Homelessness, Housing, and Health Geography:

The Impact of Housing on the Health of Chronically Ill Homeless Adults

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These people have taught me everything I know about what it truly means to live without a home. I hope this work does justice to their profound life stories, full of tragedy and triumph.

Dedication

This dissertation is dedicated to a former patient of mine named Aung, who was discharged into homelessness after being diagnosed with terminal bone cancer. Despite facing every obstacle – no family or support, language and cultural barriers, and excruciating pain – his tenacity of spirit remained along with his determination to live and die in his own home.

Abstract

Interventions are needed to reduce the health disparities that exist in homeless populations. Housing, often viewed as an outcome to be achieved, has become increasingly recognized as an innovative health care intervention. Through the lens of health geography, this study sought to understand *how* housing is health care for formerly long-term homeless adults with chronic illnesses.

The study (a) explores how the places of homelessness impact disease management, (b) identifies the processes by which the home becomes a therapeutic landscape, (c) explicates the place effects of housing on health, and (d) uncovers nursing's 'place' on supportive housing teams. A sample of formerly homeless adults (n=16) was interviewed. Nursing (n=2) and non-nursing (n=9) service providers participated in focus groups.

Findings reveal that homeless adults face extreme environmental, spatial, and social conditions, demanding creative strategies to manage illness. Closing the door on homelessness and making the home into a therapeutic landscape involves: negotiating home space with old and new social networks, finding a place that meets needs and desires, setting up a personal home, and enjoying home's sensual pleasures. The home affords a sense of normalcy and a *desire* to care for one's health. It also gives one the *ability* to care for health. Home essentials for health include: water, shelter, a private bathroom and shower, one's own bed for sleep and recovery, kitchen amenities, an electrical outlet, four walls, space and place for medications, an address and telephone, a place for pets, and a safe neighborhood.

Nurses can be figurative stepping-stones out of homelessness and into health care. As care navigators, they assume some of the burden of disease management and triage, which is important for those newly housed and entering care for the first time.

Providing care work on the street and in the home gives nurses an intimate knowledge of how 'place' impacts a person's health narrative. These narratives are shared to advocate for client needs and encourage moral and political action. It is hoped that findings spur research on housing's effect on chronic illnesses; support homeless, housing, and health care policy; and guide nurses in place-based care work.

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Chapter One: Introduction

"Will you please go find Jack and figure out why he hasn't been taking his insulin? He has been in and out of our Emergency Room six times this past week. Every time he comes in, he is incoherent because his blood sugar levels are sky high. We load him up with saline and insulin, stabilize him, and then send him out the door with a brand new bottle of insulin and plenty of supplies. I just don't know why he is having such a hard time with this."

Although she was dead tired after a long day, this pleading phone message from the Emergency Room convinced Mary, an outreach nurse, to head over to the night shelter and see if she could locate Jack. To her surprise, she saw him right away, lying wrapped up in his coat on the hard tile floor of the shelter. Despite the fluorescent lights and loud outbursts coming from the guy next to him, Jack was trying to get some sleep. He needed just a few hours, since he had to be out the door at six in the morning and was hoping to get some temporary work the next day. Mary knelt down and nudged his knee, "Hey Jack, can we talk for a second? I'm worried about you. The ER called and said you've been pretty sick from your diabetes. How come you're not taking your insulin?" Jack reached into his jacket pocket and pulled out the bottle they had given him that morning; it was frozen solid. Mary sighed while Jack went on to explain, "even if it weren't frozen, there's no way I could see those tiny marks on the syringe without some decent glasses, and how am I supposed to afford them?"

Determinants of Health

Jack's story is one of countless stories that illustrate how the contributors toward health and health care disparities are often located outside the realm of the individual. People like Jack, who desperately want to take care of themselves and manage their chronic illnesses, are unable to do so because of physical, geographic, social, and

economic constraints. They suffer the most direct and acute consequences of poor health, and yet ironically, health care professionals often label *them* non-compliant or non-adherent. Perhaps a more complete assessment would recognize that the homeless patient's physical and socio-political environments are not conducive to adherence?

Academic discussions of health, which focus on individual behavior while losing sight of the importance of environment and context, are due in part to the individualistic paradigm of many industrialized countries (Mechanic, 1993). Recently, however, health science researchers and practitioners have resisted this individualistic paradigm and have turned their attention toward a more holistic and social model of health. A variety of disciplines are reexamining the structural, environmental, geographical, and social determinants of health on individuals, including public health (Frenk, 1993), social epidemiology (Krieger, 2001), spatial epidemiology (Ostfeld, Glass, & Keesing, 2005), and health geography (Kearns & Moon, 2002). Alongside this spatial and structural shift in perspectives on health, there has been a growing interest in health and health promotion at the population level, versus a sole concentration on disease and its individual risk factors. High quality education, a thriving economy, and safe and affordable housing are considered vital in the world's efforts to promote health and social well being (Kickbusch, 2003).

The collective voice of these disciplines urges us to "look upstream at the causes of poor health and inequalities in health, rather than downstream at their expression in individual behaviors or ill-health" (Macintyre, Ellaway, & Cummins, 2002, p. 127). People who are homeless experience the poorest of health and the greatest of health and health care inequalities (Gallagher, Andersen, Koegel, & Gelberg, 1997). Looking upstream and truly understanding the causes of these disparities is not a simple task,

however, as the relationships between homelessness, health, and housing are incredibly complex. The following discussion attempts to tease out some of their interactions.

The Rise of Homelessness

Although there are younger people for whom homelessness has always been a constant in the landscape of their cities and their lives, older generations can remember a time when homelessness was not a visible and ever-growing societal problem (Rubin, 2007). Today, however, the National Law Center on Homelessness and Poverty estimates that, in a given year, approximately 3.5 million adults, youth, and children experience homelessness in the United States (MacReady, 2008). Given the enormity of these statistics, it is hard to imagine the rise of homelessness only began in the early 1980's (Lee, Wolch, & Walsh, 1999).

There are a number of social and political reasons for the emergence of homelessness on this scale. The first was Title I of the Housing Act of 1949, which included federal funding for urban renewal. Social advocates expected this urban renewal to improve the living conditions of city 'slums' and fund the betterment of poor urban communities. At the same time, business leaders touted the renewal as a means to increase tax revenues and draw people, namely "lucrative upper-middle-class shoppers," back to metropolitan areas (Teaford, 2000, p. 445). Teaford goes on to say, "the provisions of Title I were ambiguous enough to accommodate the dreams of its varied supporters" (p. 444). Vague language in the legislation allowed for loopholes and exploitation. In the end, the federal government subsidized the destruction of many poor residential areas, which were eventually gentrified and replaced with hotels, businesses, urban parks, and hospitals (Wolch & Philo, 2000). One historian explains:

> Within a decade after its passage, Title I had become a pariah to some of those who had originally supported it. It displaced poor residents, did not adequately

> provide for their relocation, and seemed dedicated to enhancing the wealth of the central cities by getting rid of the less affluent (Teaford, 2000, p. 448).

The Housing Act *did* provide funding for over 800,000 public housing units, but ultimately more housing was destroyed than was created (Rubin, 2007).

A second main cause of the epidemic of homelessness in the United States was the manner in which deinstitutionalization of the seriously mentally ill was implemented. In the 1940s and 1950s, several exposés revealed the horrific conditions of asylums and their treatment of mentally ill persons, leading to public outcry against these institutions. Alongside this new social awareness, psychotropic medications were on the horizon, which would allow many people suffering from mental illness to gain stability and the chance to live in the community. The hope for effective pharmacologic management of serious mental illness coupled with social demands to stop involuntary commitment to asylums led, in 1963, to the passage of two key pieces of federal legislation. The first was the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which provided federal funding to states to build community mental health centers as an alternative to institutions. The second, now called Supplemental Security Income, gives individuals financial support to live in the community in low cost housing, board-and-care homes, or low cost hotels (Rubin, 2007). These initiatives and deinstitutionalization may have been well intentioned, but underfunding and poor planning eventually resulted in hundreds of thousands of mentally ill people ending up homeless on the streets and cycling through the criminal justice system (Lamb, 1984).

Federal funding for these and other social and mental health programs experienced significant blows during the recession of the 1980's and the Reagan era. Currently, only two percent of state budgets for mental health services come from the

federal government (Rubin, 2007). Housing programs were also reduced. Between 1980 and 1987, the Department of Housing and Urban Development had their budget reduced by forty-five billion dollars, resulting in a major loss of affordable, subsidized and public housing units (Lozier, 2006). Among other causes, there was a "simple mismatch between the number of old (institutional) bed spaces lost and the number of new (community) bed spaces provided" (Wolch & Philo, 2000, p. 142). This significant loss of low rent housing was coupled with greater income inequality and rapidly growing rates of extreme poverty. During the short time period of 1979 to 1983, there was a 45% rise in the number of families living below poverty and a 21% rise in poor single adults (Freeman & Hall, 1987). These historic events culminated to give rise to a visible and ever-growing homeless population in the United States.

Health and Health Care Disparities of Homelessness

Though there are many disastrous personal consequences of homelessness, poor health and high mortality rates are among those that are well documented. Dr. Jim O'Connell reviewed studies on homeless mortality rates from around the world. He found that, when comparing homeless populations to those of similar ages in the general population, there was "a remarkable consistency that transcends borders, cultures, and oceans: homeless persons are 3-4 times more likely to die" (2005, p. 13). In addition to suffering from mortality rates higher than any other segment of the population, people who are homeless experience premature mortality. The average life expectancy in the United States is about 80 years, but subsets of homeless populations have life expectancies between 42 and 52 years (O'Connell, 2005). In fact, homeless adults ages 40-50 years suffer from health problems and functional limitations typically seen in populations over 65 years of age (Gelberg, Linn, & Mayer-Oakes, 1990).

The physical and mental health problems of homeless populations have been investigated extensively (Carter, Green, Green, & Dufour, 1994; Gelberg, Linn, & Mayer-Oakes, 1990; Gelberg, Linn, Usatine, & Smith, 1990; Reichenbach, McNamee, & Seibel, 2001; Savage et al., 2006; Savage, Gillespie, & Lindsell, 2008; Wilk, 1999; Wojtusik & White, 1998). In 1988, the Institute of Medicine compiled data from 16 homeless clinics and described the health problems of homeless adults (1988). Common health problems include chronic diseases such as diabetes and hypertension; dental, vision, and foot problems; skin problems and wounds related to trauma, victimization, and poor hygiene; respiratory and infectious diseases; functional disabilities; mental illnesses; and problems related to chemical dependency. Regarding their perceived health status, 37% of homeless individuals rate their health as fair or poor, compared to only 10% of the general population and 24% of housed populations living in poverty (Gallagher, Andersen, Koegel, & Gelberg, 1997). These findings are not surprising, considering this population experiences exposure to infectious diseases in crowded emergency shelters, harmful and extreme environmental conditions, and violence on the streets.

