Research with Homeless People Uncovers a Model of Health

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This grounded theory research study explored health experiences of 11 homeless persons in shelters in three New Brunswick cities and the strategies that they used to attain, maintain, or regain health. Audiotaped interviews were conducted, transcribed verbatim, and analyzed. The model that emerged from analysis consists of three pathways to health. This model of health has two central components, person and health. Person is influenced directly by family values and beliefs, and directly and indirectly by societal values and beliefs. Health is the outcome and is reached through two mediating factors of lifestyle behaviors and sector services. The first pathway to health contains the mediating factor of lifestyle behaviors, the second contains the mediating factor of sector services, and the third contains both mediating factors. Pathway strategies of choosing, accessing, and appraising appropriateness of methods influence the active participation of the person that directs the action within the model. Implications of the study include that a fragmented system of help hinders access to services intended to promote health in this population.

In Canada, homelessness is becoming recognized as a societal problem (Boydell, Goering, & Morrell-Bellai, 2000; Goering, Durbin, Trainor, & Paduchak, 1990; McCormack & Gooding, 1993; Spector, 1999; Toronto Disaster Relief Committee, 1998). A homeless crisis situation in Toronto resulted in the declaration of a state of emergency (Toronto Disaster Relief Committee, 1998) that informed all levels of government that homelessness is not acceptable and that commitments to the nation's most vulnerable people need to be honored. In response, a Federal Coordinator for the Homeless was appointed and increased funding was directed toward the emergency shelter system. A long-term strategy aimed at eliminating homelessness is not evident (Progressive Conservative National Caucus Task Force on Poverty, 2000). In the health sector, street clinics have evolved to address the

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health needs of the homeless. As interim measures, these external resources help homeless persons address crisis situations. This article discusses the internal resources used by homeless persons, the preferred external resources needed, and the process selected when homeless persons seek health assistance.

HOMELESS PERSONS AND HEALTH

Health is compromised when housing is below standard and is challenged further when housing is absent (Barrow, Herman, Cordova, & Struening, 1999; Canadian Public Health Association, 1997; Conway, 1995; Dickey, Latimer, Powers, Gonzalez, & Goldfinger, 1997; Harris, 1999; Lechky, 1999; Power et al., 1999; Segal, Gomory, & Silverman, 1998; Spector, 1999; White, C., 1999; White, M. E., 1999). Homeless persons expend tremendous energy on survival strategies such as obtaining shelter, food, and a place to rest (Capponi, 1997; McCormack & Gooding, 1993). Only after having satisfied these basic human needs are homeless persons able to consider other issues related to their health (Bawden, 1990; Burg, 1994; Flynn, 1997; Gelberg, Gallagher, Andersen, & Koegel, 1997; Gillies, Tolley, & Wolstenholme, 1996; Nyamathi, Kington, Flaskerud, Lewis, Leake, & Gelberg, 1999; Power et al., 1999; Terrell, 1997).

A review of the literature revealed that homeless persons experience a wide range of health problems (Committee on Community Health Services, 1998; Green, Ennett, & Ringwalt, 1999; Malloy, Christ, & Hohlock, 1990; McCormack & Gooding, 1993; Reilly, Grier, & Blomquist, 1992; Sachs-Ericsson, Wise, Debrody, & Paniucki, 1999; Ugarriza & Fallon, 1994). Nurses and other health providers have offered care in street clinics designed to address the health needs of homeless persons (Douglass, Torres, Surfus, Krinke, & Dale, 1999; Ovrebo, Ryan, Jackson, & Hutchinson, 1994; Reilly, Grier, & Blomquist, 1992; Sachs-Ericsson et al., 1999). Access to appropriate health care, even when services are designed to address the health needs of homeless persons, remains a challenge for many (Cousineau, 1997; Douglass et al., 1999; Gelberg et al., 1997; Hwang & Gottlieb, 1999; Ugarriza & Fallon, 1994; Wojtusik & White, 1998). The appropriateness of strategies that have been developed and implemented to address the health care needs of homeless persons can be evaluated only when such challenges as circumstances preventing consistent participation over time and confusion around the delimiting attributes of homelessness have been overcome (Connor, Ling, Tuttle, & Brown-Tezera, 1999; Hunter, 1992; Hunter, Getty,

Kemsley, & Skelly, 1991; MacDonald, 1995; Mercier, Fournier, & Peladeau, 1992).

In the past decade, qualitative studies (Boydell et al., 2000; McCormack & Gooding, 1993) have increased the understanding of the health experiences of homeless persons in Canada. Regional surveys (Acorn, 1992; Ambrosio, Baker, Crowe, & Hardill, 1992; Stuart & Arboleda-Florez, 2000) have described health status and health needs from within a medical paradigm. There are no reported research studies describing the experience of being homeless in Atlantic Canada. The literature also indicated the need to move beyond a paradigm that focuses on curing to a paradigm that uses a multisectoral approach to health (Ambrosio et al., 1992; Bond, 1999; Power et al., 1999) and integrates services (Gillies et al., 1996; Rosenheck et al., 1998).

RESEARCH QUESTIONS

The purpose of this study was to understand how homeless persons in three New Brunswick cities describe their health experiences and the strategies they use to attain, maintain, or regain health. The research questions directing this study were: How do homeless persons perceive health and their own health status? What health strategies do homeless persons employ in order to meet their health needs? What is the nature of homeless persons' interactions with societal systems in their pursuit of health?

