by some in a paternalistic manner (Charles, Gafni, & Whelan, 1997), they feel more secure in their consultations with homeless clients. This is because clients appear to have respect for this person as they are there to genuinely help them, even though they may carry the 'doctor' label.

NGO personnel 6: I've still got that doctor label. You know, I shouldn't appreciate it but I do appreciate it, people come in and they, yeah they might have been a bit aggro out there, but they come in and sit down and they go 'Yes Miss'. So yeah I have got a bit of a safety bubble around me.

It is important that practitioners recognise the potential 'power' they can hold as a professional in the doctor-patient relationship. It is a traditional assumption that patients should always trust their doctor's perspective, as they are professionals who hold advanced medical knowledge that many lay people do not have access to (Freidson, 1994, in Dew & Davis, 2005). Some of the clients I interviewed were aware of the power that practitioners could have in consultations, as they had experienced imbalances of power in medical settings (see chapter four). However, a doctor's "bedside manner" was seen as important to the doctor-patient relationship. If a practitioner is caring and displays empathy while working in a professional manner, trust can be developed, and clients may wish to play an active role in the relationship.

NGO personnel 5: ...if you want to try and do anything at all for that guy's life, more than just their immediate acute need then you need to build a relationship...

The practitioner here is stressing the importance of building relationships with homeless clients (Johnsen et al., 2005) if a practitioner wants to do more than just meet acute primary healthcare needs. Developing a relationship with the client means that they are more likely to come back to the clinic for further appointments, and potentially have multiple health issues addressed.

Some clients may have very little memory of their health histories, and are unlikely to carry medical records with them. In order to establish a homeless client's health needs, practitioners need to come up with innovative ways to ascertain those needs, such as working with the patient in a holistic manner, as illustrated in the following quote.

NGO personnel 1: ...there was a woman in here this morning and, she wanted a refill of her pain medication... I ended up not giving her a refill of the pain medicine, but... almost doing a complete physical exam and history on her, and connected her with the social worker, and we connected her with the homeless mental health crisis team and between the three of us, realised that she had... run out of a holding mental health situation in another town... and so... it required a whole team um, and what she came in here for was not what she received on the other end... it was fairly interesting because um, it was really the best way to get the history from her... as I did the exam she would pop up with a lot of different things. So that was much more holistic, just to have this hands-on experience with her, in asking her questions, by the time I was done I felt like I had a more accurate history.

As a holistic service, there is a greater emphasis on integrated health management rather than simply addressing patient symptoms or acute health requirements. An appointment with a medical practitioner in the NGO clinic is an opportunity to uncover health histories and medical needs that homeless people have, because practitioners are prepared to work with patients to ascertain those needs, rather than simply meeting their requests.

This practitioner also discussed how developing their approach to treatment within the clinic is an experience of day-to-day learning in terms of patient needs and wants. This person believes their ability as a practitioner within the NGO clinic is enhanced every time they see and work with a patient.

NGO personnel 1: ...people that work on, that live on the street or [are] rough sleepers or whatever, are pretty savvy... and probably teach me more than I could teach them... about a lot of different things. So, when I see them come in, um, I don't really have any agenda except to help them, so I try to really let them define what they need and then work from that starting point, and then try to... broaden it out a bit, from that point. And you know try to understand what their needs are and see if it's reasonable, or see the healthiest way that we can try to meet the need.

The respect and humility shown by this staff member would most likely reduce the potential power differential and distance between themselves (professional) and their patients. They recognise that rough sleepers are able to function in their homeless life situations without too much trouble, whereas if a lay person was forced to live on the street, they would probably struggle as they live a completely different life, constructed as 'normal'. This acknowledgement of a homeless person's life world means that treating their health needs is going to be a different experience to treating a domiciled person, and will need a different approach.

The following quote demonstrates this practitioner's degree of humility in their attempt to understand the life world of the patient rather than simply enforce treatments. Clinic staff will evaluate how reasonable needs and wants are, given the resources available and ability of the clinic to meet them.

NGO personnel 5: ...you do as much as you can with what the client wants... and some of them don't want their health needs met and some of them do; some of them aren't aware of it. So, you're there, you know, just to offer what you can...

Considering the implications of not wanting to have health needs met, many people could become perplexed as being healthy is often conceptualised as necessary for anyone to function in society (Williamson & Carr, 2009). However, a homeless person's conceptualisation of being healthy is not necessarily about physical condition. It could be about wellbeing, particularly enjoying life with friends. Research shows that smoking, excessively consuming alcohol, and drug abuse can cause chronic health problems (Ministry of Health, 2004). However, the social

interaction surrounding the use of these substances with friends on the street is known to be important for health and wellbeing as it helps to strengthen social networks (Hodgetts et al., 2007; Radley et al., 2006).

The fact that some homeless people may not even be aware of certain health issues, supports Hodgetts and colleagues' (2007) argument that rough sleepers' inevitable bodily decline sneaks up on them and surprises them when they are made aware of their illnesses. The shock of discovering that one has an illness can impact upon a person's wellbeing alongside the impact of the illness itself, as noted by Radley (1993): "How people make sense of and respond to their disease or disability is a function of the everyday beliefs and practices according to their social groupings" (p.1). Illness can change a person's perspective of themselves, their families and their ability to function in society (Radley, 1993). This could be the same for homeless people.

In their constructions of the NGO clinic, personnel describe a place where they treat homeless people's health needs in a humanistic, holistic manner. Meeting patient needs and developing meaningful relationships with clients are part of Johnsen and colleague's (2005) conceptualisation of 'spaces for care' for homeless people. Spaces for care are imperative to ensure that homeless people can access the care that they need without barriers.

This section focussed on the day-to-day functions of the NGO clinic as a holistic medical service integrated within the wider NGO service structure. The integration of the whole service and the impact on the clinic was explored from the perspective of clinic staff, and how that integration is achieved in practice – consulting with patients and meeting their various needs. Keeping the service at a low cost is a way of making the NGO clinic accessible to people who cannot afford healthcare at other clinics, thus ensuring their health needs are met. Finally, relationship development between clinic staff and homeless patients is recognised as imperative for the capacity of the clinic to meet patient needs.

Collaboration within, and with other organisations

As mentioned previously, the NGO clinic is included in a group of services that are integrated within a wider umbrella organisation. Clinic personnel understand how imperative it is for them to collaborate with other staff and services within the NGO in order for clients to receive the best healthcare possible, although it can be difficult sometimes.

NGO personnel 1: I think out in primary health care... it's nice if you talk about collaboration, but because you have such a clear family or patient history most of the time, it's not required. Here [at the NGO clinic, with clients who often do not know their medical histories] it's required... Where if you don't do it you're going to make, really, a lot of mistakes. So you really have to pull in as much information from outside sources.

This quote provides an example of why collaboration within the NGO is imperative to its day-to-day running. There appears to be an assumption in the 'domiciled' health system that patients will know their medical history, and that doctors will have kept records of patient visits. This is not necessarily the case for a homeless person who has been living on the street for a long period of time. They might have sought healthcare, but only as a casual at an emergency department or a walk-in clinic for example, which means records could be kept in several different places. Some people have memory loss which could be due to mental illness or injuries to the head (see Howard's health biography, chapter four). Collaboration includes information sharing, and keeping up with communication with other staff members when new information comes to light, which is very important when patients do not have a clear medical history.

NGO personnel 4: ...what I really want is a seamless service. That just moves on from one place to the other, that when they go to the doctors they don't have to repeat what they've done elsewhere...and that all that information feeds in to making the doctor make a better decision.

This clinic staff member envisions a 'seamless' wrap-around service model for the NGO, but it is acknowledged that such a vision is almost always an

ideal, as health is a contested field in terms of public funding. To ensure that the NGO service is seamless it will need to be entirely integrated, and information about clients will need to be available to all professionals/services who consult with respective clients. However, there will always be constraints. Even if more services are offered on-site people may still need to be referred to other service providers, in particular, secondary healthcare or employment services (Work and Income, 2009).

Alongside the collaboration of the medical services with other social services provided within the NGO, there is a need for the clinic to also collaborate with secondary medical services outside of the NGO premises.

NGO personnel 5: So there needs to be a lot of bridging into the next support level, a lot of these guys won't go to hospital... I had a guy come in the other day with a stroke, and he refused to go to hospital, so there needs to be a lot of bridging into the next level services, and a lot of understanding of why that doesn't happen...

Hospitals and other secondary support services can be difficult to refer homeless people to, as some clients, such as Howard (see chapter four), want as little to do with hospitals as possible because of negative experiences within such environments. Many homeless people also lack the necessary physical and material resources needed to get to secondary health services, such as transport. NGO clinic staff can make the transition into secondary health services for homeless people easier, through their collaboration with those services (see below).

The NGO clinic has collaborated with a local tertiary education provider. This institution provides specialised medical services to homeless clients who visit the clinic, in exchange for these consultations being used for educational purposes by the institution. This is an invaluable opportunity for the NGO, as the amount of public funding that they receive to run their services is minimal. This is also beneficial for the tertiary provider as it provides a real medical setting for training students outside of the institution. A nurse practitioner employed by the tertiary provider as a nursing lecturer works in the NGO clinic once a week, as part of their

ongoing clinical work experience. As well as this, podiatry students and dentistry students from the tertiary institution work in the NGO clinic once a week as part of their clinical training. Staff in the NGO clinic recognise that basic daily necessities such as cleaning one's teeth and taking care of one's feet are taken for granted amongst the domiciled public but are difficult for homeless people to achieve. A collaborative relationship with a tertiary institution that can provide such services for the homeless clients at the NGO clinic is a positive step forward for the NGO service.

It has also been recognised by clinic staff that if organisations for homeless people collaborate to deliver results for the populations they serve, they will be able to respond to a wider range of situations, thus extending the different forms of assistance available to people in need.

NGO personnel 4: ...we've been working with other homeless agencies to [see] how can we make seamless services for homeless people...

NGO personnel 5: There's neat other community things like, there's a church group down the road you know, just linking in... We had a woman walk off the street the other day with a bad back and, needed to get her to hospital and the local church group came to help...

It is recognised amongst NGO clinic staff that overall, there is not enough networking and collaboration between people and organisations in communities. Communities and social environments are important factors that influence wellbeing (Nelson & Prilleltensky, 2005). People involved in the GP clinic and the wider NGO service are working towards greater collaboration with other organisations, and have established communication with other homeless agencies for the purpose of ensuring they work together in a way that is client focussed (Roussos & Fawcett, 2000). For example, this could mean that if one organisation cannot provide a service at a particular time, another organisation could step in to provide assistance.

Collaborating with other health services can be a difficult task, as some services have criteria for entry that some clinic practitioners consider unrealistic and unhelpful, particularly when they need to find services for

clients urgently. This is similar to Douaihy and colleagues' (2005) research, who argue that homeless people in the United States find integrated care is difficult to obtain because social service systems do not match up.

NGO personnel 5: I recently had a guy who's got severe depression, and I was trying to get him into the mental health services and they won't see him because he's got an alcohol problem. And well he won't stop drinking due to his depression and [the mental health service is] going, 'well we can't treat his depression he's got alcohol'. And this is a dual diagnosis problem... So there are very limited mental health services.

The comorbidity of mental illness and drug and alcohol problems are a common problem for clients (and their doctors) seeking treatment for them. Mental illness is an important contributing factor to drug and alcohol addiction, as research has found high comorbidity rates between some mental illnesses and substance abuse (Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin, 1990). In these cases, if mental illness is treated, then addiction problems can be treated more easily. Unfortunately, mental health treatment programmes do not often accommodate the needs of patients with addiction issues, and there is a lack of collaboration with addiction services to ensure that all needs are met.

Homeless people can experience great difficulty in accessing secondary services. Some service providers are not local, homeless people do not have reliable access to transport or resources to get to those services, thus can struggle to meet appointment times. This is consistent with international literature on barriers to healthcare use for homeless people (Geber, 1997). If clients miss their appointments, this reinforces stereotypes of homeless people who are either 'too lazy' or 'too drunk' to make it to their appointments (Laurenson & Collins, 2006). If people miss appointments, it is a waste of resources for secondary services, and they will be taken off waiting lists for essential treatment. Clinic personnel are trying to address these issues, and have had some success but they are always aware that some arrangements might not work out as intended.

NGO personnel 3: It's, it is quite difficult, I mean doctors refer them onto the hospital for many different reasons and often they just don't turn up to their appointment time. And of course if they haven't done that once or twice they're then taken off the list. And this happens time and time again. Their lives are just too chaotic to actually get there... one woman who's coming tomorrow being cardiac... the specialist nurse is actually coming here to see her... Which is really good, and another man who's diabetic, um he's going to [a] hospital [in another suburb] later on but I've got all three appointments on the one morning, so that he'll get there... and he'll see the doctor, he'll see the nurse specialist and he'll get his iron test done all on the same morning. Those type of things I'm able to sort of try and facilitate... Smooth the process over for those who really, really need to be there. But I mean you can't do that for everyone. You've just got to say, you know you've got to take responsibility on, to get there, they're not going to just keep waiting for you.

This staff member is working towards making it much easier for their clients to attend appointments with secondary services, to the extent of arranging specialists to come to them at the clinic. It is understood that clients who 'really, really need' specialist healthcare will need to be assisted in this way, and clients perceived as capable of making their own way to appointments with secondary services will be encouraged to do so. Keeping lines of communication open with other specialist services, such as hospitals, is a positive step forward in terms of collaboration. However, there is always the risk that clients for a range of reasons may not turn up for appointments, despite clinic staff members putting considerable effort into making this process as straightforward as possible.

The clinic's collaboration within the NGO service and with external organisations is imperative for its day-to-day operations and appears to work well in many cases. Sometimes, collaborating with secondary healthcare services such as mental health, drug and alcohol treatment facilities and hospitals can be difficult. However, it is a necessary task, so clinic staff attempt to come up with solutions to make the transition from primary to secondary health services as simple as possible for clients.

Dilemmas in providing care for homeless people

There are many dilemmas and challenges associated with providing healthcare services to a homeless population. While homeless people who present at the clinic can have complex medical and non-medical (mental illness, addictions, social) problems, lack of compliance in healthcare regimes is also an issue – including the use of medication – so clinic staff also make an effort to come up with ideas to make compliance easier for clients.

Since clients are sometimes responsible for getting blood tests, coming to follow-up appointments, and taking medication; there are many compliance issues, because as clinic personnel acknowledge, sometimes life can be quite ‘chaotic’ for rough sleeping homeless people. A homeless person may forget to have a blood test because they lose the form, have ‘thought disorder’ (see section on health issues, chapter four), or because they have, as discussed in chapter one, competing priorities (Gelberg et al., 2007).

NGO personnel 3: ... to get from here down to [the middle of town] to get your blood taken seems to be a virtual impossibility for a lot of people, and to remember to fast.

Interviewer: Oh that too... Well especially when you wake up cold, you're going to want a hot cup of tea.

NGO personnel 3: Well that's right, of course, yes.

It appears that because homeless people do not get enough to eat, they will take every opportunity to eat or drink – particularly if it warms them up on a cold morning – regardless of whether they have to fast for a blood test. Also, laboratory blood collection centres can be quite a distance from the clinic itself. Several of the clinic staff members expressed frustration about this.

The issue of clients not returning to the clinic on a regular basis for follow-up appointments is also something practitioners were concerned about,

particularly when bandages on wounds need changing. Homeless people are vulnerable to injuries on the street – the following quote illustrates the severity of some types of injuries, and the consequences of not complying with treatment plans, such as having bandages changed.

NGO personnel 3: ...follow-up, it's very irregular. You know you have, I mean, just looking at wound dressings for instance, you know you've got to come regularly, and it's got to be changed, otherwise it's not going to heal. So I'll put a dressing on like a new deep dog bite or something, and they might come along to begin with because it's really sore, and then but it's still not healed, and I'll put [another] dressing on. I might see them 10 days later, I might not... the healing process can be really slow, because of this...

This is related to what was found in Hunter and colleagues' (1991) study on health practitioner perceptions of homeless people. Health practitioners are seen to be sympathetic to the health needs of homeless people, as it can be more difficult for homeless people to comply with healthcare regimes (Hunter et al., 1991). Such regimes include reporting back to the clinic on a regular basis so a practitioner can check the process of recovery and put measures in place to ensure that recovery is quicker. The life world of a rough-sleeper will often mean that injuries do not heal quickly because of harsh living environments and lack of access to basic necessities, and this is worsened by a lack of compliance to treatment which can include medication.

Medications present other dilemmas for practitioners when treating homeless patients. Decisions in relation to prescribing medications to homeless people involves consideration of a number of issues. They include delayed presentation to the clinic, medication abuse, and various reasons involved with non-compliance – losing prescriptions/medications or simply forgetting to take their pills (see Sarah and Pete's health biographies, chapter four). Clinic personnel use their professional judgement when prescribing medications: Keeping a homeless client relatively 'healthy' far outweighs the risk of clients potentially abusing medications.