Homeless people directly suffer the consequences of poor health, but society also bears a considerable cost. Homeless adults utilize the health care system at high rates, visiting the Emergency Room and hospital at almost four times the rate of the general U.S. population (Kushel, Vittinghoff, & Haas, 2001; Pearson, Bruggman, & Haukoos, 2007). They have prolonged hospital stays, further contributing to the high cost of health care for this population. One study examined 18,864 admissions of homeless adults to New York City's public hospitals and found that, after controlling for several demographic and clinical measures, homeless adults had an average of 36% longer stays compared to non-homeless patients (Salit, Kuhn, Hartz, Vu, & Mosso, 1998).

There are several reasons people who are homeless experience poor health, disproportionately use acute health services, and underutilize primary and preventative care. One, not unique to this population, is inadequate access to insurance (Hwang, 2001). They also have exceptional problems accessing and utilizing the health care system appropriately. Competing priorities make them less likely to obtain needed health care and seek out a regular source of care. These include securing a place to sleep and getting enough to eat (Gelberg, Gallagher, Andersen, & Koegel, 1997). Homelessness is also severely stigmatized, creating a barrier to appropriate utilization (Kim et al., 2006). Homeless adults have expressed feelings of discrimination and not being welcomed by health care providers due to this stigmatization, causing them to avoid primary health care settings (Wen, Hudak, & Hwang, 2007).

Interventions to improve the health of homeless populations and promote their early and appropriate use of the health care system would have significant and positive effects on people experiencing homelessness and society at large. What remains less clear is which interventions are effective, especially considering the underlying problem: even if health is improved in the short term, continued homelessness perpetuates a vicious cycle of poor health. A systematic review of homeless literature revealed that intensive case management and treatment, support services, and monetary incentives were among successful interventions for the chemically dependent, mentally ill, and those with latent tuberculosis, respectively (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005). Ultimately, society will not discover lasting and successful interventions for the homeless population unless it examines the causes of their poor health. Since a lack of housing seems to be a fundamental cause, it is a fitting place to start.

Housing – Outcome or Intervention?

Given that homeless populations fare worse than even the poorest of housed populations, it is reasonable to presume that lack of housing could be one of the greatest contributing factors to their poor health status and increased mortality. Housing has not always been viewed, however, as a first-line intervention to improve the lives of those who are homeless. In 1987, the federal government passed the McKinney Homeless Assistance Act, which provided funding to homeless health care programs, shelters, and housing programs. Ironically, permanent housing was the last service offered. Homeless individuals were required to move through a "Continuum of Care" before they achieved the final *outcome* of housing. This continuum included drop-in center programs, vocational services, shelters, transitional housing and treatment programs, all of which were intended to make someone experiencing homelessness ready to accept the responsibilities of housing (Couzens, 1997). This approach assumed a person was not 'housing ready' unless they were psychiatrically stable and able to maintain sobriety (Tsemberis, Gulcur, & Nakae, 2004). This linear approach to ending homelessness did not necessarily prove successful, however, as the numbers of homeless individuals and families continued to rise (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009).

During the past decade, a paradigm shift has occurred in the world of homeless and housing services. The shift began in 1992 when Pathways to Housing introduced the "Housing First" model. This practice and consumer driven model is based on the idea that housing is a human right, and it should be offered 'first' and free of conditions. The program places people, especially those who have experienced chronic or long-term homelessness, directly into housing regardless of their readiness to accept supportive services or treatment Supportive services including mental and chemical

health treatment, vocational services, and health care are available, but program participants are not required to accept them in order to maintain their housing (Tsemberis, Gulcur, & Nakae, 2004). Research has demonstrated that, compared to the continuum of care, the housing first approach can significantly reduce societal costs by breaking the constant institutional cycle of emergency room, hospital, homeless shelter, detoxification, and jail use. These programs have also demonstrated 80-90% housing retention rates, higher than other housing models requiring sobriety or service involvement (Corporation for Supportive Housing, 2006; Kertesz et al., 2009; Swope, 2005; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004).

As a result of the Housing First movement, academics, politicians, and the popular media have shifted their attention from soup kitchens and emergency shelters to housing and support programs. Housing has become increasingly recognized as an innovative *intervention* to improve the lives and health of homeless populations (Kidder et al., 2007). Numerous studies have investigated how housing impacts health outcomes and health care utilization patterns of homeless adults. A systematic review of these studies revealed improvements over time in a variety of health outcomes (Petroskas, 2011). Homeless adults who receive housing coupled with support services have shown improvements in mental and emotional health (Clark & Rich, 2003), quality of life (O'Connell, Kasprow, & Rosenheck, 2008; Wolf, Burnam, Koegel, Sullivan, & Morton, 2001), chemical use (O'Connell, Kasprow, et al.; Fichter & Quadflieg, 2006; Larimer et al., 2009), public health risk behaviors (Aidala, Cross, Stall, Harre, & Sumartojo, 2005), HIV viral loads and immunity (Buchanan, 2009), and health care utilization (Culhane, Metraux, & Hadley, 2002). Sampling in this body of literature is primarily from homeless adult populations with mental illness, chemical dependency, and/or HIV and AIDS. Only one study sampled from the chronically ill

homeless population (Sadowski et al.). This literature represents a growing evidence base to support the idea that housing itself is a health care intervention. There are significant gaps in the evidence, however. Further research is needed to understand *how* housing influences health and health care utilization.

Health Geography: Filling the Gaps

How and why housing impacts the health of homeless populations, especially those who are chronically ill, remains to be fully understood. Save a few studies (Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; Padgett, 2007), there is a striking absence of qualitative, ethnographic, theory-driven, and community-based participatory research in this body of literature (Kyle & Dunn, 2008; Nelson et al., 2005; Petroskas, 2011). In 2009, the Research Coordinating Committee of the National Healthcare for the Homeless Council published a research agenda and stated that the former types of research were needed to "better capture the diversity and complexity of the homeless population" (Healing Hands, 2009, p. 1). Furthermore, qualitative methods are necessary to fully "explore the links between housing and health" (Mifflin & Wilton, 2005, p. 408). No one can speak with greater impact about the health benefits of housing than those who have been homeless. Listening to their perspectives would bring the health benefits of housing into sharp relief, and first-hand accounts would help researchers begin to unpack the 'black box' of housing as a health care intervention (Rog & Randolph, 2002, p.70).

No studies have explored how nursing is implicated in discussions of housing as healthcare. This is surprising, as nurses are intimately involved with the care of homeless and formerly homeless persons. They assist in the development and management of community health clinics that serve homeless and formerly homeless adults (Reilly et al., 1992), are instrumental in taking care of such patients before and

after discharge from the hospital, and often work tirelessly to reach out to those who are the most disenfranchised and distrustful of the health care system (Donovan, Dee, Thompson, Post, & Zerger, 2007). Nurses also participate in Assertive Community Treatment (ACT) and supportive housing teams. ACT teams are interdisciplinary and support severely mentally ill persons in housing; nurses have proven to have an active role in case management, relationship building, medication management, and surveillance (Wallace, O'Connel, & Frisch, 2005). Some ACT teams work exclusively with homeless patients (Tsemberis, Gulcur, & Nakae, 2004), but no studies were located that investigated how nurses on these teams support homeless individuals.

The emerging sub-discipline of health geography, which explores the "dynamic relationship between health and place," could begin to fill the gaps in this body of literature and offer valuable contributions to the discussion on the health effects of housing for homeless individuals (Andrews & Moon, 2005a, p. 55). Kearns and Smith (1994) have called for an expanded geographical inquiry in the area of housing, homelessness, and health. They recognize that the relationships between these concepts, which can be both literal and metaphorical (in the case of a housed person feeling 'home' less), are deeply complex and need to be "disentangled in theory and research" (1994, p. 423). They explain why geography offers a unique and relevant approach.

> Housing, both individually as dwellings and collectively as neighborhoods, occupies *space*; and home is a concept that unequivocally involves relationships between people and dwelling *places*. It follows, therefore, that housing and homelessness and their health implications ought to lie close to the heart of contemporary research in human geography (p. 420).

Central to geography is the concept of place, which is full of nuance and meaning.

Place can be considered a static or literal concept, as in an exact geographical location in space (i.e. longitudinal and latitudinal coordinates). These places consist of material or physical structures that identify them such as streets, libraries, parks, and churches. In this sense, place connotes locale, or an area for social activity. Places take on social, cultural, and political meaning when people interact with or 'practice' them, when they feel a 'sense of place.' Practicing place primarily involves going about the routines of daily life like grocery shopping or running through a neighborhood (Cresswell, 2009). Andrews & Shaw (2010) note that "places influence people, and people make places in an ongoing and reciprocal process" (p. 1805). The home, as one kind of place, is a "location where meanings and attachments are most intense" (Cresswell, 2009, p. 5), and it is a "rich and important site for geographical study" (Blunt & Varley, 2004, p. 4). As a practiced location, the home is infused with this materiality and meaning, and as such, influences health in both tangible and subtle ways (Dunn & Hayes, 199).

The concepts of place effects and therapeutic landscapes are also predominant themes within the discipline of health geography. The concept of therapeutic landscape refers to how social, psychological, economic, and political processes transform an environment into a healing place (Carolan, Andrews, & Hodnett, 2006). It also involves the "positive psychological attachments that people have with places and how these attachments … act to sustain health" (Andres & Moon, 2005a, p. 57). Former studies have conceptualized the place of home as one such therapeutic landscape (Williams, 2002). Place effects refer to the environmental and contextual factors that influence health, health care, and health disparities such as access to clean air, water and public transportation (Macintyre, Ellaway, & Cummins, 2002). Though research often investigates the harmful place effects of substandard housing and surrounding neighborhoods (Bashir, 2002; Shaw, 2004), the home offers amenities that affect

health positively as well. The former concepts can be used as a framework to understand the processes and mechanisms by which housing influences health.

Through an emphasis on place, health geography informs and expands on the concept of environment, which - in addition to the concepts of person and health - constitute the metaparadigm of nursing (Andrews and Moon, 2005b). A person's health is shaped by the places they interact with, including their homes, so nurses should understand these dynamics to provide better care. The places where care is provided also directly influence experiences with care and the type of care that can be delivered. Because place is central both to a person's health and their receipt of care, it should be made explicit in housing and nursing research (Kearns, 1993). A health geography perspective provides a framework to accomplish this and "has great potential to elicit dedicated evidence on the nursing environment" (Andrews & Moon, 2005b, p. 151).

Environment and places of care have been a nursing concern since Nightingale (Andrews, 2003b). In her *Notes on Nursing: What it is and What it is Not,* Nightingale underscores the significance of environment on illness experience and course of disease:

> In watching disease, both in private houses and in public hospitals, the thing which strikes the experienced observer most forcibly is this, that the symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different - of the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness, or of punctuality and care in the administration of diet, of each or all of these (1859, p.5).