METHOD

Study Design

Grounded theory was chosen for this study because its theoretical underpinnings of symbolic interactionism focus on meanings people give to their experiences (Glaser & Strauss, 1967; Kools, McCarthy, Durham, & Robrecht, 1996; Strauss & Corbin, 1990, 1994; Wuest, 1995). The goals of this study—to uncover the meanings inherent in health activities of homeless persons and to understand how they achieve health—are consistent with symbolic interactionism.

Access to adult persons who stayed in shelters providing overnight accommodation was arranged through administrators of three shelters located in three New Brunswick cities. Administrators of the shelters

approached potential participants about becoming involved in the study. After participants were introduced to the researcher, and prior to beginning the data collection interviews, the study was explained, questions concerning the study were answered, and audiotaped consent was obtained. The guided interview technique was used to gather data in tape-recorded interviews conducted in privacy within shelter environments. Both authors separately collected data. A common interview guide in which interview prompts evolved from initial and ongoing data analysis was used. Because of the challenge of locating homeless persons for a second interview to confirm understanding of the data, an iterative process was used in data collection. Perceptions were developed and shared with subsequent participants and the interview guide was modified as necessary. In this way, later participants confirmed the data collected and analyzed early in the study.

All interviews took place during the winter season because of the increased likelihood of the need to access shelter accommodation for protection from the weather. Interviews lasted approximately one hour. Questions asked centered around participants' understanding of health; participants' health status, behaviors, and activities that maintain and regain health; and participants' evaluations of the success of their actions to achieve health. Pseudonyms were assigned to participants to protect their anonymity in this description.

Analysis of Data

Analysis proceeded simultaneously with data collection. The constant comparative method of data analysis, as described by Glaser (1978), involved initial data coding followed by clustering related codes into categories and subsequent repeated comparison of codes in new data to existing codes and categories. Joint analysis of the transcribed interviews by the two researchers while listening to the audiotapes increased theoretical sensitivity to the data; agreement on coding was high. When categories became saturated, no new data were collected about them. Theoretical coding conceptualized the connectedness of the core concepts and categories and surfaced the basic social process through which homeless persons promote their health. "Grounded theory provides a way to transcend experience—to move it from a description of what is happening to understanding a process by which it happens" (Artinian, 1998, p. 5). That is, the data were moved from a descriptive to a theoretical level. When data were perceived at a theoretical level, it was observed that the environment influencing the emergent process was illustrative of primary health care.

Participant Profile

The demographic characteristics selected to describe this sample population included age, level of education, work history, length of time without permanent housing, and transiency. Previous research confirmed that these characteristics contributed information significant to understanding the homeless population in Canada (McCormack & Gooding, 1993).

Participants' ages ranged from 17 to 56 years. Participants of both genders were interviewed but strategies to promote health were not found to vary according to gender. All participants except one had some high school education, three were high school graduates, and one had some university education. Four others continued their learning through a variety of courses.

All participants described work experience. Three participants had more than 20 years of work experience, whereas others had between 2 and 10 years. Participants described a variety of paid work experiences ranging from custodial work to owning a successful business. Volunteer, or unpaid work, was also viewed as a valuable contribution to society and was seen as work. Participants connected volunteer work with paid work and were hopeful that potential employers might observe their skills and offer employment. All participants indicated a desire to work. In most discussions, work evolved as a measure of achieving human potential and health (Atkinson, Liem, & Liem, 1986; Avison, 1996; Osberg, 1996; Sullivan, Uneke, Lavis, Hyatt, & O'Grady, 1996). Consistent with findings related to housed people, years of work are directly related to age (McCormack & Gooding, 1993).

Five of the 11 participants had been in the shelter system less than 1 year, another five had been in the shelter system from 1 to 6 years, and one participant could not recall when he last had permanent housing. Six participants identified home as the city or surrounding area in which the shelter was located, whereas four others had family living in the community. The remaining participant was transient. Mobility among the three shelters was evident and reflected the efforts of participants to access all available resources without wearing them out. For this reason, no differences in participant characteristics between shelters were found.

Shelter Profile

There were only three shelters operating in the province and these were located in cities approximately 2 hours' drive from each other. One shelter, although receiving government funding, was operated by a religious group who provided personnel to manage the shelter. This shelter was located in a

downtown area and provided accommodations and meals for men of all ages, including some juveniles. The second shelter was supported financially by the community in which it existed; they also received donations of food and supplies so that meals were provided. This shelter could accommodate men, women, and families in rooms that housed two to four people. The third shelter, located next to the local soup kitchen, received funding from municipal grants, provincial subsidies, and fundraising organized by its board. This shelter had a small separate room for housing two or three women; however, because of the room's location off the main room where about 20 men stayed, it lacked privacy. The staff of all three shelters showed their commitment to the clientele through their respect and efforts to help.

