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Exploring Health and Social Exclusion Within Hidden Homeless

by

Josie Watson

A Thesis Submitted to the
Faculty of Graduate Studies through Nursing
in Partial Fulfillment of the Requirements for the
Degree of Master of Science at the
University of Windsor

Windsor, Ontario, Canada
2012
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"Exploring Health and Social Exclusion Within Hidden Homelessness"

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Authors Declaration of Originality

I hereby certify that I am the sole author of this thesis and that no part of this thesis has been published or submitted for publication.

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Abstract

Homelessness and poverty are extreme forms of social exclusion which extend beyond the lack of physical or material needs. Using Brunner and Marmot's social determinants of health model (1999, 2004), this secondary analysis explored the everyday living conditions of a hidden homeless population. The purpose of this study was to explore and expand the understanding of the physical, psychological and social health impacts associated with material and social deprivation. The study aimed to expand the concept of social exclusion within the social determinants of health perspective. Health professionals who understand health behaviours as coping mechanisms for poor quality social environments can provide more comprehensive and holistic care. The findings of this study should be used to show that the need for a national housing policy is a key factor in the health and well being of people who experience poverty, homelessness and social exclusion.

Dedication

I wish to honour my late father Lawrence Norman MacDougall, who taught me the importance of a strong work ethic, by dedicating this thesis to him.

Acknowledgements

I wish to acknowledge and thank my supervisor, Dr. Jamie Crawley, for her kindness of spirit, patience, and enduring positive encouragement throughout this work. Dr. Crawley is the embodiment of a caring and compassionate nurse and represents for me excellence in the nursing profession. I am deeply grateful for Dr. Crawley's meticulous insight and knowledge so generously shared. I also wish to acknowledge and thank my thesis committee, Dr. Debbie Kane and Dr. Shelagh Towson for their guidance and expertise in supporting this work. Special thanks to Dr. Kane, who provided the opportunity for becoming involved with the original study that this secondary analysis is based upon.

Without a supportive partner and family I could not have completed this work. First I wish to thank Jeff for constantly encouraging me to believe in myself and my own achievements. Thanks Jeff for being an incredible sounding board, for listening to my never ending concerns with an open ear, providing support and understanding, and for constantly reminding me that while life can be difficult, it can also be joyful.

Thanks to my mother Lise, whose sharp and practical wisdom have always been a guiding foundation for me, and to my sister Marina for her belief and reassurance that I would never give up. Thanks to my brother and sister-in-law, Douglas and Nicole, who encourage and inspire me, and to my wonderful niece Neroli who continually teaches me the value of laughter and creativity. Finally, to my wonderful supportive extended family from Windsor to Garson who provide me with all the courage, nourishment, love and joy that any one person could ever need.

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CHAPTER I

INTRODUCTION

"It would hardly seem necessary to argue the case that housing-- and homelessness in particular-- are health issues, yet surprisingly few Canadian studies have considered it as such" (Bryant, 2009, p. 238).

Problem Statement

Homelessness and poverty are extreme forms of social exclusion that extend beyond the lack of material necessities (Baumeister & Leary, 1995; Galabuzi, 2006; Hwang et al., 2010; Marmot & Wilkinson, 2006; Raphael, 2009). The processes that lead to social exclusion within a society can have detrimental health outcomes for individuals and populations (Galabuzi, 2012; Raphael, 2009; Shaw, Dorling & Davey Smith, 2006). To understand Bryant's (2009) framing of homelessness as a health issue, it is necessary to explore the concept of health. Health, as defined by the World Health Organization, is "a resource for everyday life, not the objective of living" (1986, p.1). This concept of health as a resource, which followed from the *Ottawa Charter* (1986), posited health as an empowering force which included social aspects inherent within the health promotion movement.

Health promotion stresses the importance of building and creating health in opposition to the biomedical view of disease prevention and treatment (Raeburn & Rootman, 2009). The *Ottawa Charter* (1986) is credited for heralding in a new era of health promotion which specified prerequisites for health. These prerequisites included basic life requirements such as food and shelter, but also included the concepts of peace, political stability and social justice (World Health Organization, 1986). This was a clear recognition that health was not determined simply by the "absence of disease or

infirmity" (World Health Organization, 1978, p.1) but rather was determined by interconnecting physical, psychological, and social determinants (Brunner & Marmot, 1996, 2004; Marmot & Wilkinson, 2006; Raphael, 2009).

These determinants, and their negative impact on health, are reflected in low levels of education and employment, lack of social and community supports, physical, psychological and social health impairments. The accumulation of stress associated with homelessness and poverty has a strong positive relationship with cardiovascular disease, diabetes and chronic illness (Brunner, 1997; Hwang et al., 2010; Marmot & Wilkinson, 2006; McEwan, 2004; Mikkonen & Raphael, 2010). Hallerod and Larrson (2007) describe the difficulty inherent in disentangling health and social problems from one another. Health and social problems which involve social and material deprivation can compound over time, contributing to negative health outcomes (Marmot & Wilkinson, 2006; McEwan, 1998; Mikkonen & Raphael, 2010).

The negative health impacts of material and social deprivation must be explored in the everyday living conditions of those experiencing homelessness. When the conditions of everyday life for those who are homeless are explored, a more meaningful interpretation of health behaviours and personal coping mechanisms can be understood (Fish, 2010). It is within these conditions of everyday life that poverty and social exclusion determine health outcomes (Hallerod & Larrson, 2007). Therefore, it is the quality of physical, psychological and social conditions and the individual health behaviours in response to everyday life, which collectively determine our health (Juster, McEwan, & Lupien, 2010; Marmot & Wilkinson, 1998, 2006; Raphael, 2009).

The social determinants of health are the social and economic conditions which shape lives and determine the health of individuals and societies in so far as they regulate the availability, quality, and quantity of social and economic resources (Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010; Raphael, 2009). The social determinants of health model (Brunner & Marmot, 1999, 2004) conceptualizes health beyond the physical state of individual functioning, to equally involve what people are capable of achieving as human beings (World Health Organization, 1978). A necessary condition of human survival is the satisfaction of basic life requirements. Satisfaction of basic life requirements is a prerequisite to obtaining an education, employment, an income and stable housing. Basic life requirements must be satisfied so that humans can develop the capabilities needed to function in ways that are meaningful to humans and which are valuable to other humans in society (Lewontin & Levins, 2007; Marmot & Wilkinson, 2006; McMurtry, 1998; Noonan, 2006, 2012; Raphael, 2009; Sen, 1992).

Few would argue that homelessness is the result of one single causative factor. Many of the negative physical, psychological and social impacts of homelessness are a direct result of social and material deprivation (Marmot & Wilkinson, 2006). While currently there is no official Canadian definition for homelessness, generally two aspects of homelessness are considered. The first is the specific type of shelter or housing state that one is in, and the second is the frequency and duration of homelessness that one experiences (Echenberg & Jensen, 2008). Homelessness is interpreted as being on a continuum which includes absolute homelessness on one end of the continuum and relative homelessness at the other end of the continuum. Absolute homelessness refers to people living directly on the street, whereas relative homelessness refers to people

residing in unsafe, inadequate housing and people who are at risk for homelessness (Echenberg & Jensen, 2008).

In the middle of the continuum is hidden or concealed homelessness (Echenberg & Jensen, 2008). A troubling trend has been developing in Canada during the past decade as reported by Shapcott (2010) and The Homeless Hub (2008). This trend indicates a growing number of younger people experiencing this phenomenon called hidden or concealed homelessness (Echenberg & Jensen, 2008; Shapcott, 2010). People who experience hidden homelessness tend to find or obtain shelter in cars, abandoned buildings, under bridges, and on friends or family members' couches or floors (Echenberg & Jensen, 2008; The Homeless Hub, 2008). The state of homelessness, whether relative, absolute or hidden stands in contradiction to the basic life requirement for shelter (World Health Organization, 1948, 1978, 1986).

Significance for Nursing

Nursing confronts moral and ethical challenges on a daily basis (CNA, 2005; Nathaniel, 2006). Nursing has a social and moral mandate to promote peace, dignity, equality, and social justice (CNA, 2009; Falk-Rafael, 2005; Fish, 2010; Nathanial, 2006; Pfettscher, 2002; RNAO, 2006). Raphael (2011) reported that despite the knowledge and the evidence that health is determined in large part by daily living conditions, Canada's social and health policies do not reflect this holism of health. An individual's daily living conditions can influence, and can be influenced by, his or her lifestyle choices and subsequent health behaviours. Therefore, individual lifestyles and health behaviours must not be considered in isolation but rather should be considered within the context of social and economic structures in which individuals live their daily lives.

Nurses are challenged to provide holistic care to patients who experience homelessness, poverty and social exclusion. Nurses practicing within the social determinants of health framework have the responsibility to understand these impacts on health which are created by daily stressors and threats, such as homelessness. As nurses, we must understand that homelessness can result in social exclusion which then contributes to diminished quality social support, increased risk health behaviours and compromised physical and psychological health outcomes. This knowledge must be used to promote changes within the current health care system and nursing practice. The knowledge and application of the social determinants of health framework is essential in physical, psychological, and social assessments to guide appropriate interventions and future supports.

Research Purpose

The purpose of this study was to explore the everyday living conditions of a hidden homeless population and was intended to expand the understanding of physical, psychological and social health impacts associated with material and social deprivation. As noted earlier, it is the physical, social, and psychological conditions of everyday life, in conjunction with biological and individual coping behaviours, which collectively determine health (Juster, McEwan, & Lupien, 2010; Marmot & Wilkinson, 1998, 2006; Raphael, 2009).

The study hopes to expand the concept of social exclusion within the social determinants of health perspective. Social exclusion is an inability to participate fully in the economic, cultural, social and political aspects of a society (Galabuzi, 2006, 2012; Raphael, 2009). Social exclusion is characterized by a “clustering of disadvantage”

(Raphael, 2009, p.24). The disadvantage arises when resources within society are unequally distributed. The processes and outcomes of social exclusion can result from the complexities of poverty and homelessness. The experience of social exclusion can contribute to diminished quality social supports, higher risk health behaviours and compromised physical and psychological health. Social exclusion can occur for marginalized groups who experience an inability to access basic life requirements.

Life requirements are basic necessities that human beings must satisfy if they are to avoid objective forms of harm to both their organism and to their agency. Human life-requirements form what John McMurtry calls the 'life-ground of value' (McMurtry, 1998). McMurtry defines the life-ground of value as "the connection of life to life's requirements as a felt bond of being" (p.23) to emphasize that the satisfaction of these requirements is not simply a biological imperative, but a goal that people care about because it is the real basis of human agency and the ability to make meaningful contributions to one's society. Making the life-values underlying the social determinants of health approach explicit demonstrates that health is not simply a state of the biological organism, but a value that embraces both our organism and agency (Brunner & Marmot, 1999, 2004; McMurtry, 1998; Noonan, 2006, 2012). It is through this deprivation of life requirements that social exclusion exists for people experiencing hidden homelessness.

CHAPTER II

LITERATURE REVIEW

The health of individuals and society is shaped by the social determinants of health (Brunner & Marmot, 1996, 2004; Marmot & Wilkinson, 2006; Raphael, 2009, 2011). These social determinants of health are understood as the social and economic conditions which have an impact upon and shape one's health. A distribution of social and economic resources sufficient to satisfy people's life requirements is a fundamental basis of health for all (World Health Organization, 1948, 1986). As previously stated, according to the social determinants of health model, health is not simply a state of functioning of the human organism, but equally involves what people are able to do and achieve as human beings (Marmot & Wilkinson, 2006; Raphael, 2009; Sen, 1999; WHO, 1986).

In this sense, health can be understood as the degree to which individuals are enabled to express and enjoy physical, psychological, social, and personal capabilities (Sen, 1992, 1999). The degree to which people are able to express and enjoy their capabilities depends on structural factors, namely, the degree to which economic and social policies provide fair and equitable resources (Marmot & Wilkinson, 2006; Raphael, 2009). A lack of equitable resources may lead people to experience challenges with health and social exclusion. The social determinants of health model enables the conceptualization of economic, social, and cultural factors and their impact upon social and work environments, health behaviours and health outcomes. This study employed the social determinants of health model developed by Brunner and Marmot (1999, 2004)

to explore the social environments, health behaviours, and health outcomes of people experiencing hidden homelessness.

Brunner and Marmot's model (1999, 2004) depicts the social determinants of health as influencing and shaping the material, work and social environments of a society. It is important to reiterate that the quality of these determinants of health is a reflection of how equitably the material and social resources are distributed within a society (Marmot & Wilkinson, 2006; Raphael, 2006a, 2006b, 2008, 2011). While Brunner and Marmot's model recognizes that individual health is determined in part by biological factors and individual characteristics, the model also stresses that health outcomes are largely dependent on the material, social and work structures in which we live our everyday lives (Brunner & Marmot, 1999, 2004; Marmot &Wilkinson, 2006; Raphael, 2009).

Conceptual Model

Social Determinants of Health Model (Bruner & Marmot, 2004, p.9)

ERIC BRUNNER AND MICHAEL MARMOT | 9

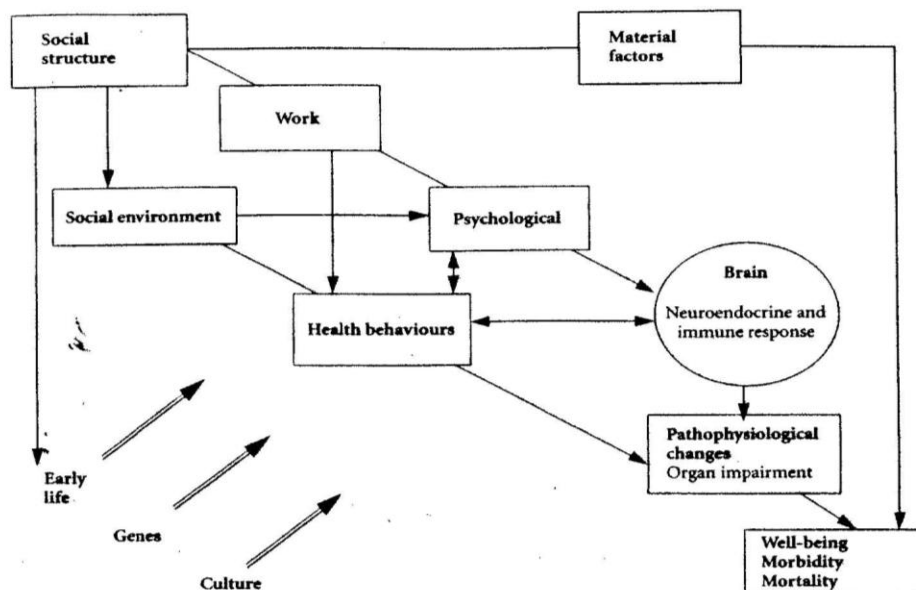


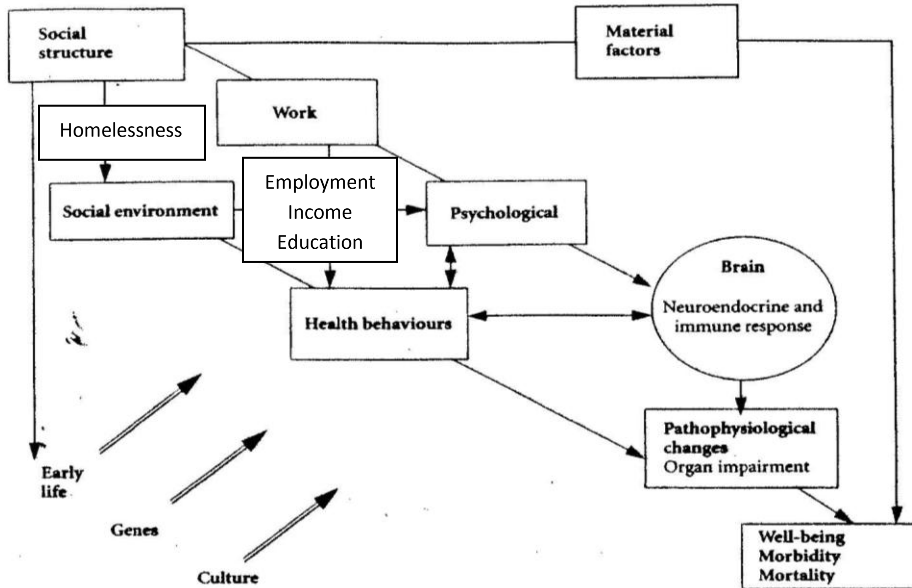
Fig. 2.2 Social determinants of health. The model links social structure to health and disease via material, psychosocial, and behavioural pathways. Genetic, early life, and cultural factors are further important influences on population health.

Brunner and Marmot’s social determinants of health model was first developed in 1999 and revised in 2004. The model depicts how the organization of social structure affects health outcomes. The social structure which is the organization and structure of institutions within society, shape the determinants of health which in turn shape individual and population health and illness via material, social, psychological and behavioural pathways (Brunner & Marmot, 2004; Marmot & Wilkinson, 2006; Raphael, 2009).