Many nurses since Nightingale have recognized the importance of place on health and health care, and several have begun to research these relationships through both a nursing and geographical lens. Areas of inquiry include the changing spaces and places of nursing practice in institutions (e.g. hospitals) and the community (e.g. homes); the spatial dynamics of the nurse and patient relationship, especially since the advent of technology; and the ethical and political implications of nursing care on these spaces and places (see Andrews, 2006 for a comprehensive review of geographies of health in nursing). Health geography has informed this body of nursing research, yet just as important, this nursing research has inspired health geographers to call for an expanded focus on geographies of direct care work (Andrews & Evans, 2008). Though nursing has yet to pursue a sub-disciplinary focus on nursing geographies, Liaschenko (1994, 1996, 1997, 2001) and Peter (2002, 2003) are two "pioneers of nurse geographies" whose work and writing can offer a "firm theoretical foundation" for nurse researchers (Andrews, 2006, p. 112). By expanding on health and nursing geographies, this study has four specific aims.

Specific Aims

The overall purpose of this study, entitled *Homelessness, Housing, and Health Geography: The Impact of Housing on the Health of Chronically Ill Homeless Adults,* is to understand how and why housing impacts the health of formerly homeless, chronically ill individuals, and the 'place' that nursing has in housing work.

The specific aims of this study are:

1. To determine how the spaces and places of homelessness impact the management of illness and injury.
2. To identify the processes by which the home becomes a therapeutic landscape for formerly long-term homeless adults with chronic illnesses.

3. To explain how formerly long-term homeless adults with chronic illnesses describe the place effects of housing on their health and healthcare utilization patterns.
4. To uncover the ways in which nursing supports formerly long-term homeless adults with chronic illnesses in their homes.

History proves that housing research informs both policy and practice. Partly in response to the body of research demonstrating that housing status predicts improvement in clinical markers of HIV/AIDS and public health risk behaviors (Leaver, Bargh, Dunn, & Hwang, 2007), the federal government created a program called Housing Opportunities for Persons with AIDS (HOPWA). The HOPWA program, founded on the assertion that housing is healthcare, began in 1992 and has provided rental assistance to thousands of low-income and homeless individuals with HIV/AIDS (NAHC, n.d.). Certainly homeless individuals with other chronic diseases experience health benefits from housing. Since research drives housing and health care policy, we may someday witness the creation of housing opportunity programs for people like Jack, who are homeless and are struggling to manage their chronic diseases in shelters and on the street.

Chapter Two: Review of Related Literature

There are logical reasons to believe providing housing to homeless people experiencing chronic illnesses can improve their health and health care utilization patterns. Shubert and Bernstine (2007) present a brief case study of a formerly homeless man named Malcolm who was living with HIV when he received a housing voucher. Commenting on his health, they state:

> A permanent address made it easier to make and keep doctors' appointments. The safety of his own home, a clean bathroom, running water and a refrigerator enabled Malcolm to store and take medications, cope with side effects, and eat regularly. Malcolm's CD4 count rose to 500 within just a few months, and after 10 years he remains stably housed (p. S172).

Malcolm's story is a powerful testimony to the role housing can play in the life and health of homeless people. Research and empirical evidence, however, can also be used to corroborate his experience with housing as healthcare.

The Evidence Base: Is Housing Healthcare?

Numerous peer-reviewed studies have explored how the health and health care utilization patterns of homeless adults change after receiving permanent housing. As mentioned, research in this body of literature is largely quantitative, and whether quantitative or qualitative, most studies employ a rigorous design and are of high quality (see Table 1 and Table 2 for a summary of quality appraisal). Findings from these studies are easily grouped according to type of health outcome including: mental and emotional health, quality of life (QOL), chemical use, public health risk behaviors, physical health, and health care utilization (see Table 3 for a detailed summary of articles cited).

Mental and Emotional Health

Many supportive housing programs target the severely and persistently mentally ill (SPMI) population and receive government subsidies to house this segment of the homeless population. They are often required to report outcomes in order to receive these subsidies, so ongoing research and development structures exist to monitor progress in their residents' mental and emotional health (United States Department of Housing and Urban Development, 2008a).

Different aspects of emotional and mental health have been measured over time. One tool commonly used in research is the Colorado Symptom Index (CSI), which measures the frequency of psychiatric symptoms and has been shown to have good reliability and validity in homeless samples. The results are mixed regarding whether CSI scores improve for homeless adults with SPMI after they are housed. Two randomized trials testing various housing models monitored CSI scores over time periods of 18 to 24 months. One study noted significant improvements in both groups (McHugo et al., 2004), while the other found no improvements for either group (Tsemberis, Gulcur, & Nakae, 2004). Clark & Rich (2003) noted improvements over time on CSI scores, yet no p-values were reported on these outcomes. Researchers have used other scales to demonstrate housing's impact on depression (CES-D), psychological distress (BSI), and general mental health (SF-12) (Mares & Rosenheck, 2009; Wolitski et al., 2010)

There is evidence that mental health improvements due to housing can be confounded by substance abuse. A subset of homeless adults without SPMI or chemical dependency experienced a reduction in psychological distress after being housed (Wong, 2002), and perseverations have been shown to improve after moving into group housing for those with SPMI that do not have problems with substance

abuse (Caplan, Schutt, Turner, Goldfinger, & Seidman, 2006). Interestingly, for those with only SPMI, perseverations worsened when they moved into independent housing. Two measures of executive functioning, memory and sustained attention, improved after housing regardless of housing type or chemical dependency (Caplan et al.).

A three-year prospective study of homeless adults, with an adequate retention rate of 73% and comparable attrition group, investigated the effects of permanent housing on two groups; one with scores of mental illness severity and alcohol consumption above the group's median versus one with scores below. Those in the high-risk group had greater improvements after housing in obsessive-compulsive symptoms, interpersonal sensitivity, depression, and anxiety than those in the low-risk group. Several other measures of mental and emotional health significantly improved after housing regardless of risk group (Fichter & Quadflieg, 2006).

Quality of Life

Homeless adults randomized to receive housing have been shown to experience significant improvements over time in QOL compared to those who do not receive immediate housing (McHugo et al., 2004; O'Connell, Kasprow, and Rosenheck, 2008; Sadowski, Kee, VanderWeele, & Buchanan, 2009). Wolf, Burnam, Koegel, Sullivan, and Morton (2001) followed homeless adults over 16 months and showed, using bivariate analysis, a significant correlation between moving into independent housing and better QOL. The former relationship did not remain with multivariate analysis, but poorer health status at baseline *did* remain a significant predictor. Interestingly, homeless people who perceived their health as poor reported greater gains in QOL after exiting homelessness than others, controlling for multiple variables such as homeless history, chronic substance abuse, and mental illness (Wolf et al., 2001).

Two qualitative studies assessed the impact of housing on the lives and health of homeless mentally ill individuals. One explored the impact of housing on social support, community integration, and quality of life. Interviews revealed improvements in personal identities, supportive relationships, and connection to vital resources. In this study, a resident offered a powerful representative quote of how housing can change QOL: "They got me on the right medication … I can't say anything higher about the program … This is the best my life has ever been" (Nelson, Clarke, Febbraro, & Hatzipantelis, 2005, p.100). The second study examined how housing influenced the ontological security of homeless adults. Emergent themes included increased control and self-determination, the ability to complete the routines of daily life, privacy and freedom from supervision, construction and repair of self-identity, and the need to confront the question 'what's next?' after being housed (Padgett, 2007).

Chemical Use – Drugs and Alcohol

Some evidence exists to demonstrate that housing homeless adults can reduce their alcohol use over time. Fichter & Quadflieg (2006) measured alcohol use in grams per day and found that a high-risk group of homeless adults reduced their use of alcohol after housing, from an average of 245g/day to 154 g/day. One standard drink in the United States is equal to 14 grams, making this a reduction of about 6.5 glasses of alcohol per day (National Institute on Alcohol Abuse and Alcoholism, n.d.). Similarly, homeless adults placed into a Housing First program had a 2% decrease per month in daily drinking and a significant decrease in days intoxicated in the year following placement (Larimer et al., 2009). Homeless adults given immediate housing, compared to those only offered case management without housing, have also been shown to experience a reduction in both alcohol and drug use over time (Cheng, Lin, Kasprow, & Rosenheck, 2007; Clark & Rich, 2003; O'Connell, Kasprow, et al., 2008).

Acquisition of stable housing impacts the frequency of illegal drug use as well. One 18-month prospective study measured abstinence from cocaine through urine drug screening, but only outcomes at six months were reported due to poor compliance with the measure. Those in both sober and non-sober housing reduced their use of cocaine compared to those not in housing. (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005). A multi-site evaluation observed a reduction in crack, cocaine, and marijuana use after housing (Mares & Rosenheck, 2009). Finally, among homeless, unstably housed, and stably housed persons living with HIV and AIDS (PLWHA), improvement in housing condition reduced the odds of hard drug use (heroine, cocaine, crack, or methamphetamines) by 54 percent (Aidala, Cross, Stall, Harre, & Sumartojo, 2005).

It should be noted that four studies utilizing The Time-Line Drug and Alcohol Follow-Back Calendar, a reliable and valid measurement tool of self-reported days of alcohol and drug use within the last six months, found no significant differences in either drug or alcohol use after housing or between housing groups (Mares & Rosenheck, 2009; McHugo et al., 2004; Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, Gulcur, & Nakae, 2004).

Risk Behaviors

One study examined the correlation between public health risk behaviors among PLWHA and changes in their housing situation. For those in the sample who were followed over time, the group who reported a housing improvement from baseline reported reductions in needle use and/or needle sharing compared to those with no housing change, and they had lower odds (63%) of having unprotected sex at last intercourse. Those whose housing worsened had considerably higher odds (411%) of having used sex in the past six months to obtain money, drugs, or a place to stay

compared to those with no housing status change (Aidala et al., 2005). Wolitski et al. (2010) also measured several high-risk sexual behaviors and noted improvements over time for both the intervention and comparison groups, yet these results were not statistically significant.

Healthcare Utilization

Aidala, Lee, Abramson, Messeri, and Siegler (2007) followed PLWHA over 12 years and investigated the relationship between housing needs and appropriate use of medical care. They found that those with housing needs - including PLWHA who had housing but were anticipating eviction - were less likely to be receiving appropriate HIV care, while those who had housing needs and received housing assistance were 79% more likely to enter appropriate HIV care at next interview than PLWHA who did not receive this assistance. For PLWHA who were not receiving any medical care, the need for housing reduced their odds of entering care by half. Those who received housing assistance, however, were over 100% more likely to enter any medical care than those who did not regardless of demographics, mental illness, and drug use. Notably, social services and case management were also highly correlated with the use of medical care. These results are supported with retention rates of 85 to 88 percent.

Prospective randomized controlled trials support the claim that housing reduces homeless adult utilization of acute care, emergency, and chemical dependency services (Larimer et al., 2009). The Chicago Housing for Health Partnership (CHHP) completed a four-year longitudinal study in 2007 of chronically ill homeless adults who were discharged from the hospital. Participants were randomized into a permanent housing or usual care group. After 18 months, those in housing experienced a reduction in emergency room visits (24%), hospitalizations (29%), and total number of hospital days (29%) (Sadowski et al., 2009).

