



Come walk with me: Homelessness, nursing and engaged care



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ABSTRACT

To be without a home and live in public spaces or a rooming house is to experience chaos in one's daily life with compromised food, medication, income, and physical security. This, in turn, leads to a compromised ability to foster and maintain linkages with mainstream health services. Health outcomes for homeless individuals in Australia are shocking, or at least they should be.

How do nurses work with people experiencing homelessness in Australia? What does person-centred care look like for a person who is homeless and for those who work with them? These are fundamental questions about nursing as skilful relational work in marginalised spaces with vulnerable people. Specialist nursing roles are relatively rare in these spaces.

Creative non-fiction is a reflexive writing approach that portrays the complexity and humanity of persons who are key subjects in the narrative. A community health nurse uses it in an ordinary day at work as she engages with "Lisa", a young homeless woman, throughout a health intervention that doesn't end when she is admitted to hospital. The broader social aspects integral to working with this marginalised group are included to support the narrative. Suggestions are made regarding future research into this complex area of nursing practice and health care.

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It's a freezing morning. Walking through the park I wonder how Lisa is.¹ As always I'm apprehensive when I walk towards her tree. She has her 'spot'. Her bed is set up, well hidden beneath some scrub, with a tarp over it, but that doesn't mean others don't know she is here. I wonder if she is okay—lately I have been concerned for Lisa; her health has been poor as have the choices she has made regarding people she has been seen with. I understand what lies behind these choices but am fearful for Lisa. It wouldn't be the first time I have tried to see her only to find her hurt, or distraught with her backpack and belongings stolen. And, it wouldn't be the first time I outreach to a homeless client only to find them dead.

Hard to believe isn't it? This is Melbourne, 2016, the second largest city in a land of plenty. To think there are women, men and even children, without a home is mind-boggling to most people.

And to others, they would prefer to turn a blind, non-seeing eye. But this is the reality for increasing numbers of Australians. According to the Australian Bureau of Statistics census in 2011 the number of homeless people Australia-wide was 105,237. In Victoria, 22,789 individuals were found to be without a home (ABS, 2011). On census night alone 2204 Victorians were sleeping rough, meaning that they 'slept' under a bridge, in a park, on the beach or in a doorway; this constituted 11% of the homeless population (Chamberlain & Mackenzie, 2009). In 2010 it was found that "...just over 1.1 million people had experienced at least one episode of homelessness in the previous 10 years" (ABS, 2014, p.2). The issue of homelessness touches more than most of us imagine.

Walking through the cold morning air I am mindful of people and noises around me. I have never been assaulted or threatened in sixteen years of nursing in the community, but it doesn't mean I am safe—you just never know. I've always found that the people I meet respect me, feel my concern and care for them as genuine, and even offer me a bit of protection at times. So I keep on walking toward Lisa's tree.

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¹ Lisa is a composite picture of clients commonly encountered in the first author's caseload. No identifying data related to any clients is used in this narrative.

To be homeless is to experience terrible health and social disadvantage. Chamberlain and MacKenzie describe three levels of homelessness: primary (people who sleep rough); secondary (those moving from one form of temporary accommodation to another) and tertiary (individuals living in boarding house type accommodation) (2009, p. 10). By its very nature, being without a place to close the door to the world and thereby to keep important documents and belongings, store and cook food, manage medications and have a safe, clean place to shower and toilet will produce and exacerbate complex health concerns. As a community nurse with the Royal District Nursing Service Homeless Persons Program, I find that diabetes, epilepsy, mental illness, and substance use issues are rife amongst these most marginalised people within society. The second principle of the constitution of the World Health Organisation embodies health as a human right, stating, “The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition” (WHO, 2010, p.1). So what has gone wrong here?

I walk closer to Lisa’s tree and can see something isn’t right. It’s freezing and blankets and a wine cask are strewn across the wet grass. As I reach her ‘spot’ I see Lisa—she’s almost naked in the cold, wet morning, but fortunately she is snoring loudly.