The social determinants of health model (2004) maps three pathways. The first pathway illustrates a direct link between social structure, material factors and health status. The second pathway illustrates how the social and work environments act on psychological and behavioural responses mediated by brain functions which affect health status. The third pathway uses the same social and environmental factors as the second pathway to depict health behaviours having a direct impact on physical bodily functions (Brunner & Marmot, 1999, 2004, 2006; Raphael, 2009).

Social structures affect early life (pre/post natal and maternal health), genes, and cultural factors through all the processes outlined in the model. Brunner and Marmot’s (1999, 2004) framework was selected because it offers a general overview of the interconnectedness of the concepts of social structure and health. Three health determinants selected from this model and examined for their influence on health and social exclusion included the following: 1) social environments, 2) health behaviours, and 3) health status.

Modified Social Determinants of Health Model 2012



The modified social determinants of health model (2012) uses Brunner and Marmot's (1999, 2004) model to situate some of the social determinants of health identified by Mikkonen and Raphael (2010) in relation to social exclusion. The four determinants of health added to the model are housing (homelessness), education, employment and income and represent the broader aspects that contribute to the processes and outcomes of social exclusion.

Situating Mikkonen and Raphael's (2010) social determinants on the left side of this model reinforces the complexity and interconnected nature of the determinants. It also illustrates the mutability of these determinants in that if social structures impacting social institutions are fair and equitable, brain and pathophysiological changes leading to ill health might be avoidable. The three pathways in the modified version (2012) remain the same as the original model. Homelessness, which is situated between social structure and social environment in the modified version, remains a direct link to material factors and ill health. The second pathway, social and work environments, and the third

pathway, social and environmental pathways, remain the same in their impact upon psychological and behavioural responses mediated by brain functions which ultimately impact health outcomes.

Social Environments, Health Behaviours and Health Status

To understand the health impacts on people who experience homelessness, there is a need to explore the everyday life of the individual person within their social environment. It is within the social environmental context that the conditions of everyday life are experienced and where poverty and social exclusion directly affect health behaviour and health status (Brunner & Marmot, 1999, 2004).

Social Environments. According to Brunner and Marmot's social determinants of health model (1999, 2004), social environment is one of the three pathways determined by social structure. The social environment describes the degree and quality of social interactions and relationships which are directly and indirectly influenced by social and material resources provided by the social structure. These interactions and relationships are experienced in the conditions of everyday living. Supportive or positive social interactions and relationships have a direct positive relationship with health.

Stansfeld (2006) describes the "buffering effect" (p.151) of supportive social interactions and relationships that can help to ease the impact of negative stressors. Positive quality social supportive relationships are both interactive and transactional. Stansfeld refers to this interactive, transactional relationship as a reciprocal relationship between two people where there is an equal amount of give and take. Geckova, Van Dijik, Stewart, Groothoff and Post (2003) found that the buffering effect of social support had a strong positive influence on health, especially for disadvantages groups

experiencing social and material deprivation. Adolescents appear to be especially vulnerable to lack of social supports. Cheever and Hardin (1999) reported that adolescents who lacked social support following traumatic events had a decline in health status.

While it is true that a positive relationship exists between strong individual social supports and an individual's health, it is also evident that this positive relationship between strong social supports exists for the larger society as a whole. The society whose social institutions do not mitigate higher degrees of inequality tends to have higher rates of morbidity and mortality (Wilkinson & Pickett, 2007). As Noonan (2012) states, "all major social institutions have a fundamental life-supportive function" (p.91). To this extent, Canadians lacking in safe and secure shelter represent a crack in Canada's social institutions and social welfare systems (Gaetz, 2010; Hwang et al., 2010).

Health Behaviours. Brunner and Marmot's model (2004) defines health behaviours as a representation of coping measures which are directly associated with material and social deprivation. In the broadest sense health behaviours are the physical, psychological and social health decisions and actions of individuals and societies in response to the quality of the social determinants of health (Glanz, Rimer, & Viswanath, 2008). Health Canada defines health behaviours as positive which are health promoting, or negative which are risks to health promotion. Health Canada attributes health behaviours to personal choice while clearly acknowledging that health behaviours are influenced by material and social environments (Health Canada, 2010).

When the quality of the material and social determinants of health is poor, health behaviours may be negatively affected. Unhealthy behaviours may contribute to poorer

states of health and at the same time prevent one from obtaining material and social resources (Raphael, 2009). The social determinants of health model, provides an understanding that health behaviours such as smoking, diet or exercise, alone, do not determine health. Health behaviours or coping mechanisms are to a large extent determined by the social and economic resources available to individuals and populations. When the economic and social resources are lacking such as in homelessness, one might expect to see health behaviours or coping mechanisms that might be deemed “unhealthy.” Yet, the social determinants of health model demands that we look beyond the behaviour to better understand the causes and conditions that may contribute to these behaviours.

Health Status. Brunner and Marmot’s model (2004) illustrates that the availability of social and economic resources is associated with health status and health outcomes. Socioeconomic status is thought to affect health status, whereby those who are poorer tend to have higher rates of morbidity and mortality (Berkman & Kawachi, 2000). Illness and disease can develop when the quality of social determinants of health is poor. The daily living conditions that an individual experiences have a strong effect on one’s health status (Raphael, 2009). Stressors associated with poverty and homelessness have been correlated with the onset of cardiovascular disease, chronic illnesses, and diabetes (Hwang et al., 2010; Marmot & Wilkinson, 2006; McEwan, 2004; Mikkonen & Raphael, 2010). Again the social determinants of health model demands that we look beyond the physical onset of disease to understand how the psychological and social conditions contribute to health status.

Health in a social determinants of health model. Health, as defined by the World Health Organization (WHO), is “the state of physical, mental and social well-being and not merely the absence of disease” (WHO, 1948, p.100). The concept of health has evolved over time within the purview of the WHO through many initiatives to promote health in both the developed and developing world (WHO, 1978, 1986, 2005). The population quality of life and health have become important variables as mortality rates decrease and morbidity rates increase.

Health promoting behaviours for most of society have increased, for those who are poor however, there remains little improvement (Curry-Stevens, 2009; Rothman, 2006). This may be evidenced within Western society, as the gap between rich and poor continues to grow (Coburn, 2004; Curry-Stevens, 2009; Raphael, Bryant, & Rioux, 2006; Wilkinson & Pickett, 2007; WHO, 1986). The WHO is correct to view health as more than just the absence of disease. Substantial evidence shows that factors which determine health, such as one’s daily living conditions, are equally if not more important than biology and lifestyle behaviours (CNA, 2009; Coburn, 2004; Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010; Raphael, Bryant, & Rioux, 2006; Raphael, 2009; WHO, 1986; Wilkinson & Pickett, 2007). As Blane, Brunner and Wilkinson (1996) stated, “A society which nurtures people’s skills and abilities throughout the population, which provides economic opportunities for all and which fosters a cohesive and social environment, would do more for health than curative medical services are able to” (p.12).

The Canadian Government’s awareness of this relationship among social, economic and health factors was first published in 1974 and is considered to be a landmark paper. Marc Lalonde, who was the Minister of National Health and Welfare in

1974 authored this landmark paper which was entitled, *A New Perspective on the Health of Canadians* (Lalonde, 1974). The Lalonde paper outlined indicators of health which did not fall within the largely biomedical model of the health care system. The publication of *Achieving Health For All: A Framework for Health Promotion* (Epp, 1984), noted income inequalities among different groups, and policies to reduce inequalities were recommended for the Government. The *Ottawa Charter* (1986) stressed health as a positive resource (WHO, 1986). In 1998, Health Canada's *Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff* reported strong evidence that there were determinants of health, such as employment, physical and social environments, that were located outside of the health care system, but which had strong influences on population health (Raphael, 2009).

In 2002, York University's School of Health Policy and Management held a conference called, "Social Determinants of Health Across the Lifespan: A Current Accounting and Policy Implications" (Raphael, 2009). This conference identified important determinants or indicators that overwhelmingly impact the health of Canadians. The list included Aboriginal status, early life (pre/post natal and maternal health), education, employment, working conditions, food and housing security, gender, health care services, income distribution, social safety net, social exclusion, and employment security (Raphael, 2009, p.7). Mikkonen and Raphael (2010) added race and disability to this list of Canadian social determinants of health. These determinants or indicators of living conditions are not intended to be restrictive and are understood as interrelated concepts that have important impacts on the health of individuals and their societies (Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010). In 2003, the World

Health Organization published *Social Determinants of Health: The Solid Facts,* signalling a growing global awareness of the interrelated social, economic, political and cultural phenomena that affect individual and population health (Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010, Raphael, 2009).

To date there have been no studies using the social determinants of health conceptual model with a hidden homeless population. Regidor (2006) has suggested that identifying social and health inequalities to be both confusing and ambiguous. The inherent confusion and ambiguity may contribute to the difficulty in clearly defining the concepts within the social determinants of health model (Hallerod & Larrson, 2007; Rigador, 2006). Recently, Marlier and Atkinson (2010) expressed an urgent need to develop common indicators to measure social exclusion as an identified determinant of health. One common indicator of social exclusion identified by Marlier and Atkinson, was the involuntary aspect of social exclusion related to social and material deprivation as evidenced in homelessness and poverty.

Homelessness and poverty are complex phenomena which affect individual, psychological and social functions (Hwang, Frankish, & Quartz, 2005; Marmot & Wilkinson, 2006; Raphael, 2009; Shapcott, 2010). Homelessness and poverty can contribute to the process and outcome of social exclusion, affecting overall health by denying the individual's ability and right to fully participate in the everyday functioning of their society (Galabuzi, 2009; 2012; Room, 1995). The experience of homelessness, poverty and social exclusion has many implications for the development of human capabilities for individuals, families and societies (Marmot & Wilkinson, 2006; Raphael, 2009; Sen, 1992, 1999). Lack of adequate housing and the experience of material and

social deprivation contribute to increased stress affecting physical and psychological health. Children are especially vulnerable to material and social deprivation (Galabuzi, 2004; Pascal, 2009; Rothman, 2006). Health complications are associated with long periods of stress, especially when individuals have the perception that their ability to control their situation is threatened and limited (Brunner, 1997; Brunner & Marmot, 2006).

Lewontin and Lewis (2007) described two types of threats (stressors) that people can experience within the context of material and social deprivation. One type of threat is described as “low frequency, high intensity threat” (p.308). For example, threats such as being gunned down in one’s neighbourhood may not happen to everyone but the threat alone that it could happen can cause high levels of stress. The other kind of threat is described as “high frequency, low intensity threat” (p. 309). This type of threat describes the everyday kinds of stressors, the struggles to meet basic life requirements such as food and shelter. People who are homeless and experience social and material deprivation must contend with one or both of these kinds of threats and stressors on a daily basis.

McEwan’s allostatic load hypothesis (1998, 2004, 2008) links such threats and stressors to the psychological, physical and social dimensions of disease. Allostasis is the ability of the entire body to maintain the stability of internal and external environments, via stress hormones and neurotransmitters, which respond and adapt to daily life stressors (McEwan, 2004). Stress hormones and other mediators of allostasis operate during times of internal and external stress to maintain stability as the body adapts to stressors or threats (McEwan, 1996). The body’s ability to adapt to stressors is an important factor in overall health and well-being. If, however, stress hormones and other mediators of

allostasis are not functioning properly, it may lead to allostatic load and allostatic overload (McEwan, 2004). Allostatic load is associated with stress and aging and is thought to be a factor among many diseases, in particular heart disease, cancer and chronic illness (McEwan, 1996, 2004, 2008).

Allostasis, as defined by McEwan (2004), is the normal “wear and tear” (p.2) of everyday life. Allostatic load however has a cumulative effect. For example, the struggle to satisfy basic life requirements on a daily basis has a cumulative effect on physical, psychological and social functions. The allostatic load hypothesis suggests that overuse of stress hormones and other neurotransmitters can lead to negative psychological and physiological responses in the body. Stress hormones and neurotransmitters in constant use manifest as physical symptoms in the body and can cause higher rates of morbidity (heart disease, cancer, chronic illness) and mortality (Green et al., 2010; McEwan, 1998, 2008). As noted earlier, stress is associated with health complications which can affect one’s ability to work and to provide oneself with the basic life requirements. This inability to provide for oneself can lead to social exclusion within a society (Raphael, 2009).

Galabuzi (2006; 2009; 2012) defines social exclusion as the inability of certain groups to participate fully in political, economic, social and cultural aspects of a society. Baumeister and Leary (1995) in their review on the importance of belonging among humans found that social exclusion in which people were isolated from others was a strong indicator for anxiety. People who lack safe, adequate and affordable shelter are at risk for marginalization and isolation because they are restricted from full participation within their society. Marginalised people experience poorer health and are less likely to

access health resources (Hwang et al., 2010). Particular attitudes and practices of discrimination towards marginalized groups, including negative attitudes of health care practitioners, may prevent groups experiencing social exclusion from accessing health and social services, and can directly affect health status (Galabuzi, 2006; Pauly, 2008).

Homelessness in Canada. Canada is experiencing a homelessness crisis (Frankish, Hwang, & Quantz, 2005; Gaetz, 2010; Layton, 2000; Shapcott, 2010). Canada has lacked a national housing policy since 1993, and since this period, deplorable living conditions have been reported for some marginalised populations (Gaetz, 2010; Hwang et al., 2010; Kothari, 2007). Shapcott compares the numbers of people who are homeless and sleeping on park benches and street corners as the tip of an iceberg. The greatest numbers of people experiencing homelessness are hidden, much like the body of an iceberg. Canada's homeless population has been estimated to range between 150,000 - 300,000 people but it is known that millions of Canadians who migrate to urban areas experience inadequate or unsafe shelter (Khandor & Mason, 2007; Laird, 2007; Shapcott, 2010).

There has been a trend toward increased numbers of people migrating to cities for several decades (Laird, 2007; Layton, 2000; Murphy, 2000). Along with this migration to urban areas has come an increase in the number of individuals, families, children, young adolescents, disabled women, single mothers and new immigrants huddled on city streets (Hwang et al., 2010; Laird, 2007). It is estimated that the numbers of visible homeless people represent just one fifth or twenty percent of the actual numbers of people "living" in this situation, indicating that four fifths or eighty percent of the population who are homeless are not seen and are, effectively, invisible. This invisible population, that is,

the body of the iceberg as Shapcott (2010) suggests, represents people who experience hidden homelessness.

Available data exist on the measureable use of homeless shelters. Shapcott (2010) reported that 80% of people requiring shelter did not use homeless shelters and therefore would be excluded from homeless shelter use or census data (Girard, 2006). Exclusion from these data reinforces hidden homelessness as invisible to the public and the policy makers (Bryant, 2009; Girard, 2006; Whitzman, 2006). These exclusionary processes, such as not being included in census or shelter data, lead to the lack of representation within a society, and are processes of social exclusion (Galabuzi, 2006, 2009, 2012; Room, 1995).

The actual word homelessness was not used in Canada until the mid 1980s, to define a growing social problem which included the absence of shelter and its associated detrimental factors (Hulchinski et al., 2009). As will be discussed below, this growth coincided with structural and economic reforms taking place in Canada at that time (Bryant, 2009; Laird, 2007; Shapcott, 2010). Homelessness has been increasing in Canada, as it has increased in all industrialized nations. Until the 1980s however, the traditional and perhaps stigmatized street dweller was the visible vagabond, the beggar who was identified as an older male, usually with alcohol or substance abuse issues (Simons, Whitbeck & Bales, 1989). It was noted in 1989 that the characteristics of people who were homeless were changing and no longer fit this stereotypical image.

Thus more than twenty years ago it was noted that people experiencing homelessness constituted diverse populations which included young people, single women, families, those with and without substance abuse histories, immigrants, women

with disabilities and many others who were experiencing material deprivation and marginalisation. People who are homeless are known to experience greater isolation and exclusion with lesser degrees of social and supportive services (Hwang et al., 2010; Khador & Mason, 2007; Simons et al., 1989).

Although the factors related to homelessness are multidimensional, two factors are certain. The first is the restructuring of our national economy and the second is the lack of affordable housing (Bryant, 2009; Gaetz, 2010; Layton, 2000). In the late 1980s the trend towards privatisation and decentralisation of our federal government caused a shift that led to a reliance on non-governmental agencies and informal networks to provide social and economic support for both individuals and families. This shift of support increased the numbers of people living in poverty (Layton, 2000). Also during this period in the late 1980s and early 1990s Canada was experiencing a change in housing policies. In 1993 the federal government ended the national housing policy which led to a lack of affordable and adequate housing for low-income earners. Presently in 2012, there is still no national housing policy that is linked to income (Layton, 2000; Bryant, 2009).