Retrospective investigations report similar results (Martinez & Burt, 2006). In one study, over 3,000 homeless people with SPMI who received housing were matched with homeless persons who did not receive housing. Psychiatric inpatient hospital days were reduced, on average, by almost 50% for those placed in housing, while there were no significant reductions in the homeless group. Those in housing also had a 21-24% reduction in medical inpatient hospital days, and inversely, their outpatient visits increased by 76% on average (Culhane, Metraux, & Hadley, 2002). A similar retrospective study found no significant differences between a supportive housing and usual care group on the use of emergency, inpatient, or ambulatory care services, but this study did not use a matched control group (Kessell, Bhatia, Bamberger, & Kushel, 2006).

Regarding the use of mental and chemical health services, one study found no changes in a variety of services over time or between different housing models (Dickey et al., 1996). Three studies *did* find significant increases in the use of substance abuse treatment or psychiatric services over time for certain types of housing, though these results were expected since housing in these programs was contingent on service utilization (Milby et al., 2005; Padgett et al., 2006; Tsemberis et al., 2004). Another anticipated finding is that those placed in Housing First models from psychiatric hospitals had a 50% reduction in subsequent psychiatric in-patient stays compared to those placed in housing that had contingencies such as sobriety or treatment (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). Comparably, Siegel et al. (2006) report reductions in psychiatric crisis use for those in low versus high demand housing.

Physical Health

Only a few studies included measures of physical health. When measured, subjective health was either unchanged over time (Mares & Rosenheck, 2009) or

results were ambiguous. Homeless PLWHA who were *not* assigned to housing in one study experienced significantly earlier improvements in physical health compared to those who *did* receive housing, although this difference disappeared over time (Wolitski et al., 2010). The former multi-site study, titled the Housing and Health Study, has been considered "the first effort to rigorously evaluate housing as a structural HIV prevention intervention for homeless or unstably housed PLWHA" (Kidder et al., 2007, p. S159). Objective measures of health included CD4 counts and viral load. These did not significantly improve for the housed group in an intent-to-treat analysis, but an as-treated analysis revealed a significant association between homelessness and a detectable viral load (Wolitski et al.). Strengthening the evidence, the Chicago Housing for Health Partnership study reported significant reductions in viral load for those randomized to the housing group and, compared to the usual care group, they also had a 63% relative improvement in survival (Buchanan, Kee, Sadowski, & Garcia, 2009).

Strengths and Limitations of the Evidence

The evidence summarized in this chapter was abstracted only from longitudinal studies, which are more effective than cross-sectional research in recognizing predictor variables. Though some of the studies were observational, many had experimental designs, further strengthening the evidence for causal relationships between housing and health outcomes. The samples were inclusive of all genders, minority ethnic groups, and different degrees of homeless chronicity, broadening the generalizability of results. Across most studies, attrition rates were acceptable considering the challenges of retaining this transient population.

So the question remains: Is housing healthcare for homeless adults? The majority of the literature supports the hypothesis that housing *improves* health and

health care utilization outcomes for homeless adults. A review on the effect of housing on the health, quality of life, and healthcare use of people with severe mental illness (but not necessarily homeless), came to a similar conclusion. Kyle and Dunn (2008, p.12) state:

> The strongest evidence of the effect of housing on the health of people with SPMI [severe and persistent mental illness] comes from studies with people who were once homeless.

In this review, only one measure of mental health worsened after housing in a small subset of severely mentally ill adults. The authors of that study suggest that isolation and lack of social experience in independent housing may account for this finding (Caplan, Schutt, Turner, Goldfinger, & Seidman, 2005). By and large, statistically significant findings across all studies and outcomes were positive.

Considering health outcomes separately, the strength of evidence varies. There is inconsistent evidence regarding housing as an intervention to improve psychiatric symptoms, and strong but limited evidence supporting improvements in quality of life. Evidence related to physical health and drug and alcohol use after housing also varies; both significant and non-significant changes in use were reported. As with other outcomes, however, drug and alcohol use never worsened after housing. Finally, evidence was found to support the claim that housing has a positive effect on the use of health services; several rigorous studies indicate remarkable changes in health care utilization patterns.

When housing was found to improve health outcomes, it was usually coupled with varying support services or intensive case management, making it difficult to determine housing-specific effects in studies without a control group also receiving the same case management. This limitation should not, however, downplay the

importance of either intervention in improving the lives of people who are homeless. Measurement scales based on self-report were often used to track health related changes, which are reliable and valid for certain outcomes, but they could have been supported by triangulation with other data sources such as health records.

Though two studies monitored CD4 counts and viral loads in PLWHA over time, no studies identified measured health outcomes related to chronic illnesses other than HIV/AIDS such as diabetes, hypertension, and cardiovascular or pulmonary diseases. Sampling in this body of literature is primarily from homeless adult populations with mental illness, chemical dependency, and/or HIV and AIDS (Sadowski et al., 2009). Health outcomes were occasionally secondary outcome measures, limiting the ability to abstract detailed data. One article noted a significant reduction in crisis service use over time, which included both emergency room and crisis service use, but it did not provide a thorough breakdown of these results (Siegel et al., 2006). Another article mentioned health measurements at different time points, but it did not discuss their analysis (Wong, 2002).

There is evidence to conclude that housing coupled with support services can help, and certainly does not hinder, outcomes related to drug and alcohol use; risk behavior; and mental, emotional and physical health. Housing also improves the use of health care systems. Housing policy makers and program advocates who serve formerly homeless individuals – especially the mentally ill, chemically dependent, and PLWHA - can include health care improvements in the larger body of evidence on the benefits of supportive housing. While it has been shown that housing does improve health, further theory-driven research is needed to uncover *how* housing improves health. Health geography is a fitting approach to answer this question.

The Approach: Health Geography

Health geography, which investigates the dynamic relationships between place and health, did not emerge as a sub-discipline of human geography until the mid-1990s. Until that time, medical geography was the dominant science in this area, and it was primarily concerned with two distinct and yet occasionally intersecting streams of geographic research. The first concerned the geographic patterns and distributive features of diseases and death. This area of science, using technical mapping systems to survey populations and disease, was predominately quantitative. Advanced statistical methods made it possible to determine the impacts of neighborhood and community factors on mortality and prevalence of disease. The second area of inquiry in the field of medical geography was the distribution and accessibility of health care services. Research in this vein often took a critical approach, demonstrating how the inaccessibility of services leads to inequities in health and health care (Dummer, 2008; Kearns and Moon, 2002).

Through the medical lens, health was viewed as absence of disease, and health care as clinical procedures and interventions. In the early 1990s, a seminal paper challenged the limitations of this perspective (Kearns, 1993). It sparked a heated debate (Kearns, 1994; Mayer & Meade, 1994; Paul, 1994), which eventually began to "nudge the collective focus of medical geography towards a cultural/humanistic standpoint through the advocacy of 'post-medical geographies of health'" (Kearns and Moon, 2002, p. 608). Health geographers followed suit and began to embrace more socioecological and sociocultural models of health. They expanded their notions of health to include wellbeing, and health care to include human experiences with care and the care work that is conducted in non-medical or non-traditional care settings. As a result, post-positivist and qualitative researchers began to explore the impact of ones

'place' on health and health care. Previously, place had remained a somewhat static and literal concept in research. Within health geography, however, place came to life as a theoretical concept filled with constructed meanings and subjective experiences. Similarly, health became a relative concept imbued with social and cultural meaning (Kearns, 1993).

Therapeutic Landscapes

Developing theoretical underpinnings, health geographers began to explore the intersection between mind, body, and place. They sought to understand the processes by which people found their 'place in the world,' especially with regard to health and healing. In 1992 Gesler, influenced by new ideas in cultural geography and social theory, coined the term "therapeutic landscape," which became a metaphor for the way in which the healing process "works itself out in places (or in situations, locales, settings, and milieus)" (p. 743). Places that were renowned for their healing capacities such as mineral springs and mountain top retreats initially piqued Gesler's interest, and they spurred his exploration into the meaning of places and their potential for aiding in physical, mental, and spiritual healing.

Countless health geographers and social scientists have applied the theoretical concept of therapeutic landscapes in their research exploring the impact of place on health. Smyth (2005) summarizes the therapeutic landscape literature by suggesting three main bodies of work in this area.

The first body of research utilizes the concept of therapeutic landscape in relation to exceptional and specific places that are reputed to have therapeutic effects. Examples include the beautiful and historic spa city of Bath, England (Gesler, 1998), and Alaska's Denali National Park (Palka, 1999). Places like these become therapeutic because of their actual geographic characteristics such as natural beauty, hot springs,

or proximity to water, which is associated with holiness and healing in several world religions. Within this theoretical framework, therapeutic places do not merely provide a static background for healing processes to occur. Places themselves have complex and ever-changing meanings, and they are situated within social, historical, economic, political, and cultural contexts that give them the capacity to promote health and healing for certain populations (Smyth, 2005).

The second major body of therapeutic landscape literature examines more general places and spaces of care, including locations where health practices and procedures are carried out. In these landscapes, "the specific geographical location is of less significance in its therapeutic role than the physical, social and symbolic organization of the space itself" (Smyth, 2005, p. 488). Geographers have critiqued the design and structure of health care institutions such as hospitals and clinics to show how they are or are not conducive to health and healing, and furthermore, how restructuring their 'landscapes' can create new meanings for people experiencing these environments.

In an era where people have become consumers instead of users of health care (Parr, 2003), hospitals are finding new ways to create spaces that are more friendly and welcoming to their patients. Hospital birthing rooms, once sterile and institutional, are now being designed by architects to appear homelike in order to invite women into a more relaxing and domestic experience of the still quite technical hospital birth (Fannin, 2003). Hospitals have also redesigned their landscapes to include hairdressers, concerts, and even fast-food restaurants like McDonalds, thereby changing the sights, sounds, and smells of health care environments (Parr, 2003). Homes, typically intimate and private places, are becoming the stage for highly technical health care providers and interventions, thus inviting in the 'medical gaze'

and changing the landscape of home (Liaschenko, 1994). These alterations of spaces and places of care have created new therapeutic landscapes, but not without subsequent political, cultural, ethical, and economic implications. Health geographers have employed the concept of therapeutic landscape to begin this critical discourse.

The third area of therapeutic landscape research reaches beyond "the formal spaces of care (clinics) into the community and home, thereby, creating a 'therapeutic environment'" (Smyth, 2005, p. 493). It is the therapeutic networks of care in these places that contribute to the recovery and maintenance of health. These networks can consist of family, friends, and informal caregivers (Williams, 2002), as well as alternative therapists practicing complementary medicine (Andrews, 2003) and even online services supporting health and healing (Smyth, 2005). Therapeutic landscapes, in this view, are seen not only as physical surroundings or natural settings, but as places to nurture human relationships and connectedness. They are created and influenced by a person's mind, agency, and social structures. For example, research has revealed that communal gardens become therapeutic landscapes for older people. They provide an opportunity to directly engage with nature and enjoy its aesthetic benefits, but they also prevent social isolation and help older people develop lasting social networks, improving quality of life and mental health (Milligan, Gatrell, & Bingley, 2004).