FINDINGS

The emergent model of health indicates that homeless persons are active participants in promoting their health. The model consists of three pathways to health. The first pathway to health contains the mediating factor of lifestyle behaviors, the second contains the mediating factor of sector services, and the third contains both mediating factors. The two components of person and health center the interaction in the model and are consistent across pathways. The person is an active participant directly influenced by family values and beliefs, and both directly and indirectly, by societal values and beliefs. Person selects to move toward health through at least one of the two mediating factors, lifestyle behaviors and sector services. All three pathways have primary and secondary strategies of choosing, accessing, and appraising the appropriateness of methods (see Figure 1). In this discussion, the central components of person and health are outlined first followed by the mediating factors, lifestyle behaviors and sector services, and the pathway strategies of choosing, accessing, and appraising the appropriateness of methods. Each pathway is presented.

Central Components

Person

The person directs all action in the model. Homeless persons included the perspectives of self-confidence and self-image in the concept of person. Self-confidence evolved from the data through participants' descriptions of their ability to speak for themselves and to accomplish tasks. Self-image

encompassed how participants presented themselves to the world and how they saw their self-reliance in negotiating systems of help. Personal values and beliefs emerged from the data and were reflective of both family and societal values and beliefs. One example from the data was that the personal value of being prepared for work and other life experiences was reflected in the family value that family members work and the societal value that people work for money. Working for money enhanced both self-confidence and self-image.

The person is the assessor of health status. The process of assessment involves receiving feedback through personal observations of health, weighing options, making decisions, and analyzing costs, benefits, and risks. This assessment of health is ongoing. Being an assessor requires the full participation of the person. The benefit of feeling healthy motivates participation and promotes self-reliance. All participants identified themselves as the primary resource when promoting health.

Health

Health, as the outcome of this model, generates feedback that is a precondition to further action. Conception of health and health status were the two aspects of health revealed in the data. Conception of health was defined by the participants' world views of health, whereas health status was an indicator of health. Six different conceptions of health emerged from the data when participants were asked to describe their meaning of health. One participant's world view of health was "being a whole person," whereas four participants integrated physical and mental dimensions of health. Another participant identified mental, physical, and emotional as separate dimensions of health. One participant perceived physical, mental, and spiritual health separately. Another saw dimensions of mental and physical health separately, whereas two identified physical health only. The conception of health for one participant was not clear. Conception of health directly influenced the choice of health behaviors selected and the sector services accessed for help.

Health status was determined by asking the question: Do you think you are healthy? Participants generally assessed their health according to their current life situation. Five considered themselves healthy, whereas six participants who were experiencing health challenges considered themselves unhealthy. Of these six, four identified chronic illnesses (cardiac disease, diabetes, stroke, and mental illness) that were currently challenging health status and needed attention; a fifth, a drug addict, identified that this lifestyle habit influenced his health adversely; and a sixth, who had just discovered

that she was pregnant, viewed this normative life event as a health challenge. In her words, "I am scared . . . I'm not ready for a kid, like, financially, emotionally, or age wise . . . The problem is . . . you can't take care of yourself very well because . . . I don't know, [the shelter is] just not a good place [to have a baby]" (Jane).

Mediating Factors

Mediating factors include the informal lifestyle behaviors adopted and all essential health care services contained within the formal sector services. Sector services refer to formal resources designed to assist in attaining, maintaining, and regaining health. The sector services offering assistance to promote the health of these participants included housing, health, employment, protection, correction, religious, recreation, social, transportation, government, and education.

In this study, lifestyle behaviors were composed of internal resources reflected in health promoting behaviors, illness-preventing behaviors, survival behaviors, and hindering behaviors. Health-promoting behaviors were often related to physical strength and endurance. Carl related that "I would usually go out for a walk for about an hour or two." Illness-preventing behaviors were demonstrated by participants' efforts to avoid getting sick or injured. "Being diabetic, the first thing I think about is proper nutrition" (Lemuel). Survival behaviors referred to those actions that sustained life. Adam's strategy was to hide his medication and carry a 1-day supply only because medication is often viewed as a type of street currency. Hindering behaviors were identified as those behaviors that participants continued to do even though they recognized that these behaviors affected their health adversely. Earl stated that "I am addicted to diazepam, which is for anxiety, muscle spasm. I have to have them because I have been taking them for quite some time and that is a health problem."

Pathway Strategies

The pathway strategies used by the person include choosing, accessing, and appraising the appropriateness of methods. The pathway selected determines which of these strategies is primary and which are secondary. No action can occur until the primary strategy is activated, triggering secondary strategies. The pathway strategy of choosing is active, indicating that participants seek and recognize options and examine these options before accessing and appraising the appropriateness of methods. For example, Lemuel chose the illness-prevention behavior of not disclosing insulin and needles

to the shelter staff so that he could manage his own self-care. By keeping his knapsack that contained his insulin constantly in his possession, he created access to this strategy. He appraised it as appropriate for him in spite of the shelter rule that all medications were held by staff.

The pathway strategy of accessing is influenced by the infrastructure of the sector that usually addresses the particular challenge identified and by the participant's choice and appraisal of the appropriateness of the services offered by that sector. Access for these participants was influenced by the social distance between sector service providers and the members of this population. These homeless persons identified that providers imposed social distance through their use of language, lack of trust, and disrespect for age, which forced these participants into isolation from society. Jane said, "It's like . . . I don't know what . . . they [health care providers] were talkin' about, so they don't fill me in. They just . . . go around it . . . It's really annoying." Social distance was reduced when providers accepted and respected the homeless person, making navigation through the sector accessible. According to participants, even in Canada where insured services ensure financial accessibility to care, access to services remained a challenge. The secondary strategies of choosing and appraising the appropriateness of the sector services accessed followed.