The effects of the restructuring of policies led to the exclusion of some people from full engagement and participation in the economic and social realms of their society. Social exclusion reflects the degree of isolation, marginalization, stigma and discrimination from social, economic, cultural and political aspects of a society. The effects of social exclusion on the physical, psychological, and social aspects of life can dramatically impact one’s self-esteem. This is especially true for adolescents (Galabuzi,

2006, 2009; Hwang et al., 2010; Karabanow, 2006; Prilleltensky, 2010; Raphael, 2009; Shaw, Dorling, & Smith, 2006; Wilkinson & Marmot, 2006).

Youth homelessness. Karabanow (2004, 2006) reports that the average age for adolescents experiencing homelessness is fifteen. Young people are highly vulnerable to social and material deprivation which limits their ability to fully develop the capabilities whose expression constitutes a meaningful and valuable life (Haldenby, Berman & Forchuk, 2007; Mc Murtry, 1998; Noonan, 2006). Adolescents experiencing homelessness are at high risk for abuse, depression and substance abuse (Hwang, 2001; Karabanow, 2006; O'Connell, 2004). Adolescents who are homeless are in no way a homogeneous group, except for the one defining characteristic which is the lack of a safe and secure home (Karabanow, 2004; Robinson, 2008).

Family stress and dysfunction where physical, sexual, and emotional abuse are present appear to be the leading factors for adolescents leaving their homes (Karabanow, 2006). While early understandings of street youth focussed on individual characteristics of youth as the primary causes, it is now widely accepted that the root causes of youth homelessness are related to structural problems within families and societies (Robinson, 2008). A large percentage of males and females experiencing homelessness reported home lives which included, "violence, mistrust and fear, with very little evidence of feeling loved, cared for, and supported" (Karabanow, 2008, p. 28).

Karabanow (2006) undertook a qualitative study to explore identity construction of youths experiencing homelessness. This study included 98 interviews with youths who were homeless as well as interviews with 42 service providers working in homeless shelters in Montreal, Toronto and Halifax. Karabanow's goal was to understand and

humanize the youth who identified as being homeless. This study was an effort to illuminate how young people understood themselves, and it sought to present youths who were homeless as “participants with substantial agency in defining their actions, movements, travel, and decisions” (p.51). In Karabanow’s analysis, youth who were homeless were not viewed as victims, but rather as individuals attempting to establish their place within society. Karabanow’s study revealed that in labelling youths who are homeless as runaways, delinquents, prostitutes, substance abusers, thrill seekers or victims, we risk the consequence of losing a holistic understanding of the actual person, and instead focus on the behaviours of the person.

An important finding in Karabanow’s 2006 study accounts for a population of youths who are homeless in relation to their developmental period of adolescence. It was found that subgroups have evolved within the larger category of youths who are homeless. These subgroups were identified as (1) young people who were on the street as a result of violence or abuse and (2) young people who were on the street for the perceived independence it might provide. What is remarkable about this finding is that youths who were homeless perceived themselves as adolescents (teenagers) with similar characteristics and traits of all adolescents. Karabanow’s findings should be interpreted with the recognition that the causes of youths experiencing homelessness are largely the social structural conditions (Galabuzi, 2006; Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010). The idea that one may choose a homeless lifestyle must be understood within this context.

People who are homeless experience social exclusion, which is deeply embedded into processes that prevent certain groups from participating and benefiting from

Canada's major social institutions (Pauly, 2008). Harter, Berquist, Titsworth, Novak & Brokaw (2005) conducted an ethnographic study of service provision for youths experiencing hidden homelessness. Over the course of one year, at two separate youth homeless shelters, a total of 12 interviews were conducted with administrators or staff and a total of five focus groups among 48 homeless youth. The purpose was to explore the invisibility of youths who were homeless. As reported by the Homeless Hub (2008), the number of youth experiencing hidden homelessness is on the rise. The invisibility of youth who are homeless prevents opportunities for early intervention, thus reducing opportunities for human development and achievement. Harter et al. (2005), report that it is the invisible aspect of homelessness in hidden homelessness that contributes to the marginalization of the youth. Although this study looked only at youth who were homeless, the nature of the invisibility is common for all groups experiencing hidden homelessness.

In 2010, Barnaby, Penn and Erickson surveyed 100 youths who were homeless and who self-reported poly-substance drug use. The results of this survey were then presented to focus groups comprised of 27 youths who were homeless, to discuss their reactions to the survey results. Youths experiencing homelessness were asked to describe the way they thought others viewed them. The youths used words such as "trash, scum, and useless" (p.58) to describe the way they felt they were viewed by others. Negative perceptions that become internalized directly affect self-image and ability to manage activities of daily living (ADLs) and may contribute to a lack of access to care (Pauley, 2008; Thorne et al., 1998). The youths in this study articulated feelings of shame and

hopelessness that their situation could or would ever change from its current state (Barnaby, et al., 2010).

Homelessness and health. People who are homeless experience a wide range of health problems, both physical and emotional. In order to have physical, psychological and social health, each individual must have access to basic life requirements (Malloy & Leeseberg Stamler, 2007). Health can also be viewed as personal and social (Meleis, 1989). According to Meleis, if we view health as a personal matter, this implies that only people who are able to realize aspirations and satisfy their needs can be healthy. In this personal view, people unable to realize aspirations and satisfy their needs, those who are constrained by economic and societal conditions such as homelessness and poverty, cannot be healthy (Meleis, 1989; Thorne et al., 1998).

How one perceives oneself within society, as well as how one is perceived by others can have a dramatic effect on one's overall state of health and health outcomes. If youth experiencing homelessness perceive that their society does not value them, as Barnanby et al. (2010) reported, their health and social well-being can be negatively impacted. One's level of confidence and ability to advocate for oneself within the health care system is extremely important for overall health and well-being (Thorne et al., 1998). Feelings of social and health inequality can prevent people who are experiencing homelessness from accessing social or health services (Bryant, 2009; Galabuzi, 2009; Hwang et al., 2010; Pauly, 2008).

Homelessness and health service use. People who are homeless can have increased susceptibility to many health problems but are less likely to access health care services (Hwang et al., 2010; MacKinnon & Varcoe, 2009; Nichols, 2008; Pauly, 2008).

Discrimination, lack of proper credentials (OHIP, birth certificate), lack of money for prescriptions and the lack of transportation are significant barriers to accessing health and social services (MacKinnon & Varcoe, 2009; Nichols, 2008; Pauly, 2008). Youth who are homeless may fear recrimination or the real possibility of being sent back to a home they have fled. Women with children may fear loss of custody or feel powerless in an abusive relationship. Others want to avoid negative attitudes from care providers (Haldenby, Berman, & Forchuk, 2007; Hwang et al., 2010; Khadar & Mason, 2007).

People who are homeless tend to use emergency departments when there are no other choices and their health has become unmanageable. The point of entry to health care is frustrating for both the health care practitioner and the person who is homeless because it is generally understood that a quick fix is not adequate to address the homeless person's complexity of needs. Improving the social conditions that have contributed to homelessness and poverty is time consuming, resource taxing and often beyond the resources available during a quick trip to the emergency department (Pauly, 2008).

The negative attitudes of health care providers can be attributed in part to the structuring of our current health care system which is based on the biomedical model, a model which sees health as something that can be restored (Pauly, 2008). In the biomedical model, the body is viewed much like a machine and the physical and psychological issues can be diagnosed, treated, and ultimately cured. It is this ideology of cure and biomedical engineering which provides the basis for diverting resources away from community care and towards acute care hospitals in which the object is to fix the broken part as efficiently as possible (Armstrong & Armstrong, 2002). Nurses practicing in acute care centres may feel powerless when caring for people who are

homeless and socially excluded, because solutions to the serious social concerns are beyond the capacity of acute nursing interventions (CNA, 2010; Pauly, 2008).

Measures of Poverty. The social determinants of health model views poverty beyond the measurement of low income (Hallerod & Larsson, 2007; Marlier & Atkinson, 2010). Poverty is both a cause and a consequence of poor health whereby poverty affects health negatively when there is an inability to buy nutritious food, access affordable housing or quality education (Hallerod & Larsson, 2007). Poverty, in the social determinants of health framework, is a condition of human deprivation involving physical, psychological, and social aspects related to unequal access to social and economic resources in a society (Marmot & Wilkinson, 2006; Raphael, 2009).

There has been much debate about the meaning of poverty, its sources and causes. While there is no consensus on the definition of poverty in Canada, it is generally indicated by income levels which are often measured using low-income cut-off rates to determine level and depth of poverty (Curry-Stevens, 2009). Low income cut off rates, or spending greater than 60% of one's total income on basic life requirements for food and shelter are examples of this type of poverty measurement (Statistics Canada, 2009). According to Statistics Canada in 2009, 3.4 million Canadians were living in poverty as measured by low-income rates. Poverty affects numerous material, social, and environmental factors such as nutrition, housing, education, employment, income and health. A strong body of literature supports a positive association between poverty and poorer health (Dunn, Hayes, Hulchanski, Hwang & Potvin, 2006; Marmot & Wilkinson, 2006; Raphael, 2009).

Levels of income are often determined by stable employment opportunities and thus determine one's ability to provide the basic necessities for life where one's capabilities can develop. Poverty, while it may indicate low or no income, must also be viewed as that which causes deprivation beyond material deprivation (Sen, 1992). Material deprivation is an inability to satisfy basic life requirements which impacts on all aspects of further human achievement and development (Sen, 1999).

Social and work environments are closely linked and are affected by material deprivation. Poverty and social exclusion create barriers to equal access to resources (Khadar & Mason, 2007). Being denied access to adequate housing, employment, education and income prevents full engagement and participation within the social environment and the entire social structure. In other words, it marginalizes particular groups of people. People who are homeless are marginalized populations, excluded from full participation within society (Bryant, 2009; Galabuzi, 2006; 2009; Room, 1995).

Theoretical concepts of poverty focus on the lack of material and economic resources. Social exclusion extends beyond the lack of economic resources to encompass the marginalization of individuals and groups from full participation in the communities and societies in which they live (Marlier & Atkinson, 2010; Raphael, 2009). Several studies suggest poverty, unemployment, homelessness and social exclusion manifest as clusters of social problems (Bask, 2005; Hallerod & Larrson, 2007).

Fiedler, Schuurman, and Hyndman (2006) used Canada Mortgage and Housing Corporation's (CMHC) indicators for the core housing need model. This model identifies core needs when half of one's household income is spent on housing costs. Using these census based indicators for housing, recent immigrants to Greater

Vancouver, who rented rather than owned houses (N= 621, 825) were assessed for housing core needs. Findings from this study demonstrate that if we use narrow definitions of poverty and look only at ability to afford housing or economic disadvantage, there is the potential to completely miss a growing population at risk for homelessness. The current study highlights the invisible hidden homeless, a population that typically lack information due to lack of access to transportation, phones and other means of communication. Collected census information only reflects the needs of those who participated in the formal self-report census information.

Canada has a publically funded health care system with universal health care as a core value (Galabuzi, 2006; Hwang et al., 2010). According to Pauly (2008) the people who need the greatest access to health care are the people who access it the least. As Hwang et al. reported, it is not well understood why disadvantaged groups, such as people who are homeless have less access. People who suffer from poverty and deprivation tend to be weaker and in poorer health. As Hwang et al. (2010) caution, unequal access to health care appears to be growing among stigmatized and marginalised populations who are socially excluded from health and social institutions.

The current study used quantitative and qualitative findings from interviews with 21 hidden homeless participants to explore their everyday living conditions and how these everyday living conditions were affected by social environments, and affected health behaviours and health status. The social environment, health behaviours, and health status exploration of the participants was guided by the social determinants of health model (Brunner & Marmot, 1999; 2004). The social determinants of health model,

guides the present study's attempts to increase the understanding of homelessness and poverty's multidimensional social concerns which can lead to social exclusion.

Research Questions

The research questions were:

1. How do social environments impact everyday living conditions for a hidden homeless population?
2. What are the health behaviours/coping mechanisms of a hidden homeless population?
3. What is the health status of a hidden homeless population?
4. How is health affected for a hidden homeless population by the processes and outcome of social exclusion?

CHAPTER III

METHODOLOGY

The current study used focused ethnography to explore the daily life experiences of people who are hidden homeless, as described and reported in interviews with the participants in a South Western Ontario city. Focused ethnography is an appropriate research tool to because it has the capacity to discover unique cultural beliefs through language and behaviours within a hidden population (Singer, 1999). Descriptions of the research design, sampling, data collection, protection of participants' rights, measures, data analysis and trustworthiness are presented below.

Research Design

The current study is a secondary analysis of data collected for a research project, project titled *Hidden No More: Needs Assessment of Service Use by the Hidden Homeless* (Atkinson et al., 2011). Funding for this larger project was provided by the Housing Partnership Strategies in Windsor, Ontario, Canada. The Principal Investigator (PI), Liz Atkinson was the former Chair of the Health Committee/Homeless Coalition of Windsor-Essex County. Co-investigators were professors at the Faculty of Nursing, University of Windsor, Windsor, Ontario. Approval for this study was obtained from the University of Windsor Research Ethics Board in June, 2010. The purpose of the original study was to gather quantitative and qualitative data to complete a needs assessment to understand the barriers experienced by the hidden homeless when accessing health and social services. The questions asked in the current study were developed to determine the relationship between the social determinants of health and hidden homelessness.

The current study is a partial concurrent mixed method design including both qualitative and quantitative data (Traynor, 2011). Qualitative, focused ethnography

(Speziale & Carpenter, 2003; Spradley, 1979) was used to explore the culture of a hidden homeless population. A focused ethnography facilitates an interpretation of a group's language and behaviour which may be expressed in narrative components of the interview tool. Ethnography allows for a holistic inquiry of the experiences of a particular group (Creswell, 2007; Loiselle & Profetto-McGrath, 2004; Spradley, 1979). The exploration of a hidden homeless population's experiences of their social environments, personal health behaviours and general health statuses identified unique folk concepts, meanings, themes and categories within this particular culture (Spradley, 1979). Crosstabulation using Fisher's exact test was used to compare two categorical variables (Munro, 2005).

Sampling

The survey sample in the original study included males and females older than 15 years of age who were identified as being hidden homeless with a pre-screening question, "Do you have a permanent residence/a home that you can return to whenever you choose?" Respondents answering "no" to this pre-screening question were included in the original study. Targeted sampling (Burns & Grove, 2005), which is selecting a particular population for a study, was used with the help of recruitment from participating agencies from the local urban area. Potential participants were referred from local community agencies and peer mentors. Peer mentors were individuals from the local urban area and the surrounding rural environment who had personal experience with being homeless and who had access to the hidden homeless population. A total of 122 participants were pre-screened, with 34 respondents meeting eligibility requirements. The completed interviews of 21 participants were examined for this study. Persons

identified as homeless but who were sleeping on the streets, or accessing homeless shelters were excluded from this analysis.

Prior to data collection for the original study, training sessions were provided by the PI for the three interviewers to help maintain uniformity and consistency of interviewer behaviours when asking questions. Debriefing meetings were organized by the interviewers when it was felt the information garnered from the survey was particularly troubling, such as hearing participants describe their experiences of abuse.

Data Collection

Two participating agencies, one from the local urban area and one from the surrounding rural area, agreed to be the sites for recruitment of participants and data collection. Prior to administering the survey, informed consent was obtained from each participant. The letter of consent was read aloud to each participant by the researcher. This ensured that each participant received consistent information about the study. The letter of consent outlined the purpose, procedures, and potential risks and benefits of the survey. Questions about the study were answered during that time and at any time throughout the interview. Participants were assured that all information would remain confidential and that they could withdraw from the study at any time. Participants were also told that if they felt overwhelmed at any point throughout the interview they would be referred to appropriate counselling services. Informed consent included two signatures, one to agree to participate in the study and the other to allow audio recording of the interview. Interviews were recorded for later transcription. A $20.00 honorarium and a referral booklet of community agencies were given to each participant upon

completion of the interview. Participants were also invited to take part in a future community meeting at which the survey results would be shared with the public.

To maintain consistency, only the trained interviewers conducted all research interviews. Participant confidentiality and anonymity of were maintained by assigning each participant an identification number used for referencing purposes. All data, including audio recordings and questionnaires, were kept in a locked office at the Street Health Homeless Initiative with only researchers involved with the study having access to these files. Informed consent forms containing signatures of participants were kept in a separate locked filing cabinet.

Measures

The interview tool was modified from an original survey tool developed by Dr. Olivia Washington, Professor emeritus at Wayne State University (see Appendix A). The original interview tool was used in research studies involving homeless women living in a homeless shelter in a larger, urban centre. The survey questions focused on obtaining information from the participants about their current living arrangements, housing resources, use or non-use of community and health resources, health status and suggestions to improve resources for hidden homeless populations. The modified interview tool consisted of 108 questions.

Data Analysis

Ethnographic research adopts a holistic understanding of a particular group or culture. This holistic understanding can be achieved through exploration and examination of language, behaviours and relationships (Tappen, 2011). Domain analysis is a strategy that was used in the current study to explore the meaning of language,

behaviours and relationships among a hidden homeless population (Spradley, 1979; Tappen, 2011). Responses by participants to the interview questions, which address the everyday living conditions of poverty, homelessness, and social exclusion, were analyzed for themes and patterns. Three analytic domains based on the social determinants of health model were identified by the researcher and include: (1) social environment (2) personal health behaviour and (3) health status.