NGO personnel 1: ... probably the majority would go out with a prescription of some sort. Yeah asthma, hypertension, infections, antibiotics, which is interesting to me because um, we do talk about not abusing antibiotics so much, but it seems to me that groups [of homeless people] that I've worked with in New Zealand it's such a delayed presentation that most of the people that request the antibiotics indeed, need antibiotics.

This particular practitioner indicates that when they have worked with similar populations, there have been incidents of 'antibiotic abuse'. However they recognise that in this setting, more people are requesting specific medications because they actually need them, and their conditions are much more serious. Research shows there is a culture around delayed presentation to medical clinics within the homeless population (Wright & Tompkins, 2006), and practitioner's decisions are influenced by this.

NGO personnel 1: [An example of] a typical case... [is] I lost my medication... It's typical. You know, so you're always trying to discern... the use of it.

Interviewer: How true that is...

NGO personnel 1: Are you selling it, are you giving it away, you know what's happening there, so [pauses]. So you know I think that, that interferes a bit, it's sometimes, um, if you're the kind of person that wants to believe everybody's telling the truth until they don't, um, that's always a fine balance between being [a] safe prescriber, or a safe provider, and not feeling like you're distressing everybody that walks in the door...

This quote illustrates an inner conflict, where the practitioner cannot be entirely sure whether medications are going to be used as they are intended. Strategies need to be put in place to ensure that the clinic service is not 'abused' in this way. There can be issues where the odd client may come to the doctor to ask for medications that can be abused, or sold on the street to manufacturers of other illegal drugs, and drug users themselves. This is a form of prescription drug diversion, which "involves the unlawful channelling of regulated pharmaceuticals to the illicit marketplace" (Inciardi, Surrat, Kurtz & Cicero, 2007, p.171). Clinic personnel are aware of these practices and while sympathetic to the fact that some people can become desperate, they acknowledge that it puts these people at further risk and so will be careful about the prescriptions that they do give out. Developing relationships with clients is seen as a

strategy to prevent these kinds of incidents from occurring. These relationships need to be fair on both sides, and respected by both the client and the practitioner.

Clinic practitioners often have to make decisions about whether some medications are the 'best' option for treating some medical issues that homeless people have. Treatment for certain conditions is administered with the consideration of current life situations, so that clients will be better off, rather than worse off. This can often mean exploring non-allopathic treatments, but care must be taken to ensure that this is not beyond the practitioner's scope of practice.

NGO personnel 1: If someone came in and wanted um, they were... in detox, and they wanted help with sleeping and, they wanted benzodiazapines. Well... they're just giving up medications and so to me it doesn't seem really reasonable to be giving them [an]... other medication subsidy. So, um, just trying to work on other non-pharmaceutical [inaudible] ways to help them relax... I'm not trying to say that I'm getting into areas other than what I'm trained for but sometimes it's hard to... get those type of specialists around... a homeless centre when you need them.

It is not a particularly good idea to give benzodiazepines to people with addictions because of their addictive properties. This means that practitioners consider non-pharmaceutical options, and suggest alternatives for treatment. However, such alternatives outside of the NGO clinic can be inaccessible for homeless people. People with disposable income will have more options as many specialised non-allopathic treatments are not subsidised, and are unlikely to be provided free of charge.

The following quote illustrates a clinic staff member's approach to treating a homeless client addicted to drugs, through introducing them to complementary medicine used within the NGO's detox service.

NGO personnel 2: [I saw a homeless man] ...when I was on duty, he came [into the NGO] a few times all sweaty, shaky, he had withdrawal symptoms, and I said to him...well man do you want some vitamins? I can get them from our detox, they're good quality vitamins and they'll just help you out'. And yeah okay, he took the vitamins a few times, and then he approached us and said 'well, actually can I come to detox?'... If we just introduce the

idea oh here's the detox centre, he of course will ask around and see if other fellas found it alright there... and get an idea of what is going on there... Since we've integrated our services I've seen more homeless clients coming through detox which is a good thing to see.

Giving clients options in terms of their treatment is more constructive than telling a person: 'You need to go to detox – I am admitting you now'. Even if it is said with the best intentions, that kind of approach takes away a person's autonomy and their ability to make their own decisions, as seen in Hoffman & Coffey's (2008) research, where homeless people experienced 'objectification' and 'infantilization' in their interactions with service providers. This clinic staff member also understands that social networks can be an important information source for clients who wish to seek help (see section on social networks, chapter four). The integration of the services under the umbrella of the NGO gives clinic staff more opportunity to refer clients to other services within the NGO, and collaborate with other NGO staff; thus allowing clients to manage their various needs within the NGO.

Paying for prescriptions for medicine, even if they are subsidised by the government, is an important issue for homeless people. Their income is usually limited to social welfare, such as the sickness benefit or the unemployment benefit (Work and Income, 2009). The cost of living tends to exhaust these limited funds, and there is often no money left for visiting the doctor, or medication prescriptions. There are a number of strategies that clinic personnel have employed, or attempted to employ to try to ensure that homeless clients are able to get the medication that they need.

NGO personnel 2: ...on a case-by-case basis we might help with pharmacy costs, which the majority of the cases would be three dollars for the medication because clients, they [will] have a community services card...And the majority of clients won't have that much money. If they don't and say 'I can't afford this medication', well we'll have a discussion of what's happening, and we can offer additional support for the patient to get the medication...

This clinic staff member outlines the additional support they can offer homeless clients, particularly in terms of being able to pay for prescriptions. The idea that it is done on a case-by-case basis means that

those clients will be evaluated by staff members for their ability to pay for prescriptions, as well as their ability to pay for a doctor's appointment. Clinic personnel have been unsuccessful to date in trying to find a local pharmacist willing to waive the three dollar prescription fee for subsidised medications. However, they did mention that it was still possible to provide some medications to patients free of charge.

NGO personnel 6: We do have a few [medications] now, like antibiotics, painkillers um, inhalers, on-site that we can hand out...

Interviewer: How do you get those?

NGO personnel 6: ...Oh, all GPs do, you get, its a thing called a PSO... it's a prescription that isn't for a patient, it's for the clinic...

Interviewer: So you can give them out to certain people who need them?

NGO personnel 6: Yes. [It is a] limited list, but it's quite a big limited list.

This practitioner can give out particular medications obtained via a PSO (Practitioner's Supply Order), to clients that cannot afford to pay for them. A PSO for medication can be used to obtain subsidised medications for emergency use, and teaching and demonstration purposes (Pharmac, 2009). If a homeless person cannot afford to pay for medications that they need to treat or prevent illness, it could be classed as emergency grounds for the practitioner to dispense medications.

Clinic personnel face many dilemmas on a daily basis in their consultations with homeless people. Aside from the complex medical and non-medical problems that homeless people present with at the clinic, there are various lifestyle issues that may affect how their treatment is managed. Lack of compliance with diagnosis and treatment programmes is an issue, and can prolong certain health issues. As well as this, there can be many dilemmas surrounding prescription and utilisation of medicines. It can be a challenge for clinic personnel to deal with these issues, but some can be managed within the clinic setting.

Constraints: Practicalities of funding vs. Vision for service provision

Constraints with running the clinic come from disjuncture between the clinic staff's vision for holistic healthcare and integrated services, and the practicalities of the current funding structure. While the NGO clinic receives prioritisation funding from the regional DHB, there is still a struggle to ensure that the holistic vision espoused by clinic staff is met, due to funding constraints. The health service delivery model espoused by the health system in New Zealand is not based on holistic care. Private, domiciled GP clinics are not necessarily entirely integrated within umbrella organisations, therefore do not provide the holistic care idealised by the staff of the NGO clinic. The New Zealand health system is based on an ideal principle of universally accessible primary health care to people in communities, however, not all primary health care is publicly funded in full (King, 2001). This is because PHOs are "...funded by District Health Boards for the provision of a set of essential primary health care services to those who are enrolled" (King, 2001, p.viii). This means that only some primary health care services will be fully funded – but many will be partially subsidised. Although primary health care in New Zealand is defined as universally accessible, only those populations with the greatest health needs will have financial barriers reduced (King, 2001). This does not mean that there will not be some financial barriers for undefined populations, such as homeless people (Statistics New Zealand, 2009).

The primary health care structure in New Zealand is population based, but there seems to be an assumption that all populations generally have access to the basic necessities of life such as adequate shelter, food, and clothing (and money to obtain these necessities). The health system does not appear to recognise that there are people without such basic necessities, such as rough sleepers (and even some housed people) who have considerably different health needs. Nonetheless it is clear from NGO clinic staff responses that achieving the vision for the clinic is difficult, considering the assumptions mentioned above.

One of the difficulties experienced by clinic staff was learning how to negotiate a health system set up for a domiciled population, with the purpose of providing population-based healthcare for homeless people. In this case below, the health services mentioned are based around the assumption that all people have houses to live in, and can afford healthcare.

NGO personnel 6: ...Some of the frustration is saying 'I've got a guy with a foot ulcer, how do I get a district nurse if he hasn't got a home? Cause a district nurse does visits to your home don't they?' ...how do you get a scan to somebody who's pregnant, because they, you pay for a scan, I mean who's got 25 dollars in their pocket or 35? But there's a, a midwife for the homeless and she can get scans. So I can ask her to arrange the scans rather than me arrange it, it's just knowing the systems and knowing the way in.

These issues reflect the challenges of working with this particular population because the health system has been created around the assumption mentioned above, that all people generally have access to life's bare necessities. Health is conceptualised according to the lives of domiciled people, and clinic staff have to seek out additional information and create novel approaches to ensure that homeless people, who do not fit into the domiciled 'mould', get the specific healthcare that they need. Renedo and Jovchelovich's (2007) concept of 'cognitive polyphasia', (discussed in chapter one) is relevant here in terms of the experiences of professionals who work with homeless people. Professionals experience difficulty because they know they must deliver a particular service, yet struggle to do so because of resource and/or structural constraints (Renedo & Jovchelovich, 2007). The professionals at the NGO clinic recognise that the health needs of homeless clients are significant, yet the funding can be difficult to secure, or does not cover the extent of health needs. This could create a significant degree of cognitive polyphasia for clinic staff, as they have the skills to take care of patients, but do not have the means to address every health issue. Clinic personnel are aware that rough sleeping homeless peoples' lives are potentially at a higher risk if they are not treated for health conditions. The clinic personnel genuinely want to help homeless people (see section on motivations, this chapter),

but practically are constrained, and will often not be able to do enough to help.

As mentioned earlier, developing rapport, understanding contextual factors and establishing relationships with homeless patients can mean that their health needs are more likely to be met. However, this can take time and some clinic staff find that appointments with practitioners in the clinic do not always have a medical component. This does not seem to be a problem for the staff, but it is a strain for the clinic financially if people are just visiting the doctor for free for a bit of a talk and a catch up, rather than a medical appointment.

NGO personnel 4: ...for quite a few of them [clients of the NGO clinic] it's a nice social contact and they will just come to the doctor every day if you allow the doctors to be there. So there's this balancing act of saying you can go six times, but on the seventh I'm going to charge you a dollar. Which may in fact make them start to think about this as a service of value and worth...

While it is acknowledged that these social contacts are important for wellbeing and 'keeping in touch' with reality (Hodgetts et al., 2007; Kearns, 1991), this uses up practitioner's time, which is a precious resource as they can only be there for specific times during the week. It can also compromise the needs of other patients who may have acute medical conditions. Charging a small fee to those who can afford to pay helps to ensure that the clinic is used for what it is intended for, as resources are strained.

NGO personnel 4: I actually believe there's a huge number of people that go to a GP, and it's not necessarily about something physical.

Interviewer: Oh, totally... we know the evidence of it, it's there.

NGO personnel 4: Yeah but in 15 minutes what are you going to do? You know? And in 15 minutes what do they do?

The funding received for the clinic from the regional DHB is based on 15 minute time slots. This is an economic constraint that has implications for the long-term sustainability of the clinic. Most of the personnel acknowledge this constraint and try to work within it. However, they

argue that consulting within 15 minutes is difficult, particularly in terms of the primary objective of the clinic – to provide holistic health care. While the clinic personnel idealise developing relationships as part of ongoing healthcare for homeless people with multiple conditions, holistic healthcare takes time. Even if a practitioner has a productive consultation with a client with many physical needs that require follow up, there is still a chance that the client may not come back to the clinic. Trying to avoid making other patients wait can sometimes mean that patients may not get all their healthcare needs met.

NGO personnel 5: ...you cannot see, you know 25 to 30 patients a day and offer a good service while trying to negotiate all the needs of these people.

This staff member recognises that the nature of the service means that it is unlikely the 15 minute consultation model will work in this clinic. The reality of the clinic model is that clients come in to the drop-in centre at 9AM on the days that the clinic is open, and sign up to see the doctor: 'first come, first served'.

NGO personnel 6: ...It's a list. That's the list for the day but the patients still have this idea 'but my appointment was 12.30' but it's an order list really, it's a first come first served...[for example,] if I spent an hour with you, the next person might get grumpy...

Clinic personnel acknowledge that the time they spend with each patient can vary dramatically with regard to their needs. Assisting one patient in a more holistic way has implications for other patients in that they may have to wait longer for potentially shorter appointments. Many patients choose to wait in the drop-in centre just in case appointments are quicker, or if someone leaves the drop-in centre and missed their appointment because they have not been able to get back in time. Three of the clinic practitioners expressed concern about the amount of time their clients must wait for medical appointments, because of the nature of being on a 'list'. While according to DHB guidelines an ideal consultation time is 15 minutes, this can vary considerably depending on the needs of particular clients. One staff member was particularly concerned, because they were

aware that homeless people have their own lives to live, and cannot spend their entire day waiting.

NGO personnel 3: I'm very aware of trying not to keep people waiting. These clients especially will go, if they're kept waiting too long. They just disappear. They um, have very low tolerance for being kept waiting, they're often uncomfortable sitting inside somewhere having too many people around them... and, they... just go.

Such concerns are highlighted by Crisis UK (2005) in their claim that long waiting times for appointments were a barrier to service access. This has implications for the vision of the clinic as it will not be reaching all of its target population. Clinic personnel acknowledge that conflict can arise because some people who use the clinic service have grievances with one another, and tempers can flare in the waiting room. However, another clinic staff member reported that most of the time, clients in the waiting room are reasonably calm and some will even let other people see the doctor before them, regardless of the order of the list, if they perceive the needs of others to be greater than their own. Many patients at the NGO clinic can be waiting most of the day, and generally wait much longer than domiciled people would expect to wait in a GP clinic. This is consistent with Ensign and Gittelsohn (1998) and McCabe and colleagues (2001) who found that homeless people were likely to be patient in healthcare settings even if they knew they would be waiting a long time, because they knew they would be seen eventually (see chapter one).

Major constraints on the running of the NGO clinic, centre on the funding structure. Clinic personnel are concerned that they are unable to meet the requirements of the structure, based on 15 minute consultations for any patient at any one time, as well as being concerned about making other homeless patients wait lengthy times for consultations. While developing meaningful doctor-patient relationships is a major goal for the clinic, achieving these within 15 minute consultations is difficult. Time is an important resource for the NGO clinic, and there does not seem to be enough.

Motivations – ‘making a difference’

All of the clinic staff spoke positively of the NGO clinic, the vision, and the work that they do. While they come across many challenges in their work and know that the clinic does not provide a panacea, they are optimistic in that they feel they are making a difference in the lives of their clients.

A clinic staff member talked about the time it took before they felt they were ‘accepted’ as a trustworthy member of the clinic by the homeless clients that utilised the service on a regular basis. Achieving acceptance within the homeless community was important to this person, as they would always do their best to ensure that they would carry out the best practice possible that was appropriate for the needs of the clients. When the person realised that they were accepted into the clinic setting, they noticed positive changes in their ability to work with clients.

NGO personnel 3: ...it took a good four months before I was accepted as being okay, it's a very tight-knit little community... and you've gotta get the okay from the people out there. And I mean, as you know the majority of our clients are Māori, so, and we're all Pākehā, and seen as middle class, so they've got to get to know you... But once they find out you're okay, people started coming, it was really amazing... They talk to each other... and then the word got out... so... a lot of people started coming in ... they get to know you and know that you're yeah, non-judgemental...

There seemed to be an initial uneasiness with this practitioner when they first started working at the clinic. However, clients spoke with each other about their experiences with that person in consultations. Amongst clients within the homeless community, social representations developed of this practitioner as being trustworthy (e.g. Kelly and Caputo, 2007; Wright, 1990) and accepted. This practitioner thus became part of the welcoming setting of the NGO clinic.

Clinic personnel help to create an atmosphere in the environment of the NGO clinic, where homeless and other low-income clients feel welcome, as in Wen and colleague's (2007) research.