Appraising appropriateness of methods is another pathway strategy. Earl indicated that even when sector services were appraised by society as appropriate, and a choice was made to access these services, care was not always acceptable.

> I know they have Detox . . . but, . . . I don't think that I'd be able . . . to take that, . . . See, the person coming out of the alcohol problems suffering from the . . . after effects of alcohol, and me, from the after effects of Valium, . . . I may not like it because I may feel guilty or wrong for being there.

Sector services are constructed to reflect societal values and beliefs. Society considers that these available services designed to address a known challenge are acceptable and appropriate. Participants identified many appropriate strategies used by providers thus indicating that sector services have the capacity to help homeless persons achieve a higher level of health. Many inappropriate strategies were also evident in the data, creating barriers that hindered the attainment of health. All but one participant recognized that after accessing sector services and choosing to follow directions, health status remained compromised.

Pathways to Health

Three pathways to health emerged from the data. Each pathway contains the central components of person and health. Although participants first tried to pursue the pathways in a sequential manner, when the primary pathway strategy was absent, participants moved to the next pathway. For example, choosing is the primary pathway strategy for the pathway in which lifestyle behaviors is the mediating factor but when participants perceived they had no choice, they had to attempt to access the pathway containing the mediating factor of sector services.

In accepting their responsibility for self-care, all participants first selected to promote their health through the mediating factor of lifestyle behaviors. This pathway is delineated in Figure 1 by the solid lines connecting person with lifestyle behaviors and lifestyle behaviors with health. The lifestyle behavior that was embraced, revised, or removed was influenced by the primary pathway strategy of choice and the secondary pathway strategies of accessing and appraising appropriateness of methods. For example, when George was experiencing dental pain but was unable to pay for dental care, he chose the lifestyle behavior of imagery to control the pain. "I can have toothaches for 3 or 4 days . . . very simple, you just block the pain. I think it is just changing your thought patterns." Such informal strategies have fewer formal gatekeepers. Homeless persons found informal strategies more accessible and appraised them as appropriate within their living situation. The person receives feedback about the effectiveness of the lifestyle behavior used and adds this information to the ongoing health assessment. After moving along the lifestyle pathway to health, if feedback reflects that the health work done is inadequate, the person selects the second pathway to health.

In those situations where health remains compromised, the feedback directs the person through the pathway containing the mediating factor of sector services. Accessing external resources then becomes necessary. This pathway is delineated in Figure 1 by the dashed line. The sector selected as the most appropriate to meet the identified challenge influencing health is determined by the primary pathway strategy of accessing and the secondary pathway strategies of choosing and appraising the appropriateness of methods. For example, when Frank had a heart attack he accessed formal medical care. He recognized that he could not manage this problem without intervention from the health care sector. This situation demonstrated that choosing was secondary to accessing and appraising appropriateness of methods. In this pathway, the person receives feedback about the effectiveness of the sector services used to improve health and this information is used in the

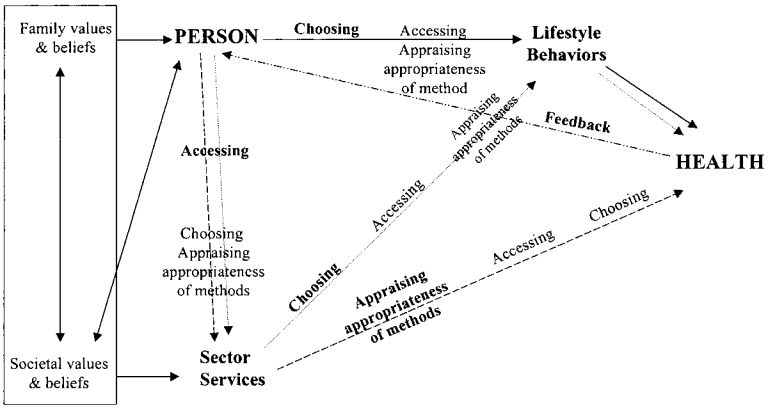

Figure 1. Pathways to health.

ongoing assessment. After moving along the sector service pathway to health, if feedback reflects that the health work done is inadequate, the person often selects the third pathway to health.

In the third pathway to health the person uses both mediating factors of sector services and lifestyle behaviors. This pathway is delineated in Figure 1 by the dotted line. Even when the same sector is accessed again, new approaches may be offered and tried. At this time, the person also uses the pathway strategy of choosing to integrate lifestyle behaviors with the sector services accessed in order to attain increased health status. Both the sector and lifestyle behaviors selected as the most appropriate to meet the identified challenge influencing health is determined by the pathway strategies of accessing and choosing, and the secondary pathway strategy of appraising the appropriateness of methods. For example, Carl, who was hospitalized for a month, found the treatment ineffective. When he combined accessing physician follow-up services with choosing the lifestyle behaviors of working and staying active, he appraised the methods as appropriate and feedback indicated that his health improved. Modifying lifestyle behaviors reflects the active participation of the person.

Internal and External Resources

The mediating factors of lifestyle behaviors and sector services identified in these pathways reflect internal and external resources, respectively. All participants accepted individual responsibility for health and considered

lifestyle behaviors prior to accessing formal sector services. The internal and external resources used by homeless participants reflected their perspectives of essential health care.