One cross tabulation using SPSS statistical software version 19.0 was used to perform statistical analysis. Two nominal variables: (1) reason for no permanent housing and (2) source of income were categorized into categorical variables. Fisher's exact test for categorical variables was then performed because cell counts were less than five.

Trustworthiness

Trustworthiness is a term used to describe the evaluative criterion of qualitative data (Loiselle & Profetto-McGrath, 2004; Tappen, 2011). Trustworthiness or rigor in qualitative studies is denoted by credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility is similar to the internal validity of quantitative research whereby it can be inferred that the independent variable is having an observable effect on the dependent variable. Credibility is achieved through prolonged observation and engagement, member checking, peer debriefing, negative case analysis, and triangulation (Lincoln & Guba; Tappen). Credibility was maintained in the current study through secondary analysis of the original data. The original data were gathered from each participant using an interview tool that included 108 questions. The average time for collecting these data ranged between one to one and a half hours. The self-reports from the participants were treated as truthful credible data.

Transferability is equivalent to the external validity of quantitative research and refers to the degree to which the results of a study have generalizability (Lincoln & Guba, 1985; Tappen, 2011). Triangulation of the qualitative, quantitative and literature review increased the transferability of the data and generalizability of the findings.

Dependability is equivalent to the reliability of the instrument used to measure an attribute in quantitative research (Lincoln & Guba; Tappen). Dependability or reliability was maintained in this study by using all of the raw data that was collected and tape recorded at the time of collection. Transcriptions of the voice recordings were used to maintain dependability (Tappen).

Confirmability is equivalent to the effort to maintain neutrality and objectivity of quantitative data (Lincoln & Guba; Tappen). Confirmability was maintained through objectivity with regards to the data and analyses and any conclusions that were drawn.

CHAPTER IV

RESULTS

The descriptive tables address each of the analytic domains chosen for this study from Brunner and Marmot's social determinants of health model. Table 1 displays indicators related to social environment, Table 2 displays indicators related to health behaviours, and Table 3 displays indicators related to health status. Each of the descriptive tables is introduced and followed by narrative quotations from the participants addressing each analytic domain: social environment, health behaviour and health status. Table 4 displays broad aspects of social exclusion in relation to housing, education, employment and income to show how these broad aspects are interconnected with the processes and outcomes of social exclusion. Table 5 is a crosstabulation which considers two categorical variables: (1) reason for no permanent housing and (2) source of income.

Table 1: Social Environment

Male Partici-pants (N=13)	Age (Years)	Sexual Orient-ation	Marital Status	Children # (age)	Social Support	Feel Safer/Sec-ure Where Staying	Hours of Sleep	Assaulted in Last 6 Months
3	18	Gay	single	0	Friends	Sometimes	Sporadic	Y
4	25	Hetero	single	0	Family	Y	3-4(sick), 6-8 (on drugs) sleep disorder	N
5	26	Hetero	single	2 (5,7)	Friends	N	0-4 (sleep disorder)	N
6	29	Hetero	partner	2 (3,5)	GF	N	6	N
7	29	Bi	single	3 (6,9,12)	SW only	N	4.5 (sleep disorder)	Y (GF)
8	31	Hetero	single	1 (10)	Friends	Y	6	N
12	33	Hetero	separated	3 (6,9,12)	None	N	8 (sleep disorder)	Y (3x WPD)
13	34	Hetero	single	0	Family	N	5	N
17	46	Hetero	single	0	None	N	6	Y (Police)
18	49	Hetero	single	0	Family	Y	8	N
19	52	Hetero	single	0	Friends	Y	6-8 (sleep disorder)	N

20	53	Hetero	divorced	2 (14,16)	None	Sometimes	3-4 (sleep disorder)	N
21	69	Hetero	widowed	1 (42)	Family Friends	Sometimes	4	N
Female Partici-pants (N=8)								
1	16	Bi	single	0	Friends SW	Sometimes	5.5	
2	18	Bi	partner	0	Friends BF SW	Y	10 (sleep disorder)	N
9	32	Bi	single	2 (10,15)	Friends	Y	5	N
10	33	Hetero	single	5(2,3,10,10,13)	None	Y	6-7	Y (Person known)
11	33	Hetero	single	5(6,9,12,14,16)	None	Sometimes	4 (sleep disorder)	Y (Stranger)
14	36	Hetero	separated	2 (12,15)	Friends	N	2	N
15	36	Bi	separated	2 (9,21)	Friends	N	4.5	Y (Ex-BF)
16	38	Hetero	single	3 (6,17,20)	Friends	N	6	N

As indicated in Table 1, 13 of the 21 participants were male, and eight were female. Male participants ranged in age from 18 to 69, and female participants ranged in age from 16 to 38. Eleven of the 13 male participants (85%) and four of the eight females (50%), or 15 of the total sample of 21 (71%) reported their sexual orientation as heterosexual. Of the six non-heterosexual participants, five reported being bisexual (one male, four females) and one male reported being gay.

Social Environment. Brunner and Marmot's model (1999, 2004), shows that social environment is determined by the degree and quality of social supports. As previously discussed, the degree and quality of social supports are influenced by lack of material resources and the conditions that an individual experiences in their everyday life. As indicated in Table 1, the 21 participants in this study showed evidence of poor quality social environments.

The majority of participants (71%) were single. A total of 62% of the participants had children ranging in age from two to 42, with a mean age of 11.39 years. All but three

of the children were below the age of 20. Of the participants who did have children 92% reported that their children were not currently in their care. While 76% of the participants reported family or social worker supports and 16% of the participants reported friend supports, 24% of the participants reported having no supports at all. While 33% of the participants reported feeling safe and secure where they were staying, 43% of the participants did not feel safe and secure, while 24% of participants felt safe and secure only sometimes.

Examination of Table 1 indicates that sleep disorders were reported by more than a third of the participants. The amount and quality of sleep depends on many things, one of them being social environment. When one does not feel safe and secure in their environment disturbances in sleep would be an expected outcome. Recall that the total number of participants who said they did not feel safe and secure as well as those who stated that they felt safe and secure only sometimes totalled more than three quarters of the participants. It is also important to note that more than a third of the participants reported having been assaulted within the past six months.

The first domain, social environment focuses on the degree of social supports and the quality of social interactions. The following themes emerged from the participants narratives: (a) lack of quality social interactions and supports (b) housing: commodity or basic life requirement (c) the daily struggles of street life (d) poor environmental/sanitary conditions of homeless shelters and (e) the courage to hope for a better future. The following section will describe the themes that emerged from the participants' interviews.

Lack of Quality Social Interactions and Supports

"I have a family but I don't talk to them much" (P-17)

In general, the participants lacked quality social supports. The narratives were analyzed for evidence of emotional and practical types of social support. Emotional supports can include informational support, such as the support provided by agencies and supports which helped the participant to problem solve or feel positive about their situation. Practical or instrumental types of support were found in some of the services accessed by the participants such as housing, disability and employment services. While 76% of participants reported social support from friends, families or social workers, 23% of the participants reported no social supports suggesting almost one quarter of participants experienced isolation and social exclusion.

The youngest participants (P-1, P-2, P-3) respectively 16, 18 and 18 years of age all reported that friends were their main sources of social support. All three reported unstable and or abusive relationships with their parents and stated that it was the main reason why they were homeless. Homelessness resulted from them leaving or being kicked out of their home. P-1 and P-2 reported that they were first homeless at age 14, while P-3 reported age of first homelessness at 15 years of age. Of notable interest is that P-1 and P-2 reported their sexual orientation as bisexual, and P-3 reported his sexual orientation as gay. Participants may have experienced negative treatment due to their sexual orientations.

Additional demographic information included that 71% of the participants were single, 14% were separated, 10% reported having a partner and one participant (5%) reported a divorce. As noted earlier, 62% of the participants reported having children and of this 62% who had children, 92% reported that they did not have their children in their

care at present. The survey did not follow up with the participants to inquire whose care the children were in, as the majority of children were below the age of 20.

Although 76% of the participants reported family/social worker support there was almost no evidence of any family support or interaction that was positive. One participant (P-12) mentions his father saying "I try to stay with my Dad but I tend to bounce around because of his temper...I've seen him snap solid steel cold." The majority of support experienced was practical or instrumental support, that is, the support provided from support workers at various agencies such as the food bank and shelter systems. This support, as reported by the participants, could be both positive and negative. Some examples of negative practical support reported by the participants were, "Yeah the workers *could* call you back" (P-5) was a response to the question of how Disability Services might improve their overall services. This participant (P5) indicated that she often did not have her phone calls returned by support services. "Yeah. Um, you know it sounds kinda stupid but probably more compassionate workers there" (P-3) was a response to how one agency could improve services. "And most of the majority of the people that work there are just paycheck workers...some makes...make your stay there, like really miserable and I can't, it's...Yeah. I can go on and on about that" (P-7). This statement was in response to a question about homeless shelters in the community.

There were examples of positive practical support reported by the participants. The following quotation from P-11 expressed a desire for direction, "And she's given me a lot of wisdom, she's helped me out...that's important for me to hear that, right, yah know, I need encouragement too just as the other one does...somebody who's going to listen, you know and possibly send me, you know direct me. Not just listen and that's

that. I need direction, y'know. Other options." Further evidence of positive practical support included, "They provide lunch every day" (P-10) and "I use them for uh to see a nurse practitioner there or if I need some supplies like soap or shampoo, anything on that line...they're great over there" (P-16). One participant reported a friendship with someone working at an agency stating, " Um...because a good friend works here and has helped me throughout my recovery that way" (P-15).

While several participants reported that they had friends who supported them, the following quotes are examples of poor quality supports. "Yeah. They're just, they're friends, you know. If they wanna throw me out in the middle of the night they can. It's their house" (P-21), and, "I dunno, I wouldn't consider them as friends um they're just user acquaintances um bunch of junkies that uh just uh have the door open um as long as you got something to uh fork up that uh will put me up for the night then I am good" (P-11).

In general there did seem to be a lack of social support and quality social interactions among the participants which contributed to a weakened social environment. The struggles of everyday living, in which there is material, social and psychological deprivation are exacerbated by poor quality social supports and interactions. These processes contribute to social exclusion.

Housing: Commodity or Basic Life Requirement

"I cannot find a place affordable enough" (P-8)

The lack of a national housing policy and the lack of affordable housing has had devastating consequences for people with little or no income. A major theme among the participants was the awareness that they lacked permanent housing because they could

not access safe and secure housing due to lack of financial means and lack of quality social supports.

One participant described feeling responsible for his homelessness due to poor money management stating, “I had a hard time managing my money” (P-5). The following quotation addresses the lack of financial resources and also highlights the tenuous social supports available to this participant, “Well it’s tough. Like I don’t have any money, I have no finances. And it’s hard to get on social assistance cause my friends are on assistance so they don’t want you to interfere with their collecting a cheque at their place...If they are on assistance and you say you’re living with them then your income becomes their income. And then they lose money....This is the way the government works. Its kind a like once you’re down you gotta stay down. They don’t really help you much” (P-9).

The reality of money as an obstacle to accessing housing can be heard in these two quotes, “Because I don’t make enough money to have a permanent house....$200 is not enough to live off. It’s enough to get a week or two of groceries if you buy groceries (P-12), and “I currently got laid off from my job and I was getting unemployment insurance benefits for a while and they don’t give you very much money...applied for Social Services, which Social Services gives you shit money” (P-16).

The Daily Struggles of Street Life

“ Panhandling or sitting wishing I was dead” (P-12)

Many of the participants described the daily struggles inherent in being homeless. The daily struggle to find food and shelter was an undeniable stressor. The participants described periods of idleness during the day which was spent moving from one public

space or place to another which allowed them access to another. Most access to public space ends at six p.m., and participants expressed worry and concern about this. Many felt the stress of not being allowed to loiter in public areas. Obtaining food throughout the day was an obvious struggle, and the sentiment that overwhelmingly seemed to be expressed was the lack of dignity or social aspects related to satisfying one's appetite. For instance, as one participant stated, "Pretty much leave wherever I am, grab my backpack, leave...Get a bite to eat somewhere along the way, find a place to stay for the night" (P-4). The constant struggle to find food is expressed in this quotation, "I usually go for a walk in the morning and see what food banks I can use for the day or whatever. Like, a couple times a week I go to the food bank, I'll go to the Mission and eat" (P-16).

Another challenge for participants was transportation. A large number of participants describe walking around for hours on end. "A lot of walking around and panhandling...a lot of walking around, like from one Win...end of Windsor to the other. I got these shoes, not even a month ago and they already have holes in the soles" (P-9).

"Hanging out" was a term used by many to describe time spent in fast food restaurants, public spaces, sitting by the river, spending time with friends and seeking out alcohol/drugs. "I try to get drunk, drinking, um try to find drugs, usually" (P-6).

The daily struggles to find food and shelter could be characterized as the high frequency, low intensity threats discussed by Lewontin and Levins (2007). The constant threat of having nothing to eat, and nowhere to stay, increases levels of stress and contributes to the allostatic overload. This allostatic overload in turn can cause an increase in chronic disease processes.

<u>Poor Conditions of Homeless Shelters</u>

"People doing drugs there and just a bad environment" (P-7)

More than half of the participants reported poor conditions in the sheltering services which included poor sanitary conditions, infestations, concerns for safety, overcrowded conditions, and the use of drugs and alcohol. Several participants reported that they were not treated well by staff and two participants reported being "kicked out" for using drugs and alcohol.

Many participants stated that the poor conditions of the shelter prevented them from accessing the service. A participant who has been homelessness for 11 years explained that he did not access shelters because of "bedbugs, infectious diseases, crabs, lice. They're filthy. If I wanted to live in filth, I'd stay in a ditch" (P-12).

One participant stated she would not go to a shelter because of what she had heard others say about them, specifically, "Things get stolen from you, you could get beat up, there are people like throwing up on you, there's tons of different people in there that are mentally disabled" (P-2). Although the participant herself did not have this experience this quote suggests that she might avoid seeking shelter based on what others experiencing homelessness have told her. Another participant echoes a similar note "Because people steal your stuff. You're in a room with six complete strangers" (P-5).

A few participants stated that they could not access shelters because of their drug or alcohol addiction. One participant stated that it was "pride" that prevented her from going to a shelter. "I can live on the street and do it myself" (P-9). The poor conditions of sheltering systems are a strong deterrent to seeking refuge at a shelter. While it is understandable that infestations can result when people are in such close proximity, it

simply is not healthy. Some of the participants' observations expressed an inability to tolerate these poor conditions.

<u>The Courage to Hope for a Better Future</u>

"Hopefully a place of my own and stuff, you know" (P-19)

Some of the participants did share a hope that their future might improve. Participants responding to the question, "Where do you see yourself in three years?" demonstrated a desire for a more hopeful future. In particular, the youngest participants, that is P-1, P-2, and P-3 all said that they expected to have their high school diploma. While several had no idea where they would be in three years, stating that they could only envision making it through one day at a time, P-17 stated "Dead. I see myself dead". Some of the participants did have hope that the future would be brighter and they would be successful. As one participant mused "Hopefully with a good job and a nice house, hopefully" (P-10).

Social environment is the degree and quality of social supportive interactions and relationships. The aforementioned themes demonstrate the link between lack of social quality support systems and the disadvantages that follow. When an individual lacks social support it can directly affect the everyday living conditions. Not having social supports decreases the options one has available. The systems that are in place to help and assist homeless people are lacking in quality and directly affect the resources available to the homeless person. The lack of material and social resources impacts physical and psychological well being. Health, understood as a positive resource, cannot be achieved within this deprived social environment.

Health Behaviours. In Brunner and Marmot's model (1999; 2004) health behaviours can be influenced by material and social deprivation. Health behaviours can also be affected by a lack of supportive social networks and poor quality social environments. The health behaviours chosen for analysis in the current study were those behaviours that directly affected physical, psychological and social health.

Many health behaviours can affect one's overall functioning and therefore are not easily categorized. For example, the decision to go to a shelter or not, can impact upon physical, psychological and social health. The choice to ingest one or two meals per day, or the choice to use a condom, has more to do with the availability and accessibility of healthy food choices and contraception than it does with simply making a personal choice. The choice to use alcohol, drugs and tobacco may have more to do with finding a means of coping with poor social environments, than simply a desire to abuse substances. When choices are limited to poor choices, health is negatively impacted.