NGO personnel 6: ...I think they're glad to be seen, and glad to be seen by somebody who likes them... I think they do realise that... they're liked and appreciated here and yes, so, it works both ways... So I think the fact that I expect to like the person who comes through the door, makes them a lot easier to work with and yeah, they end up hopefully, coping with me in a much easier way as well.

Clinic staff believe that homeless clients like and appreciate the fact that this clinic is available to them, and that they are able to access it relatively easily. Personnel believe that because of their attitude towards homeless people, their clients will feel more comfortable in the NGO clinic setting. This provides an excellent opportunity to develop strong client-practitioner relationships, so that homeless people will continue to use the clinic service and hopefully have their healthcare requirements met.

Clinic personnel also acknowledge that one of the benefits of this clinic for the homeless clients is because it is located within a wider NGO service that they know and trust. It is recognised that this particular setting would be more appropriate for homeless people in terms of the specialist population-based services they can provide, rather than an acute outpatient service in a hospital, for example.

NGO personnel 2: Oh it's great... to see that you can provide a good quality medical service to clients who... don't really get that, and clients who might be judged at other places, might not be comfortable, clients who are accepted here, and who know their community is here. They have a sense of belonging to their community in this place, and they're always welcomed, looked after, and provided with the care they need. And they know that if they have a problem they can come here to discuss it with us, see a doctor, [or] see a social worker...

Staff understand that homeless people are often not comfortable in certain clinical settings, due to negative past experiences (see chapter four). The situation of the clinic in a place that clients are familiar with, and where their social networks are based (see chapter four) is a way to circumvent this issue, and increase accessibility to a much-needed service amongst this population. Whilst being aware of the various issues that can make their jobs challenging, all clinic staff expressed positive sentiment about working in the clinic.

NGO personnel 3: ...you can get a lot of satisfaction out of it, yes. And some [homeless people] can be extraordinarily grateful, and I think that's, that's always what you want at the end of the day, is that someone was pleased that you've done something for them.

International literature has also found that personnel who work in specialised services for homeless people enjoy working in those services (Johnsen et al., 2005). This person feels that they gain a feeling of satisfaction from working in the clinic, particularly because they know that they are helping people who are often in dire need for healthcare.

NGO personnel 2: It's actually a real privilege to work here personally, the rewards of the job are great.

NGO personnel 6: I just think it's a lovely place to be, I think there's some really good spirit around here and some lovely people, and if the patients are lovely, the staff are lovely, everybody's, you know, working together. It's very positive and it's a nice feeling.

These quotes illustrate the atmosphere of the clinic within the wider NGO. Even though personnel are aware of the constraints and dilemmas of working in the NGO clinic, they are still able to maintain a positive perspective of the people and the setting. The general idea of the clinic within the wider NGO service is positive, and the collaborative philosophy is positive. The reality is that it takes considerable time and effort to ensure services like this run smoothly. Unfortunately, the effects of health systems change on health status can be difficult to measure within communities, because it is difficult to establish cause and effect relationships (Kreuter, Lezin & Young, 2000). However, it is encouraging to hear people who work at the coalface of the NGO clinic express such positive perspectives about their work and the service they work for, despite the various challenges they are faced with on a day-to-day basis.

To further make a difference in the lives of their clients, the wider NGO service is currently fundraising for a venture that will allow them to upgrade their premises, and provide more integrated services to more low income and homeless people in their area. Once the clinic is successfully established there are plans for adding services such as women's health,

dentistry, outreach healthcare, physiotherapy, and a pharmacy. The clinic would also be upgraded alongside the development of these health service initiatives.

Chapter Summary

This chapter discussed features of the day-to-day running of the NGO clinic. Initially, excerpts from interviews shed light on the development and structure of the NGO clinic as a population-based primary healthcare provider funded by the regional DHB, and the challenges associated with that restructure. To follow, staff career backgrounds, social representations of working in the clinic, and roles within the service were covered. The clinic's vision of providing holistic, population-based healthcare integrated within the wider NGO service structure was then explored, as well as discussion around responding to complex patient needs, and the challenges in the development of meaningful doctor-patient relationships. A collaborative philosophy fits within the vision of the clinic, and examples were provided that detail collaboration within the wider NGO service, and with other organisations. However, the day-to-day running of this clinic is not without its dilemmas. There are several dilemmas in providing a population based healthcare service to a homeless or low-income population, such as treatment compliance and follow up, and challenges around medication use/misuse; but personnel are attempting to create solutions to these dilemmas. There is also a disjuncture between the idealised vision of the clinic, and the practicalities of running a clinic in this way under a tight budget. However, clinic staff are motivated by the idea that they are 'making a difference' in the lives of homeless people.

Since the NGO clinic's humble beginnings as a small 'suitcase clinic' open one day a week, it has now developed into a population-based primary healthcare provider, funded by the DHB, running four days a week. The

clinic's population-based framework means that homeless people can now seek healthcare on a long-term ongoing basis, as this population are known to experience a variety of ailments, illnesses, as well as mental illness, and social issues. All of these have an impact on each other, and influence psycho-social wellbeing (Flick, 2007). The location of this clinic within a wider NGO service that provides a range of social services to homeless people means that this population is able to access more holistic care, and have their needs met. The collaborative philosophy of the service means that the clinic personnel are able to connect with a range of much-needed services and organise referrals, making the process of seeking various types of services more streamlined for homeless clients.

Staff social representations of working in the NGO clinic appear to reinforce findings from research on homeless professional's social representations of working in similar organisations overseas (Renedo & Jovchelovich, 2007). NGO clinic staff described a humanistic approach to healthcare, with a focus on understanding patient needs and developing relationships with clients. Staff also experienced 'cognitive polyphasia' with this ideal approach (Renedo & Jovchelovich, 2007) because of funding and time constraints.

The NGO clinic's holistic, population-based, integrated vision for healthcare could possibly be the same for similar healthcare settings, but is limited by funding constraints. New Zealand government policy documents such as *The Primary Healthcare Strategy* (King, 2001) also espouse population-based visions for success across primary healthcare providers, but holistic care is not a priority. A holistic, collaborative health service is necessary for low income and homeless clients, particularly rough sleepers. Clinic staff must work around this domiciled healthcare framework to ensure that their 'non-domiciled' clients can obtain the healthcare that they need.

Time is another constraint. The funding for the NGO clinic is based on 15 minute time slots for each medical appointment. However the reality is that providing holistic healthcare that covers all the health needs of a single homeless person, takes time. Hence, the rationale for an enrolled, population based framework. Fifteen minutes is not enough time to address all of the potentially complex needs of patients, but if homeless patients can enrol and relationships can be developed with practitioners, ideally they will come back for further appointments with the same practitioners to address other issues.

Services of this nature – welcoming, comfortable, accessible, appropriate settings or ‘spaces for care’ are important to homeless and low income populations (Hodgetts et al., 2007; Johnsen et al., 2005; McCabe et al., 2001; Wen et al., 2007). However, the longevity of such services is often dependent upon auditing the services’ utilisation of public funding, and customer satisfaction with services (King, 2000). Unfortunately, it is difficult to measure the effects of such service structures on the health status (Kreuter et al., 2000) of homeless rough sleepers as health issues can be multiple and complex (Mora, 2003, in Leggatt-Cook, 2007).

This chapter focussed on the NGO clinic and staff accounts about consulting with their patients, the work environment, and the general management of the clinic. The clinic personnel accounts provide evidence to suggest that the positive, helpful characteristics of the NGO clinic point towards the notion that it is an ‘ideal’ healthcare provider in the community it serves, despite various challenges. All of the staff interviewed expressed their enthusiasm for the clinic, and the usefulness of its structure in this population. However, they were mindful of the constraints, and dilemmas, associated with running a service of this nature. The next chapter focuses on the homeless participants, the accounts of their health, health practices, and experiences in using health services, including the clinic.

Chapter Four: Homeless Clients

This chapter analyses homeless clinic patient responses in order to understand their social representations of health, illness, social networks, and the NGO clinic setting. This chapter will be divided into four main sections. First of all, the health of homeless clients will be discussed through the use of individual biographies that explore health histories, current health status and/or illness and disease, living situations, and social representations of health. Second, the three most pertinent health issues reported by clinic staff will be discussed in light of patient accounts of these issues, and practitioner's experiences of treating/healing these issues. Third, the influence that social networks have on homeless people's health will be discussed. Fourth, clinic patients' social representations of health services and the clinic service in particular will be explored. Overall, this chapter will explore whether the NGO clinic service is conceptualised as appropriate or 'ideal' for homeless people in the eyes of the clinic service users.

Homeless people's conceptualisations of health, illness and the NGO clinic are explored and illustrated through the use of a military metaphor. The potential relevance of this metaphor first became apparent in the repeated accounts from staff and clients about foot problems. A link was noticed between the types of foot problems that homeless people suffer from, immersion and trench foot (Institute of Medicine, 1988), and those experienced by soldiers in some major military conflicts throughout the last century (Friedman, 1945). This military metaphor is employed to reinforce the uniqueness of medical practices such as the NGO clinic, and enhance understandings of homelessness. In the context of SRT, this is an example of 'anchoring' ideas we may not be so familiar with (e.g. homelessness) within the context of what we are familiar with (e.g. the military), thus creating new social representations (of homelessness) (Moscovici, 1988).

In my notes from field research, I had used the word 'camaraderie' to describe social networks amongst homeless people I had interacted with. Comradeship is often used to describe friendship amongst soldiers at war (Ashworth, 1980). Links with the military were noticed in some other main ideas to be explored in this chapter. For this reason, rough sleeping homeless clients are compared with soldiers and war veterans, health issues with those experienced by soldiers and war veterans, and the clinic setting with that of a field hospital within a war zone.

While it may seem dramatic to use a military metaphor to describe certain characteristics and experiences of homeless people and the clinic they utilise, that is not the purpose of its application. Many domiciled people⁵, more often those in middle to higher socio-economic status, are known to have particular representations of homeless people and their life worlds, often using labels to describe them as 'bums', 'tramps', and 'vagrants' (Riley et al., 2003). The military and the 'horrors of war' are concepts perhaps more readily understood by domiciled people (Ellis, 1976). By applying this military metaphor to the life worlds of homeless people, an understanding might be gained of the very real material hardships experienced by homeless people who 'sleep rough'⁶. What is more compelling is the fact that many war veterans can spiral into homelessness, mental illness, and substance abuse (Frisman & Rosenheck, 1997). The purpose of using this military metaphor is as a narrative device to extend domiciled perceptions of homelessness, while emphasising the uniqueness of the NGO clinic.

⁵ I do not wish to imply that domiciled people are all completely unaware of the life worlds of homeless people; nor convey that many domiciled people do not have similar experiences in their lives even though they are housed. It is well known that many people of lower socio-economic status (SES) live in substandard, overcrowded housing, have poorer health than higher SES people, fewer resources, lack nutrition, and do not receive satisfactory healthcare (National Health Committee, 1998).

⁶ Homeless 'rough sleepers' are the focus of this research, and while it must be noted that the goal is not to homogenise homeless people; it is crucial to acknowledge that I do not wish to homogenise 'rough sleepers' either as each of their life experiences are unique and a story worth telling.

Homeless clients and health biographies

The identification of Māori as the majority ethnic group of the client population the NGO clinic serves is significant, as it is reflected in recent general population health statistics in New Zealand. Māori have a greater need for healthcare and suffer from more serious health conditions than the rest of the population therefore services need to be targeted to suit their needs (King, 2001; National Health Committee, 1998). The acknowledgement that men comprise 75% of all clients is similar to statistics on rough sleepers in Auckland, New Zealand where just under 70% of all 'primary' homeless people were male (Ellis & McLuckie, 2008). My own field observations indicate that more men than women use the service (Field notes, 23 July 2008).

Biographies of health issues, experiences and medical histories in relation to the street were created for each client interviewed. Each health biography was constructed from perspectives gained from interview recordings, and background sheets filled in for each participant during field research in July 2008, when information was collected for this thesis (see chapter two). It is important to remember that people's lives can change drastically over the course of many months, and the stories of these people's lives might now be taking different paths in relation to health and well-being. However, these health biographies help to illustrate the rationale for the existence of this specialised medical clinic for homeless people and other low-income groups. A summary of the issues raised in the ten health biographies is outlined at the end of this section.

Robert

Robert is a 43 year old Māori male, and had been homeless since about 2001. In the seven years previous to our interview, he had been on and off the street and in insecure accommodation due to a family break up, which lead to addiction problems with alcohol and drugs.

Robert: ...back then I couldn't work 'cos I was on drugs and alcohol and I realised I needed help so they stuck me on the sickness benefit for alcohol and drugs and then umm... I've been on it for a long time... But... yeah actually my health's been a lot better... I'm starting to put on a bit more weight and I'm eating a lot more 'cos when I was living on the street I wasn't really eating much, just... [pauses] just surviving eating meals up here and eating out there, and not really having a regular meal. Some days go cold and hungry, 'cos I spent all my money on alcohol.

Robert's addiction to drugs and alcohol has been problematic for him – when the addictions took hold of his life he lost jobs, he was forced to live on the street, and his health deteriorated. He conceptualised his addictions as a disease because of the gradual deterioration of health he has experienced due to his heavy drinking, similar to Hodgetts and colleagues' (2007) findings on embodied deprivation. Robert now gets asthma because he lived out on the street, and he constantly had colds or the flu in the winter. At the moment, he has a place to stay as he is trying to get his life back on track. He had been through detox and rehabilitation programmes and was still struggling with alcohol and drugs, but had found that spirituality and religious beliefs were helping. He visits the doctor at the NGO clinic to get his sickness benefit renewed because he cannot work at the moment. Robert talks about his pathway to health in terms of believing in God, and the social support he gets from the people who have helped him with his addiction. He strongly believed that he was getting better because he made the right choices. He knew that it would take a long time, but hoped that as long as he stayed on his current path to recovery, his health would improve, and he would be able to have a job so he could improve his life situation.

Thomas

Thomas is a 56 year old Tongan New Zealander, he had been homeless for five or six years because he was 'kicked out' of home by his siblings, and was sleeping rough at the time of the interview. Thomas had many disabling chronic health problems. He had diabetes – he was not specific as to which type, but due to the fact he was overweight and on *Metformin* (a medication for type 2 diabetes), one can assume he had type 2

diabetes. He sustained terrible injuries about three and a half years ago when he was staying in a night shelter and awoke to find that his feet were being stabbed by somebody (Field notes, 9 July 2008). This caused a range of health issues. He has had operations to help his feet heal up but due to his life situation they kept getting infected because he had been unable to clean them on a regular basis - he was taking *Augmentin*, an antibiotic, to help with infection. A complication of these injuries was that he developed oedema (fluid retention) in his legs. He had very poor circulation, and has had heart failure. He had been in hospital many times over the past 12 months due to this.

Thomas mentioned *Spiractin*, a medication for heart failure which he had been on in the past but was not on at the time of the interview. He was also on medication – a diuretic for fluid retention problems. In relation to this, a week after I had interviewed Thomas I saw him again – he had just been in hospital and had 20kg of fluid drained from his system (Field notes, 23 July 2008). He also used to drink alcohol excessively, but had cut back. Thomas' problems with his feet meant that he visited the NGO clinic on a regular basis to have his feet cleaned, and also to have his toenails clipped because they were so hard he could not do it himself. The issues with his feet in particular affect the way he is able to live his life because his physical mobility is hampered. Thomas appeared to conceptualise health in the way that he was still able to function, and maintain practices to keep himself out of danger and relatively 'healthy' (Flick & Röhnisch, 2007). Thomas seemed to rely on the NGO, other health services and medication in order to get through the days.

Howard

Howard is a 48 year old third generation New Zealand European, and did not identify as a homeless person. Howard said he normally lived overseas but had to come back to New Zealand for medical treatment. When he was overseas he was hit over the head with a crowbar which cracked his skull. This injury had left him with some chronic health issues.

The crack in his skull caused a blood clot in his brain which resulted in a stroke. He has experienced memory loss due to this incident, and suffers from epileptic seizures, so must take medication for his epilepsy (*Epolin*).

Interviewer: So how come you went to the doctor yesterday?

Howard: Uh... because [they] upped my dose of epolin and it's just about knocking me out... I could hardly stand... I've noticed since Friday every time I took a 500... milligram tablet of epolin, about half an hour later I was wonky as anything. So [they've] reduced it.

Howard often had seizures while out and about, which meant that a member of the public would call an ambulance and he would get taken to hospital – which he hated. Howard also had a health condition called pancreatitis which seems to have been caused by drinking excessive amounts of alcohol. This gave him chronic pain from time to time, which meant he had to go to hospital for pain relief (a *Morphine* drip) that knocked him out for weeks. He did not like this because he lacked control over his life. Howard also had a broken cheekbone, but could not have it operated on because he had haemophilia (a genetic condition of impaired blood clotting). The haemophilia has created many complications for him on various visits to hospitals. Despite his health problems, Howard seemed to look after himself through eating a healthy diet. However, it is clear that he conceptualised health in a functional manner, as his health problems (epileptic seizures in particular) create an enormous disruption to the way he wants to lead his life (Flick & Röhnisch, 2007).