The home can be a place of deep meaning and connectedness, and as such, the concept of therapeutic landscape is an "idealized framework to explore the health-promoting properties of home" (Williams, 2002, p. 141). Unlike extraordinary therapeutic landscapes that are experienced for a short time, the home is encountered every day. Thus, experiencing the home as a therapeutic landscape is particularly relevant for people who are facing long-term care or chronic illnesses and those who

need to heal from serious illnesses (Williams, 2002). Women suffering from breast cancer noted the importance of creating places within their home that allow them psychological retreat and healing. The mix of sunlight, color, candles, religious symbols, and music were all aspects of their home environments that helped them cope with their illness and discomfort (English, Wilson, & Keller-Olaman, 2008).

The concept has even been expanded to include non-physical places. Therapeutic landscapes of the mind are nurtured and explored in therapy sessions by complementary therapists, often to bring about healing from fears, phobias, and other disorders. Conjuring up images of therapeutic landscapes from the past can aid in processing life events, unlocking the unconscious mind's desires and emotions, and promoting relaxation in the mind and body (Andrews, 2004). Nurses and other health care practitioners have also, perhaps inadvertently at times, used visualization of therapeutic landscapes to help patients cope with the anxiety and fear that come from painful or invasive medical procedures (Andrews & Shaw, 2010).

In this brief review of an extensive body of literature, it is clear that therapeutic landscapes are indeed "individualized, everyday, dispersed, unbounded, and complexly constructed" (Gastaldo, Andrews, & Khanlou, 2004, p. 159). This study aims to uncover these complexities through identifying the processes by which the home becomes a therapeutic landscape for formerly homeless adults with chronic illnesses.

Place Effects

The theoretical framework of therapeutic landscapes was defined and developed exclusively by qualitative health geographers (Andrews & Moon, 2005a). The concept of place effects on health, however, has been used and expanded upon by a host of disciplines such as geography, sociology, ecology, and epidemiology (Cummins, Curtis, Diez-Roux, & Macintyre, 2007). Place effects, also called area effects, are community

or environmental factors that contribute to individual health outcomes. They include contextual (e.g. clean air and water) and collective (e.g. community norms) variables. From a quantitative perspective, they have been defined as "variables that are associated with individual health but are independent of association at the individual level" (Judd, Cooper, Fraser, & Davis, 2006, p. 211).

Scientists became interested in place effects on health in the early 1990s. Prior to this time, academics were wary of studying environmental impacts on health because of what was termed the 'ecological fallacy,' which is falsely inferring an individual level outcome from the average of the group to which they belong (i.e. stereotyping). At the time, there was also a strong societal and academic emphasis on the individual. Statistical methods focused on individual level variables and multivariate analysis, epidemiology underscored the importance of individual lifestyle choice and behaviors, and political issues were viewed through the lens of individualism and capitalism (Macintyre, Ellaway, & Cummins, 2002). Place effects on health were not at the forefront.

In the early 1990s, however, social scientists became interested in isolating contextual, or place based, variables from compositional, or individual level, variables. This is because contextual variables were often used in place of compositional variables and vice versa, without critique or consideration (Macintyre et al., 2002). Compositional variables include: demographics such as race, gender, ethnicity, and marital status; health factors such as body mass index, alcohol and cigarette use, and exercise habits; and socioeconomic status such as income, level of education, home ownership, and occupation (Andrews & Moon, 2005a). Contextual variables include: physical factors influencing health such as air quality, water availability, and climate; the availability of healthy environments such as clean housing, non-hazardous work,

and safe play areas; the provision of support services such as quality education and accessible transportation; and the collective sociocultural features of an area such as its reputation and morale, ethnic and religious traditions, and degree of community integration (Macintyre et al., 2002)

Until recently, place effects on health were considered distinct and mutually exclusive from compositional effects on health, but this dichotomy and "false dualism" is dissolving with the recognition that interactions and relationships between individuals and place are complex, interdependent, and mutually reinforcing (Curtis & Riva, 2010a, p. 218). Occupation can be largely influenced by the local labor market, and individual diet by the availability and accessibility of healthy food and grocery stores. Individual compositional factors, once thought of as confounding variables in place effects literature, are now being recognized as intervening, mediating, or moderating variables (Macintyre et al., 2002). To illustrate, gender and age have been shown to be moderators for rate of suicide in areas of socioeconomic disadvantage; men between the ages of 30-54 year have the highest rates of suicide in these areas (Cantor, Slater, & Najman, 1995).

Researchers were presented with statistical and theoretical challenges once they recognized that the processes linking place, health, and the individual are incredibly complex and interdependent. Literature elucidating place effects on health had been largely quantitative and lacking solid theoretical frameworks (Cummins, Curtis, Diez-Roux, & Macintyre, 2007). However, new statistical models allowed researchers to better identify causal pathways and test theories of place and health. Hierarchical related regression (HRR) incorporates both place and individual level predictors in analyses. For example, Jackson, Richardson, and Best (2008) used HRR and found that in Greater London there is a significant association between self-reported limiting

long-term illness and area-level deprivation (i.e. low social class, lack of car ownership, overcrowding and unemployment), even after adjusting for individual variables that also increase risk of long-term illness. Other statistical innovations in health geography include: spatial mixed modeling, which uses geographic information systems data on individuals to determine area variation in health service utilization (Chaix, Merlo, & Chauvin, 2004); and agent-based or systems-dynamic models that can represent complex systems involving person, place and time (Auchincloss & Diez-Roux, 2008).

Sorting out place effects on health has also required new qualitative methodologies. Since research has largely demonstrated that place does matter for health, the question becomes: *how* does place matter for health (Cummins et al., 2007)? Phillimore (1993) states, "the characteristics of places may be as important as the characteristics of people for an understanding of particular patterns of health" (p. 176). To develop targeted interventions, researchers must start to understand the processes by which a person's place shapes their health, and what specific characteristics or aspects of place influence particular health outcomes (Auchincloss & Diez-Roux, 2008; Frohlich, Corin, & Potvin, 2001). Regarding place effects on health, Macintyre et al. comment:

> "Context" is thus often treated as a residual category, containing those factors influencing human health behaviors or health which remain once every imaginable individual characteristic is taken into account. It is indeed a black box, and unspecified "miasma" which somehow, but we do not know how, influences some aspects of health, health-related behavior or health risks in some population groups (2002, p. 129).

Scientists are calling for qualitative research and hypotheses to unpack this so-called 'black box' of place, and to articulate the *mechanisms* by which place affects health.

Specifically, with regard to the 'black box' of housing, "qualitative methods could be used to more fully understand individuals' lived experiences of different housing arrangements" (Kyle & Dunn, 2008, p. 13).

One qualitative study investigating the place effects of neighborhoods on health inequalities underscored the importance of lay knowledge expressed through narratives or life stories (Popay et al., 2003). Examining these stories allows researchers to better understand the means by which place impacts health. For example, one participant living in a low-income neighborhood noted:

> The doctor put me on Prozac a few months back for living here. Because it's depressing. You get up, you look around and all you see is junkies ... I know one day I will come off, I will get off here. I mean I started drinking a hell of a lot more since I've been on here. I drink every night. I have a drink every night just to get to sleep. I smoke a lot more as well (Popay et al., 2003, p. 68).

This woman makes clear how living in an economically depressed area influences her mental health and health behaviors. It is important that researchers hear firsthand accounts such as this to fully understand place effects on health.

Places that influence health outcomes can range from large political geographies to small, intimate locales. They can be a state, county, school district, neighborhood block, and even a home (Diez-Roux, 2001, p. 1785). This study sought to reveal the specific features of home that influence health outcomes for formerly homeless adults with chronic illnesses, so each participant was asked to share their story and describe the place effects of housing on their health and healthcare utilization patterns.

Chapter Three: Methodology

Design and Methods: Overview and Rationale

Naturalistic inquiry and design guided the formation of this study. Naturalistic inquiry was first thoroughly explicated in the 1970's by Egon Guba and Yvonna Lincoln (Erlandson, Harris, Skipper, & Allen, 1993). Inquiry in this paradigm is conducted under the assumption that knowledge and multiple realities are actually created or constructed through the interaction of the researcher and research participants. Through this lens, knowledge is subjective and context dependent, and is discovered within 'natural,' versus controlled, environments. Accordingly, naturalistic design allows an "emergent plan for a highly interactive process of gathering data" (Owens, 1982, p.11). These perspectives contrast with positivistic and post-positivistic inquiry where researchers distance themselves from participants to prevent biasing the results and to discover an objective reality, and where designs involve ordered procedures and timelines.

In order to understand the complexities of human experience in its natural environment, and through the eyes of the participants, qualitative methods are usually employed in naturalistic design (Lincoln, 1985). In contrast to quantitative methods, which seek knowledge of quantity, qualitative methods ask 'how' and 'why' questions to elicit subjective knowledge regarding quality (Polit & Beck, 2008). Methods to collect qualitative data include participant interviews or focus groups, document analysis, and observation (Owens, 1982). This study used individual interviews with 16 formerly long-term homeless adults and three focus groups of homeless service providers and nurses to answer the following research questions:

1. How do the spaces and places of homelessness impact the management of illness and injury?

2. How does a home become a therapeutic landscape for formerly homeless adults with chronic illnesses?
3. How do formerly long-term homeless adults with chronic illnesses describe the place effects of housing on their health and healthcare utilization patterns?
4. How does nursing support formerly long-term homeless adults with chronic illnesses in their homes?

These questions sought to understand the unique life experiences of formerly homeless adults with housing, health, and health care. It was assumed that there were multiple answers to these questions and no correct answers. Though some who adhere to positivist and post-positivist paradigms feel that subjectivity in research is a weakness and to be avoided, it was fundamental to uncovering the lived realities of those who participated in this study. Commenting on the dynamic relationships between health and place, Williams asserts that "meaning is the key to the importance of places, and it is the subjective experiences that people have within places that give them significance" (2002, p. 148). Naturalistic inquiry and qualitative methods were most suited to this study because sampling, data collection and data analysis were viewed as iterative processes. The nature and quality of data guided these aspects of the design through assessment of data saturation and constant comparison.

Setting

This study was conducted in the Twin Cities metro area, which consists of seven counties: Hennepin, Ramsey, Dakota, Anoka, Washington, Scott, and Carver. Hennepin and Ramsey counties are home to the largest communities of adults experiencing homelessness in Minnesota. A 2009 survey revealed that there were close to 3,000 single homeless adults in these two counties; almost 200 single homeless

adults were identified in the five other surrounding counties (Wilder Research, 2009).