Table 2: Health Behaviours

Male (N=13)	Why go to shelter	Why not go to shelter	OHIP Card/last MD/NP Visit	Safe Sex/Condom Use	? STI Testing	Meals Per Day	Where Food Comes From	Alcohol/Tobacco	Drugs	Age First Used Drugs	$ for Drugs or Self
3	No other options	No transportation	Y/x 1/12	Abstains/N	Blood work	1	Supermarket	Y/Y	Marijuana	15	$10/wk mows lawns
4		No reason	Y/x 1/12	Y/Y	>1 yr	2-3 small meals id	Food bank, supermarket	N/Y	Opium, Benzo's, Oxy's, Codeine	14	$30-40/day $210/wk
5	No other options	Theft Overcrowding	# no card/x 1/12	Sometimes/Sometimes	>1/12	1	Soup kitchen, food bank, grocery store	N/Y	Oxy's, Heroin	11	Don't buy
6	Food & Lodging	Drug Use	N/x 6/12	Y/?	>6/12	1	Friends	Y/Y	Meth, Oxy's, Sedatives, Barb, Valium, Crack	15	Rob drug dealers $1000/wk
7	Addiction (Gambling)	Bad Environ. Other's Drug use	Y/x 2/52	N/?	>1 yr	1	Food bank, mission	N/Y	Weed, Cocaine, Oxy's, Benzo's, Crack, Meth	11-12	Binges $3-4000
8	Not used	Overcrowding Dirty	Y/x 3-4/12	Y/Y	>3 yrs	1	Fast food, pan handles	Y/Y	Cocaine, Meth	17	Pan handling $80/wk
12	Would not	Bedbugs, lice, crabs, infestation diseases, filthy	Y/x 1/12	Y	>3/12	1	Mission	N/Y	Crack, Oxy's, Perks, Cocaine, Meth, Heroin	11	Pan handling

13	To avoid street	No reason	Y/x 4/12	N/N	Never	1-2	Food bank	Y/Y	Marijuana	16	$50 smokes
17	Injured		Y/x 1day	Y/Y	>7 yrs	3	Food bank	N/Y	Valium, Crack, Meth, IVDU-Methadone	13	Freely available
18	To avoid street	No answer	Y/x 1year	N/Sometimes	Don't know	1	Food bank	Y/Y	N	Alcoholic	?
19	Weather	If overcrowd ed	Y/x 2/52	Y/N	>3/12	2	Mission, food bank, soup kitchen	Y/Y	Crack, Meth, Marijuana	28-30	$80/wk
20	? Health	can be very scary	N/x 1 day	Sometimes/ Sometimes	q 6/12	2	Mission	N/Y	Oxy's, Meth	16	Barter
21	Weather		Y/x 1/12	Y/Y	Don't know	2- 1-	SA, Mission	N/Y	Oxy 40's (prescribed)	54	$4 for script (Oxy 40)
Female (N=8)											
1	No other options	Infestation	Y/x 1/12	Y/Y	>1½ yrs	1-2	Food bank, supermarket	N/Y	Oxy's, Perks, Marijuana	14	$ or self
2	No other options	Theft Violence	Y/x 3/52	N/N	>1½ yrs	1	Supermarket	Y/Y	Marijuana, Codeine, Valium	14	$100/wk be supplies
9	Would not	Pride, bugs, disease/sic kness	Y/x 1½ yrs	Sometimes/Y	>2 yrs	1-2	Food bank, mission	N/Y	Perks, Marijuana	12	None
10	Domestic Violence	No reason	Y/x 1/12	Y/Y	Don't know	1-2	Food bank, mission	N/Y	Valium, Meth, Oxy's	18	$100-150
11	Don't get along with women	Don't get along with women	Y/x 6/12	Y/Y	>1 yr	Don't really eat	SM, Food bank, garbage cans	N/Y	Opium, Meth, Oxy's, IVDU-Methadone	26	Hustle, steal, rob $80/day
14	To avoid street	Because shy - cold not go	Y/x 6/12	Y/Y	>6/12	1	Mission	N/Y	Crack, Cocaine	34	Don't buy, will not sell soul for

		there									drugs
15	Safety	No reason	Y/x 1 day	N/Sometimes	>1/12	2	Food bank	Y/Y	Oxy's, Perks, Crack	13	Usually free
16	No other option	Health hazards, bedbugs, roaches	Y/x 2/12	Y/Y	Don't know	2	Food bank	N/Y	Coke	27	$200 prostitution

Health behaviours are the actions and habits that help to maintain, restore and improve one's health. According to the social determinants of health model health behaviours can also be thought of as the coping mechanisms used to endure and tolerate material and social deprivation. The following personal health behaviours were explored: diet, drug, alcohol and tobacco use, and sexual behaviour. Themes that emerged were (a) lack of quality and quantity of healthy food (b) the pain of addiction (c) lack of sexual intimacy.

As indicated in Table 2, a large number of participants (81%) received their food from food banks and soup kitchens. Ninety percent of the participants reported eating only one to two meals per day. The quality of food was described by many as food that is canned or boxed, with fresh fruits and vegetables being consumed on average once per week. The following section describes the participants' feelings about quality of food, substance abuse and sexuality.

Lack of Quality and Quantity of Healthy Food

"Not healthy, that's why I'm tired all the time" (P-11)

The following quotations from several participants describe the overall condition of available food for this hidden homeless population which lacked nutritional value. "Cheap food like...cans...boxes...Kraft dinner...if I'm lucky, meat" (P-1). As reported by the participants, 90% had one to two meals per day, "One [meal per day] if I'm lucky" (P-12). One participant reported rarely eating a meal, "I don't really eat anything. I maybe have a muffin and a coffee...There's been times garbage cans, um I'll grab my pop just from the garbage and refills are free" (P-11). The following participant expresses a belief that when homeless you must tolerate the worst conditions. "Anything. Food is

food man. I'm not fussy. When you don't have it you're not fussy" (P-21). Finally the monotony of the same food day after day is expressed by this participant, "Pasta, peanut butter...um sandwiches. That's basically it" (P-16).

Overall the participants did not enjoy the social and cultural meanings that food can give. The food itself did not seem to bring pleasure, yet the participants understood the necessity of eating if only to provide some sustenance. The following comment from one participant about his use of a soup kitchen highlighted the social aspect of eating, "I won't eat at the [soup kitchen]...yeah but that's a social thing that's not for the food" (P-12). Obtaining and seeking out food was not enjoyable for many of the participants but rather becomes a necessary stress that a person who is homeless must contend with on a daily basis.

The Pain of Addiction

"I'm sick of being a slave to this, to this dope" (P-12)

Participants described challenges with drugs and alcohol. A large number of participants (71%) reported between 11 and 18 as the age of first time drug use. In the current analysis, 18 of the 21 participants (86%) reported poly-substance use, 38% of participants reported alcohol use and all of the participants reported tobacco use (see Table 2). Ninety percent of participants reported having used drugs in the month prior to the day of the interview. While some participants reported never having to buy drugs due to availability on the street, many reported theft, hustling, prostitution and bartering as resources for obtaining drugs.

The pain of addiction and the lifestyle it entails for the homeless person is evident in their desire to be free of the addiction. A quarter of the participants verbalized a desire

to stop using drugs, while many others alluded to the realization that drug addiction was the source of their myriad problems. Many of the participants understood that it was their addictions that were responsible for the loss of their families, friends, jobs and past life styles. The following participant understands his physical and psychological addiction "I'd ask for my central nervous system to be totally repaired, and off opiates yah know, and like never tried them before" (P-4). In this quotation the participant expresses an awareness that his injuries are responsible for his addiction "And just for everything to go back to the way they were before the injuries and the doctor put me on the goddamn pain pills" (P-5).

Many of the participants reported using drugs for the first time to feel a sense of belonging and to fit in, as expressed here "I grew up in the rave scenes so I did do a lot of uh pharmaceutical stuff...been getting into alcohol more...it takes the edge off my...I, I craved to do cocaine..." (P-7). Several of the participants described having sought treatment for addiction. The number of times that these participants sought treatment for drug addiction ranged between one to fifteen times. Many indicated that they had failed addiction treatment, "NA, NA, and AA both" (P-6). The participants were aware that their addictions were a sickness, as in this quotation "I don't know when I am high I get probably, well not high but when I have opiates in my system, I get probably about 6-8 hours [of sleep] but if I don't have any then I probably get about like maybe 4 hours. Like 6-8 hours when I am alright but when I am sick I probably get maybe 3 or 4 hours" (P-4). This final quotation summed up what many participants wished for, either directly or indirectly, "To be able to live on my own, to stop using drugs, to have a normal life" (P-1).

Lack of Sexual Intimacy

" I don't practice sex...when I do its safe" (P-9)

As indicated in Table 2, twelve of the participants (57%) reported practicing safe sex, five of the participants (24%) reported not practicing safe sex, three participants (14%) reported sometimes practicing safe sex, while one participant (5%) reported abstinence. It is known that unsafe sex can expose one to sexually transmitted illnesses. Sexual relationships and intimacy appear to serve more as an instrumental need, for example to purchase drugs, than as a means for an intimate connection with another person. The female participants overall had little choice in deciding if a condom would be used. The female participants may be at risk for sexual violence, abuse and exploitation. Sexual health is part of overall health and well-being. The majority of participants' daily living conditions affected their capacity for stable intimate relationships.

One female participant who shared that she sometimes sells her body for drugs and stated "Condoms...it's not necessarily safe all the time because I don't have a condom, you know, there's times where I don't have a condom" (P-11). Some participants expressed that they did not practice safe sex "No. I didn't have to [use condoms]...cause she got checked every week" (P-19). One participant (5%) who reported being gay stated "I don't practice safe sex" (P-3). A female participant expressed a complete powerlessness to make choices about her body when she stated, "They buy them, the male" (P-1). For many of the participants sexual intimacy was lacking in their relationships with others.

Health Status. For Brunner and Marmot (1999: 2004) health status is directly impacted by the social determinants of health. Social environments, the degree and quality of social supports along with personal health behaviours are factors which affect health. Other factors that impact upon the daily living conditions collectively determine health status and health outcomes. The onset of disease and illness is shaped by material, social and psychological disadvantage. Table 3 reports the self reported health status of the participants as well as medical and psychological diagnoses. Dental (33%), cardiac complications (29%) and respiratory conditions (24%) were among the most frequently reported physical concerns. More than half of the participants reported depression (52%) while 57% of participants reported anxiety.

Table 3: Health Status

Male (N=13)	Health Self Report	Medical DX	Psych DX
3	F	Dental	Major depressive disorder
4	F	Dental, Drug, Hep C (+), liver, sleep, disorder, skin	Anxiety
5	P	Previous MI x2	Depression, anxiety
6	G	-----------	-----------
7	G	Severe asthma, ↑BP	Depression, anxiety, bipolar tend, OCD, PTSD, ADD (severe)
8	G	Foot problems, eye, ulcers, dental	Depression, bipolar, OCD, anxiety
12	P	Anemia, Dental, Gum, Acid reflux, ↑BP, liver	Personality disorder, ADHD, anxiety, depression
13	F	Eye/Dental problems	-----------
17	F	Dental, gerd, HIV (+), Hep C (+)	?
18	F	-----------	-----------
19	F	Foot, eye problems	Depression, anxiety
20	P	Foot problems, pulemb	Depression, anxiety
21	P	Asthma, bronchitis, arthritis	-----------
Female (N=8)			
1	F	Dental	Depression, anxiety
2		Respiratory Lung	Depression, OCD, anxiety,

			ADHD, manic dep disorder, anger mgmt
9	G	Breathing problems	-----------
10	G	↑BP	-----------
11	P	Dental, ↑BP, Liver, Sleep	Anxiety
14	F	↑BP	Bipolar, depression, anxiety
15	F	Dental, resp/lung, heart, skin, liver, epilepsy, Hep C (+)	Depression, anxiety
16	F	-----------	Anxiety

Participants rated their own state of health based on what they perceived state of health to mean. As indicated in Table 3, three-quarters of the participants self reported their state of health to be fair or poor, and one-quarter reported their state of health as good. No one rated their health as excellent which was the only other option. Therefore from this finding it can be concluded that 76% of the participants fell below the 50% percentile for state of health in this survey.

The medical diagnoses reported were: cardiac (29%), respiratory (24%), dental problems (33%), Hepatitis C positive (24%), foot problems (3%), and HIV positive (5%). Psychological diagnoses most prevalent were anxiety (57%), depression (52%). Forty-eight percent of the participants reported both anxiety and depression. While it is easy to calculate medical and psychological diagnoses through self report, it is not so easy to calculate the health toll on an individual's overall functioning where social and material deprivation exist. Evidence in the three analytic domains would suggest that physically, psychologically and socially, the majority of the participants experienced negative health impacts. A major theme that emerged was that all participants were aware that their health was compromised by lack of shelter. An overriding theme was a desire to better the health of homeless people and the communities where they lived.

Many of the participants were aware of their poor state of health. One very powerful exemplar stated by P-2 demonstrated a strong desire to not be stereotyped based on homelessness while expressing a real desire to improve conditions for the whole community. This exemplar is summarized in one theme, (a) desire to better the health of homeless people and the community.

Desire to Better the Health of Homeless People and the Community

"Homelessness sucks" (P-1)

"When it comes to dealing with homeless people, I want to broaden the perspectives of people's ideas when it comes to what a homeless person is, how they act, who they are as a person, what they've been through, their future, all of those things. Because I really want to get it through every single person's head, that homeless people cannot be stereotyped...Because every single one is different. I mean I've met so many different people who have been through the exact same thing that I have been through. It's just because the circumstances are the same, doesn't mean that the person is the same. I mean, there's bad homeless people out there and there's good homeless people out there...Just like there are good normal people and good bad people. I just...I want the change to not be out of sympathy; I want it to be out of helping the community, to better our own community" (P-2).

At the time P-2 made the above statement she was 18 years old. When she was 14 years old she experienced homelessness for the first time, having been thrown out of the house by her father after being beaten by him. "My Dad beat me and then threw me out of the house literally, like threw me off the porch...I was in crocs and boxer shorts and a t-shirt....it was the middle of January" (P-2). She reported her health as fair. Her diet consisted of "a lot of carbs" and fresh fruit "probably about once a month" and fresh vegetables "maybe twice a month". She stated she was diagnosed with anemia, respiratory/lung conditions, ulcers, sleep disorders, depression, obsessive compulsive disorder (OCD) and anxiety.

P-2 stated she had experimented with drugs when she was 14 years old after a friend/sexual partner introduced her to drugs. Like many adolescents her age she tried drugs for the first time to experiment, but also stated she tried drugs because of her nerves, low self-esteem and a desire to be accepted. She described her typical day as one in which she would, “wake up next to my boyfriend...smoke marijuana...watch TV”...take a shower...go downtown and hand out resumes...I hand out resumes close to a daily basis” (P-2). She stated that she does not practice safe sex, does not use condoms, and uses alcohol, drugs and tobacco.

This young woman is aware that her physical, psychological and social health status is equally impacted by the condition of her everyday living conditions. When asked the question, If you had a magic wand what three things would you ask for or change? P-2 replied, “Unlimited amounts of money for myself, the chance to go to school and chase dreams, and to help people.”

Social Exclusion. The complexity of social exclusion is associated with poverty and the implications of poverty such as homelessness. The participants experienced social exclusion as a result of homelessness which diminished quality social supports, increased health risk behaviours and compromised physical and psychological health. Participants described various forms of marginalization, for example being restricted from shelter use due to substance abuse history. Table 4 identifies the broad aspects of social exclusion.

The broad aspects explored were those issues pertaining to housing: age when first homeless, number of years homeless and reasons for not having permanent housing, educational level, and employment history and income. These aspects are interrelated in many ways. The earlier that one experiences homelessness and deprivation can

determine the negative impacts on physical, psychological and social development. Not having a supportive system that living in a house can provide, such as a safe place to sleep and a quiet place to do homework, the ability to be successful in school and achieve an education can be negatively impacted. In this highly technical society, the need for higher education becomes a necessity to obtaining gainful employment. Without stable employment it is difficult to earn an income. This continuing cycle of unaffordable housing, lack of education, lack of employment and income, becomes a vicious cycle that is very difficult to interrupt and intervene without looking to solve these root causes. For this reason the social determinants of health model is useful in understanding these interrelated root causes.