Sarah

Sarah is a 41 year old Māori female. She had been homeless since about 1998, when she left her son with her best friend and ran away from home. She was staying with a friend but was also seeking other accommodation. She was asthmatic and had mental health issues, and was supposed to take medication for both, but said she could not because her services were in another city. She did not believe that the medication for her mental health issues worked.

Sarah: ...I've got asthma, so I'm supposed to be using the asthma pumps but I left them behind when I left.

Interviewer: Are you going to get some more?

Sarah: Not at the moment because all of my services are back in [another city]. I've got services down there like the... chemist and places like that. And I've got nurses and doctors down there but they're from mental health services, yeah. I haven't been seen there for months.

Interviewer: Do you take any medicines at all?

Sarah: Not at the moment, no I'm not. I'm supposed to be on some medication because I hear voices, but I haven't been taking them for months.

Interviewer: How come?

Sarah: Well I just can't... to be honest I gave up taking the medication because it wasn't working, it wasn't doing anything for me.

Sarah did not appear to be actively doing much about these health issues, so they may not have been of great concern to her situation at the time. Health may have been less relevant to Sarah, as other issues took precedence (Flick & Röhnisch, 2007). Sarah seemed to be a lonely person without many social contacts. She did not believe that many people liked her, but thought that the people at the NGO service were friendly and helpful. The fact that she had a mental illness and few social contacts, therefore had difficulty finding accommodation, meant she would be at risk of developing various ailments and illnesses, particularly throughout the cold winter months.

Arthur

Arthur is a Māori male in his early forties (he was unsure of his age). He had been living on and off the streets and in boarding houses since the 1980s, and was living in accommodation provided by Housing New Zealand. Arthur had a myriad of health issues he coped with on a day-to-day basis. He has had asthma since he was born, and goes through a lot of inhaler medication due to excessive use of drugs such as marijuana and 'P', which exacerbated his asthma. He also looked as though he has a skin problem, as he had scars all over his face. In the years beforehand, Arthur had driven a car under the influence of alcohol and drugs, and he

ended up having a very bad accident, smashing the car into a power pole. He ended up having serious heart surgery, and had an artificial pacemaker implanted in his chest. He has to go to hospital every six months to have it checked. He also has issues with his short term memory. Arthur had to have his spleen removed, but it was not clear what had caused this. He knows that he is not supposed to drink alcohol, but still does. He recounted a time when he drank 'top shelf', which he had a serious reaction to.

Arthur: ...I still drink... but I just keep away from whiskey 'cos I spew out blood. You know I went to the doctor's and they sent me to the hospital, I says 'I'm spewing up blood', and um... they put this tube down my throat and there's a screen you know, where it showed all these bubbles... and they pulled it out... and then she says 'oh no'. And then I said, 'What's all those bubbles?' I was looking at on the TV screen and she says 'You drank top shelf'. I says 'Yeah I drank whiskey'...[Then] I says, 'Well what were all those bubbles on the inside of my guts?' And she says 'Oh they're ulcers, and the ulcers are bursting' and that's why I'm spewing up blood.

Interviewer: That must have been really painful.

Arthur: Well no not really 'cos I was always drunk at the time. When I was spewing up in the toilet, was all coming up red, you know, so I thought I'd better go... get it checked out.

Arthur had also suffered from a bout of pneumonia which left him in a coma, and he was admitted to hospital. He had also lost his big toe on his left foot. While Arthur was aware of his serious illnesses, he was still not willing to give up what makes life bearable for him. Arthur appears to conceptualise health as mental wellbeing (Flick & Röhnisch, 2007) – his personal life enjoyment equates to his wellbeing and feeling good, regardless of any physical illness.

Pete

Pete is a 40 year old man with Chilean heritage. His family immigrated to New Zealand in the 1970s. He had been in insecure accommodation and worked odd jobs since 1992 due to being made redundant, and was sleeping rough. Pete had a variety of ailments that could lead to more serious health issues. He had injured his foot – ripped heel tissue – in one of the last places he was employed due to standing for long hours, and the

fact that he was wearing shoes that did not support his feet properly. Because of his obesity, the excess weight put pressure on the injury, and walking exacerbated it. However, living on the street and having to walk long distances has meant that Pete had lost some weight. He had high blood pressure which made him feel lethargic, for which he was supposed to take medication (*Inhibase*). He had lost his last bottle of medication, so had not been taking it for about a month. There is a history of diabetes in his family which he thought he was at risk for, and had recently had some tests to see whether he had it or not. He was a bit worried about the outcome. Because Pete slept outdoors in the doorway of a building at a busy intersection, he had noticed that he was starting to have some respiratory problems due to all the dust and fumes from the cars.

Pete: Since I've been staying up here my throat has become very... you know I think it's because of all the fumes, you've got constant cars... coming in. So yeah I'm a bit worried about it in that sense... When I was staying under the bridge it was pretty cool. Like I never even got sick.

Interviewer: Yeah? Must be less traffic.

Pete: Oh yeah, yeah... far less traffic. But um, we weren't right next to the road, right, we were covered as well, but yeah I'm right next to the road... you know you've got dust and... you know the blanket helps a bit...

Pete used to sleep under a bridge and claimed that he never got sick once when he stayed there. His living situation was discovered by authorities and he was evicted, and a lot of his warm clothing and possessions were taken away. Pete identified as an alcoholic. He drank only a couple of times a week, but to excess. He also took drugs to escape reality. While Pete (like Arthur) recognised that that kind of behaviour can cause social and physical health problems, he engaged in it to socialise and enjoy himself. He was trying to get a house and get a job, and had just found out he would be able to stay with some friends. Other things took precedence before 'health' (Flick & Röhnch, 2007).

Sean

Sean is a 45 year old Māori man, and had been homeless on and off since the 1970s. He had held down some diverse jobs, and trained in medicine

in the 1980s. He was homeless when he was interviewed, but staying with a friend. He has suffered from a variety of ailments in the street such as bronchitis and influenza, and recalls when he had a boil on his chest that it just 'came up overnight'. This was likely to have been caused by an inability to wash his skin, and unhygienic living conditions which can increase a person's susceptibility to skin infections. Sean also had badly injured hands when he was interviewed. He had broken them four weeks previously when he got into a fight with someone who had kicked him in the head while he was asleep. This had affected Sean's ability to do a lot of things as he could not use his hands while they were in casts – so he took them out of their casts. He is also on a medication, *Tramadol*, for pain relief.

Sean: I took them [the casts] off after a week because they were just... chilling my hands too much... I've still got, on this hand here, bones that have sat like that... I've also got... something wrong with my inner wrist as well.

Interviewer: Is it still swollen?

Sean: No, the swelling has gone down. But I've got limited movement... After there (points to hand), it's like I've got broken bones... and yet the hospital hasn't picked it up, there's been x-rays taken, they reckon 'oh no, there's nothing wrong with your wrist' I said you better fucking look again. Um, anyway, there's supposed to be an operation going on, on this...

Sean also has a heart condition. He suffered a stress-related heart attack in 2006 after becoming homeless again, which put him in hospital for several days. He takes aspirin for his heart condition, and is a recovering alcoholic. Sean acknowledges the fact that being homeless means that you are susceptible to a lot of diseases, as it is something that he has lived with for awhile. He has attitudes about health and wellbeing that are both informed by his training in medicine, and his experiences on the street. He was quite fatalist when talking about being homeless and the consequences it can have for health, even being so blunt to say he did not look after his health as it was difficult to do so, given his living conditions. Flick and Röhnsch (2007) also reported homeless youth's fatalist attitudes to health. However, Sean had hopes to regain his health.

William

William is a 35 year old Māori man. He was residing in a detoxification centre when he was interviewed – another service that the NGO provides, and has used the clinic service as well. He had experienced brief periods of homelessness and transience throughout his life, but he had his own home where he will live after he had completed his rehabilitation. William had struggled with drug addiction for most of his life. He traced the beginnings of his addiction to when he was 13, when he started to use drugs as a form of escapism from the physical and sexual abuse he experienced as a child through to his teenage years.

William: I use drugs as a form of escapism. Eventually they became an addiction. Yeah, that's what it was for me, like drugs are a way to escape my life. And I started really early on, I was 13... I was... 16 years old when I was diagnosed as a drug addict.

He had also suffered from mental illness and did not specify which, but was on *Risperidrone*, a medication that is used to treat schizophrenia and bipolar disorder; and *Loxapine*, an antipsychotic drug.

William: [The] medication for [my violent outbursts has] helped centre me a lot... I'll stay on it for the rest of my life if I can, if it stops the violence.

William liked to keep informed by researching and reading about the health issues he has.

William: I read everything from Dr. Seuss to Dr. Freud and everything in between to be quite honest. And um, a lot of my stuff is self-diagnosed but a lot of the times I haven't been far wrong either... I just, I read anything I can lay my hands on, and especially about my disease. Yeah, I read everything I can about my disease 'cos there has to be a way out for me.

Interviewer: So your disease you're identifying is your addiction?

William: Yep, yep.

William's description of his addiction to drugs as a 'disease' is likely to be influenced by what he has read on the subject. By identifying his addiction as a disease he may have hoped to minimise its impact on his life, thus making it easier to deal with, and perhaps even 'curable'. In terms of his

physical health, William was obese and smoked cigarettes, but was in surprisingly good physical health regardless of his size. He had good blood pressure and cholesterol, but also had some gastrointestinal health concerns. William has social representations of his health as physical and mental wellbeing (Flick & Röhnisch, 2007) – he may be healthy physically, but has serious mental health and addiction issues. However, he has a lot of hope for his future and believes he has survived the tough times because of a few important people in his life. When he beats his drug addiction, he wants to train in social work to help others in his situation.

Liz

Liz is a 50 year old Fijian New Zealand woman. She was staying in Housing New Zealand accommodation but had experienced periods of homelessness throughout her life, and had slept rough a couple of times. Liz's most prominent health issue is her addiction to 'P'. She had taken a variety of illegal drugs since she was a young woman, has had periods without drug use, but P is what she is addicted to currently. She is trying to quit. One of the consequences of a P addiction is having irritated patches of skin on the face. Liz is prescribed a cream for this, which is effective as she does not display these symptoms. The main reason Liz took P is because she suffered from depression. The drug was like an antidepressant for her, which made it very hard for her to give up, as legal antidepressants like *Prozac* did not help.

Liz has suffered a myriad of other health issues. She has hepatitis C which she believes she caught from having unprotected sex with a man who told her he had hepatitis B after they had started having sex. This situation had motivated her to take the test, although she was diagnosed with a different form of hepatitis. She had a pain in her neck that was misdiagnosed as cancer, but turned out to be a streptococcus infection. Her hepatitis C treatment was cut off at this stage, as it was seen as pointless to carry on the treatment if she indeed had cancer. Liz caught Chlamydia when she was younger and living overseas – she had been getting excruciating

pains in her abdomen and had to be taken to hospital. The doctors did not treat her for it, instead Liz believed that the doctors prejudged her because they saw needle marks in her arm. She did not find out that she had Chlamydia until many years later when she had sobered up and wanted to have children, and discovered that she was infertile. This had a huge impact on her depression, and so she started taking drugs again.

Liz has a reasonably stoical attitude towards her health situation – she will be in denial about a health problem, and not see a health professional until it starts to affect her daily functioning (Flick & Röhnsch, 2007), as in the cases above. She liked to keep herself informed about the health issues she had dealt with in her life, so that she knows what she may or may not expect with regards to her future. Liz had been referred to a mental health service that she was waiting to hear from, and wanted to start drug rehabilitation but had not sought it out just yet.

Clinton

Clinton is a 47 year old Pākehā male. He had experienced periods of homelessness for over 10 years because he had a mental illness, living both on the streets and in boarding houses or staying with family. Due to the fact that he had slow cycling bipolar disorder, he said he preferred to live on the street.

Clinton: ...but the great thing what's... actually very good for my mental health, [is] sleeping out because I have to get up... I was depressed when I ... left my living situation at the end of last year. But within a few weeks, I was happier, happier living out, even with the terrible mosquitoes, than I was indoors. Because once I got going... I had a routine, a structure... if I didn't get to a certain place at a certain time I missed out on a meal, I missed out on... dropping my gear off... And yeah... people who are unstable need a structure more than other people perhaps, everyone needs it, you know. So that's good for my mental and physical health... I can't emphasise strongly enough, for some of us there are beneficial aspects to living on the street...

Living on the street forced Clinton into a routine in order to survive, because if he was living in a boarding house or with a friend, he could not bring himself to get out and about due to his mental illness – he would also gain weight because he did not exercise. Clinton has taken medication in

the past for his bipolar disorder, but it does not appear to work for him so he is currently not on any. Having a routine in order to be able to function in society is 'healthy' for Clinton (Flick & Röhnsch, 2007). He was staying with his mother at the time of the interview, as he was going to have cataract operations on both of his eyes and needed somewhere to stay so that he could recover. Clinton had been on the waiting list to get cataract operations for about 15 months and could not read at the time of the interview. He was also having some problems with his teeth, which he suspected was giving him sinus problems. He could not afford to visit a dentist as treatment can cost up to \$2000, and a subsidy would not cover that. If he had known about the subsidy when the problem was more manageable, he would have been able to have the problem fixed. Clinton would like to have a job but his bipolar disorder hinders him and he is not as reliable as he would like to be. The only way that he felt that he could function psychologically is by living on the street, but this has impeded his health physically. Financially, he is not able to get the health care he needs. Clinton lives in a vicious cycle of poor health and homelessness, but seemed to be a reasonably self-sufficient person and was learning how to cope and live with his mental illness.

To summarise, the homeless people I interviewed had experienced a wide range of illnesses during their time on the streets. Each person experienced some type of chronic illness that they had to deal with on a day-to-day basis. Illnesses and ailments experienced included respiratory illnesses such as asthma, bronchitis and pneumonia; colds and influenza, dental problems, skin and wound infections, sexually transmitted infections, heart conditions, mental illnesses, drug and alcohol abuse, and serious injuries. Each of these health problems has been identified in previous research on specific health conditions that homeless people have (e.g. D'Amore et al., 2001; Hunter et al., 1991; Hwang, 2001; Wright, 1990; Wright & Tompkins, 2006). These health biographies also provide evidence that health issues such as mental illness and drug and alcohol abuse can be contributing factors that lead to a person becoming

homeless, amongst a range of other socioeconomic vulnerabilities (Reitz-Pustejovsky, 2002; Shinn et al., 2007).

Participant experiences of health issues also show that the life situation of being homeless puts people at risk of developing more serious health conditions than if a person was not homeless, and that treatment and recovery is impaired due to being homeless (Kidder et al., 2007; Weinreib et al., 1998; Wright, 1990). As well as this, ailments and illnesses that occur while a person is homeless can be a contributing factor to other health problems due to lack of service access and affordability (Geber, 1997; Padgett et al., 1990). Some health biographies also showed that injuries suffered in the course of being homeless can have enormous health implications for a homeless person.

The clients talked about their own personal life beliefs in relation to their health. They emphasised that social connectedness, and enjoying life are important factors that influence health. Clinton said that having bipolar disorder made relationships difficult, but his closest friends were generally supportive of him and encouraged him to take more control of the mental illness, particularly when he had a manic episode.

Clinton: ...my close friends know me so well that when I start going over the top they pretty much say so, and they, if I don't toe the line... I don't see them... And so I've had this ongoing thing where, where I've not necessarily behaved badly... or let anyone down in a big way, I just, am over the top...

This is similar to research described by Hodgetts and colleagues (2007) which shows that homeless people conceptualise well-being in terms of relational dimensions. Such dimensions include social interactions with friends – both domiciled and homeless, and practices that can enhance psychosocial wellbeing, such as participation in drinking schools. Other research describes how social capital and connectedness are important to homeless people's psychosocial health and well-being (Cattell, 2001; Grigsby et al., 1990) (see section on social networks, this chapter). Clients also talked about having knowledge of their own health conditions as being a source of empowerment, and some talked about researching,

talking to friends and doctors and reading about health issues to gain that knowledge (see William and Liz's health biographies).

By analysing homeless participants' health practices and approaches to health and illness, we are able to understand how they conceptualise 'health' (McCormack & MacIntosh, 2001). Flick and Röhnsch's (2007) research on homeless youth's social representations of health informed the analysis of these participants' social representations of health. Some clients who overtly articulate ideas about what health is to them invoked their day-to-day health-related practices, and ensuring that they have what they need to 'survive' on the street, such as food, shelter, and keeping warm (Capponi, 1997, cited in McCormack & MacIntosh, 2001).