In the context of health promotion, Doug stated, "I eat good, I walk a lot." About disease and injury prevention, Adam related, "I always got clean needles, eh? I used to buy them all the time but [my friend] went to one party . . . [used somebody else's], just got unlucky." Adam continued to describe supportive care, "The older people that are out on the street look after the younger ones. And that's the way it is . . . ." With respect to rehabilitative care, Kurt described a sector service experience:

> [When I left the hospital after my stroke], I couldn't afford to take the wheelchair with me. And, they didn't even give me a cane . . . . And, when I went back . . . the nurse said, "You need a cane." So they went and got me a cane. And, I found I do a lot better with a cane.

In the context of curative care, Kurt was hospitalized for a stroke, but Bill described the need to address curative care challenges without the help of sector services. "A guy pulled a razor and slashed me across my elbow and I had to get another guy to stitch it for me because I didn't have Medicare."

Participants indicated that providers from all sectors in society need to collaborate to promote the health of individuals, families, and communities. Harold described many helping sectors in society and the isolation of existing services. Although sector service providers were aware of each other, partnerships to facilitate a system of help were not evident. The best Harold could expect was referral:

> I went to the police station [for help] . . . . They told me to call social assistance so I called them and they said, yep, we can help you. Do you have any ID on you? Well, I just lost my wallet . . . . Well, sorry, we can't do a thing for you. So they gave me the number of a gentleman at the Salvation Army to call. So I called him [and he helped me get some clothes] . . . and . . . recommended that I come over to the soup kitchen. I went over to the soup kitchen and they recommended me to come [to the shelter]. It took 3 months to get enough ID that social assistance would talk to me. When they did, they were really, really quick about it. I told them I finally got my card. And they said, well, I tell you what, you come in tomorrow at this time and we'll do the paper work.

DISCUSSION

In this study, a model that depicts the health journey of homeless persons emerges. This model focuses this discussion. Both lifestyle behaviors and

the interactions of providers within, and across, sector services emerge as mediating factors in the homeless person's pursuit of health. All principles of primary health care create the environment, or the context, in which this journey unfolds.

To clarify, primary health care is an approach to health care delivery that emphasizes an intersectoral approach to care with access to the most appropriate provider in a timely fashion (Gilbert, 1997; Gulzar, 1999; Leonard, 1998; MacIntosh & McCormack, 1995, 2000; Reutter & Ford, 1998; World Health Organization, 1978). This approach to care is directed by five core principles: that care be provided for essential health needs, that care be accessible, that methods of care be appropriate and acceptable, that full participation of citizens be facilitated, and that an intersectoral approach to health be used. These principles are inherent within the following definition of primary health care developed by the World Health Organization (WHO):

> Essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (WHO, 1978, p. 3)

To avoid confusion, primary health care can be distinguished from primary care, community health nursing, and selective primary health care. In an integrative review, MacIntosh and McCormack (2000) found that primary health care is misconstrued with primary care, community health nursing, and selective primary health care in 28% of 254 articles they examined. The defining attributes of each of these concepts demonstrate the uniqueness of each concept. Primary care is illness-oriented and is often used to refer to initial care offered by physicians or nurses to address common medical conditions, illnesses, and injuries (Innes, 1987; Powell, 1986; Yapchiongco, 1984). Community health nursing consists of knowledge from both nursing and public health sciences with emphasis placed on population health (Canadian Public Health Association, 1990). When comparing primary health care to selective primary health care, the philosophical underpinnings are the same but only some of the principles are enacted (MacIntosh & McCormack, 2000). This limited focus results in yet another approach to care that contrasts with primary health care.

In this study, the principles of primary health care are reflected in the data. Participants describe essential health care, such as acquiring medical diagnoses and developing social skills; accessibility to sector services, although limited; appropriate and acceptable methods of care, such as

developing trusting relationships with providers and collaborating in strategies that are compatible with the living environment; full participation in events that direct health; and an intersectoral approach for developing partnerships that enable self-reliance and self-determination. Data reveal that selected principles are sometimes implemented adequately when services are accessed; however, the absence of even one of these principles results in less than helpful care.

Essential health care needs are addressed through the informal resources of lifestyle behaviors and the formal resources of sector services. The principle of essential health care includes promotive, preventive, supportive, curative, and rehabilitative activities (WHO, 1978). In all aspects of essential health care, people may require assistance as they work toward attaining, maintaining, or regaining health. The primary health care approach to care demands that appropriate and affordable methods address essential health care needs. Such methods must be made accessible (Gilbert, 1997; Gulzar, 1999; Leonard, 1998; MacIntosh & McCormack, 1995; Reutter & Ford, 1998).

Full community participation connects all other principles and has been identified as the key to primary health care (McElmurry & Keeney, 1999). Active participation is needed from the people for whom services are being developed if self-reliance and self-determination are to be achieved (WHO, 1978). Having options is basic to community participation and partnership development. According to Morris, John, and Keen (1988) having three options provides choice, having two options leaves one in a dilemma, having one option results in being stuck, and having no option is akin to being dead. Within sector services where the provider is considered the expert, clients are often not aware of options, and having an opportunity to choose to partner is unknown. Having limited options diminishes self-esteem and precludes any possibility of self-reliance and self-determination. As Frank said, "It's just the way they get about it that I didn't like . . . . At least give you the choice first. Then you feel better . . . I took the choice. You feel like you're a person." In this study, as in other studies (Boydell et al., 2000; McCormack & Gooding, 1993), homeless persons confirmed their willingness and their ability to assess their own needs and resources.