Table 4: The Broad Aspects of Social Exclusion

Housing

Age First Homeless			# of Years Homeless		Why No Permanent Housing		
11-18	9	43%	Wk-1yr	10 (48%)	Unable to Afford	10	48%
19-29	7	33%	1-5yrs	2 (10%)	Drug Addiction	4	19%
30-69	5	24%	5-11yrs	3 (14%)	Abusive Family	3	19%
			Don't know	4 (19%)	Other	4	19%
			Couch Surf	2 (10%)			

Education

Level of Education		
Gr. 0-8	2	10%
Gr. 9-11	9	43%
Gr. 12 Diploma	7	33%
Some College/Univ	3	14%

Employment (years ago)

Last Job			Additional Skills		
0-2	8	38%	Yes	14	67%
3-10	9	43%	No	7	33%
11-15	3	14%			
Never	1	5%			

Income

OW	9	43%
None	6	29%
ODSP	2	1%
Other	4	19%

Table 5: Crosstabulation

Source of Income * Reason Why No Permanent Housing Crosstabulation

			Reason Why No Permanent Housing				Total
			Unable to afford	Drug addiction	Abusive family	Other	
Source of Income	OW	Count	3	2	1	2	8
		% within Source of Income	37.5%	25.0%	12.5%	25.0%	100.0%
	None	Count	2	1	2	1	6
		% within Source of Income	33.3%	16.7%	33.3%	16.7%	100.0%
	ODSP	Count	2	0	0	1	3
		% within Source of Income	66.7%	.0%	.0%	33.3%	100.0%
	Other	Count	3	1	0	0	4
		% within Source of Income	75.0%	25.0%	.0%	.0%	100.0%
Total		Count	10	4	3	4	21
		% within Source of Income	47.6%	19.0%	14.3%	19.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	5.892[a]	9	.751	.831		
Likelihood Ratio	7.638	9	.571	.874		
Fisher's Exact Test	5.584			.944		
Linear-by-Linear Association	1.724[b]	1	.189	.204	.111	.029
N of Valid Cases	21					

Table 4 is a representation of the broad aspects of social exclusion: housing, education, employment and income. Many of the participants expressed the desire to have a stable home and to be reunited with their family. The age when one first becomes homeless is an important consideration. In these findings, 43% of the participants first experienced homelessness between the ages of 11 and 18 years. The length of the homeless experience varied among the participants with 48% of participants experiencing homelessness from one week to one year. Interestingly, 19% of the participants did not know how long they had been homeless, and two participants (10%) reported couch surfing as their means of obtaining shelter. Couch surfing is strongly indicated for hidden homelessness and describes a situation where one is moving from one family member or friends place, usually sleeping on the couch without any form of private space. The reasons for not having permanent housing, ranged from inability to afford (48%), drug addiction (19%), abusive family (19%) and other (19%) which included job loss and incarceration.

Education levels varied among the participants. The majority of participants (76%) had education levels between grade nine to twelve. Of this 76%, 43% had obtained grade twelve. A few participants (10%) had grade eight or lower, and three participants (14%) had some higher education. Education is a strong social determinant of health and generally determines the kind of employment one can obtain. While some participants had jobs in the past, many participants faced challenges trying to obtain employment. While 38% of the participants had not been employed within the past two years, 48% of the participants had not been unemployed for three to ten years and 14% of participants had not been employed for 11-15 years. One participant (P-10) reported

never being employed. The longer the period that one remains outside the work environment, the greater are the challenges to finding work. More than half of the participants (67%) reported having additional skills other than those skills employed at their previous work. The provincial welfare program (OW) provided 43% of participants with minimal income, 1% of participants received income from the provincial disability program (ODSP), 29% reported no source of income while 19% reported other means of income which included theft, hustling and prostitution. The following chapter will discuss the findings and their implications.

Table 5 crosstabulation of the categorical variables: (1) reason for no permanent housing and (2) source of income did not yield statistical significance. However it highlighted an interesting finding. Of the nine participants receiving Ontario Works (OW) three participants reported an inability to afford permanent housing, while two participants receiving Ontario Disability Support Program (ODSP) both reported an inability to afford permanent housing.

CHAPTER V

DISCUSSION

All 21 participants shared details of their daily living conditions compounded by material and social deprivation. The participants imagined what they would change about their lives if they had a magic wand that could change three things about their current life. The participants all wished and desired for their lives to improve, mainly for their lives to be different from the lives they were currently living. The participants envisioned a better life as a life with enough money to afford the basic life requirements, to be reunited with family, children, and friends, and to be free of drug and alcohol addiction. Relative poverty denies one the ability to access adequate and affordable housing (Bryant, 2009). In the absence of adequate housing, many aspects of everyday life are affected such as the ability to access education and employment, which in turn affects ability to earn an income. These factors contribute to material and social deprivation. While social and material deprivation is not synonymous with social exclusion, social and material deprivation are contributing cumulative factors to the processes and outcomes of social exclusion (Galabuzi, 2006; Hwang et al., 2010; Rothman, 2006).

The social environments of the participants showed a generalized lack of quality and quantity of social supportive interactions. As Stansfeld (2006) suggests, social supports are not merely interactions or unidirectional relationships. Stansfeld talks about the importance of transactions among social relationships so that they are reciprocal. Stansfeld is referring to the importance of meaningful relationships where there is both give and take. This necessary aspect of transpersonal relationships was wholly absent for

the participants who relied primarily on instrumental or practical types of support from agencies and services. As the social determinants of health model (1999, 2004) illustrates, the lack of quality social supports affects ones immediate social environment by weakening it and forming a clustering of disadvantages. This further marginalizes and alienates people and thus contributes to the process of social exclusion.

The health behaviours or coping mechanisms were significant for the 21 participants. The clustering of disadvantage, weak social supports and social environments contributed to risk behaviours or coping mechanisms. The social determinants of health model implores that we look beyond the individual health behaviour. Coping with the effects of material and social deprivation are all consuming and can prevent those most in need from receiving much needed resources. When society focuses on the health risk behaviour of an individual only, it fails to see a holistic picture of the individual.

Positive health outcomes are unlikely when one faces material and social deprivation. Health risk behaviours contribute to poor health status, just as lack of material and social resources can contribute to poor health status. These contributing factors to poor health statuses become like a vicious cycle. This cycle can be very difficult to interrupt, increasing the likelihood of illness and disease. The social determinants of health model links poor quality social supports and environments, poor coping mechanisms, and negative health statuses. Together these are all aspects associated with the processes of social exclusion, that which prevents one from fully engaging and participating within their society.

Social Exclusion. Social exclusion emerged as a political concept to situate debates surrounding disadvantaged groups (Room, 1995). The term social exclusion has been criticized for claims that it is being used to replace the term poverty (Levitas, 1996; Rose, 1996). Levitas argues that social exclusion was constructed to describe the outcomes of poverty and inequality arising out of the idea of an underclass of poverty and that it has become part of the hegemonic discourse. Levitas sees this discourse as one that promotes social exclusion as an inability to integrate into the labour force.

This inability to integrate into the labour force was evident among the 21 participants in the present study. While more than half of the participants reported that they had additional skills other than those employed in their last job, they still lacked employment. As Levitas sees it, the construction of social exclusion obscures the real inequalities that create the conditions that lead to social exclusion. A social determinant of health perspective draws attention to these inequalities inherent in our social system, a system where currently the quality and quantity of resources are not equally distributed among the members of a society (Brunner & Marmot, 2006; Raphael, 2009).

Labonte (2008, 2009) notes that having an emphasis on equality of opportunity and outcomes may be idealistic. Equality of opportunity cannot exist for all people due to differences in resources and capacities. At the same time equality of outcomes cannot exist due to differences among people. These differences in resources and capacities can disadvantage those less endowed and so one outcome for all is not desirable or realistic. Labonte (2008) concludes that social exclusion is not merely a national concern but also a global concern. While it is true that not all people have equal opportunities or equal

capacities, it is also true that in order to achieve health for all, all people need to have equal access to basic life requirements as a prerequisite for health (WHO, 1948, 1978).

Bask (2005) defines social exclusion as experiencing two of the following welfare problems: "chronic unemployment, economic problems, health problems, experiences of threat or violence, crowded housing and lack of interpersonal relationships" (p.299). Without question, all of the 21 participants experienced at least two, if not more of these social welfare problems and therefore would be considered to be socially excluded as defined by Bask.

Social exclusion however, should not be considered as merely the opposite of social inclusion, as Labonte (2009) cautions. When social inclusion is understood as the "norm" in society, there is the risk of inferring that anyone not socially included is someone that is socially excluded. Labonte, much like Levitas (1996) questions the idea of including people in the societal structures that may have been partly, if not fully responsible, for excluding them to begin with.

Many of the participants described a discomfort in accessing public space. In 2000, the Province of Ontario brought into law the *Ontario Safe Streets Act* (OSSA). This law essentially prohibited aggressive panhandling in public spaces and was harshly criticized by some for targeting homeless youth, especially those youth known then as "squeegee kids" (p. 2) who engaged in washing windshields of motorists on urban streets (O'Grady & Greene, 2003). Critics expressed concerns that this law, which was initiated by business owners, prevented youths who were homeless from earning income outside of ways considered the norm (O'Grady & Greene).

Social exclusion according to Gaetz (2004) is a useful concept for understanding the marginalization of homeless youth. Social exclusion situates homeless youth across different aspects of deprivation. Deprivation of basic life requirements and restriction of public access are both elements of social exclusion. The public nature of homelessness implies that people who experience homelessness are constantly under the microscope. Some participants reported being met with hostility in the public sphere. In response to this perceived hostility it is common to develop a mistrust and resentment toward public, social and health institutions (Gaetz, 2004; Levy & O'Connell, 2004). For the homeless youth in particular, social exclusion is experienced on many levels related to shelter, employment, health care and free movement within urban space. Social exclusion may be one reason that homeless youth are choosing to obtain shelter that is hidden from the gaze of society. Recall that adolescents and young people are among a growing demographic of the hidden homeless population. As Shapcott (2011) reminds us, 80% of people who are homeless are considered hidden homeless and not visible in the society. Some participants expressed awareness that social and economic inequalities were responsible for their state of homelessness.

As Labonte stated, people may choose to exclude themselves as a matter of protest to resist the social, political, and economic inequalities which have created the very conditions which perpetuate their inequalities. This is similar in thought to Levitas (1996) who argues that social exclusion is a product of and can only exist within the current money based value economic system. The emphasis on equality of opportunity and the quality of outcomes are basic concepts to the idea of social justice. Social justice as defined by *The Ottawa Charter* (1986) is a necessary prerequisite for health.

The 21 participants experienced high levels of stress on a daily basis. The daily need to satisfy basic life requirements consumed a large portion of the day. This included having to eat at soup kitchens, obtain food from food banks, risk incarceration, "hustle" to feed addictions and experience personal disrespect in many forms. The lack of housing, education, employment and a stable income contributed to social exclusion which impacted physical, psychological and social health status. As P-5 stated, the reason he did not have permanent housing was due to "no finances...it's hard to get on social assistance...it's kind a like once you're down you gotta stay down." P-5 was a 26 year old male who had been couch surfing for 9 months, was the father of two children and reported his health as poor. He reported he had two previous myocardial infarctions and suffered with depression and anxiety. As reported earlier, according to McEwan (2008) constant exposure to daily threats contributes to allostatic overload increasing susceptibility to chronic illness and poor health status.

Health status is an important factor when considering homelessness. Young people may often become homeless due to a sexual orientation that is not acceptable to their family (Karabanow, 2006). Age when first homeless is important because becoming homeless at a young age will further impact physical, social and psychological maturation and development. It is known that males and females have specific challenges being homeless for example, gender-based violence can be pronounced for females (Haldenby, Berman, & Forchuk, 2007).

Shelter is identified as a prerequisite for health and a human right (WHO, 1948, 1986). Health as a positive resource for well-being cannot be achieved without a stable living environment. Housing as a commodity must be addressed by the social

institutional structures of that society. If shelter and housing are both rights and prerequisites for positive health and well-being, ought there to be an obligation by that society to provide that right? As Table 5 crosstabulation illustrated, five participants who were receiving provincial government supplements (OW/ODSP) were still unable to afford permanent housing.

IMPLICATIONS

This secondary analysis showed clinically significant findings for nursing. Nursing understands that the social determinants of health are key determinants for health and well-being. Positive health statuses cannot be achieved when one is experiencing material and social deprivation. Health behaviours cannot be measured in isolation from one's social environments and social supportive networks. Health behaviours must be understood as coping mechanisms where there is material and social deprivation.

The participants experienced unhealthy conditions among the sheltering services in their community. Stories of infestation, physical and psychological complications, abuse and violence were expressed by the participants. While shelters and food banks can serve as stop gap measures, they are not long term solutions for poverty and homelessness. As a beginning, shelter services, health care professionals and people who are homeless could work collaboratively to find solutions to poverty and homelessness. Participants can be encouraged to join all health care professionals to help demand political changes at the municipal, provincial and federal levels.

Many participants expressed a desire to change their lives as well as the lives of others in their situation. Participants who have knowledge of the poor social environments of shelter services could help initiate changes at a community level. The need for shelters should be gradually eliminated and a national housing policy geared to income should be reinstated. Housing and shelter must be understood as basic life requirements that when not met will impact negatively on physical, social, and psychological health status.

One future concern is the effect that material and social deprivation will have on the children of the participants. More than half of the participants (62%) had children. Of the 62% of participants who reported having children, 92% of these participants reported their children were not in their care. The total number of children among all participants equalled 33, and all but three of the children were under the age of 20. The present and future health status for these children is of primary importance. Since this study did not follow up with participants longitudinally, it is not known if the children were in the care of other family members or child care agencies, nor did the questionnaire (Appendix A) used for the primary study provide a question requesting this information.

The findings from this study show that the longer one experiences material and social deprivation, the more likely disease and illness will develop. Public health professionals can support those who have experienced homelessness through the provision of counselling services to support those trying to change and improve their lives. Health care professionals working with homeless people can create screening programs in schools to identify children at risk for social and material deprivation and for social exclusion. Early recognition and early intervention may prove to be very important for the long term health status of children experiencing deprivation.

Health care professionals, that is doctors and nurses must have the social determinants of health model included in their curriculums. Medical and nursing students must understand the complex needs and significant challenges facing people who are homeless. Providing clinical experiences that include exposure to homeless people for these students is critical to developing health care professionals who practice in a non judgemental and caring manner.

Brunner and Marmot's model (1999, 2004) clearly depicts the linkages between social environments, health behaviours and health status. Social environments were negatively impacted because of a lack of quality social supports and interactions which then affected their immediate social environments. A lack of quality social supports and environments influences health behaviours. Individual health behaviours may be coping mechanisms for poor quality support systems and social environments. One does not always make the best choices when those choices are limited and of poor quality. The choices one makes are determined by the quality of choices available to them. When we understand health behaviours as coping mechanisms for poor social environments and poor social support networks, we might not blame the victim for these circumstances.

Future research should focus on the psychological pathway in Brunner and Marmot's social determinants of health model (1999, 2004). The experience of stress related to satisfying basic life requirements compounded by social exclusion can influence and shape health behaviours and coping mechanisms. When societal resources are not equitably distributed, negative and adverse experiences are increased. These adverse experiences can influence health behaviours and in turn influence health status.

Social exclusion is exclusion from political, social, economic, and cultural participation in a society. The concept of social exclusion draws our attention to the complexity of poverty and its associated problems such as homelessness. The problems of social exclusion are the complex problems of homelessness and poverty. These complex problems of poverty and homelessness include individual and family hardships, drug and alcohol addictions, physical and psychological ill-health exacerbated by periods

of recurrent unemployment. In this way social exclusion is a cumulative process with poor health outcomes.

This study explored health and social exclusion among a hidden homeless population of 21 participants. Using Brunner and Marmot's social determinants of health model, social environment, health behaviours and health status were examined along with social exclusion. It was shown that poor social environments can lead to poor health behaviours which collectively can have a negative impact on health status. Social exclusion occurs when these complex issues and problems affect the ability to participate economically, socially, politically and culturally within a society. Health as a positive resource cannot be realized where poverty and homelessness exist nor within the concept of social exclusion.

LIMITATIONS

There were several limitations related to this secondary analysis. Although there were 34 participants involved in the original study, only 21 transcriptions were recovered and usable. The other 13 surveys may have added to the findings. Due to the small sample size, statistical power was low and reliable predictions could not be made from the data. The original study was limited to only two community agencies where the researchers were able to recruit participants. Although the participants were not supposed to be using drugs or alcohol during the survey, some of the participants indicated that they had used substances just prior to their completion of the survey. This may affect the validity of the information gathered.

CONCLUSION

The findings of this study illuminated the daily living conditions of a hidden homeless population, and the complex issues that arise from poverty, homelessness and social exclusion. Using the social determinants of health model allows for a broader view of health and its determinants. Health professionals who understand health behaviours as coping mechanisms for poor quality social environments and supportive systems can provide more comprehensive and holistic care. The findings of this study should be used to show that the need for a national housing policy is a basic requirement for health and is a key factor in the health and well being of those individuals who experience poverty, homelessness and social exclusion.

REFERENCES

Armstrong, P., & Armstrong, H. (2002). *Wasting away: The undermining of Canadian health care* (2nd ed.). Toronto, ON: Oxford University Press.

Atkinson, L., Hamilton, M., Crawley, J., Kane, D., Dobson, K., & Watson, J. (2011). Hidden no more: Needs assessment of service use by the hidden homeless. *Homeless Coalition of Windsor Essex County*

Barnaby, L., Penn, R., & Erickson, P.G. (2010). Drugs, homelessness & health: homeless youth speak out about harm reduction. *The Shout Clinic Harm Reduction Report*, Toronto: January.

Bask, M. (2005). Welfare problems and social exclusion among immigrants in Sweden. *European Sociological Review, 21*, 73-89.

Berkman, L.F., & Kawachi, I. (2000). *Social epidemiology.* New York: Oxford University Press.