Robert: ...my health's a lot better actually, I'm starting to put on a bit more weight and I'm eating a lot more 'cos when I was living on the street I wasn't really eating much... just surviving, eating meals up here and eating out there, and not really having a regular meal. Some days go cold and hungry, 'cos I spent all my money on alcohol.

Robert's alcoholism was a health issue that kept him in poverty and on the street. It meant that he was unable to maintain physical condition because he was so focussed on getting what he thought he needed – alcohol. Since he sobered up, Robert's social representation of health has changed from being unattainable and just functioning in order to survive, to becoming more of a reality (Flick & Röhnsch, 2007).

A rough sleeping homeless person often 'beds down' in generally uninhabitable conditions such as under bridges and doorways, which are often exposed to the elements. These places can be unhygienic as they are places where people urinate (Radley et al., 2006), so if people lie in such areas this can increase their risk of contracting illnesses. Homeless people may also have to fight for relatively better sleeping spots, as there are few places in the urban environment to sleep at night. There is a risk of being exposed to threats to well-being in the environment such as cold temperatures, damp conditions (see Pete's health biography), and violent attacks from members of the public (See Sean's health biography)

(Hodgetts et al., 2007). Fear of violence on the street particularly while attempting to sleep creates a continuous heightened state of alertness even when not under attack (Hodgetts et al., 2007).

The creation of health biographies was an important part of this research, because homeless participants' diverse narratives about health and illness were able to be shared, compared, and understood. Through the analysis of health biographies and clinic staff responses to interviews, three major health issues experienced by homeless clients were identified. These are explored in further depth below.

The health issues

This section looks at conceptualisations around three health issues in particular: substance addictions/abuse, mental illness, and foot problems. As seen in the health biographies, each client interviewed experienced at least one of those three health issues. Robert is recovering from addiction to alcohol and drugs. Howard 'sometimes drinks a bit much', which has taken an enormous toll on his body, resulting in pancreatitis. Sarah has mental illness issues, in that she 'hears voices'. Arthur abuses alcohol and drugs, but is aware of the consequences that this has for his health. Pete has a bad heel injury and believes he suffers from a form of alcoholism because he drinks alcohol excessively a few times a week. Sean is a recovering alcoholic. Clinton is learning to live with bipolar disorder, but has struggled with it throughout his life.

Three clients' experiences with those health issues are discussed below. Mental illness and substance addiction/abuse are grouped together, as the two clients who shared their health experiences, William and Liz, both had mental illness and drug addiction issues. Thomas' experiences with foot problems are also explored in-depth. The military metaphor is used in this section to illustrate these major health issues in a different context.

Addiction and mental illness

Addiction and mental illness were by far the most significant issues reported by both clinic patients and clinic staff. William believes that his experiences of domestic violence as a young person led him to substance abuse as a form of escapism. As illustrated in his health biography, William has been addicted to drugs since he was a teenager, and has mental health issues that are symptomatic of schizophrenia.

William: ...my father, from nine to thirteen he raped me, my mother beat me until I walked out the door... But the thing is I perpetuated the violence... I perpetuated the abuse on myself afterwards by using drugs and like by getting into gangs and violence and stuff like that, that was a form of self-abuse. That was me perpetrating the abuse onto myself as well 'cos I didn't think I deserved any better.

This shows how sexual and physical abuse can have detrimental consequences on the lives of some people. William used drugs as a coping strategy, a form of escapism. Escapism can be practiced in many ways, including taking drugs, but also drinking alcohol (Radley et al., 2006), reading books (Hodgetts et al., 2006), and listening to music (Hodgetts et al., 2009). Even though William is quite open about his past and seems to be confronting the horrific experiences he went through as a child, he still struggles with addiction and mental health issues.

William: I used to have... blackouts, now for awhile there I thought I had frontal lobe epilepsy... I used to go into a confused state, and I went into fits of anger and rage. And for absolutely no reason, and like when I'd come to I'd destroy houses or stuff like that and I had no recollection of any of them... a lot of people said 'yeah sure, you're using it as an excuse when you mess up'. But... my grandmother was a witness one day, we were sitting there talking just like you and I are fine as can be, [and] she said she saw me go blank. Literally go blank. And then my eyes changed and then she said next minute I was just destroying the house, and yeah I had no recollection when I came to, as far as I knew we were just sitting there having a conversation.

William experienced a lot of stigma from family members when these behaviours began. He knew something was wrong and researched his symptoms, but was told by people that he was coming up with excuses for this behaviour that he could not control. He was not being taken seriously,

and he found this difficult. When people with mental illness feel that they are not being taken seriously, this can be taken on and internalised by the sufferer, exacerbating feelings of stigmatisation (Anthony, 1993).

However, William's grandmother witnessed this behaviour and trusted his judgement. This motivated him to seek treatment for his mental health issues, which he is recovering from.

Liz suffers from depression and has been through periods of drug addiction and recovery throughout her life, but is currently addicted to methamphetamine.

Liz: I was thinking of starting at CADS [Community Alcohol and Drug Services]... but I've kinda been putting it off... it's just like when I get really depressed... I get really agoraphobic and just... don't leave the house for days... I've got to do it [go to CADS]. Although I don't know... if I'm ready to give up something I will, and without any help... I just can't seem to want to give up this enough, which is pathetic. Maybe it's me getting older or [pause] I don't know, it's a really bad drug... Methamphetamine, it's like God made it for drug dealers. Honestly, it's just like bam straight away, and especially for women... women with weight issues, you lose weight, women who with poor self [esteem]... honestly I can be looking in the mirror, crying thinking I'm ugly, disgusting [inaudible], have a hit of P, and I'm like, 'Damn girl!' It is that potent, brain chemicals are just... it's unreal. And... I just feel like a bit desolate about it... you know and in my rebellious days I'm like well who cares aye, you know if it's legal I'll take it every damn day, put it in a capsule, call it an anti-depressant and be done with it. You know, 'cos it really is, it's just... I've had Citalopram, I've had all the, you know... [antidepressants] like Prozac, everything. Nothing worked. Made me feel worse, made me feel suicidal. And yeah, P, it's just such a seductive thing...

This quote from Liz illustrates her struggles with methamphetamine addiction and depression. These two health issues are intertwined, and this creates complex problems, particularly in terms of seeking treatment. Liz would like to seek help from addiction services but finds it a difficult step to take because she suffers from depression. Liz's constructions of her previous life experiences – poverty, deprivation and social stress (see health biography); all contribute to her social representation of her depression, and how she makes sense of it. She believes a confluence of events throughout her life has contributed to depression, and because various anti-depressants have not worked for her and she had been addicted to drugs since she was a young woman, Liz has found it very easy to become addicted to methamphetamine. It is a form of an 'anti-

depressant' for her but also causes a raft of other problems on top of the addiction itself. This is a vicious cycle that would be detrimental to any person who experiences it.

Mental health and drug addiction issues appear to be the two most pervasive issues seen amongst homeless clients by NGO clinic staff. Practitioners who were asked about typical health issues rated drug and alcohol addictions and mental health at the top of the list for presentations to the clinic.

NGO personnel 2: ...I would say there's more patients with addiction problems... methamphetamine addictions, people who suffer physical or mental health illnesses. You see more people with personality disorder, patients with schizophrenia; I'd say... more information about their medical presentation than doctors would be able to write... Also other drug addiction[s], methylated spirits, the use of that we think is quite common... The addiction programmes are quite good, the access for mental health... We have a few patients with Alzheimer's, um, we have patients on the other side of Alzheimer's, we call Dementia... They basically need to be placed in care, and followed up by the doctors and social workers.

In this clinic staff member's representation of the typical health issues seen by the clinic, mental health issues and addiction problems are predominant. This might be due to this particular staff member's experience and knowledge in the area of mental health (which can include addictions). However, both of these health issues were talked about by all clinic personnel, regardless of previous experience. One healthcare practitioner at the clinic feels very strongly about the importance of ensuring that clients with drug, alcohol and mental health issues are able to get the care that they need.

NGO personnel 5: What really, really scares me is that if you've got somebody who's acutely unwell, like they're having an acute psychotic episode, you can get help, and they'll get admitted. If they're suicidal you can get help... but if they're over that acute attack, and they've got what we call thought disorder... they don't think straight. You know they've actually got thought damage, usually from drugs or from mental illness. There [are] no services for that level of people in our community. 'Cos we...closed all the institutions 20 years ago which was probably a right decision, but we didn't put in any middle level in place... So for example this one poor guy, and he's [got] thought disorder... the moment he picks up his sickness benefit somebody robs him. 'Cos he hasn't got enough cognitive straight-thinking power to manage his money. And yet he's not mad enough to be admitted to hospital, so where does he go? There's no community to look

after him. So what our services urgently needs is some sort of community fabric to look after the chronically unwell, who really aren't really managing alone, but they're not acutely mad or bad enough to be taken off the streets. And yet they're not functioning like you and I are functioning... they've got voices in their head... you know they think in circles? And yet day-to-day they've got to get up, they've gotta figure out how to get fed, and how to keep themselves warm. They can usually manage the basic functions and they're reasonably relatively clean half the time, but they cannot manage anything more than that... they can't manage to take their daily anti-epileptic tablets one of them, you know? 'Cos they keep getting fits... There is no awareness out there, of how hard living is for someone with thought disorder from whatever cause... So everyone assumes they're an autonomous, organism that can cope alone. And we don't want to take their autonomy off them but my God... they're not fully autonomous you know. So I think that's the tension, and that's the health need that's not met. And it's a little more obscure than people realise...

The above excerpt provides a practitioner's understanding of the life world of a homeless person with mental illness and/or addiction issues; and how homelessness can be perpetual for some. Unfortunately, a large number of mental health services are out of reach for homeless people with mental health issues who are only just able to survive on the street. Personnel at the NGO clinic are generally out of their depth with issues such as alcohol and drug addiction and mental illness, as they are specialised areas.

There is a constant need for bridging between the NGO service and other such specialised services for homeless people. There is an enormous gap in the national mental health service structure that needs to be filled with services targeted to those with what this clinic staff member describes as 'thought disorder'. The deinstitutionalisation of the mental health system in the 1970s was well intended because the idea was to relocate patients placed in psychiatric hospitals back into community settings (e.g. Joseph & Kearns, 1996). However, because little government funding has been directed towards appropriate alternative community supports available to people with mental illness, many of them fall through the cracks, and end up on the street (e.g. Belcher & Toomey, 1988).

Foot problems

Taking care of one's feet while on the street is hugely important, but not often acknowledged. A lack of resources means a lack of access to clothing such as socks, and a lack of shelter, which means a person is

more likely to keep their shoes on to keep warm in winter. Not changing socks and shoes can be very damaging to the feet (Friedman, 1945). Friedman (1945) made his observations about foot health in relation to the experiences of soldiers in the World Wars of the last century. Foot care is particularly important in military training and operations. Soldiers may have to walk for days if called into combat, and may not have the opportunity to change socks and shoes or even clean their feet, leading to a condition known as 'trench foot' (Friedman, 1945). This can be linked to the life worlds of homeless people who sleep rough and lack access to bare necessities (Street life stuck in Victorian era, 2005), as often they will walk great distances over many days without the opportunity to change socks and clean their feet (Friedman, 1945). They must simply 'soldier on' with their lives.

As indicated in his health biography Thomas has debilitating chronic foot problems, and regular foot care at the NGO clinic is important. The following interview excerpt details the regularity of the practice of visiting the clinic, and why it is important to Thomas. I had seen him at the NGO the previous week, when he was waiting for a doctor's appointment.

Interviewer: So why did you go to the doctor last week?

Thomas: Oh it was still about my feet 'cos yeah, see when I went there to get them operated on... 'cos, I felt something happen to me while I was asleep, yeah that's why I have to take my time walking. You can feel how hard they are... but when they're hard like that the circulation stops a bit, and that makes it harder to walk around...

Interviewer: ...How long have you had problems with your feet?

Thomas: Well really I've had the worst problems I've had in the last three and a half years, you know with circulation...

During this part of the interview, Thomas hinted at the underlying cause of his ongoing foot problems, but went on to talk more about his symptoms and complications. However, after the interview, I talked with a colleague who had interviewed him previously for a separate study, and reviewed the background sheet for the interview they had had with him. It was revealed that Thomas had suffered awful injuries to his feet (see health

biography). Despite having had an operation, the consequences of these injuries have been enormous, resulting in complications such as poor circulation, infection, and fluid retention. The fact that Thomas is homeless compounds these health issues, as walking is his main form of transport, he does not have access to clean socks every day, and because he sleeps rough he is unlikely to take his shoes off at night.

Practitioners at the NGO clinic try to ensure that Thomas keeps visiting them for ongoing foot care. His feet are in such poor condition due to the underlying health issues, and because he sleeps rough and lacks basic amenities, which is similar to the example of Doris Foy's' foot problems and the impact on her life, described in chapter one (Institute of Medicine, 1988, p.41). The simple exercise of washing one's feet is something that cannot be taken for granted by Thomas.

Thomas: ...if you're on the outside, and you want to have a wash, well, the only place I can think of to have a wash would be [a swimming pool facility close by] but, if they know that you're having a wash because you've got sore feet and that, I don't know whether they would let you.

Being able to wash his feet is an important part of Thomas's health practices. However, he does not seem to have access to facilities that would allow him to do so. He refers to a swimming pool complex that he might be able to wash at, but because his foot problems are quite serious he does not think that the staff there would allow him to because it might be seen as unhygienic, and may put other customers off visiting the pools. When I asked Thomas how he would look after himself, his response centred on taking care of his feet.

Interviewer: So on a day to day basis, what do you do to look after yourself?

Thomas: Just try not to get my feet into any unpredictable things like falling over and unforeseen dangers like stepping into deep ditches and that and crossing the road, making sure that there's a little bit of a curb that you can get up on... don't cross on the curb when it's too high. And in the bus try and use the ones with the [low floor] instead of stairs going up. Sometimes those steps leading into the bus are a little bit too high.

Thomas's foot problems are a very pervasive issue in his life, and affect his ability to function in the world (Flick & Röhnisch, 2007). He used to be able to rely on his feet for transport, but he now relies on buses and his daily life revolves around managing his health issues.

Thomas: I used to be quite strong before. My feet used to be quite strong too. I'd be able to walk for miles you know, but now I've got to rest even walking 100 yards aye? I have to stop and rest and then carry on. I'm lucky if its 100 yards though. Could only be about 20.

NGO clinic staff report that they see a lot of foot problems amongst their homeless clients, but they did not go into much detail around their understanding of the client's experiences of these problems.

NGO personnel 5: If [a client] walks in the door with a sore foot... we are trying to offer all his primary health care needs to that client you know, so that's what primary health care is about. It's not an A&M service, it's not just treating a sore foot.

Sore feet are seen as one of many health problems that could be experienced by any homeless client, and due to the structure of the service, clinic staff attempt to treat clients in a holistic way – treating the whole person, rather than just the acute need.

NGO personnel 3: ...there's a podiatry service in place here now on Monday with students and I mean, that's wonderful. But having those sort of things freely available to people I think is really important.

The fact that the clinic offers a podiatry service means that personnel do recognise foot problems as a particularly serious issue for homeless people. However, these understandings of homeless people's experiences were implied rather than 'spelt out' by staff in interviews. The organising of podiatry students from a tertiary institution to do foot care for homeless clients is seen as a good initiative for the clinic, and practitioners will be able to refer clients with foot problems onto podiatry students. This is helpful to the NGO clinic as the cost of a qualified podiatrist may be unaffordable in relation to other necessary clinic expenses. Access to such specialised healthcare is not something that is seen as very common

within services for homeless people, but is increasing as healthcare needs are recognised (Wright & Tompkins, 2006).

Coping with these kinds of health issues is something that homeless people must do on a daily basis. They undertake a variety of activities, or health practices, to ensure that their physical and psychological health allows them to survive, function and find some meaning or enjoyment in life despite the constraints evident in their life worlds and their wellbeing. Individual clients are often not alone in their experiences on the street. They have friends, often live in groups, and care for one another. While the wellbeing of individuals coping with specific physical and mental health issues was discussed above, the relational benefits of social connectedness is described below. The following section discusses social networks on the street and their impact on physical, mental, social and emotional health and wellbeing.

Social networks and health on the street

Clients of the NGO clinic talked frequently about their social networks and their importance. Field observation and informal conversations at the research site indicated that many of the homeless clients experience a strong sense of community. Although some people kept to themselves, others would sit in groups and converse, and some would stand outside the NGO service entrance and socialise while smoking cigarettes. Social connectedness was an important concept that featured in homeless clients' health biographies.