These seven metropolitan counties have entered into an agreement to operate a collaborative project to provide housing and support services to long-term homeless adults (Hearth Connection, n.d.). Several organizations have interdisciplinary teams that support homeless adults in the transition to housing. Their clients are placed into two types of housing: scattered site housing, which is located throughout the general rental market; and congregate housing, which couples housing with on-site support services specifically for homeless adults. The primary investigator (PI) of this study partnered with service providers from these teams and interviewed participants who are housed in both types of housing (see Table 4 for a list of housing providers and organizations).

Inclusion and Exclusion Criteria

Inclusion criteria for the selection of formerly homeless participants included:

- Ability to pass a screening tool assessing comprehension of consent documents (see Appendix B).
- Consents to participate in an interview (see Appendix C).
- Formerly long-term single homeless adult (i.e. over 21 years old). Long-term homeless was defined as lacking a permanent place to live continuously for one year or more, or at least four episodes of homelessness in the past three years. Nationally, chronic or long-term homeless persons comprise 16% of the homeless population. Homelessness is usually an episodic or short-term phenomenon (U.S. Department of Housing and Urban Development, 2008b). In order to obtain a purposive sample of individuals who were best able to reflect on the experience of acquiring housing after being homeless, this study interviewed only formerly long-term homeless individuals.

- Ability to speak English.
- Has maintained housing for more than six months but not more than five years. Most of the partnering agencies began targeting long-term homeless adults for housing five years ago. Many programs have not experienced a high turnover since admitting clients. Therefore, five years was chosen as a practical time limit. It was also felt that participants should be housed for at least six months, to be able to reflect on their transition into housing. Sandelowski states, "this ability to articulate experience depends … on participants having had enough time from the target event to process it" (1999, p. 82).
- Trusted community partner deemed the participant safe to interview privately.
- Participant reported a current diagnosis of one of the following chronic illnesses, shown to increase mortality risk in homeless populations (Sadowski et al., 2009, p. 1772):
    - Hypertension
    - Diabetes requiring medication
    - Thromboembolic disease
    - Renal failure or disease
    - Cirrhosis of the liver
    - Congestive heart failure
    - History of myocardial infarction, atrial or ventricular arrhythmias
    - Seizures within the past year or requiring medication for control
    - Asthma/COPD requiring at least one ER/hospital visit in 3 years
    - Cancer
    - Gastrointestinal tract bleeding (other than from peptic ulcer disease)
    - Chronic pancreatitis

- HIV or AIDS

Participants were excluded from this study if they were:

- Not formerly long-term homeless
- Not able to give informed consent (e.g. grossly intoxicated, acutely psychotic, developmentally delayed, cognitively impaired)
- Under 21 years old
- Exhibited threatening or violent behavior
- Not coherent enough to describe their past homeless history
- Accompanied by children
- Not suffering from a chronic health condition

Inclusion criteria for nursing and non-nursing service providers included

- Had housed a chronically ill long-term homeless adult (not necessarily a study participant)
- Had helped this person maintain their housing
- Had worked as a homeless service provider for more than one year
- Were willing to participate in a focus group with other providers

Recruitment

Formerly homeless. A purposive sample of formerly homeless adults was recruited in collaboration with service providers who had established trust with these individuals. The involvement of trusted community partners has proven crucial to successful recruitment in homelessness research (Hough, Tarke, Renker, Shields, & Glatstein, 1996). Purposive sampling is common in qualitative research and its benefits involve locating participants who have experienced or are experiencing the phenomenon under investigation, and who are willing and able to provide a detailed and rich description of the experience (Morse, 1989).

At the beginning of the study, partnering service providers were invited to attend an informational session held at a central homeless service site. The PI provided a one-page handout introducing the study (see Appendix D) and gave a brief overview of the study design and procedures. Service providers were asked to identify 1-2 participants in their programs who met inclusion criteria and could examine and describe the relationships between their home and health or health care use. They were given a flyer to hand out to potential participants (see Appendix E) and were briefed on how to introduce the study in a neutral, non-coercive manner.

If a potential participant was willing to hear more about the proposed study, the service provider facilitated a meeting between him or her and the PI. The PI met each participant at their apartment or housing facility and provided an introduction to the study, fully describing its risks and benefits. The PI made it clear that, even though she had come, they could still choose not to be a part of the study. If the person agreed to participate, he or she was asked to review the consent form and complete a screening tool assessing their capacity to consent. The tool was a short 7-question test of consent documents (see Appendix B). The homeless population is often considered socially and cognitively vulnerable, so the test was given to ascertain cognitive capacity. It should be noted, however, that "it is not at all clear that being homeless is itself reason enough to doubt a participants' decisional capacity" (Schonfeld et al., 2003, p. 18). A similar screening tool has been used in previous research to protect this vulnerable population from research exploitation (Song, 2010). If the participant passed the screening, as indicated by answering all questions correctly or getting only one wrong, they were then asked to sign the consent form. Those who were not able to read had the consent documents read to them line-by-line.

Service providers. To recruit trusted service providers, individuals who attended the initial informational meeting were contacted via email and asked to participate in a focus group. They were informed in this email of the purposes and procedures of the study, as well as its risk and benefits. Nursing and non-nursing service providers who had supported a homeless adult with chronic illness in housing were recruited. The PI used an on line system to facilitate scheduling a convenient time and date for those who agreed to participate. On the assigned date, participants met and signed the consent form (see Appendix F).

Compensation. Service providers were compensated $50 for involvement in one focus group and $50 for their time assisting with recruitment of participants. For their time, participants were given $20 upon completion of an interview. This is a typical amount in homelessness research, and although monetary compensation remains an ethical issue, the consensus is that "not to compensate ... for participation in a research activity for which others are generally paid may be condescending" (Hough et al., 1996, p. 884). Cash was used, as homeless and formerly homeless individuals often do not have identification and cannot cash checks, and payment-in-kind compensation (e.g. gift cards) can be restrictive of autonomy and the right to choose an item of personal value (Schonfeld, Brown, Weniger, & Gordon, 2003).

Participants

Formerly homeless. Sampling for demographic variation did not fit the purposes of this study, yet a diverse sample of formerly homeless individuals were recruited (n=16). The demographic diversity of participants was not surprising, as ethnic and racial minorities are disproportionately represented in the Minnesota homeless population. African Americans comprise 41%, American Indians 11%, and Hispanics 7% of the statewide homeless population. Additionally, adult women are one

of the fastest growing homeless groups, representing 23% of the homeless population (Wilder Research, 2009). In addition, the sample of formerly homeless participants represented a wide range of chronic physical and mental health conditions; chemical addictions; and homeless, educational, and social histories (see Table 5 for a full description of formerly homeless participants).

Four people recruited for the study by service providers were unable to participate. Two did not meet criteria for the study: one did not have a chronic medical condition, and the other had just moved into his apartment. Two were eligible to participate but did not: one did not consent to be audiotaped, and the other was not at her apartment two times the PI went to meet her for an interview. Sampling ended when data redundancy and saturation were achieved. Sandelowski notes that "sample size in qualitative research is one that permits – by virtue of not being too large – deep, case-oriented analysis … and that results in – by virtue of not being too small – a new and richly textured understanding of experience" (1995, p. 183).

Service providers. Three focus groups of service providers were conducted. Six providers were invited to the first and second focus groups; four and five people attended respectively. Four people were invited to the nursing focus group, but only two nurses attended. Only three housing teams in the Twin Cities metro area have nurses on staff, so a small sample size of nurses was expected. The total sample included seasoned non-nursing and nursing homeless service providers who reflected different approaches to providing care (e.g. harm reduction, housing first) and who worked in a variety of housing models (see Table 6 for a full description of service providers).

Data Collection

Once the consent and screening process was complete, the PI interviewed formerly homeless participants using a semi-structured interview guide that addressed research questions (see Appendix G). Although unstructured interviews have been shown in some studies to elicit richer depth and detail, semi-structured interviews were used to ensure that key issues and themes were discussed (Polit & Beck, 2008). Interviewing was an iterative process, so questions were added or altered according to participant response. Time was spent between interviews studying both the process and content of each interview, to hone interview technique and develop relevant questions for subsequent interviews (Rubin & Rubin, 1995).

Because a temporal process is implicit in the concept of therapeutic landscapes, narrative style interviewing was used to elicit responses to the second research question. This style encourages participants to recount their experience of a meaningful event in story form with a beginning, middle, and end (Sandelowski, 1999). A narrative approach is "particularly sensitive to the temporal dimension of human existence" (Eberhart, 1996, p. 44). In this study, the periods of interest were before housing, during the transition to housing, and after housing.

Interviews were conducted in participants' homes or housing complexes, as place and context of an interview influence the nature and quality of data collected (Polit & Beck, 2008). The PI felt that by being situated in their home environments, participants would be better able to reflect on what the place of home means to them and how their home impacts their health and healing. Sixteen interviews were conducted between April 2010 and August 2010. The interviews ranged between 45 minutes to 2 hours, and they averaged about one hour per interview.

All interviews were digitally recorded using two recorders, to ensure data collection in the event that one malfunctioned. The transcription company Tybee Types transcribed interviews verbatim and securely emailed the transcripts back to the PI. This company consists of two transcriptionists who have extensive experience with qualitative health research. Once the transcripts were received, the PI read random sections of each interview while listening to their audio, to ensure accuracy of transcription.

Once the interviewing of formerly homeless participants was complete, the PI recruited nursing (N=2) and non-nursing (N=9) service providers through housing agencies. Three focus group sessions were conducted in the evenings at the PI's home, which was in a central location and offered a quiet environment for recording. After receiving consent, the PI reviewed the purposes of the study and general rules for the session (e.g. omit names and identifiers, no derogatory statements). The PI facilitated each group using a semi-structured focus group guide, which was constructed using data from the preliminary analysis of interviews (see Appendix H). Another investigator with extensive experience in conducting qualitative research attended the focus groups in order to document non-verbal group dynamics and offer observations. Focus groups were also digitally recorded with two recorders and transcribed verbatim by Tybee Types. The length of focus group sessions averaged about 90 minutes.

Detailed field notes were taken during and after interviews and in the focus group sessions in order to capture non-verbal and contextual data. Field notes have been described as "descriptions of observed events and conversations; information about actions, dialogue, and context" (Polit & Beck, 2008, p. 406). After each interview, the PI sketched the layout of participants' apartments and carefully documented certain relevant belongings or aspects of their home environments not captured by recording.

Examples include: a calendar with an upcoming doctor's appointment, a cribbage game, an exercise ball and arm weights, scented candles, soft music, and an organized medicine cabinet. These notes were taken to allow for a more thorough transcript analysis and thick description of context (Rodgers & Cowles, 1993).

Data Management and Confidentiality

To ensure security and confidentiality, all data (i.e. tapes, transcriptions, field notes) were kept in locked file cabinets in a locked room in the PI's office. Electronic files were kept on a secure, password-protected computer in a locked office. Only the PI and her advisor had access to research data. Only first names and general demographic information were collected from participants. Identifying information was kept separate from research data and documents, and only the PI had access to this information. Research documents, including audio files, were coded with random numbers. All individual level data and identifiers such as names and places were omitted from the manuscript. Lastly, records will be destroyed ten years from the start of the study.