Blane, D., Brunner, E., & Wilkinson, R. (1996). The evolution of public health policy: An Anglocentric view of the last fifty years. In D. Blane, E. Brunner, & R. Wilkinson (Eds). *Health and social organization: Towards a health policy for the 21st century.* London: Routledge.

Brunner, E. (1997). Stress and biology of inequality. *British Medical Journal 314*, 1472-6.

Brunner, E., & Marmot, M. (2006). Social organization, stress, and health. In R. Wilkinson & M. Marmot (Eds.) *Social determinants of health.* Oxford: Oxford University Press.

Bryant, T. (2009). Housing and health: More than bricks and mortar. In D. Raphael (Ed) S*ocial determinants of health: Canadian perspectives* (2nd ed.) Toronto: Canadian Scholars' Press.

Burns, N., & Grove, S.K. (2005). *The practice of nursing research: Conduct, critique, and utilization.* St. Louis, MO: Elsevier Saunders.

Canadian Nurses Association (2005). Social determinants of health and nursing: A summary of the issues. http://www.cna-aiic.ca/CNA/documents/pdf/publications/BG8-Social-Determinants-e.pdf.

Canadian Nurses Association (2009). Position statement: determinants of health. http://www.cna-aiic/ca/CNA/documents/pdf/publications/PS-Determinants_of_Health_e.pdf.

Cheever, K.H., & Hardin, S.B. (1999). Effects of traumatic events, social support, and self-efficacy on adolescents' self-health assessments. *Western Journal of Nursing Research, 21*(5), 673-684.

Coburn, D. (2004). Beyond the income inequality hypothesis: Class, neo-liberalism, and health inequalities. *Social Science & Medicine, 58*, 41-56.

Curry-Stevens, A. (2009). When economic growth doesn't trickle down: The wage dimensions of income polarization. In D. Raphael (Ed.) *Social determinants of health: Canadian perspectives*(2nd ed). Toronto: Canadian Scholars' Press.

Davey Smith, G., Hart, C., Blane, D., & Hole, D. (1998). Adverse socioeconomic conditions in childhood and cause specific adult mortality: Prospective observational study. *British Medical Journal, 316*, 1631-1635.

Dunn, J.R., Hayes, M.V., Hulchanski, J. D., Hwang, S.W., & Potvin, L. (2006). Housing as a social-economic determinant of health. *Canadian Journal of Public Health, 97*(3), S11-S15.

Echenberg, H., & Jensen, H. (2008). Defining and enumerating homelessness in Canada. *Library of Parliament,* 1-8.

Epp, J. (1986). *Achieving health for all: A framework for health promotion.* http://tinyurl.com/2295nu

Falk-Rafael, A. (2005). Speaking truth to power: Nursing's legacy and moral imperative. *Advances In Nursing Science, 28(3)*, 212-223.

Fiedler, R., Schuurman, N., & Hyndman, J. (2006). Hidden homelessness: An indicator-based approach for examining the geographies of recent immigrants at-risk of homelessness in Greater Vancouver. *Cities, 23*(3), 205-216. Doi: 10.1016/j.cities.2006.03.004.

Fish, J. (2010). Conceptualizing social exclusion and lesbian, gay, bisexual, and transgender people: The implications for promoting equity in nursing policy and practice. *Journal of Research in Nursing, 15*(4), 303-312. Doi: 10.1177/1744987110364691jrn.sagepub.com

Frankish, C.J., Hwang, S., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health, 96(2)*, S23-S29.

Geckova, A., Van Dijik, I.P., Stewart, R., Groothoff, J.W., & Post, D. (2003). Influence of social support on health among gender and socio-economic groups of adolescents. *European Journal of Public Health, 13*(1), 44-50.

Gaetz, S. (2004). Safe streets for whom? Homeless youth, social exclusion, and criminal victimization. *Canadian Journal of Criminology and Criminal Justice, 46(4)*, 423-455.

Gaetz, S. (2010). The struggle to end homelessness in Canada: How we created the crisis and how we can end it. *The Open Health Services and Policy Journal, 3,* 21-26.

Galabuzi, G. E. (2006). *Canada's economic apartheid: The social exclusion of racialized groups in the new century.* Toronto: Canadian Scholars' Press.

Galabuzi, G.E. (2009). Social exclusion. In D. Raphael (Ed.) *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto: Canadian Scholars' Press.

Galabuzi, G.E. (2012). Social exclusion as a determinant of health. In E.A. McGibbon (Ed.) *Oppression: A social determinant of health.* Halifax: Fernwood Publishing.

Girard, M.C. (2006). Determining the extent of the problem: The value and challenges of enumeration. *Canadian Review of Social Policy, 58,* 101-107.

Glanz, K., Rimer, B.K., & Viswanath, K. (2008). *Health behaviour and health education: Theory, research and practice (4th ed).* San Francisco, CA: Jossey-Bass.

Green, T.L., & Darity, W.A. (2010). Under the skin: Using theories from biology and the social sciences to explore the mechanisms behind the black-white health gap. *American Journal of Public Health, 100* (S1), S36-S39. doi: 10.2105/AJPH.2009.171140

Grenier, A.M., & Guberman, N. (2009). Creating and sustaining disadvantage: The relevance of a social exclusion framework. *Health & Social Care in the Community, 17(2)*, 116-124.

Harter, L.M., Berquist, C., Titsworth, B.S., Novak, D., & Brokaw, T. (2005). The structuring of invisibility among hidden homeless: The politics of space, stigma, and identity construction. *Journal of Applied Communication Research, 33(4)*, 305- 327. Doi: 10.1080/00909880500278079.

Haldenby, A.M., Berman, H., & Forchuk, C. (2007). Homelessness and health in adolescents. *Qualitative Health Research, 17(9)*, 1232-1244. Doi: 10.1177/104973207307550.

Hallerod, B., & Larsson, D. (2007). Poverty, welfare problems and social exclusion. *International Journal of Social Welfare, 17*, 15-25. doi: 10.1111/j.1468.2397.2007.00503.x

Hulchanski, D.J., Campsie, P., Chau, S.B.Y., Hwang, S.W., & Paradis, E. (2009). Homelessness: What's in a word? E-book available at www.homelesshub.ca/findinghome.

Hwang, S. (2001). Homelessness and health. *Canadian Medical Association Journal, 164(2)*, 229-233.

Hwang, S., Ueng, J., Chiu, S., Kiss, A., Tolomiczenko, G., Cowan, Levisnos, W., & Redeimeier, D. (2010). Universal health insurance and health care access for homeless persons. *American Journal of Public Health, 100,* 1454-1461.

Juster, R.P., McEwan, B. S., & Lupien, S.J. (2010). Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neuroscience and Behavioral Reviews, 35*, 2-16. Doi: 10.1016/j.neubiorev.2009.10.002.

Karabanow, J., & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. *Brief Treatment and Crisis Intervention,*(1), 93-108. Doi: 10.1093/brief-treatment/mhh007.

Karabanow, J. (2006). Becoming a street kid: Exploring the stages of street life. *Journal of Human Behavior in the Social Environment, 13(20)*, 49-72. Doi: 10.1300/J137v13n02_04.

Khandor, E., & Mason, K. (2007). *The street health report 2007.* Toronto: Street Health-Creative Commons.ca. Retrieved May 31, 2010 from http://www.homelessnesshub.ca/ResourceFiles/SHReport2007.pdf.

Kothari, M. (2007). United Nations Special Rapporteur for the right to adequate housing. www.worldpress.org.

Labonte, R. (2008). Global health in public policy: finding the right frame? *Critical Public Health, 18(4)*, 467-482. doi: 10.1080/09581590802443588.

Labonte, R. (2009). Social inclusion/exclusion and health: Dancing the dialectic. In D. Raphael (Ed.) *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto: Canadian Scholars' Press.

Laird, G. (2007). Shelter - Homelessness in growth economy: Canada's 21st century paradox. Calgary: Sheldon Chumir Foundation for Ethics in Leadership & Gordon Laird.

Lalonde, M. (1974). *A new perspective on the health of Canadians: A working document.* http://www.hc-sc.gc.ca/hcs-sss/com/fed/lalonde_e.html.

Layton, J. (2000). *Homelessness: The making and unmaking of a crisis.* Toronto: Penguin Books.

Levitas, R. (1996). The concept of social exclusion and the new Durkheimian hegemony. *Critical Social Policy, 16*, 5-20.

Levy, B.D., & O'Connell, J.J. (2004). Health care for homeless persons. *The New England Journal of Medicine, 350*, 2329-2332.

Lewontin, R. & Levins, R. (2007). *Biology under the influence: Dialectical essays on ecology, agriculture, and health.* New York: Monthly Review Press.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Malloy, P. & Leeseberg Stamler, L. (2007). Poverty and homelessness. In L.L. Stamler, & L. Yiu (Eds) *Community health nursing: A Canadian perspective* (2nd ed.). Toronto: Pearson Education.

Marlier, E., & Atkinson, A.B. (2010). Indicators of poverty and social exclusion in a global context. *Journal of Policy Analysis and Management, 29(2)*, 285-304.

Marmot, M., & Wilkinson, R. (2006). *Social determinants of health* (2nd ed.). Oxford: Oxford University Press.

Marsh, A., & Mullins, D. (1998). The social exclusion perspective and housing studies: Origins, applications, and limitations. *Housing Studies, 13(6)*, 749-759.

Meleis, A.I. (1989). Being and becoming healthy: The core of nursing knowledge. *Nursing Science Quarterly,* 107-114.

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts.* Retrieved January 10, 2011 from www.thecanadianfacts.org.

McEwan, B. S. (1998). Protective and damaging effects of stress mediators. *New England Journal of Medicine, 338,* 171-179.

McEwan, B. S. (2004). Protection and damage from acute and chronic stress. *Annals New York Academy of Sciences 1032,* 1-7. doi: 10.1196/annals.1314.001.

McEwan, B. S. (2008). Understanding the potency of stressful early life experiences on brain and body function. *Journal of Metabolism Clinical and Experimental 57(2)*, S11-S15. doi: 10.1016/jmetabol.2008.07.006.

McMurtry, J. (1998). *Unequal freedoms: The global market as an ethical system.*Toronto: Grammond Press.

Munro, B.H. (2005). *Statistical methods for health care research* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Murphy, B. (2000). *On the street: How we created the homeless.* Winnipeg: J. Gordon Shillingford Publishing, Inc.

Nathaniel, A.K. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research,28(4)*, 419-438. Doi: 10.1177/01939459055284727.

Nichols, N.E. (2008). Gimme shelter! Investigating the social service interface from the standpoint of youth. *Journal of Youth Studies, 11(6)*, 685-699.

Noonan, J. (2006). *Democratic society and human needs.* Montreal, PQ: McGill-Queen’s University Press.

Noonan, J. (2012). *Materialistic ethics and life-value.* Montreal, PQ: McGill-Queen’s University Press.

O’Connell, J.J. (2004). Dying in the shadows: The challenge of providing health care to homeless people. *Canadian Medical Association Journal, 179*, 1251-1252.

O'Grady, B., & Greene, C. (2003). A social and economic impact of the Ontario Safe Streets Act on Toronto squeegee workers. *Online Journal of Justice Studies 1(1)*, 1-15. ISSN: 1492-3831.

Pascal, C. (2009). With our best futures in mind: Implementing early learning in Ontario. Ottawa, ON: *Government of Canada,* 1-68.

Pauly, B. (2008). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy, 19,* 195-204.

Pauly, B., MacKinnon, K., & Varcoe, C. (2009). Revisiting who gets care? Health equity as an arena for nursing action. *Advances in Nursing Science, 32(2)*, 118-127.

Percy-Smith, J. (2000). *Policy responses to social exclusion.* Buckingham, UK: Open University Press.

Pfettscher, S.A. (2002). Modern nursing. In Tomey, A.M., & Alligood, M.R. (Eds.) *Nursing theorists and their work.* St. Louis, MI: Mosby.

Prilleltensky, I. (2010). Child wellness and social inclusion: Values for action. *American Journal of Community Psychology,46,* 239-249. Doi: 10.1007/s10464-010-9318-9.

Registered Nurses' Association of Ontario. (2006). Briefing note issue # 3: Social exclusion. www.rnao.org.

Raphael, D. (2006a). Politics, political platforms and child poverty in Canada. *Policy Options, July-August,* 99-103.

Raphael, D. (2006b). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Sciences, 34(4)*, 651-677.

Raphael, D., Bryant, T., & Rioux, M. (2006). *Staying alive: Critical perspectives on health, illness, and health care.* Toronto: Canadian Scholars' Press.

Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy, 88,* 225-235. doi: 10.1016/j.healthpol.2008.03.015.

Raphael, D. (Ed). (2009). *Social determinants of health: Canadian perspectives.* (2nd ed.) Toronto: Canadian Scholars' Press.

Raphael, D. (2011). Mainstream media and the social determinants of health in Canada: Is it time to call it a day? *Health Promotion International, 26(2)*, 220-229. doi: 10.1093/heapro/dar008.

Regidor, E. (2006). Social determinants of health: A veil that hides socioeconomic position and its relation with health. *Journal of Epidemiology and Community Health, 60*, 896-901.

Room, G. (1995). *Beyond the threshold: The measurement and analysis of social exclusion.* Bristol: Polity Press.

Rose, N. (1996). The death of the social? Re-figuring the territory of government. *Economy and Society, 25*, 327-356.

Rothman, L. (2006). Oh Canada! Too many children in poverty for too long. *Education Canada, Canadian Education Association,* 49-53.

Simon, R.L., Whitbeck, L.B., & Bales, A. (1989). Life on the streets: Victimization and psychological distress among the adult homeless. *Journal of interpersonal Violence 4(4),* 482-501.

Singer, M. (1999). Studying hidden populations. In J.J. Schensul, M.D. LeCompte, R.T. Trotter II, E.K. Cromley & M. Singer (Eds.) *Mapping social networks, spatial data, & hidden populations.* London: AltaMira Press.

Sen, A. (1992). *Inequality re-examined.* Cambridge, MA: Harvard University Press.

Sen, A. (1999). *Development as freedom.* New York: Alfred A. Knopf.

Shapcott, M. (2009). Housing. In D. Raphael (Ed.) *Social determinants of health: Canadian perspectives* (2nd ed.). Toronto: Canadian Scholars' Press.

Shapcott, M. (2010). Precarious housing in Canada.Wellesley Institute: Author. www.wellesleyinstitute.ca.

Shaw, M. & Dorling, D. (1998). Mortality among street sleeping youth in the UK. *Lancet, 352*, 743.

Shaw, M., Dorling, D., & Davey Smith, G. (2006). Poverty, social exclusion, and minorities. In M. Marmot & R. Wilkinson (Eds.) *Social determinants of health* (2nd ed). Oxford: Oxford University Press.

Speizel, H.J.S., & Carpenter, D.R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia, PA: Lippincott Williams and Wilkins.

Spradley, J. P. (1979). *The ethnographic interview.* New York: Holt, Rinehart and Winston.

Stansfeld, S.A. (2006). Social support and social cohesion. In M. Marmot & R. Wilkinson (Eds.) *Social determinants of health* (2nd ed). Oxford: Oxford University Press.

Statistics Canada (2009). Low Income cut-offs for 2008 and low income measures for 2007. Ottawa, ON: Minister of Industry.

Tappen, R.M. (2011). *Advanced nursing research: From theory to practice.* Sudbury, MA: Jones & Bartlett Learning.

The Homeless Hub. (2008). Population: Hidden Homeless. http://www.homelesshub.ca/Topics?Hidden-Homeless-260.aspx.

Thorne, S., Canam, C., Dahinton, S., Hall, W., Henderson, A., & Reimer Kirkham, S. (1998). Nursing's metaparadigm concepts: Disimpacting the debates. *Journal of Advanced Nursing, 27,* 1257-1268.

Traynor, V. (2011). *Mixed methods presentation*. www.nswphc.unsw.edu.au

Whitzman, C. (2006). At the intersection of invisibilities: Canadian women, homelessness and health outside the 'big city'. *Gender, Place & Culture, 13(4)*, 383-399.

Wilkinson, R., & Marmot, M. (1998). *Social determinants of health: The solid facts.* Geneva, Switzerland: World Health Organization, Centre for Urban Health.

Wilkinson, R.G., & Pickett, K.E. (2007). The problems of relative deprivation: Why some societies do better than others. *Social Science & Medicine, 65,* 1965-1978.

World Health Organization. (1948). *Constitution of the World Health Organization as adopted by the International Health Conference* (Official Records of the World Health Organization, No. 2). Geneva, Switzerland: Author.

World Health Organization. (1978). *Declaration of Alma-Ata.* Geneva, Switzerland: Author.

World Health Organization, Canadian Public Health Association, & Health and Welfare Canada. (1986). *Ottawa Charter for Health Promotion.* Ottawa, ON: Health and Welfare Canada.

World Health Organization. (2005). *Bangkok Charter for Health Promotion.* Geneva, Switzerland: Author.