Although all principles of primary health care surface and because participants emphasize the importance of intersectoral collaboration, this principle will be further elaborated. Problems are created when providers in societal sectors do not collaborate openly and directly. Learning to navigate the channels between sectors leads people to assistance. For homeless persons, the shelter system seems to be a pivotal point from which to access other

societal sectors. Interaction between sectors is influenced by varying degrees of effort spent and success achieved.

The most successful partnering efforts occurred between shelters in the housing sector and income assistance in the social services sector. In all three shelters, participants were enabled to make timely connections with the income assistance department. This is significant because participants also reported that efforts to access income assistance were delayed when applications were made from outside of the shelter system. Frank related how the shelter facilitated this connection:

> Social services . . . turn me down and I say whoa, I can't work. Like it is not because I want to be here . . . it was not by choice. So I ended up at the [shelter] and from there, took me 2 days or 3 days and I had a chance. Amazing how it works. I don't know what the [shelter]'s got to do with it but [I] imagine they stepped in somewhere along the line . . . Well, they probably do because . . . when you come to here, it's usually as a last resort.

We began this study with a focus on individual health but participants' descriptions directed the examination toward the complex interactions between sectors and the importance of understanding the role of shelters as housing. Income assistance from the social services sector and the shelter system from the housing sector are linked. Participants also discussed how housing and employment sectors influenced their experiences of health. Because the activities of various sectors influence health, all sector providers need to develop competencies for creating partnerships, communicating effectively, and collaborating constructively within and across sectors (MacIntosh & McCormack, in press).

Persons at the bottom of society who try to access help encounter a fragmented system of help with many barriers (Douglass et al., 1999; Goldfinger et al., 1999; Power et al., 1999; Wojtusik & White, 1998). Primary health care is an integrative approach that directs providers to work collaboratively with consumers and with all sectors in society positioning health as an agenda item in all sectors (Barnes et al., 1995; Collado, 1992; Farley, 1993; MacIntosh & McCormack, 1994, 2000; Shoultz & Hatcher, 1997; Shoultz, Hatcher, & Hurrell, 1992; Shoultz, Kooker, Sloat, & Hatcher, 1998; WHO, 1978). Homeless persons indicated that their interpretation of an effective system of help includes many sectors. Because homeless persons generally access shelters in the region in which they have lived (McCormack & Gooding, 1993; Pollio, 1997), they are citizens of the community and their needs must be taken into consideration when designing formal sector services. Health experiences described by this homeless population point out a

lack of inclusion of homeless persons in decision making and a lack of coordination between sectors. Collaboration is not a reality.

This model of health explains how homeless participants make decisions in their pursuit of health. The three pathways presented in this model resonate with the researchers' experience with health as housed people. Although the constructs in the pathways-to-health model are identified by homeless persons, it is possible that these constructs reflect the health experiences of housed people. Primary health care was developed to attain health for all people. The unanticipated emergence of data illustrating all principles of primary health care, suggests a wide application of this model.

NOTE

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REFERENCES

Acorn, S. (1992). *Emergency shelter users in Vancouver: Characteristics and health status*. Vancouver, British Columbia: University of British Columbia.

Ambrosio, E., Baker, D., Crowe, C., & Hardill, C. (1992). *The street health report: A study of the health status and barriers to health care of homeless women and men in the city of Toronto*. Toronto: Street Health.

Artinian, B. M. (1998). Grounded theory research: Its value for nursing. *Nursing Science Quarterly*, *11*(1), 5-6.

Atkinson, T., Liem, R., & Liem, J. H. (1986). The social costs of unemployment: Implications for social support. *Journal of Health and Social Behavior*, *27*, 317-331.

Avison, W. R. (1996). The health consequences of unemployment. In *What determines health*. Ottawa, Ontario: Minister of Public Works and Government Services Canada.

Barnes, D., Eribes, C., Juarbe, T., Nelson, M., Proctor, S., Sawyer, L., Shaul, M., & Meleis, A. I. (1995). Primary health care and primary care: A confusion of philosophies. *Nursing Outlook*, *43*(1), 7-16.

Barrow, S. M., Herman, D. B., Cordova, P., & Struening, E. L. (1999). Mortality among homeless shelter residents in New York City. *American Journal of Public Health*, *89*(4), 529-535.

Bawden, E. L. (1990). Reaching out to the chronically mentally ill homeless. *Journal of Psychosocial Nursing*, *28*(3), 6-13.

Bond, M. (1999). Placing poverty on the agenda of a primary health care team: An evaluation of an action research project. *Health and Social Care in the Community*, *7*(1), 9-16.

Boydell, K. M., Goering, P., & Morrell-Bellai, T. L. (2000). Narratives of identity: Representation of self in people who are homeless. *Qualitative Health Research*, *10*(1), 26-39.

Burg, M. A. (1994). Health problems of sheltered homeless women and their dependent children. *Health and Social Work*, *19*(2), 127-132.