Confidentiality during the interviews or focus groups was maintained by conducting them in private spaces. Focus group participants were reminded that they were responsible for respecting the privacy of group members and participants, to allay the risk that they would share information with others. They were also asked to omit names and other identifiers when they shared an illustrative story about housing and health or healthcare. All personal identifiers were removed from transcripts.

Data Analysis

Data analysis was a dynamic and iterative process, involving multiple stages and continual scrutiny by the PI and her advisor. After each interview was completed and transcribed, the PI uploaded the electronic transcript to Atlas.ti®, a qualitative

software program with concept mapping and multi-level coding abilities. The PI then employed systematic content analysis and constant comparative analysis to recognize patterns in content and codes across all sources of data, including observational data. Content analysis is "the process of identifying, coding, and categorizing the primary patterns in the data" (Patton, 1990, p. 381). The same process was used after each interview, and new data and codes were compared to previous ones. Data was classified and indexed using new and identified codes. Often, one unit of analysis or note elicited multiple codes. The PI read transcripts and field notes line-by-line multiple times and at multiple stages of the data collection and analysis process, to achieve full immersion in the data. The PI's advisor manually coded a sample of complete interview transcripts, and reviewed all coding units, to ensure confirmability of coding and content analysis.

After coding, related codes were electronically clustered together as categories or sub-categories according to research aims, and through a health geography lens. Polit and Beck state, "clustering is based on similarities among units of analysis and hierarchies that conceptualize the text on different levels of abstraction" (2008, p. 518). To assist in abstracting latent constructs, Atlas.ti ® was used to color code different levels of data. It also allowed mapping of the relationships between codes and categories. For example, different arrows signified that one code 'contradicts,' 'is part of,' 'is cause of,' or 'is associated with' another code or set of codes in a certain content area.

After coding and categorization, the PI and her advisor came together to compare and contrast data analyses, and to discuss the relationships between categories and sub-categories. Discrepancies were discussed and resolved. At this point in the data analysis, preliminary findings were written in outline format and summarized. This

summary was used to guide the creation of focus group interview guides. In addition to being asked pointed questions related to major themes, members of the focus group were presented with a brief summary of findings. They reflected on these findings and offered confirmatory or divergent case studies, which was a form of members checking the data (Polit & Beck, 2008).

After the focus groups, audio files were transcribed and analyzed in a manner similar to the interviews. Discussing the unique analysis needed for focus group data, Carey states, "when using transcripts of a focus group session, the researcher needs to be mindful of the total group setting, the nonverbal data, and changes and discrepancies in a member's contributions" (1994, p. 234). Data generated from focus groups are hence more reflective of group consensus than of individual opinion. Group effects, and non-verbal observations made by a second researcher during the groups, received careful consideration during analysis and interpretation of focus group data.

The PI and her advisor used similar processes (e.g. content analysis, constant comparison, and concept mapping) when analyzing focus group data and synthesizing it with interview codes and categories. A large part of the data analysis process involved the PI and her advisor uncovering emergent themes and subthemes to present the data in a meaningful way. To illustrate, the *codes* 'hot shower' and 'breeze' were *categorized* as 'tactile pleasures of home.' This category was then *clustered* with other categories like 'olfactory pleasures of home.' This cluster became a *sub-theme* called 'Entertaining the Senses,' under the larger *theme* of 'Therapeutic Landscapes of Home.'

The final stage of data analysis involved presenting findings to an expert health geographer, a homeless and housing service provider with 15 years experience, and a group of nurses and service providers at the 2011 National Health Care for the Homeless Conference. The health geographer reviewed results for conceptual accuracy

and meaning, and the direct service providers reviewed findings for authenticity of data. Suggestions were incorporated into the last stage of the analysis process.

Ensuring Quality

Researcher preconceptions and reflexivity. The PI of this study has worked as a public health nurse with homeless adults for several years. Although this experience gives her credibility as a homelessness researcher, it could also bias her analysis of research data. She believes housing is a human right and fundamental to sustaining health and human dignity. Thus, participants were expected to describe the place effects of housing on health as beneficial or positive. However, the effects of housing have frequently been described in the literature as detrimental to health (Padgett, 2007). The author of this study did recognize that participants might underscore the negative place effects of housing and might not have experienced their home as a therapeutic landscape. To prevent leading questioning, the PI emphasized during the interview and focus group sessions that she was conducting the study to learn from participants and hear their expertise (Julius, 1998). Both positive and negative findings were coded to prevent a biased analysis of data.

It is perhaps inevitable that researchers approach and influence qualitative research with their own moral, political, and social positions. Consumers of research should therefore be informed of these positions to make their own judgments about the integrity of findings. Koch and Harrington (1998) recommend that researchers keep a reflexive journal, which would encourage them to critically assess how this 'positioning' in the world impacts each stage of the research process. The PI of this study kept a reflexive journal and remained committed to reflexivity and transparency

Strengths and limitations of methodology. An article aptly titled, "What We Didn't Learn Because of Who Would Not Talk to Us", describes how purposive

sampling using community partners to recruit participants can cause 'gatekeeper bias' (Groger, Mayberry & Straker, 1999). In this study, trusted service providers were asked to choose participants based on inclusion criteria. There was a risk, however, that their decisions about who to introduce to the investigator were based on other criteria such as their perception of the participants' quality of life or health. In light of this, the PI explicitly asked providers to restrain from using their own arbitrary criteria in determining which individuals to recruit as potential participants. The risk of systematic gatekeeper bias was also reduced in this study through the use of multiple providers for recruitment.

Limited variation as a result of gatekeeper bias, participant refusal, or purposive sampling can lead to limited transferability. Naturalistic inquiry and designs recognize that meaning underlying experience is subjective and uniquely shaped by each person, so transferability is not the ultimate goal in qualitative research (Groger et al., 1999). However, analysis generally reveals common themes and shared meanings that are relevant across contexts and to people in similar circumstances. To enhance transferability and make findings from this study relevant to others, recruitment occurred at multiple sites and a diverse sample was recruited.

There are inherent limitations to using focus groups as a data collection method. Two primary limitations are censoring and conforming. Participants who are uncomfortable with other members in the group, or who do not trust the moderator, may censor their contributions or decide not to share their opinions or experiences. Others may feel pressure to conform to the consensus of the group, or to those who are more vocal and opinionated. To reduce the likelihood of these behaviors, the PI encouraged divergent thinking and actively engaged all participants throughout the focus group sessions. The members selected for the focus groups in this study knew

each other and the PI, as she has worked in their community as a public health nurse with homeless adults. These dynamics could have promoted trust and reduced censoring or conformity (Carey, 1994).

Despite its weaknesses, focus groups are often an advantageous and efficient method of eliciting qualitative data. Group dynamics can stimulate rich and meaningful conversations, yielding a wealth of data (Polit & Beck, 2008). Members of focus groups have reported feelings of support and empowerment through participation, and because they are not required to answer every question, they may feel safer in a group setting versus individual interviews (Julius, 1998).

Trustworthiness. Just as quantitative data should be valid and reliable, qualitative data should be trustworthy and authentic (Polit & Beck, 2008). Guba and Lincoln (1994) explicate four criteria for assessing the trustworthiness of qualitative research: credibility, confirmabiliy, dependability, and transferability. Measures were used during this study to satisfy the above criteria.

Credibility is paramount and refers to the accuracy of data analysis and interpretation. Because the researcher is, in a sense, the tool in qualitative research, credibility is often contingent upon the qualifications of the researcher (Patton, 1990). The primary investigator of this study has been a co-investigator of a previous qualitative study, and has assisted with qualitative analysis for a study investigating the end-of-life preferences of homeless adults. Prior to this research project, she had conducted in-depth interviews, focus groups, and independent qualitative analysis. Her advisor has been a qualitative researcher for over 20 years, and is a leading scholar in the geographies of nursing.

In addition to using credible researchers, credibility was achieved by reflexive journaling and highlighting negative cases, or data that did not conform to the main

patterns identified (Lincoln, 1985). Lastly, person triangulation is used as a strategy to ensure both credibility and dependability (Polit & Beck, 2008). Dependability, often likened to reliability, pertains to the stability of research findings across people and contexts. In this study, data was collected from formerly homeless persons, service providers, and nursing providers.

Confirmability, defined as "the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning," was strengthened by two researchers separately coding and analyzing the data, and through consultation with an expert health geographer (Polit & Beck, 2008, p. 539). Using multiple data analysts is a form of investigator triangulation and enhances confirmability. To guarantee transparency and establish an audit trail, all raw data was maintained, process and analyses notes were made available to other researchers, and supportive quotes were presented in the following chapters (Lincoln, 1985).

Transferability, the extent to which findings may be applicable to other contexts, was enhanced during data collection through the use of detailed field notes and will be ensured during the dissemination phase by including a thick description of research contexts. Assessing whether the findings from a study are *useful* to research and practice is perhaps the best measure of the merits of a study, but this is for future researchers and practitioners to judge.

Chapter Four: Results

All qualitative researchers are confronted with the challenge of presenting a summary of their data in a way that does justice to the profound life stories and experiences that participants have entrusted to them. Interviews reveal beautiful and tragic narratives that are often more than the sum of their parts. Taken as a whole, an individual narrative can make a powerful impact and illustrate truths in a compelling manner.

In an effort to give the reader a sense of the complete stories that emerged from this study, results are presented temporally from the time participants were homeless to after they received housing. This chapter will start with a discussion of the conditions that formerly long-term homeless individuals left behind, or figuratively closed the door on, when they entered housing. It will examine how the spaces and places of homelessness influenced the lives and health of participants. The discussion will then explore the difficult and exciting transitions into housing, presenting how participants settled into their homes and came to make these places into loved therapeutic landscapes. It will also articulate the place effects of home, and *how* the place of home is making a lasting impact on their health. The chapter will conclude with a discussion of how nurses have an important and unique 'place' on supportive housing teams.

Closing the Door on Homelessness

Individuals who move into housing after being homeless for many years often leave behind, or close the door on, places and people from their past. Upon reflection, participants in this study recounted how their life and health was before housing, bringing into sharp relief the nature of their current situation. These places from their past often were, as Dear and Wolch have aptly described, truly landscapes of despair

(1987). They were literally and figuratively counter-therapeutic. The conditions of homelessness are well understood. Countless studies have examined the cultures and geographies of homelessness (see Dear & Wolch, 1987; DeVerteuil & Evans, 2010; Johnsen, Cloke, & May, 2005; Tsai, Mares, & Rosenheck, 2010; Rollinson, 1998). The themes examined in the next section emerge from this body of literature, but they are represented here through the lens of health geography and with an explicit focus on health and the management of chronic disease.

No Private Space for Self or Belongings

Participants often described the difficulties of having to share space with strangers, whether in a shelter, abandoned building, or on the street. They expressed a lack of trust in the people around them, causing constant stress and making it impossible to relax in these environments. One respondent keenly stated, "there is no way I would have any of those people that were living there in my home." Another participant noted that having strangers in his space significantly impacted his ability to get an adequate night sleep.