Appendix A

Interviewer ID # ____________________ Participant ID # ______________________

1) Male ☐ Female ☐ Other ____________________________

2) Do you consider yourself to be:

Heterosexual Gay Lesbian Transgendered Bisexual Two-spirited

3) What is your date of birth? ________/_______ mm/yyyy

4) What is your nationality/ethnic identity? ________________________________

5) What is your current citizenship and current citizenship status?

____

6) Were you born in Windsor? YES NO

If NO, how long have you lived here? ________________________________

7) How do you get around?

Bus pass Bus tickets Walking Rides Other ______________

8) What is the highest level of education you have completed? ________________

9) Are you a war vet? YES NO

10) What is your marital status?

SINGLE MARRIED SEPARATED DIVORCED COMMON LAW PARTNER

11) Do you have children? YES NO

If yes, how many? ________________________________

12) Do your children currently live with you? YES NO

Ages of children? _______/_______/_______/______/______

13) Do you have a health card? YES NO

14) What other forms of ID do you have?

Passport Driver's License Social Security Card Birth Certificate
Proof of Citizenship/Residency Military ID Proof of Aboriginal Status

Other: ____

15) Do you feel safe and secure where you are currently staying? YES NO

16) Have you ever been **absolutely** homeless, sleeping on the streets or on park benches? YES NO

17) How old were you when you were first Homeless? ________________________

18) How long? Days Months ____________ Years ______________

19) Where are you currently staying?

☐ With family ☐ On the streets ☐ In a shelter

☐ With friends ☐ Other: ____

20) Where did you live before this location and for how long?

____

21) Where have you lived in the last 6 months? ______________________________

22) What other supports do you have in your life?

Friends Social Worker Family Other: ___________________

23) Why would you say you are without permanent housing?

____

____

____

24) Why would you go to the shelter?

____

____

____

25) Why wouldn't you go to a shelter?

____

26) What is your current source(s) of income?

____

27) If you could choose, what do you see yourself doing as a job or career?

____

28) When were you last employed?

____

29) What was your last job?

____

30) Do you have any additional skills?

____

31) How many meals per day do you eat? ______________________

32) Where do you get your food from?

☐ Super market ☐ Food bank ☐ Soup kitchen ☐ Other

____

33) What kinds of food do you eat?

____

34) How often do you eat fresh fruit and vegetables?

a) Fresh fruit?

☐ Once per day ☐ 2-3 times per week ☐ Once per week ☐ Other ____

b) Fresh vegetables?

☐ Once per day ☐ 2-3 times per week ☐ Once per week ☐ Other____

35) If fresh fruit and vegetables were provided to you, would you eat it?

____

36) How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

37) Have you ever been diagnosed with any of the following problems?

Arthritis Ulcers Gum Disease HIV/AIDS

Anemia Dental problems GERD – Reflux Liver Disease

Cancer Diabetes High Blood Pressure Epilepsy

Foot Problems/Conditions Low Blood Pressure STI

Eye Problems/Conditions Heart Condition Sleep Disorder

Respiratory/Lung Condition Thyroid or Endocrine Problem/Condition

Menopausal Problems Menstrual Problems HCV

Emotional/ Mental Issues Skin Problems

Other: ____

38) Do you take medication(s) for any of these problems? YES NO

39) If no, are you supposed to? YES NO

What are the main side effects (if any) from these medications?

____

40) Why don't you take your prescribed medication?

☐ Don't like them ☐ Can't afford them ☐ Don't remember to take them

Other: ____

41) How many hours of sleep do you get in a 24-hour period? ___________________

42) Have you ever been assaulted in the last 6 months? _______________________

If so, was it by a: Stranger Person you know Police Other____________

43) Do you have any allergies? YES NO

44) Have you had any major medical procedures (ie. surgeries, etc.) (if yes, please list)? YES NO

45) Have you had any significant accidents or injuries (if yes, please list)?

YES NO

46) Do you have a Family Doctor? YES NO

47) Where do you go for your medical care?

☐ Doctor ☐ Hospital (emergency) ☐ Urgent Care ☐ Clinic

☐ Other: ____

48) When is the last time you saw a Doctor or Nurse practitioner?

____

49) When is the last time you had a physical?

____

50) When is the last time you had an STI Test (blood or urine test)?

____

51) Do you practice safe sex? ________________________

Can you tell me more about what you do to practice safe sex?

____

52) Do you use a condom? _______________

If so, where do you get your condoms? ______________________

53) What health services have you used in the last 12 months?

____

____

54) Why did you use these health service(s)?

____

____

55) Have you used any other health services?

Screening Immunizations Rehabilitation Physiotherapy

Eye Care Foot Care

56) When is the last time you had an eye exam? ______________________

57) What other services have you accessed?

Employment Services Disability Services Career Help Housing Services

When did you access them? ____

58) What has stopped you from using medical or other social services?

____

____

59)

What organizations have you used?	Do you still use their services? Y/N	Why do you still use the service?	Why do you not still use the service?	How to improve the service? Do you have any recommendations?

60) Are there any other barriers to accessing services, besides those given previously? ____

Medication

61) What types of prescription medication are you taking? (description if unsure of name of drug or dosage)

Prescription Drug	**Dose**	**Usage**	**Prescription Drug**	**Dose**	**Usage**

62) If you are not taking prescription medication, are you supposed to? Yes NO

63) Were all these medications obtained from a Doctor? YES NO
If yes, is it the same Doctor? YES NO

64) Do you take medication without a Doctor's order? YES NO

If yes, do you consider this to be 'self-medicating?' Or so you do not feel hungry?
____

____

65) Do you have prescription coverage YES NO

66) Please list any over the counter medication taken in the last 6 months?

Over the counter medication	Dose	Usage	Over the counter medication	Dose	Usage

67) Do you feel your drug use could cause you harm? YES NO

If yes, why? ____

68) Do you feel you are at risk of serious illness? YES NO

If yes, why? ____

69) Have you used in the past 6 months any of the following?

Alcohol	Powder Cocaine	Marijuana	Heroin
Inhalants	Benzos	LSD	
Amphetamines	Opium	Crack	Phenobarbital
Codeine	Sedatives	Methamphetamine	Tranquilizers
Tobacco	Barbiturates	PCP	Oxys
Perks	Valium		

Other: ____

70) Have you ever been addicted to any of the below? YES NO
If yes, which ones?

Alcohol	Powder Cocaine	Marijuana	Heroin
Inhalants	Benzos	LSD	
Amphetamines	Opium	Crack	Phenobarbital
Codeine	Sedatives	Methamphetamine	Tranquilizers
Tobacco	Barbiturates	PCP	Oxys
Perks	Valium		

Other: ____

71) When is the last time you used drugs? ______________________________

72) Do you share drug paraphernalia/items with others (e.g. straws, pipes, etc…)?
____

73) Do you inject drugs? ________________________________

74) Have you ever needed help injecting drugs? ____________________

75) Have you ever shared a needle? YES NO

If yes, when was the last time? ________________________

76) How do you dispose of your needle? ______________________

77) At what age did you start using drugs? ____________________

78) Who first introduced you to drugs?

Family member Medical professional Sexual Partner Friend

Other: ____

79) Why did you try drugs for the first time?

Experimentation	Peer Pressure	Pain control
Nerves	Low self-esteem	To be accepted
Sense of belonging	Medical Condition	

Other: ____

80) How do you pay for your drugs? ________________________

____

81) How much do you spend in a typical week on drugs? $______________

82) When did you last use alcohol? ________________________

83) Do you feel that using alcohol or drugs has affected your ability to live a normal life? YES NO

84) Do you feel your drug or alcohol use affect your overall health? YES NO

85) Have you ever used any support groups (if yes, please list)? YES NO

____

86) Have you ever been in a treatment program for addiction? YES NO

If yes, how many times? ____________________

If yes, when was the last time? ____________________

87) Have you ever been in prison or jail in the previous:

3 Months 6 Months Year

If yes, what were you incarcerated for? ____________________

88) Have you ever experienced chronic pain lasting longer than 3 months? YES NO

If yes, how long have you had chronic pain? ____________________

89) How do you treat your chronic pain? (What do you do or take to reduce the pain?)

____

____

90) Would you be interested in classes on how to manage chronic pain? YES NO

91) Have you experienced any dental pain in the last month? YES NO

92) When did you last have your teeth cleaned? ____________________

93) When you have tooth pain where do you go?

Hospital Dentist Walk in Clinic Other: ____________________

94) Are you happy with the appearance of your teeth? YES NO

95) Do you have dental coverage? YES NO

If yes, what type of dental coverage do you have?

____

96) What prevents you from visiting a dentist?

Fear Money Other: ____________________

97) Have you ever been in treatment for emotional, mental or psychiatric problems other than for an addiction? YES NO

If yes, was your treatment: ☐ Inpatient ☐ Outpatient ☐ Both

98) What were your diagnoses if any?

☐ Schizophrenia ☐ Bipolar ☐ Personality disorder

☐ Depression ☐ OCD ☐ Anxiety

Other: ____

99) Are you taking medication for this? YES NO

What are you taking? ____________________________________

100) If no, are you supposed to be taking medication? YES NO

If yes, what are you supposed to be taking?

____

101) Why don't you take your prescribed medication?

☐ Don't like them ☐ Can't afford them ☐ Don't remember to take them

Other: ____

102) If you could afford your meds, would you take you meds? YES NO

103) Do you need any other medication you can't afford? YES NO

What medications? ____________________________________

104) How do you spend a typical day? (i.e. what are some things you do with your time)

____

____

105) Where do you see yourself in 3 years?

____

____

106) If you could wave a magic wand, what 3 things would you ask for or change?

____

____

107) Any additional comments:

____

____

108) Would you like information or to learn more about:

Shelter Housing Food Transportation Other __________________

Interviewers' evaluation:

109) Did a gap get bridged? YES NO

If yes, what gaps?

____

If no, why not?

____

110) Was a referral booklet given? YES NO

Appendix B

CONSENT FOR AUDIO TAPING

Research Subject Name: ____

Title of the Project: **“Hidden No More: Needs Assessment of Service Use by the Hidden Homeless”**

I consent to the audio-taping of interviews of myself.

I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the taping be stopped. I also understand that my name will not be revealed to anyone and that taping will be kept confidential. Tapes are filed by number only and stored in a locked cabinet.

I understand that confidentiality will be respected and that the audio tape will be for professional use only.

____

(Date)

Appendix C

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: “Hidden No More: Needs Assessment of Service Use by the Hidden Homeless”

I am being asked to take part in a research study that is a partnership between Liz Atkinson, who is Chair of the Health Committee and Chair of the Homeless Coalition of Windsor-Essex County and Jamie Crawley, a faculty member at the University of Windsor. This research is looking at ‘Homelessness Knowledge Development – Data for Better Health’, funded through the Homelessness Partnering Strategy – Human Resources and Skills Development Canada.

If I have any questions or concerns about the research, I may contact Liz Atkinson (519) 252-3777 ext. 223 and/or Jamie Crawley (519) 253-3000 ext. 4816

Purpose of the Study/Why is this study taking place?

I am being asked to take part in a study looking at the experiences of being hidden homeless, which may include temporarily living with family, strangers or friends, couch-surfing or being doubled up. The researchers would like to look at possible long-term housing solutions for those who are hidden homeless and/or at risk for becoming homeless. The researchers would also like to look at ways to improve services offered for the hidden homeless and learn more about my health and service needs. The researchers would like to learn from me about what I find helpful about the current health and community services and what I would suggest are solutions to improve care. This study will help the researchers learn more about the importance of housing needs towards the use of services and health. There will be about 60 people who will be part of this study. I may ask any questions I have before agreeing to be in the study.

Procedures/What will I need to do?

If I agree to be part of this study, I will:

- Take part in an interview and will answer questions at this time or at another time here in the clinic that is best for me. I will tell the researcher about my every day world of living with hidden homelessness and will answer other questions about my health, which may include talking about substance use and/or addiction, sexual health, physical safety, incarceration, use of health and community services and housing situation. I may only take part in this study one time. The interview may take

1-2 hours to do.

- A tape recorder will be used in all interviews and the researcher will turn the tape recorder off if I want at any time.
- I only need to answer the questions I want to talk about and at any time I may stop the interview. The health care I get at the clinic will not change if I decide to not be in the study. If during the interview I feel sad or nervous from telling the researcher about my health or living conditions, the interview will be stopped. The researcher will take me to see one of the healthcare providers in the clinic.
- My answers will remain private and no names will be used when the study is written up in research reports.
- I will also need to sign a consent giving the researcher permission to tape record my voice. My voice is being tape-recorded to be sure that the researcher correctly understands the information I share during the interview.

Potential Risks and Discomforts/ Will this study hurt me in any way?

By taking part in this study, I may feel sad or nervous when I talk about my health or living conditions. There may also be risks from taking part in this study that are not known to researchers at this time. I may choose to **not** take part in the study.

Potential Benefits to Subjects and/or to Society/ How will this help me or other people?

By taking part in this study, I will have a better understanding of my every day experiences of living with hidden homelessness. Information from this study may help other people now or in the future who live with hidden homelessness. This study may assist with information that other communities may use to improve care provided in their communities.

Payment for Participation/ How will I be thanked for my time?

For taking part in this study, I will receive $20 for my time. I will also be given a referral booklet that lists local community resources and will be invited to attend a community forum in December 2010. At this community forum, the Health Committee/Homeless Coalition of Windsor-Essex County will describe preliminary findings from this study.

Confidentiality/ How will my name and information be kept safe?

All information collected about me during the study will be kept private.

The following information will be reported if during the study there is concern that:

- A child is being harmed
- I share that I am going to hurt myself or others

I will be identified in the study records by a code name or number. Information that identifies me will not be given to anyone without my written permission. When the

findings of this study are published or shared with others outside of this study, no information will be included that will tell my identity.

Because the researcher is taping my voice, my identity will be protected or disguised. All tape recordings and study interview questions will be kept in a locked filing cabinet within a locked office at the Teen Health Centre- Street Health Program. The research team will have access to these items. Pseudonyms or a made up name will be used to describe my identity. Transcripts and tapes will be destroyed as soon as they are typed and reviewed by the researchers. Information from this study will be used for educational purposes and for the creation of policies linked to the Homeless Coalition of Windsor Essex County, and will be shared with other agencies to improve services for those experiencing hidden homelessness.

Participation and Withdrawal/ Can I leave this study at any time?

Taking part in this study is voluntary or up to me. I have the right to not take part in this study. If I decide to take part in the study I can later change my mind and leave the study. I may only answer the questions I want to answer. My decisions will not change any present or future relationship with the University of Windsor or its affiliates, the Teen Health Centre- Street Health Program or other services I am allowed to receive.

The researcher may stop me from taking part in this study without my permission. The researcher will let me know if it is not possible for me to continue. The decision that is made is to protect my health and safety, or because I did not follow the instructions to take part in the study. I have the right to decide if during the interview, there is information I do not wish shared with others outside of this study.

Feedback of the Results of this Study

The researchers hope to have some findings about this study in December 2010. If I am interested in learning more, some of the findings will be shared at a community forum in December 2010. When it is available, information about this study will also be posted on the website of the Homeless Coalition of Windsor-Essex County. http://www.homelesscoalitionwindsor-essex.com/

Subsequent use of Data

Findings from this study may be used in other studies.

Rights of Research Subjects/ What if I have questions?

I have the right to not take part in this study. If I decide to take part in the study I can later change my mind and leave the study. If I have any questions about this study now

or in the future, regarding my rights as a research subject, I may contact the Research Ethics Coordinator, at the University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

Signature of Research Subject/Legal Representative

To voluntarily agree to take part in this study, "Hidden No More: Needs Assessment of Service Use by the Hidden Homeless" I must sign on the line below. If I choose to take part in this study I may leave the study at any time. I am not giving up any of my legal rights by signing this form. By signing below I am agreeing that I have read, or had read to me, this entire consent form, including the risks and benefits, and have had all of my questions answered. I will be given a copy of this consent form.

____

Name of Subject

____________________________________ ____________________

Signature of Subject Date

Signature of Investigator

These are the terms under which I will conduct research.

____________________________________ ____________________

Signature of Investigator Date

Revised February 2008

Vita Auctoris

Josephine (MacDougall) Watson was born in Sydney, Nova Scotia. She studied nursing at the Victoria General Hospital School for Nursing, Halifax, Nova Scotia graduating in 1985. She has practiced nursing in Nova Scotia and Ontario. In 2006 she received her BScN from the University of Windsor, and is currently a candidate for the MScN from the University of Windsor, with plans to graduate in Fall, 2012. While a graduate student, Josie received the Dr. Janet Rosenbaum Graduate Award, 2009. In March, 2010, she presented a paper, "Nursing and the Human Sciences" at the conference Rethinking the Human Sciences, University of Windsor. In June, 2010 she participated in a discussion panel, "The Consequences of Removing our Children from the Urban Centres and the Resulting Problems with Access to Physical and Mental Services". Josie currently resides in Windsor, Ontario. She is a strong advocate for nursing practice which implements a social determinants of health model.