In an interview, Sean talked about the difficulty of creating social networks with 'new streeties' because he has had a long period of time away from living on the street. He knows the 'originals' who have been on the streets for 20 years when he was first on the street and therefore he is more 'entitled' to seek help from those originals because he has known

them for longer than people that have only come onto the streets in recent years. Although he experiences conflict and resistance from some newer streeties, Sean knows he needs to build social networks on the street as they are often important for survival.

Sean: Most of the people here, don't know me. The one's that do, are all the old originals... So I have my networks, I um, try and have a chat with some of these guys.

The military metaphor can be used to describe Sean's 'veteran' status on the street, since he knows many of the other homeless veterans who have been on and off the streets over the last few decades. This can be related to the life worlds of veterans, in that they have respect amongst their fellows, but as many people opposed the Vietnam War, veterans have been frequently ignored or vilified by the public (Roberts, 1988). Rough sleeping homeless people are often shunned by the general population (Laurenson & Collins, 2006), and it has been found that local government bodies create laws to criminalise homelessness with the intention to move rough sleepers from public spaces (Laurenson & Collins, 2006).

Some public discourse surrounding homelessness centres on social representations of homeless people as deficient in some way and as 'taking from' rather than 'giving to' others, namely taxpaying citizens, thus earning them such labels as 'bums' and 'tramps' (Riley et al., 2003). However, the exchange below between Sean and the interviewer discusses the importance of social practices such as sharing and giving on the street.

Sean: [Some streeties that understand my situation] try and give me some kind of pointer, assistance. Um, but then they, you've got to realise that they've got their own problems, they don't want to be giving out any assistance like that. Because, they can see that they're lacking it themselves.

Interviewer: They've got to look after themselves as well.

Sean: And that just turns them on a downward spiral for awhile, and I don't like doing that to people. I'd far rather be a giver, than be a receiver, for that specific reason.

There are important health benefits associated with altruism in social groups; as opposed to always being seen as a victim or needy person. “Providing help to others can lead to increased feelings of competence, equality, social usefulness, independence, and social value” (Roberts, Salem, Rappaport, Toro, Luke, & Seidman, 1999, p.843). Furthermore, helping others in need can allow “...individuals to view themselves as having strengths, as well as needs, and provides opportunities to take on new roles and responsibilities in a safe environment” (Roberts et al., 1999, p.843). These are all examples of the psychosocial benefits of helping which can improve wellbeing. Sean talked about assisting other homeless people to improve their situation by giving advice, in order to influence better health practices on the street.

Interviewer: So do you look out for a lot of people?

Sean: I look out for as many as I can... try and tell them as quickly as possible... the quick, basic rules, what to do, what not to do... and then leave them to it. When they ask me if I know of any places where they can sleep I try and take them to as many places as I know.

In the quote above, Sean indicates his desire to help others. In part, this is out of empathy as he has experienced the hardships of rough sleeping himself. However, it is also possible that his ability to pass on information and help others cements social connections and provides meaning to his existence. Such psychological benefits of helping have been discussed by Roberts and colleagues (1999) in relation to mutual support groups. Given the physical hardships of rough sleeping and poverty however, there are very real limits in terms of what advice and resources homeless people can spare for others.

There are also real practical and health benefits of sharing and maintaining social networks (Cattell, 2001). Homeless people such as Pete recognise the need to get along with other streeties, and not to isolate themselves too much from social groups. Being part of social networks on the streets means that one will have a better chance of having access to resources such as money, food, shelter, and information.

Pete: A lot of them look out for you as well you know the more experienced ones? Yeah, sort of like a little family... you know, 'cos they even, a lot of them haven't... had a family structure, so they treat this as... you know their family structure sort of thing, they have to try and look after each other in a sense you know.

Interviewer: Yeah well if you're down on your luck, you know if you've got some money or if you're going alright then it helps to share, 'cos next time you might be needing something aye?

Pete: Definitely... definitely, yeah. The ones that don't share don't sort of [chuckles] you know... yeah you've gotta share.

Interviewer: They don't stay part of the group.

Pete: Nah. You've gotta share man, for sure.

Interviewer: It's interesting, how it's a bit like a family really.

Pete: It is, man. It's amazing.

Pete refers to a group of homeless people as a type of family structure where members can seek social support from group members, and resources if they are available. This highlights Pete's perceived shared social representations or understandings of social networks on the street, by himself and other streeties. The importance of sharing resources while on the street is emphasised in this exchange between the interviewer and Pete, as staying in a group seems to be dependent on reciprocity and helping each other out if one is able to. If a person does not share in these practices, they risk being 'outed' from the group. This can put them at further risk, as being on the streets on your own can make you vulnerable. Dachner and Tarasuk (2002) found that groups of homeless youths would pool their resources to ensure that everyone in the group was fed, for example. Social supports and sharing within homeless 'families' (Radley et al., 2006) are seen as protective for health and wellbeing (Cattell, 2001; Hodgetts et al., 2007). 'Street families' or social groups can be important to many homeless people, as some have been alienated by family, or have never had a stable family situation in their lives (Koegel et al., 1995). Lack of stable family situations has been cited as one of many potential causes of homelessness (Koegel et al., 1995).

Sarah is an example of a participant who did not have strong social connections with other streeties, but appears to have formed a friendship

with a housed person. However, Sarah believes that her friendship with this person has soured; and this has resulted in her seeking assistance from social services as she has nobody else to turn to for resources.

Sarah: I don't really have any friends, nobody really likes me. That's why I want to hopefully get into a place. Not because they don't like me, because it's freezing. It's cold out. And I slept in a friend's house last night [coughs] but I went back this morning but he keeps growling at me about going out the front door. So I, I really can't go back there.

Sarah's social experiences do not seem to be positive. Perhaps because her friend 'growled' at her for going out the front door means that he may be embarrassed about his friendship with her, a homeless person. Radley and colleagues (2006) also found that friendships between domiciled and homeless people can be quite easily dismissed by a domiciled person in the company of another domiciled person – thus stigmatising the homeless person. Even though Sarah did stay with a friend the previous night, she feels as though she may have relied on him too much for assistance and this has inconvenienced him. This reflects a social representation that many people have of 'wearing out your welcome' if you have stayed with someone and relied upon them to help you for too long (Toohey, Shinn, & Weitzman, 2004). However, if Sarah does not find somewhere else to stay, she will have to sleep out on the streets. If she must do so for a prolonged period of time, it is likely to have a negative impact on her health (Hodgetts et al., 2007), as it has for Pete.

While friendships and social networks are usually considered positive, not all are of equal quality or necessarily good for a person's health. Liz talked about the nature of her social networks in that she associates with two groups of people, socially represented as: 'normal' people, described as social workers and health professionals within the NGO service; and her 'mates', who are drug addicts.

Liz: I've got a couple of good friends, I've got lots of acquaintances but I don't really have family... but yeah there's like [a social worker] here, [they're] awesome, I just talk to him, and also um, Steve⁷ and see my other friends out there, they're all druggies [chuckles] you know what I mean as far as you know I've got two lots, kind of, you know there's a line down the middle. It's the normal people and then there's my mates out on the street you know.

Interviewer: So it's kind of hard when you're trying to get clean and you've got mates who are still using?

Liz: Yeah 'cos then I have to stay away from everyone...

Liz's associations with two different groups of people can be hard for her, as it can be for any other homeless person who has relationships with both 'normal', domiciled people, and people on the street (Hodgetts, Hodgetts & Radley, 2006). Liz believes she would experience some difficulty in this situation if she decides that she is going to try to recover from her drug addiction. Liz may need to isolate herself from her 'mates', but will lack the social support she might need from her group of friends. Associating with people who still use substances can be hard for people who have given up (or are trying to give up) substances that they were once addicted to, because socialising with these people can increase their chances of relapsing (Freidmann, Saitz, & Samet, 1998). This experience relates to evidence that once homeless people are re-housed, they can 'relapse' into further periods of homelessness sometimes because they value their friendships with other people on the street (Groot, Hodgetts, Chamberlain, Radley, Nikora, Stolte & Nabalarua, 2008).

Robert's account below indicates the value of a friendship with a person who has experienced homelessness and drug and alcohol issues. The empathy and understanding shown by this person has encouraged Robert to move towards improving his own situation.

⁷ A pseudonym

Robert: ...since I've been in ... I'm in a boarding place at the moment. I'm staying with a guy called Andrew⁸. He runs the boarding place and he works [in drug rehabilitation], so he's been looking after me... 'Cos he's been where I've been, you know he's been there, and he knows what it's like. But where I'm staying, he sometimes takes people into [rehab], and I've seen them change at his place, seen them come off the drugs and the alcohol and seen them sober up, I've seen changes since I've been there.

Robert felt that he could relate to Andrew, as he had been through alcohol and drug addiction as Robert has. This shows that the social links between people who experience addiction and those who have also experienced addiction and 'got through' can have an influence on the health and wellbeing of the addiction sufferer. Robert has been inspired by Andrew's example, and this will be a contributing factor for Robert wanting to rebuild his life and stay off the street.

Robert has also gone on to help other streeties, buoyed by his own positive experiences. This is also an example of the sense of empowerment and improved psychological health that can come from helping other people (Roberts et al., 1999). Having a positive self-image as a helper, rather than as his past identity – a homeless person addicted to alcohol and drugs – may be very important to Robert. This is related to Riessman's "helper" therapy principle (1965) in that while Robert suffers from addiction, his recovery is bolstered as he attempts to assist others in similar situations. William, another person interviewed, indicated that once he had beaten his drug addiction, he would like to train in social work in order to help others with similar problems. Other research has shown that training alcoholics as alcohol counsellors can help maintain sobriety, as well as achieving success in their professional lives (Kahn & Fua, 1992). During his interview, William talked of his ability to inspire others who were also going through drug addiction to change their lives. This seems to have inspired his vocational goals.

In terms of social networks on the street, social representations can be manifested in several ways, for example, how impressions of people and their personalities are constructed through communication with others, and

⁸ A pseudonym

'rules of engagement' with other streeties and domiciled people.

Understandings of social rules, behaviour and people are communally constructed, in the way that people share information with each other, as well as forming ideas based on their experiences of social situations.

The clinic setting

The NGO clinic is situated within a busy urban central business district, a place where many urban rough sleepers face daily battles in their lives.

The clinic can be conceptualised as a 'field hospital' that treats the wounded, injured and sick. Once treated, patients are sent back out onto the streets. If recovery takes longer, or if their illness is serious, patients will be taken to hospital. Care is taken to ensure that patients will be as comfortable as possible, within the constraints of resources.

Homeless people are generally not known for actively seeking care from mainstream health services due to a range of factors, particularly because of negative experiences that some have had with healthcare services in the past. Unfriendly staff and practitioners and the verbal and body language of other service clients can all contribute to an uncomfortable environment for a homeless person to be in. These negative experiences can manifest in homeless people feeling discriminated against in health services (Hoffman & Coffey; 2008; Johnsen et al., 2005; McCormack & MacIntosh, 2001; Quine et al., 2004; Wen et al., 2007). Clients of the NGO clinic outline some of their previous experiences within healthcare settings where they have felt stigmatised and discriminated against. These experiences are in considerable contrast to reports from both clinic staff, and clients about the setting of the NGO clinic, and the welcoming environment it provides.

Client experiences with other healthcare services

Clients shared experiences they had had with various health services. These included doctors, nurses, hospitals, mental health services, specialist clinics and other community health services. Some of these experiences were positive, with professionals and staff in the various services described as having a good bedside manner and treating their clients with respect. However, many more of the experiences described were negative, with participants describing the treatment they received as poor, with some professionals described as unprofessional, judgemental, and having a poor bedside manner.

Liz has a social representation of the medical profession as uncaring and insensitive due to several negative experiences with health services. While she acknowledges that some people should be working in the medical profession because they are the right people for the job, she believes that others are not. Liz describes a time when she was much younger when she was taking hard drugs and had to be admitted into a hospital, where she was not adequately treated.

Liz: Well while I was on heroin I got, um... I started getting pains, right, really bad pains and like, abdominal pains. And, in the end I had to be taken to a hospital in an ambulance 'cos they got so bad. And when, in those days, when [the doctors] saw my needle marks they prejudged me and thought 'she's a junkie'. And really I'd caught Chlamydia. So when I went to have children... I was sterile because they had prejudged me and not treated me for anything.

'Beneficence' is understood as a foundational ethical principle in biomedicine; where the welfare of patients is understood to be the greatest goal of healthcare (Beauchamp & Walters, 2003). Objectives associated with beneficence are: not to inflict harm, to prevent harm, to remove harm, and to promote wellbeing (Frankena, 1973, in Beauchamp & Walters, 2003). According to Liz's account, her welfare was not prioritised by the doctor, and the harm to her body was not reduced, thus, the treatment she received was unjust and unethical. There could have been a combination of factors which led to Liz not receiving an accurate diagnosis and treatment. However, it is important to point out the stigma and social

exclusion experienced by certain groups, including homeless people, in relation to access to healthcare, and experiences in healthcare settings (e.g. McCormack & MacIntosh, 2001; Surber et al., 1988) (discussed in chapter one). Unfortunately, Liz was not diagnosed with anything and did not receive any treatment from the doctor she saw, until she found out several years later the consequences of that doctor's inaction, in particular the very personal suffering she now tries to deal with.

Liz: ...you know there's a lot the medical profession do that I don't agree with. I don't particularly... I don't see them as gods, like that. That's not saying that some of them aren't really, really good and that but, that you have to sit and worship at their feet and take their absolute word on everything when you know what's going on with your own body...

Liz describes how some health professionals tend to wield considerable power over their patients because they perceive themselves to be at a higher status than the people that come to them for advice, therefore taking a paternalistic approach to treating patients (Charles et al., 1997). She seems to be advocating for health professionals to take into consideration the perspectives of patients in order to serve them properly, as clients are likely to know their own bodies better – they have to live with them every day.

When William sought help from a mental health service because he felt like he was losing control of his behaviour, he was not impressed with the consultation he received.

William: ...I had a run in with [a mental health service]. And the reason I had to go see them is to get on the Risperdol. And it was just when my son was first born, I felt that I was going crazy and I was hearing voices and everything, and I um said to the doctor I said, "I feel like I'm going to hurt my son". And he sat there and goes: "You're a tiger. Tigers hurt their cubs, it's a natural reaction". And I just went: "What?!" I put a formal complaint and everything in, and ever since then I've not had a good impression of [that service], because I mean, what if it had of been someone who didn't have the capacity to understand what was wrong, like I did? What the doctor had just done was justifying any action they would have done afterwards... I was very, very pissed off with that comment.

Like Liz, William recognises the power that some professionals can have over their clients. If he had not made a complaint, this professional may

have gone on to say similar comments to other clients, who may not have been empowered enough to make a complaint against them because mental illness can be a very disempowering and vulnerable experience (Kloos, 2005). There is likely to be an assumption that the advice a health professional gives you will be the 'right' advice based on their work experience. Sometimes the wrong advice is given, because professionals can hold certain social representations or stereotypes of groups of people (Howarth, 2001).

Many homeless participants talked about 'negative' previous experiences with health services, but Clinton appears to take a pragmatic approach to his healthcare and health service use, even if he is not taken seriously by a health practitioner he sees on a regular basis. Clinton shared his experiences with this doctor (not at the NGO clinic) whom he sees to have his sickness benefit approved.

Clinton: ...you basically get two or three minutes with her, you know, bam bam bam bam bam... And she signs the form, and boy she's quick. But when I have had specific questions for her, she's okay but she's pretty much given up on me so... for instance, she's been full and, and um, lead up the garden path so many times by [other homeless clients] that she doesn't believe anything anyone tells her. So when I told her I had cataracts, and 'would you please put that on my form as well...' she didn't do it, she wouldn't do it, she didn't believe me, she didn't take me seriously. She didn't ask me next time I saw her, she didn't ask me about my eyes... the information was sent from the hospital to my GP as is standard, she never mentioned it, she never... said that she'd got it...

Clinton does not believe that he receives the healthcare he needs from this service, even though he has quite serious health issues. This is apparently because this particular health professional has been misled by other homeless clients, thus informing her social representation of homeless people, and so does not seem to trust those clients anymore. However, Clinton is still able to utilise the aforementioned service for his own benefit, but he did say that he would use other health services if he had a pressing medical issue in future.

Some homeless people report having had negative experiences when they have utilised health services in the past. However, the following

sections show that staff and clients find the NGO clinic setting to be much more appropriate for homeless people. The setting and environment is considerably different from that of domiciled clinics, not just because of the different populations, but because of the treatment homeless people receive from the clinic staff.

A space for care

This section discusses the attributes of the NGO clinic that sets it apart from the medical settings described by homeless people in the section above. Developing relationships and creating trust and rapport between clinic staff and homeless clients are important characteristics of the clinic in order to ensure an appropriate, caring, comfortable setting (Johnsen et al., 2005; Wen et al., 2007). These attributes all point towards a welcoming environment for both homeless people, and the staff that work in the NGO clinic.