Canadian Public Health Association. (1990). *Community health/public health nursing in Canada: Preparation and practice*. Ottawa: Author.

Canadian Public Health Association. (1997). *Position Paper: Homelessness and Health*. Ottawa: Author.

Capponi, P. (1997). *Dispatches from the poverty line*. New York: Penguin.

Collado, C. B. (1992). Primary health care: A continuing challenge. *Nursing & Health Care*, *13*(8), 408-413.

Committee on Community Health Services. (1998). Health needs of homeless children and families. *Pediatrics*, *98*(4), 789-792.

Connor, A., Ling, C. G., Tuttle, J., & Brown-Tezera, B. (1999). Peer education project with persons who have experienced homelessness. *Public Health Nursing*, *16*(5), 367-373.

Conway, J. (1995). Housing as an instrument of health care. *Health and Social Care in the Community*, *3*, 141-150.

Cousineau, M. R. (1997). Health status and access to health services by residents of urban encampments in Los Angeles. *Journal of Health Care for the Poor and Underserved*, *8*(1), 70-83.

Dickey, B., Latimer, E., Powers, K., Gonzalez, O., & Goldfinger, S. M. (1997). Housing costs for adults who are mentally ill and formerly homeless. *Journal of Mental Health Administration*, *24*(3), 291-306.

Douglass, R. L., Torres, R. E., Surfus, P., Krinke, B., & Dale, L. (1999). Health care needs and services utilization among sheltered and unsheltered Michigan homeless. *Journal of Health Care for the Poor and Underserved*, *10*(1), 5-18.

Farley, S. (1993). The community as partner in primary health care. *Nursing and Health Care*, *14*(5), 244-249.

Flynn, L. (1997). The health practices of homeless women: A causal model. *Nursing Research*, *46*(2), 72-77.

Gelberg, L., Gallagher, T. C., Andersen, R. M., & Koegel, P. (1997). Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *American Journal of Public Health*, *87*(2), 217-221.

Gilbert, L. (1997). Pharmacist and nurse: A team approach towards primary health care or a convenient "therapeutic alliance"? *International Journal of Nursing Studies*, *34*(5), 367-374.

Gillies, P., Tolley, K., & Wolstenholme, J. (1996). Is AIDS a disease of poverty? *AIDS Care*, *8*(3), 351-364.

Glaser, B. G. (1978). *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine.

Goering, P., Durbin, J., Trainor, J., & Paduchak, D. (1990). Developing housing for the homeless. *Psychosocial Rehabilitation Journal*, *13*(4), 33-42.

Goldfinger, S. M., Schutt, R. K., Tolomiczenko, G. S., Seidman, L., Penk, W. E., Turner, W., & Caplan, B. (1999). Housing placement and subsequent days homeless among formerly homeless adults with mental illness. *Psychiatric Services*, *50*(5), 674-679.

Green, J. M., Ennett, S. T., & Ringwalt, C. L. (1999). Prevalence and correlates of survival sex among runway and homeless youth. *American Journal of Public Health*, *89*(9), 1406-1410.

Gulzar, L. (1999). Access to health care. *Image: Journal of Nursing Scholarship*, *31*(1), 13-19.

Harris, R. (1999). Housing and social policy: An historical perspective on Canadian-American differences: A comment. *Urban Studies*, *36*(7), 1169-1176.