Lisa has known me for some time now and has come to trust me. For those who don’t know me, and are understandably suspicious of everyone, engagement is the prime clinical skill in my nursing ‘toolbox’. To engage someone who has no trust in others, is wary of ‘the system’ that has constantly failed them, has been abused in many forms (usually from a very young age) and who is frequently assaulted verbally and physically, is both the most vital, and most difficult, skill to master as an outreach nurse. Fundamentally, engagement is about genuinely connecting with another human with empathy, utilising an attitude of non-judgement, and a demeanour that states not only do I genuinely care, but that I am willing to go out of my way to walk with them in order to provide any required support. My professional and personal ethical frameworks come into conscious play in my everyday practice. The ideals of promoting autonomy, beneficence, non-maleficence and social justice are important to practice. The Code of Ethics for Nurses in Australia recognises the “. . . universal human rights of people and the moral responsibility to safeguard the inherent dignity and equal worth of everyone” (Nursing and Midwifery Board Australia, 2008, p.1). My work is also informed by Rosemarie Parse’s eloquent discussion of the promotion of ‘human becoming, in particular her evocation that, “The artful honouring of human dignity is the reverent way of bearing witness to the awesome mystery of humanness in considering the human as a seamless symphony of becoming” (Parse, 2010, p.260). Parse goes on to say, “Being honest in sharing information, trustworthy in keeping promises and comfortable with doing the right thing based on straight thinking preserves trust and fosters human regard (2010, p. 260)”. Similarly, Moore, Manias & Gerdtz acknowledge that, “Treating people who are homeless with respect and within a supportive environment is essential for successful engagement and continued access to health services.” (2011, p.481). These principles guide my everyday professional practice and underpin my approach to working with Lisa. Out of necessity I regularly reflect on my engagement skills, as marginalised people have well-honed radars to fakery; “faking it till you make it” is not an option in the world in which I work.

As I walk toward Lisa, I am already assessing, planning and prioritising her health needs. I am able to rouse her, however at first she doesn’t recognise me, taking a minute or so to put me into context in her mind. Lisa is an insulin dependent diabetic. I know she hasn’t been looking after herself for the past month—when I last saw her I provided insulin and medication, a glucometer and food. In the past we had spoken in detail about diabetes and the

importance of maintaining her health but I am aware just how very difficult it is for someone who is homeless to prioritise their health. In my experience, I have found it to be difficult to begin to address any health concerns without safe accommodation, as an inability to keep medications, food and other belongings secure precludes most everyday health care practices.

Understanding the road to homelessness is fundamental to addressing this health issue. It has been reported that 46% of the homeless population in Australia become so due to family relationship failure, 19% due to housing crisis and 17% because of substance use issues (Johnson & Chamberlain, 2011; p.3). Mental illness was found to be always implicated in the young person’s route to homelessness along with other contributing factors such as adverse childhood experiences and parents experiencing their own mental health issues (p.3). The impact of being without home is ongoing and cyclical in effect. To be without privacy, food security, a storage space for belongings and the ability to close the door on the world is to exacerbate mental and physical illness which, in turn, continues the cycle of being ‘apart’ from the world. Having a place to call home “had both a positive impact on people’s mental health as well as providing a stable base through which medical interventions could be more effectively delivered,” found (Johnson & Chamberlain, 2011; p.5).

I ask Lisa when she last ate or had her medication. She can’t remember; it seems Lisa has been on a binge of alcohol and heroin over the previous days. Lisa returns to substance use particularly when things are bad, using it as a self-medication of sorts—she once told me stories of terrible and shocking abuse as a child which has continued throughout her life. Lisa is only 28 years old but has already had her two children taken from her by a government authority; this serves to compound in the harshest way the effects of a lifetime of abuse. On top of these complex issues, Lisa has been diagnosed with major depressive disorder and has attempted suicide two times of which I am aware. Her grief and despair, always present, are overwhelming at times, making her need to self-medicate all too understandable.

Warmth, clothes, food and medication are prioritised by me for Lisa at this point, but first some nursing observations are necessary. I have a glucometer with me; Lisa allows me to check her blood glucose level, which is far above normal limits. A blood pressure check also reveals skyrocketing levels, and I notice a suppurating abscess to her right cubital fossa secondary to Lisa injecting heroin and missing a vein. The wound is red, swollen and painful, with cellulitis evident and infection radiating up her arm. She needs to get to hospital, have a course of intravenous antibiotics, undergo urgent management for her diabetes and hypertension, and, in the short-term, eat something nourishing.

Herein lies the difficulty. From previous experience I know that Lisa will not present to hospital and if I call an ambulance, and if it ended up arriving (another problem faced by unwell homeless people), Lisa would probably refuse to be transported to hospital. So I sit and speak quietly with Lisa about what is happening with her health, the abscess, her blood glucose levels and blood pressure and I stress the need for a hospital admission. I tell Lisa I will take her and stay with her in the Emergency Department until admission, then visit her daily to provide support. Reluctantly Lisa agrees to come, so we make our way to Access Health, the primary health clinic in which I am based. We walk up the busy street—Lisa has a dirty blanket wrapped around her, is filthy, her hair is matted, and she staggers as she walks with me. The stares from people are poorly disguised at best and indicative, in the main, of overt disgust; Lisa is viewed in a way that others on the street are not. She is stigmatised and by association so am I. Although I am used to being an observer of this stigmatisation I muse on its foundation.

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