Client perceptions of the NGO clinic are predominantly positive – the clients made optimistic comments about the accessibility, affordability, staff, and the environment of the NGO clinic. Most of the homeless participants mentioned that they themselves and other streeties they know seem happy with the clinic, and how the ability to have their health ‘covered’, so to speak, is one step forward in a long journey to escape from the poverty trap. In his interview, Arthur highlighted the fact that it is a socially mediated decision for his ‘lot’ to visit the NGO clinic, rather than another health service for homeless people in the area. Arthur sees the NGO clinic as a more appropriate healthcare setting for him and his friends to visit, mainly because it is open for four days a week (the aforementioned service is only open one day a week).

Robert, and other homeless people I talked to, emphasised the fact that the service is affordable – free, or very cheap for many homeless clients.

Robert: ...I do find these services pretty good because I'm saving \$30 and I'm saving money 'cos I'm really living on a low income at the moment, I'm struggling and I've got to use... what's out there, to help me in life so that I get ahead... I'm learning how to budget... and I can't afford it... some doctors you go to, like I went over to the ones [in another suburb], and they [charge] \$40 a visit...

Robert points out that because he is saving money, he is able to improve his health without creating a financial burden for himself. A 30-40 dollar fee for a consultation is simply not affordable for a population that has either a minimal or no social welfare benefit, where the benefit barely covers accommodation expenses in a night shelter for a week. Like Robert, William and Liz speak very highly of the people that work in the NGO clinic.

William: [They were] cool! Yeah, very efficient, very nice... [they were] great... yeah. No [they were]... fantastic.

Liz: ...[they're] lovely, [they] really [are], [they're] awesome you know, best bedside manner. You know some people are compassionate, some people were meant to be doctors and others do it for the money. You know what I mean? That's a horrible thing to say, but it's true. But [the clinic staff] really [are] awesome... I really wanted to come here 'cos this is where... I know everyone and that? And I'm not a stranger and everything. So, and also I kind of come and see like [an NGO staff member] and the social workers... 'cos they're cool.

These clients commend the treatment that they receive by practitioners at the NGO clinic. Liz compares the clinic staff to the type of treatment she had received from other services. She prefers to come to this clinic because she feels comfortable being in the environment as she has social contacts within the wider NGO service.

This was a perspective of the NGO clinic from William who had used the clinic, but was not homeless. He praises the accessibility of the service for homeless clients.

William: I think it's a great idea, I think what they're doing up there is a great idea because I mean, I know it's a short walk from the [NGO service] to [a health service]...but, a lot of [homeless people] won't do it, whereas, they're already at the [NGO service], so it's really no, not out of their way... it's just walk through a door and go in and see a GP there. I think its ideal for them.

William recognises the benefits of having the clinic at a service that already provides many services to homeless people, because it is much more accessible (Sachs-Ericsson et al., 1999). He believes it is 'ideal' for homeless people, and points out that if people cannot reach a service for whatever reason, they will not use it.

Clients spoke very positively of the clinic, of its service models, accessibility, hours, location, and staff. This sort of attitude towards a service is bound to increase utilisation amongst a population of homeless people – as the clinic becomes more well-known through word of mouth amongst the homeless community, more homeless people will be able to have their health needs met within a setting that focuses on providing ongoing, holistic healthcare in a welcoming environment. The NGO clinic is a 'space of care' for homeless people (Johnsen et al., 2005); a place that is easily accessible to homeless people because they are familiar with the setting, and the staff are friendly (Kearns, 1991).

Chapter Summary

The purpose of this chapter was to discuss homeless people's constructions of health, illness, disease, and the NGO clinic. Patient health biographies set the scene for this chapter, discussing health histories, current health issues, and conceptualisations of health. Three major health issues identified by clinic staff were then discussed in relation to homeless people's experiences with these issues. To follow, the impacts of social connectedness and networks on the psychosocial health of homeless participants were discussed. Finally, homeless patient thoughts on the clinic setting in comparison to previous experiences with other health services were explored. Social representations theory informed the analysis, and was linked to homeless patient responses where necessary.

A military metaphor was woven throughout this chapter to emphasise the material hardships associated within the life world of a rough sleeping homeless person. Furthermore, this metaphor also highlights some unique characteristics of this clinic relative to 'standard' domiciled GP services. The comparison of the life worlds of homeless, rough sleeping clients with those of soldiers, is an attempt to point out the adversity of a homeless person's life experience. Survival hinges on having access to basic amenities to ensure relative health and wellbeing is intact. This means having enough food and clean water, being warm, being able to wash, and having somewhere safe and secure to sleep, as well as being able to rely on friends for access to physical resources and emotional support. A soldier's life world can be similar, in that they must also at times ensure they are able to survive in relatively uninhabitable conditions (compared to that of a domiciled person), and rely on their comrades for resources and social support.

Homeless participant social representations of health were related to Flick and Röhnisch's (2007) research. Homeless participants' conceptualisations of health could be drawn from their explanations of their daily practices and how these influenced health. For the participants in this study, health was conceptualised as physical and mental, functional, and sometimes relative – dependent on their current situation. Some participants were in denial of health problems or perceived certain health issues as less important than other things in life – mainly obtaining relatively better living standards, or enjoying oneself. Other participants had a fatalist attitude to health and believed it was out of reach.

The health issues experienced by many homeless rough sleepers are also reflected in the issues experienced by some soldiers during war, and post-war periods. Drug and alcohol addiction, as well as mental illness, are issues common amongst homeless rough sleepers, and war veterans, compared to the general domiciled population. These types of addiction can result from an attempt to escape the harsh reality of the real world, as seen in research carried out with war veterans who develop post-traumatic

stress disorder (Roberts, 1988). Foot issues are another important issue for rough sleeping homeless people, as noted by clinic practitioners, and Thomas, whose day-to-day life is affected by his chronic foot problems, and exacerbated by his homeless life world. The foot problems homeless people experience are similar to 'trench foot', a common condition among soldiers who fought in the trenches during World War One, characterised by oedema, haemorrhage, cyanosis, bullae, and gangrene, and exacerbated by the environments that soldiers lived and fought in (Friedman, 1945).

Homeless participants conceptualised the NGO clinic as an 'ideal' healthcare setting. They believed that the staff in the clinic setting provide a friendly, caring environment for homeless clients who are sick or injured. Having an appropriate healthcare setting is crucial to a homeless person's ability to function in society. Some health services that homeless people have sought out have been known to do more harm than good, as seen in Quine and colleague's (2004) research. This is particularly dangerous for such a vulnerable population, as if they do not feel welcome, liked or appreciated within the services they seek, they are not likely to use any services at all. This puts them at risk of developing worse health problems, and dying below life expectancy (e.g. Quine et al., 2004). This chapter has identified that homeless clients feel that the most important characteristic of the NGO clinic is that they are accepted and non-judged within the setting. According to the positive responses of homeless participants, they seem to have a social representation of the clinic as a 'space for care' (Johnsen et al., 2005).

Chapter Five: Discussion and Conclusion

This thesis has explored the meaning and social representations held by health professionals and homeless clients of a clinic situated within an NGO. Health professional's social representations of working with homeless clients, and homeless clients' social representations of health and illness were discussed. The intention of this chapter is to bring together and discuss the analyses of responses (micro-perspectives) from the two participant groups in relation to the literature explored in chapter one, to inform a macro perspective of the NGO clinic (Flick, 2008) as an 'ideal' health service for homeless people. Existing knowledge will be used as a tool to interpret and discuss the main themes from the analysis.

The purpose of this research was to investigate the importance of the NGO health clinic to homeless people, and other marginalised groups. This thesis documented the processes involved in providing a specialised healthcare service for homeless people in the CBD of a city in New Zealand. Homeless people's health practices, as well as conceptualisations and experiences of health and illness were contextualised according to their life situations and social networks through the use of health biographies. Homeless people's use of healthcare services was explored in light of their past and current health issues, and perceptions of care. NGO clinic staff perspectives of issues arising in the provision of the clinic service were also discussed in relation to their everyday work with homeless people.

The research was guided by social representations theory (SRT). I found SRT to be a useful conceptual tool and perspective to work from throughout this research, because it offers a means to take into account the perspectives and worldviews of different groups – in this case, homeless patients and clinic staff – to create and inform a case study of the NGO clinic. The use of a military metaphor highlighted the uniqueness of the NGO clinic. The metaphor was used to create an understanding of

the serious physical and material hardships associated with being a rough sleeping homeless person. I was able to support and strengthen these ideas through the use of literature and research, however it must be acknowledged that the idea of social representations should not overshadow the very real experiences and health issues of rough sleeping homeless people.

Homeless patients at the NGO clinic experienced multiple complex health issues. This is illustrated in their health biographies and is consistent with previous research on the types of ailments homeless people experience (e.g. D'Amore et al., 2001; Hunter et al., 1991; Hwang, 2001; Wright, 1990). The most prevalent health problems were addictions, mental illness, and foot problems. Every patient interviewed experienced at least one of these, and clinic staff reported them as being the most severe health issues observed in their homeless client group. There is overlap with the health issues experienced by the participants of this research and those documented in international literature. Responses given by the NGO clinic staff suggest that their homeless clients experience higher incidences of more severe illness and disease than patients they would see if they worked in a domiciled clinic setting. Clinic staff also understood that such health issues were exacerbated by living on the street as a rough sleeper (Wright, 1990).

Central to this research is homeless people's conceptualisations and social representations of health. Such social representations influence health related practices, and attitudes towards health and illness (Flick & Röhnisch, 2007). Homeless people's social representations of health help us to understand why, when, and how they access certain services and not others; and what practices they engage in to keep 'healthy' and feel well. This New Zealand based research identified similarities with international research in terms of homeless people's social representations of health (Flick & Röhnisch, 2007). Health was conceptualised as physical and mental wellbeing, in that people were well in body and mind (Flick & Röhnisch, 2007). Health was also

conceptualised as functional – something that allowed or did not allow homeless people to carry out important tasks and function in their day-to-day lives (Flick & Röhnsch, 2007).

Homeless participants' accounts of their illness experiences were not conceptualised in a strictly physical manner. They used multiple explanations to make sense of illness, disease and injury in relation to their lived situations (Hodgetts & Chamberlain, 2000). Narratives of illness, disease and injury emphasised the impact that such issues had in homeless people's lives, and how such issues came about. Illness and affliction affected the participants' individual behaviour, altered their previous conceptualisations of illness, their relationships with other people, and living situations (Herzlich, 1973). This highlights the notion that homeless people are affected by illness, disease, and injury in a holistic way.

Health practices reported by the rough sleeping homeless participants centred on survival on the street, in particular, ensuring that basic necessities to life were met to some extent – shelter, food, clothing, water, and bathing (Quine et al., 2004). However the quality of these life necessities certainly would not meet the standards expected by many domiciled people. Obtaining resources needed to survive on the street was enhanced by having strong social networks. In this way, social networks can be health protecting physically (through acquiring some necessary resources), as well as psychosocially by providing a source of comfort, familiarity, and support on the street (Flick, 2007). While this applied to the people I interviewed, it is important to note that not all homeless people rely on social networks for resources or wellbeing (Hodgetts et al., 2009). I did, however, talk to one homeless person (Sarah) who seemed to be more isolated and disconnected from social networks.

This thesis emphasises that many homeless people (like domiciled people) are not passive consumers of health services, but people who

actively engage in health services to ensure that they receive the best healthcare possible, and make conscious decisions about practices that they undertake in their day-to-day lives to enjoy life and feel good – such as smoking cigarettes, drinking alcohol, and taking drugs (Hodgetts et al., 2007; Radley et al., 2006) in spite of the advice given by medical professionals. Some medical advice can be difficult to follow and adhere to – particularly for rough sleepers, as they lack a relatively comfortable environment and resources that would help with following such advice. This supports the notion that people's notions of health and wellbeing can be contradictory (Williamson & Carr, 2009). Homeless participants gained information on health by reading about their health issues, and talking to their friends (and families). Previous research suggests that domiciled people approach their healthcare in a similar fashion (Radley, 1993), even though people who sleep rough arguably experience higher incidences of more severe health issues.

The clinic provides medical care to homeless people within a context of social care. The highest priority for NGO clinic staff was to meet the various complex needs of their patients. Homeless clients not only presented at the clinic with serious physical health issues, but also drug and alcohol addictions, mental illness and social problems. The integration of the clinic within the wider umbrella structure of an NGO that provides a range of specialised services for homeless people meant that the many needs of patients were able to be met in a holistic manner. Homeless people's accessibility was ensured by having the clinic located within the umbrella NGO service, which is already frequented by a large number of homeless and low-income people in the area. This complements findings from Sachs-Ericsson and colleagues (1999), that the locations of such organisations are crucial to ensure service utilisation.

The collaborative nature of the clinic within the wider NGO service means that it is linked with other services in the community, thus expanding the amount of services available and their accessibility to homeless people (Roussos & Faucett, 2000). Providing a holistic, integrated clinic service

means that if there is a problem that staff cannot deal with, they will be able to contact a relevant service provider in order to address such issues. However, clinic staff reported that collaboration and integrated care between services could be problematic. This could be because service goals and treatment/care plans often did not match up, resulting in disjointed care and gaps in service provision (Douaihy et al., 2005).

While there are some dilemmas in providing healthcare to a homeless population, clinic staff attempt to work around them in their everyday practice. Dilemmas reported by clinic personnel were confirmed by the homeless clients that were interviewed – including delayed presentation until health problems became acute (Gelberg et al., 1997; Power et al., 1999; Stein et al., 2007), and lack of compliance with treatment, follow up, and medications (Hunter et al., 1991). A point of comparison is that delayed presentation to health services – depending on the health issue – has been recorded in domiciled populations, as various studies have shown (Rosenstock, 1966). Strategies reported by clinic staff to solve dilemmas within funding restrictions reflect their commitment to their clients and their treatment programmes. Professionals who work with high-needs populations need to be committed to their work and enjoy what they do, as this will enhance their practice and their ability to develop relationships with clients (Bennett et al., 2008).

Because the clinic is part of a PHO and patients must enrol with the clinic to receive subsidised healthcare, it is a much 'safer' way for homeless people to seek healthcare. This is because homeless people can consult with the same practitioners about various primary healthcare needs over a period of time, and through subsequent visits, comprehensive patient records of current issues and medical histories can be developed. This is an important goal of New Zealand's *Primary Health Care Strategy* (King, 2001). Through this system, 'global' health needs can be met more easily, rather than just having acute needs met in an Accident and Emergency setting. Researchers have argued that there is a need for more health services that meet health needs in a holistic, population based manner,

that are accessible to disadvantaged populations – such as homeless people (van Laere, 2008). Furthermore, van Laere (2008) advocates for knowledge and skills in the arena of social/medical care for disadvantaged people to be a core part of the training of doctors. Similarly, health professionals in Aotearoa/New Zealand have reported on their experiences with high-needs populations, with the goal of creating an understanding of the importance of being sensitive to patients and their social/historical/cultural contexts (Bennett et al., 2008).

NGO clinic personnel understand their homeless patients in terms of their health and illness issues. They are humanistic in their approach to working with clients (Renedo & Jovchelovich, 2007), and they are aware that their clients may often have multiple complex health and social needs. Clinic staff work with their patients, reducing power differentials, creating trust, in turn developing relationships based on equality and respect (Bennett et al., 2008). Practitioners recognise the need to develop meaningful relationships with patients in order for the new clinic structure system to work and for patient needs to be met. This is crucial as it is well documented in the literature that negative practitioner attitudes to homeless people (Masson & Lester, 2003), and power imbalances in doctor-patient relationships can serve to increase the barriers homeless people experience in their attempts to access healthcare (Charles et al., 1997).

Practitioners in the NGO clinic understand that many homeless people have had negative experiences with some health services, including discrimination, stigmatisation, unwelcomeness, and neglect (Wen et al., 2007). By not judging their homeless patients, treating them as ‘human’ and showing respect, humility and empathy, practitioners hope to make homeless people feel more welcome at the NGO clinic and more likely to access the service (Wen et al., 2007). Not only do clinic staff believe they should practice in this manner, they *want* to work with homeless people and other disadvantaged populations. Staff believe that providing healthcare to high-needs populations such as homeless people is

important, as healthcare is a basic human right that many do not have access to. This is because homeless people often experience several barriers to health services (Douglas et al., 1999; Geber, 1997; Kelly & Caputo, 2007; Stein et al., 2007). Through the accounts of both homeless clients and clinic staff, the NGO clinic can be conceptualised as a 'space for care' (Johnsen et al., 2005). Clients utilise the service because the staff are friendly, it is low cost, and they feel comfortable within the setting. Clinic personnel want to and do provide this type of service – they are aware that they need to provide a space for care at the clinic, otherwise homeless clients will be less likely to utilise it.