Hunter, J. K. (1992). Making a difference for homeless patients. *RN*, *55*(12), 48-54.
Hunter, J. K., Getty, C., Kemsley, M., & Skelly, A. H. (1991). Barriers to providing health care to homeless persons: A survey of providers' perceptions. *Health Values*, *15*(5), 3-11.
Hwang, S. W., & Gottlieb, J. L. (1999). Drug access among homeless men in Toronto. *Canadian Medical Association Journal*, *160*(7), 1021-1022.
Innes J. (1987). Primary health care in perspective. *Canadian Nurse*, *83*(8), 17-18.
Kools, S., McCarthy, M., Durham, R., & Robrecht, L. (1996). Dimensional analysis: Broadening the conception of grounded theory. *Qualitative Health Research*, *6*(3), 312-331.
Lechky, O. (1999). Bringing health care to the homeless. *Canadian Medical Association Journal*, *161*(1), 13.
Leonard, L. G. (1998). Primary health care and partnerships: Collaboration of a community agency, health department, and university nursing program. *Journal of Nursing Education*, *37*(3), 144-148.
MacDonald, H. (1995). San Francisco's Matrix program for the homeless. *Criminal Justice Ethics*, *14*(2), 2-5.
MacIntosh, J., & McCormack, D. (1994). Primary health care: Interpreting the concept. *Info Nursing*, *25*(1), 10-11.
MacIntosh, J., & McCormack, D. (1995). Primary health care progress in nursing citations. *International Nursing Review*, *42*(4), 115-120.
MacIntosh, J., & McCormack, D. (2000). An integrative review illuminates curricular applications of primary health care. *Journal of Nursing Education*, *39*(3), 116-123.
MacIntosh, J., & McCormack, D. (2001). Partnerships identified within primary health care literature. *International Journal of Nursing Studies, 38*(5), 547-555.
Malloy, C., Christ, M. A., & Hohloch, F. J. (1990). The homeless: Social isolates. *Journal of Community Health Nursing*, *7*(1), 25-36.
McCormack, D., & Gooding, B. A. (1993). Homeless people communicate their meaning of health. *Canadian Journal of Nursing Research*, *25*(1), 33-50.
McElmurry, B. J., & Keeney, G. B. (1999). Primary health care. In J. J. Fitzpatrick & J. S. Stevenson (Eds.). *Annual review of nursing research* (pp. 241-268). New York: Springer.
Mercier, C., Fournier L., & Peladeau, N. (1992). Program evaluation of services for the homeless. *Evaluation and Program Planning*, *15*, 417-426.
Morris, N., John, G., & Keen, T. (1988). Mentors: Learning the ropes. *Nursing Times*, *84*(46), 24-27.
Nyamathi, A. M., Kington, R. S., Flaskerud, J., Lewis, C., Leake, B., & Gelberg, L. (1999). Two-year follow-up of AIDS education programs for impoverished women. *Western Journal of Nursing Research*, *21*(3), 405-425.
Osberg, L. (1996). Summary of economic policy variables and population health. In *What determines health*. Ottawa: Minister of Supply and Services Canada.
Ovrebo, B., Ryan, M., Jackson, K., & Hutchinson, K. (1994). The homeless prenatal program: A model for empowering homeless pregnant women. *Health Education Quarterly*, *21*(2), 187-199.
Pollio, D. (1997). The relationship between transience and current life situations in the homeless service-using population. *Social Work*, *42*(6), 541-552.
Powell, G. (1986). Primary health care: What is it? *New Zealand Nursing Journal*, *79*(12), 20-23.
Power, R., French, R., Connelly, J., George, S., Hawes, D., Hinton, T., Klee, H., Robinson, D., Senior, J., Timms, P., & Warner, D. (1999). Health, health promotion, and homelessness. *British Medical Journal*, *318*(7183), 590-592.
Progressive Conservative National Caucus Task Force on Poverty. (2000). *It's up to us!* Ottawa, Canada: Senate of Canada.

Reilly, F. E., Grier, M. R., & Blomquist, K. (1992). Living arrangements, visit patterns, and health problems in a nurse-managed clinic for homeless people. *Journal of Community Health Nursing*, *9*(2), 111-121.

Reutter, L. I., & Ford, J. S. (1998). Perceptions of change in public health nursing practice: A Canadian perspective. *International Journal of Nursing Studies*, *35*(1/2), 85-94.

Rosenheck, R., Morrisey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health*, *88*(11), 1610-1616.

Sachs-Ericsson, N., Wise, E., Debrody, C. P., & Paniucki, H. B.(1999). Health problems and service utilization in the homeless. *Journal of Health Care for the Poor and Underserved*, *10*(4), 443-453.

Segal, S. P., Gomory, T., & Silverman, C. J. (1998). Health status of homeless and marginally housed users of mental health self-help agencies. *Health and Social Work*, *23*(1), 45-53.

Shoultz, J., & Hatcher, P. A. (1997). Looking beyond primary care to primary health care: An approach to community-based action. *Nursing Outlook*, *45*(1), 23-26.

Shoultz, J., Hatcher, P. A., & Hurrell, M. (1992). Growing edges of a new paradigm: The future of nursing in the health of the nation. *Nursing Outlook*, *40*(2), 57-61.

Shoultz, J., Kooker, B. M., Sloat, A. R., & Hatcher, P. A. (1998). Four ways to teach primary health care in a changing world. *International Nursing Review*, *45*(6), 187-191.

Spector, A. (1999). Abandoning the homeless. *Canadian Housing*, *15*(3), 22-23.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, CA: Sage.

Stuart, H. L., & Arboleda-Florez, J. (2000). Homeless shelter users in the post deinstitutionalization era. *Canadian Journal of Psychiatry*, *45*(1), 55-63.

Sullivan, T., Uneke, O., Lavis, J., Hyatt, D., & O'Grady, J. (1996). Labour adjustment policy and health: Considerations for a changing world. In *What determines health*. Ottawa: Minister of Public Works and Government Services Canada.

Terrell, N. E. (1997). Street life aggravated and sexual assault among homeless and runaway adolescents. *Youth and Society*, *28*(3), 267-291.

Toronto Disaster Relief Committee. (1998, October). *Homelessness in Toronto: State of Emergency Declaration*. Toronto: Author.

Ugarriza, D. N., & Fallon, T. (1994). Nurses' attitudes toward homeless women: A barrier to change. *Nursing Outlook*, *42*(1), 26-28.

White, C. (1999). Combating homelessness in Great Britain. *Canadian Housing*, *15*(3), 24-26.

White, M. E. (1999). The challenges of devolution at the municipal government level. *Canadian Housing*, *16*(1), 23-24.

Wojtusik, L., & White, M. C. (1998). Health status, needs, and health care barriers among the homeless. *Journal of Health Care for the Poor and Underserved*, *9*(2), 140-152.

World Health Organization. (1978). *Primary health care: Health for all*. Series No. 1. Geneva: Author.

Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Health Research*, *5*(1), 125-137.

Yapchiongco, A. (1984). Competence of community health nurses in primary health care: A perceptual study. *Philippine Journal of Nursing*, *54*(3), 101-103.