Although the NGO clinic is most certainly a positive health service initiative for homeless people, clinic staff experience constraints between meeting the ideal vision of the clinic as a fully integrated, holistic medical service, and the lack of resources to meet this vision. Even though the practice of having homeless people enrol in the clinic should hopefully be addressing time and funding constraints (appointments can be staggered over time to meet needs rather than all at once), these constraints are still experienced. NGO clinic staff could potentially experience what Renedo and Jovchelovich (2007) call 'cognitive polyphasia' – a conflict between their values and vision for caring for their clients in a holistic manner, and resource/time constraints (see chapter three). Findings show that NGO clinic staff care for their homeless clients and show compassion towards them, but are very aware of the severity of their health issues and the hardships that many experience in their everyday lives on the street. Not being able to do enough for their clients because of resource constraints could cause NGO clinic staff to experience significant inner conflict, and cognitive polyphasia while working in this environment.

Although NGO clinic personnel are motivated by the vision and philosophy of the clinic and meeting the needs of their patients, and patients speak highly of the clinic staff and service, it can be difficult to ascertain how the development of the NGO clinic is improving the health status of this group of people (Kreuter et al., 2000). Homeless people can be a difficult

population for researchers to reach, and their input will be needed in order for the regional DHB to make decisions about the future of the clinic – even though the future of the clinic within the NGO service is looking optimistic.

To conclude, healthcare for homeless people needs to move forward in the direction of the NGO clinic. The model of the NGO clinic integrated within the wider NGO service is unique and responsive to the needs of the people it serves, and could be implemented elsewhere. The findings from the analysis shows that the NGO clinic is an ideal health service for homeless people – from the perspectives of both clinic staff and homeless clients. This is articulated by William (see ‘a space for care’ chapter three), who believed that the NGO clinic service was ‘ideal’ for homeless people. While William was not homeless, nor a clinic staff member, he was able to empathise with homeless people who needed healthcare as he was struggling with some significant life issues – which meant he utilised the clinic and other NGO services. William’s statement provides an outside, as well as inside perspective of the NGO clinic, and links the many social representations of the clinic shared by all the participants in the analysis. The responses from every participant detailed many different aspects that frame the NGO clinic as an ideal health service model, but William’s statement provides a snapshot of the macro social representation of the NGO clinic.

The NGO clinic is an ‘ideal’ health service for homeless people because it is low cost, aims to provide holistic healthcare and is situated in a familiar setting where homeless people seek other much-needed social services. Clinic personnel appear to share a professional and personal ethos to assist and work with people who are often stigmatised from society. The clinic staff are committed to providing a humanistic, holistic population-based service, developing relationships with their homeless clients, and going the extra mile to ensure that their patients receive the healthcare that they need. Homeless clients feel welcome, cared for, and comfortable in the setting, and do not feel judged by the staff.

Funding structures need to accommodate health services such as the NGO clinic, not only for homeless people, but other high needs populations. However, this could be difficult. Service providers must go through an application process for such funding from PHOs and DHBs (as the NGO clinic did – see chapter three), and this requires resources. Homeless people are not defined as a population in New Zealand (Statistics New Zealand, 2009), so their various health issues and health service needs (particularly for rough sleepers) may go unrecognised at a policy level. A definition of homelessness could thus be helpful for developing policy and delivering much-needed health services. Furthermore, broader understandings of health, social equity, and service accessibility need to shift. The health issues that homeless people face must be considered within contexts, environment, and living situations. Rough sleeping homelessness is in itself, ‘unhealthy’, as it causes and exacerbates illness and disease (Wright, 1990). This must be taken into account when designing health policy and services for homeless people.

Homeless people are human, and like everybody else, they have human rights. While having access to healthcare is obviously a human right that directly relates to this thesis, basic standards of living are also relevant – warm, dry, secure accommodation, nutritious food, clean drinking water, clean clothes and shoes, and basic hygiene facilities. As mentioned in chapter one, being a rough sleeping homeless person can mean lacking all of the above (e.g. Reitz-Pustejovsky, 2002). Findings indicated that having a medical service integrated with other social services that address other human needs was a positive initiative, and encouraged greater health service access for homeless people.

Finally, health services need to be ‘spaces for care’ if they are going to be accessible to homeless people (Hodgetts et al., 2005; Johnsen et al., 2005). Such spaces and places need to: be located somewhere convenient; be low-cost, comfortable, welcoming, and employ non-judgemental, compassionate health professionals that work with patients

to meet their health needs in an ongoing manner. This will help to ensure that patients will receive the holistic healthcare that they need, and experience physical and psychological wellbeing.

Social representations theory was a helpful framework to understand individual and group perspectives in the context of this research. SRT was useful because it allowed the inclusion of 'micro' perspectives (or social representations) from two different groups – homeless patients and NGO clinic staff – to inform a 'macro' perspective (or social representation) (Flick, 2008 – see chapter two) of the NGO clinic as an 'ideal' health service model for homeless people. The social representations from these two participant groups had shared, as well as distinct aspects; yet they could be brought together in a way that accounts for the perspectives of professionals and clients on a significant issue – the appropriateness of the NGO clinic for homeless people. This type of research could be used to create case studies for other services the NGO in this study provides, and other health-related organisations used by homeless people – such as rehabilitation services, mental health and addictions services and hospital emergency departments. It is important to understand the perspectives of both service providers and service users, to determine whether services are successful or not.

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APPENDIX A

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THE UNIVERSITY OF
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Te Whare Wānanga o Waikato

Health at the [REDACTED]

Information Sheet (homeless participants)

What is this study about?

You are invited to take part in a study of your health experiences and use of the health clinic at the [REDACTED]. Your GP has suggested that you may be interested to take part in the study because you are a client of the [REDACTED] clinic and have slept rough for at least 3 months. We are asking 10 to 12 homeless people to take part in the study, which will be held in one of the private consultation rooms at the [REDACTED].

You do not have to take part in this study and can take as much time as you like in considering whether you wish to take part. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your continuing health care at the [REDACTED] health clinic.

Who is conducting the study?

A group of researchers from the University of Waikato and Massey University in Albany with service providers including the Auckland City Mission, Anglican Action, de Paul House and Methodist City Action. This research is funded by the Royal Society of New Zealand Marsden Fund and is approved by the Northern X Regional Health Ethics Committee. For further questions see contact details at the bottom of this information sheet.

What will I be asked to do?

We would like to talk with you individually about your experiences of health and health care. This will take about 40 minutes at a convenient time. You will be asked to talk about your situation and specific health events in your everyday life. At the completion of the interview you will receive compensation for your time and travel expenses. The interview will be audio recorded to make sure we have an accurate account. The recordings will be stored on a secure computer during the study and deleted at the completion of the research.

How is the study likely to benefit homeless people?

There is a lack of information about how and when homeless people access health services, and how you understand your own health care needs. The effectiveness of the health

service at the [REDACTED] is reliant, in part, on such information. Even a modest amount of information from homeless people such as yourself will inform service developments.

Researchers will pass on any information about unmet health needs to the [REDACTED] health clinic.

What can I expect from the researchers?

You can:

- ask questions at any point during the study
- ask for the audio recorder to be turned off at any point during the interview, decline to answer any specific questions, and withdraw from the research at any point during or after the interview
- contact your GP or [REDACTED] staff if you have any concerns about the study
- contact the people listed at the end of this document for further information, or if you have any concerns about the study
- expect that the information will be kept confidential to the researchers and that other people will not recognise you

If you have any further questions or concerns regarding this study please do not hesitate to contact the principle researchers:

Kerry Chamberlain
(09) 414-0800, ext 41226
K.Chamberlain@massey.ac.nz

Darrin Hodgetts
(07) 838-4466 Ext. 6456
dhdgetts@waikato.ac.nz

If you have any questions or concerns about your rights as a participant in this study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050
Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)
Email (NZ wide): advocacy@hdc.org.nz

This study has received ethical approval from the Northern X Regional Health Ethics Committee.

APPENDIX B

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THE UNIVERSITY OF
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Te Whare Wānanga o Waikato

CONSENT FORM (homeless participants)

PARTICIPANT'S COPY

Research Project: Health at the [REDACTED]

I have read and I understand the information sheet (approved on 23 May 2008) for volunteers taking part in the study designed to explore homeless people's health and use of the [REDACTED] health service. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing health care. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part and know who to contact if I have any further questions about the study.

I consent to my interview being audio-taped

YES / NO

I _____ (full name) hereby consent to take part in this study.

Date _____

Signature of participant _____

Full name of researcher _____

Researcher contact phone _____

Project explained by _____

Project role _____

Signature _____

Date _____

CONSENT FORM (homeless participants)

RESEARCHER'S COPY

Research Project: Health at the [REDACTED]

I have read and I understand the information sheet (approved on 23 May 2008) for volunteers taking part in the study designed to explore homeless people's health and use of the [REDACTED] health service. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing health care. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part and know who to contact if I have any further questions about the study.

I consent to my interview being audio-taped

YES / NO

I _____ (full name) hereby consent to take part in this study.

Date

Signature of participant

Full name of researcher

Researcher contact phone

Project explained by

Project role

Signature

Date

APPENDIX C

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psychology/](http://www.waikato.ac.nz/wfass/subjects/psychology/)



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Interviewee Name: _____

Interviewer: _____ Date of the interview: _____

Location of the interview: _____

Service agency: _____

Participation fee: _____

Signature: _____ Date: _____

Darrin Hodgetts, (07) 838-4466 Ext. 6456, dhdgetts@waikato.ac.nz
Lecturer and project coordinator

Signature: _____ Date: _____

Ottillie Stolte, (07) 838-4466 Ext. 6454, ottillie@waikato.ac.nz
Lecturer and project coordinator

APPENDIX D

Interview Guide: Health at the [REDACTED] Homeless – new participants

Overview of semi-structured interview content for each of the groups involved.
Individual interviews with 10-12 homeless people presenting at the clinic:

Interview topics:

Background and biography

Why are you on the street? For how long?

What social networks do you have – who cares for you, looks out for you?

Health care practices and prevention

Objective: [Elicit the story of their **healthcare**.]

Use of health services – including clinics, hospitals, chemists, dentists, etc.
Informal advice about health/symptoms – other homeless people, hostel staff, domiciled people.

How do you look after your health? Treatment in the past?

Current perceived health status

Objective: [Elicit the story of their **perceived health status**.]

How is your health?

What symptoms /problems / health-related concerns do you have at the moment?

Do you take any medicines? What, and what for?

Are you undergoing any treatment at present? What, and what for?

Current consultation

Objective: [Elicit the story of **this current consultation**.]

Why have you come here today? (What is the problem?)

What made you decide to come to see the doctor now? (Why not before?)

How long have you had this problem? Have you sought advice before today? With what result?

APPENDIX E

New Participants-Homeless

Health at the [REDACTED] Participant Background Sheet

Interviewee Name: _____

Interviewer: _____ Date: _____

Duration of the interview: _____

Gender: **M** **F** Age: _____

Ethnicity: _____

Current housing status: _____

Additional information (including health issues, disability, marital status, parenting, area of origin)

Family/whanau contacts? _____

Location of the interview (brief description): _____

Charting the interview

Impression of the interviewee: _____

Impression of how the interview went: _____

Initial themes to emerge in the interview: _____

Potential revisions for the interview guide: _____

Synopsis: _____

APPENDIX F

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Health at the [REDACTED]

Information Sheet (clinic staff)

What is this study about?

You are invited to take part in a study of the health experiences of homeless people and their use of the health clinic at the [REDACTED]. Your participation in the research would be valued by the researchers due to your work in the [REDACTED] clinic. We are asking 6 staff associated with the clinic to take part in the study, which will be held in one of the private consultation rooms at the [REDACTED].

You do not have to take part in this study and can take as much time as you like in considering whether you wish to take part. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your continuing employment at the [REDACTED].

Who is conducting the study?

A group of researchers from the University of Waikato and Massey University in Albany with service providers including the Auckland City Mission, Anglican Action, de Paul House and Methodist City Action. This research is funded by the Royal Society of New Zealand Marsden Fund and is approved by Northern X Regional Health Ethics Committee. For further questions see contact details at the bottom of this information sheet.

What will I be asked to do?

We would like to talk with you individually about your experiences of the health needs of homeless people and associated services. This will take about 30 minutes at a convenient time. You will be asked to talk about the [REDACTED] clinic, your work there, and the health care needs of clients. The interview will be audio recorded to make sure we have an accurate account. The recordings will be stored on a secure computer during the study and deleted at the completion of the research.

How is the study likely to benefit homeless people?

There is a lack of information about how and when homeless people access health services, and their health care needs, or the experiences of health service staff working with this client population. The effectiveness of the health service at the [REDACTED] is reliant, in

part, on such information. Even a modest amount of information from staff, along with the homeless clients we are interviewing, will provide the basis for informing service developments.

Researchers will pass on any information about unmet health needs to the [REDACTED] health clinic.

What can I expect from the researchers?

You can:

- ask questions at any point during the study
- read any reports written by the researchers and participate in a feedback session with the research team
- ask for the audio recorder to be turned off at any point during the interview, decline to answer any specific questions, and withdraw from the research at any point during or after the interview
- contact your professional organisation if you have any queries or concern about your rights as a participant in this study
- contact the people listed at the end of this document for further information, or if you have any concerns about the study
- expect that the information will be kept confidential to the researchers and that other people will not recognise you.
- expect the researchers to make the general research findings available to you through the [REDACTED] Client Advisory group and posters displayed in the clinic.

If you have any further questions or concerns regarding this study please do not hesitate to contact:

Kerry Chamberlain
(09) 414-0800, ext 41226
K.Chamberlain@massey.ac.nz

Darrin Hodgetts
(07) 838-4466 Ext. 6456
dhdgetts@waikato.ac.nz

If you have any questions or concerns about your rights as a participant in this study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone (NZ wide): 0800 555 050

Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz

APPENDIX G

Department of Psychology
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Phone 64-7-856 2889
Facsimile 64-7-858 5132



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

CONSENT FORM (clinic staff)

PARTICIPANT'S COPY

Research Project: Health at the [REDACTED]

I have read and I understand the information sheet (approved on 23 May 2008) for volunteers taking part in the study designed to explore homeless people's health and use of the [REDACTED] health service. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing employment at the [REDACTED]. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part and know who to contact if I have any further questions about the study.

I consent to my interview being audio-taped YES / NO

I _____ (full name) hereby consent to take part in this study.

Date _____

Signature of participant _____

Full name of researcher _____

Researcher contact phone _____

Project explained by _____

Project role _____

Signature _____

Date _____

CONSENT FORM (clinic staff)

RESEARCHER'S COPY

Research Project: Health at the [REDACTED]

I have read and I understand the information sheet (approved on 23 May 2008) for volunteers taking part in the study designed to explore homeless people's health and use of the [REDACTED] health service. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing employment at the [REDACTED]. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part and know who to contact if I have any further questions about the study.

I consent to my interview being audio-taped YES / NO

I _____ (full name) hereby consent to take part in this study.

Date _____

Signature of participant _____

Full name of researcher _____

Researcher contact phone _____

Project explained by _____

Project role _____

Signature _____

Date _____

APPENDIX H

Clinic Staff - New Participants

Health and Homelessness in New Zealand

Interview schedule

We would like to talk with you about the following in no particular order:

Participant's role and contribution

What roles and responsibilities do you have here at the clinic?

Is your work here a voluntary or paid position?

How many hours do you spend on average working here?

Are these hours sufficient for you to do what is required?

Background

What can you tell me about the history, aims and function of the clinic?

How do these factors sit with your own reasons for working in this clinic?

What are your views on what the clinic is seeking to achieve?

Relation of this work to other work

Where else do you work (or volunteer) apart from this clinic?

How do you balance the demands of your other work and the work at the clinic?

How is working at this clinic different to other places you work or have worked?

Why did you decide to work at the clinic?

What sacrifices have you made in order to work at the clinic?

Patients and their conditions

Broadly speaking, what is the range of ailments the patients present with?

What are the most typical cases?

Are there any typical trends in homeless people's responses to diagnoses, medication regimes and referrals?

Rewards, dilemmas, and frustrations

What is it like to work with this patient group?

What are the main challenges?

What changes would you like to see to support people who choose to work to improve the health of homeless people?

APPENDIX I

New Participants-Clinic staff

Health at the [REDACTED]

Participant Background Sheet

Interviewee Name: _____

Interviewer: _____ Date: _____

Duration of the interview: _____

Gender: **M** **F** Age: _____

Ethnicity:

Role at the clinic: _____

Occupational background (and additional information):

Initial contact with [REDACTED]: _____

Location of the interview (brief description): _____

Charting the interview

Impression of the interviewee: _____

Impression of how the interview went: _____

Initial themes to emerge in the interview: _____

Potential revisions for the interview guide: _____

Synopsis: _____