- When I was on the street, I couldn't sleep that hard. I'm a hard sleeper; I could sleep through a tornado probably. But when I was on the streets, I had to kind of stay awake and sleep. I don't know if you know what that means, because anything can happen out there. I have to sleep with one eye open … I wasn't relaxed because I was always scared that I was going to have to defend myself against someone that's trying to mess with me. I was tired all the time. I was really run down.

Crowding in the shelters made it difficult to establish personal boundaries or secure belongings, including medical supplies and medications. The following quotes illustrate how having strangers in their space directly impacted participants' health, health behaviors, and ability to manage chronic illness.

- I'm not against children, but I was staying in a room with them, and they could fit up to fourteen people in a room. Not that it ever got to that, but I was very unhappy in the room. Then they decided that since I had been diagnosed with this brain injury, chaos is probably something I didn't need, so they put me in a room with one family, and the next thing I knew, they were putting me back in my old room.

It was no good; it was very bad, so I purposely got myself kicked out by using. I just knew that was a way out.

- When I was homeless it was so hard for me to secure my space and say 'This is my space; that's your space. I have my own problems, you got yours; I got nothing to do with yours. I'd like to focus on mine, you focus on yours, but it doesn't happen.

- Somebody took my syringes and shot up in the bathroom and he was shooting up for quite a while. He banged on my locker and opened it up. He knew I was diabetic and he stole quite a lot of my syringes.

It was next to impossible to have any privacy in the shelters or drop-in centers, as people were always milling around. One participant noted how a lack of privacy impacted his medication compliance.

- I: How often did you take your medications when you were homeless?
  R: Half the time, because people were like 'What is that? What are you doing?' I ain't going to tell them that I got HIV, you know.
  I: What was challenging about taking your medications?
  R: People seeing me taking it. That was hard because I didn't want nobody to see me taking it.

This quote reflects an apprehension to expose one's chronic disease to others who are homeless. At the least, one would have to deal with the annoyance of the probing and personal questions that come from other guests in the shelters or drop-in centers. At the worst, this 'baring' of their illness or injury could set them up for violence and vulnerability (Kushel, Evans, Perry, Robertson, & Moss, 2003). Participants commonly complained of being assaulted or harassed when they were homeless, and of having their medications or medical equipment stolen.

The themes of wanting privacy, and not wanting to share space with strangers, have been echoed in previous research exploring experiences with shared housing or rooming houses (Means & Smith, 1996; Mifflin & Wilton, 2005). In these housing arrangements, residents receive only a small room and share common areas such as the bathroom. Though residents have some measure of privacy, they also complain of having personal items, like food, stolen by other residents (Mifflin & Wilton, 2005).

Participants in the former studies also disliked having rooms that were small, as they offered little space for personal items (Mifflin & Wilton, 2005). Those in this study had similar problems. Space in homeless shelters is limited, so people are often required to take their personal belongings with them during the day. This made it extremely difficult for participants to keep track of the things they needed to take care of themselves like medications, inhalers, medical dressings, equipment such as blood sugar machines and insulin syringes, and personal hygiene products.

Two participants noted:

- Being homeless, for me, I wouldn't remember to take my meds, I wouldn't get prescriptions filled, or I wouldn't remember what meds I took. Sometimes I'd have backpacks all over the place, a backpack here, a backpack there, so the meds would be in a backpack that's on the other side of town. I really wasn't taking meds as I should, and I wasn't really seeing the doctors.

- When I was in shelter it was so hard to keep up with my things that I bring, and then sometimes I will store it somewhere and I wasn't able to get access to it unless, you know, I can get to that spot where I left it. Sometimes I'd leave my medication there, but at night, when I'd forget, I'd have to wait until the next day or through the weekend until they opened.

Several participants also remarked how physically exhausting it was to haul around heavy bags of clothes and supplies that were "like a walking bathroom and pharmacy and closet too," especially with chronic illnesses. One man with severe COPD mentioned that he could hardly manage to transfer buses with all of his things because he became so short of breath, and another said carting water out to his camp often gave him chest pain. These bodily strains of living on the street have been shown to be catalysts for change and instigate a readiness to leave homelessness (Jost, Levitt, & Porcu, 2010).

No Place to Go or Stay

Studies exploring geographies of homelessness have articulated how people without a home feel placeless, displaced, or out-of-place (Bender, Andrews, & Peter,

2010; Cresswell, 1996; Johnsen, Cloke, & May, 2005; May, 2000). Kawash observes:

> The homeless are forced into constant motion not because they are going somewhere, but because they have nowhere to go. Going nowhere is simultaneously being nowhere: homelessness is not only being without home, but more generally without place (1998, pp. 327-328).

The burden of having no destination can take a toll on people's spirits and minds. Reflecting on having no place to go, one participant became teary eyed and stated, "that's the hardest experience or feeling to go through, and believe me, it is. Got nowhere to go, nobody to turn to help you, that's a hard life, it is." Many people commented that not knowing where they would sleep at night, or if they would secure a shelter bed, made it hard to care about their health or make it a priority. This theme echoes other homelessness literature, which has found that people who are homeless are less likely to engage the health care system because of competing needs (Gelberg, Gallagher, Andersen, & Koegel, 1997). One participant, when asked how being homeless made it hard to stay in touch with his health care provider, noted:

- I was constantly worried about a place to stay, so that was enough to forget about my health and make sure I have a place to stay. It was a constant back and forth stress and worry ... I was constantly worried about a safe place to stay, you know, especially in the winter, so that was my focus.

Being constantly on the move was also physically exhausting. Participants became especially weary when they were acutely sick or injured and had no place to rest inside during the day. Orthopedic injuries requiring casts or crutches were difficult to manage along with bags of belongings. Having the flu with diarrhea and vomiting was miserable without a readily accessible bathroom. One woman explained:

- It's so hard to be homeless and be tired, and it's worse if you're sick because there's no place to go. You can go to the drop in center, but you're not going to get well. I've seen people down there so sick; you could see they were running fevers, but they'd have to get up and leave. The same with the shelter, they were making sick people leave at six a.m. in the dead of winter.

One woman with COPD explained how she would have to "plot [her] travels by where there's benches" so she could sit and catch her breath for a moment. Another participant with avascular necrosis, a painful degenerative joint condition caused by poorly managed kidney disease, described:

- When I'm constantly on my feet, it really does take its toll on me; and I could feel it. The pain was so sharp. It caused me to limp and I can't endure it sometimes. If I'm out there sitting on one spot on a bench and the security guard … I get questioned why I'm loitering. I get charged with loitering or bothered, get approached, but I was just sitting actually, to ease the pain.

This quote illustrates how people who are homeless are excluded from certain areas such as neighborhoods, sidewalks, parks, and shopping centers. Strategies for geographic exclusion include imposing rules restricting sleeping or sitting in public areas, and constructing public areas to discourage sitting or loitering. Susser (1996) observes:

> Homeless people in the United States are significant not for their numbers but because they represent the incursions of increasing impoverishment into public space – particularly space occupied or desired by middle-income and even wealthy people (p. 417).

Many banishment practices are enforced by law and lead to stigmatization and shaming of people experiencing homelessness, compounding their stress and feelings of having no place to turn (Foscarinis, 1996; Herbert & Beckett, 2010; Mohan, 2002). Participants in this study commented on how geographies of exclusion exacerbated health problems and made treatment challenging.

- I couldn't imagine having to deal with something broken on my body, and all the walking that's included in homelessness, because nobody really wants you in their park … I'd be sitting in the park, a cop would come up to me, ask me how long am I going to be here and stuff like that, when all these other people are sitting around and he's not asking them how long they're going to be there.

In addition to exclusion from public spaces, participants in this study experienced geographical exclusion from health care spaces. At the time of this study, recipients of General Assistance Medical Care, a health program for uninsured and low-income people in Minnesota, could only seek health care in the Twin Cities metro area. Additionally, people experiencing homelessness, though often transient and not linked to one geographic area, are only able to seek services in the county in which they applied for benefits. One service provider recounted a story of a woman who was geographically constrained from receiving needed care:

- She's homeless, and the only hospital left is in Hennepin County, so that's where she's going, but because she's an Anoka County resident, Hennepin County won't give her treatment ... She's going to be having diarrhea, be throwing up, terrible fatigue, but Hennepin County said no. Her choice is either to go to Anoka County where she's thirty miles from her chemo and her care, or basically, it's a migration of shelter users to near where their hospitals are.

Similarly, a study examining the spatial distribution of homeless services in Los Angeles found that service placement influenced the geographical movement of poor populations into the inner cities.

> The relative dearth of social services in other densely populated parts of cities, however, generates an inevitable drift of service dependent populations to the inner city. A self-reinforcing cycle of co-location of service-dependent populations and human services can result, perpetuating the spatial confinement and marginalization of service-dependent people in zones of dependence (Lee, Wolch, & Walsh, 1998, p. 130).

The geographies of health care exclusion observed in this study made access to health care impossible for some, as they were unable to move to service-rich areas. Therefore, cycles of health and health care disparities were exacerbated as well.

Effect of Homeless Places on Health

Maintaining health and managing chronic illnesses in shelters, cars, camps, or on the streets was incredibly challenging for participants. Not surprisingly, many mentioned how disease-ridden the shelters were. Those with asthma or COPD frequently acquired pneumonia or upper respiratory illness and experienced exacerbations. They also developed skin infections such as scabies and other infectious rashes, which are typical in homeless populations (Gallagher, Andersen, Koegel, & Gelberg, 1997). One participant who had recently undergone a surgery for arthritis stated:

- It was staph. I was catching diseases and stuff like that from that place [shelter]. My nose was severely infected; my eyes would get severely infected. I thought I was going to have big crater holes in my nose because it would get so infected … It was horrible. There was no way I could have surgery like this while living there.

One woman developed a prudent strategy to avoid the skin infections typical in homeless populations. Maintenance staff in the shelter cleaned the showers around noon, so she would usually skip lunch and wait until she smelled bleach; then she knew it was "safe to shower." The facilities and amenities of the shelters were also lacking. No toilet paper, dirty mattresses, loud noises, rancid smells, and poor temperature regulation were common complaints.

Those who managed chronic illnesses outside or in cars faced a different set of challenges. As expected, frostbite, heat stroke, and mosquitoes were mentioned. Others described more unique experiences. One man with diabetes used a Rubik's Cube to help manage his diabetes. He could normally solve a Rubik's Cube, so he knew that when it became difficult for him to solve, he had low blood sugar and needed to eat something. Unfortunately, one day he went unconscious from low blood sugar and fell on the heater that was keeping him warm and ended up with third degree burns. The following conversation illustrates the place effects of homelessness on his health:

- I: In the van, were you checking your blood sugar three or four times a day like you are now?
  R: No, it was too difficult to keep in the van because of the cold. It needs room temperature.
  I: The machine?
  R: Yes, I had to keep it in my pocket at all times, along with the test strips, keep them warm.
  I: So that was just too hard to do when you were camping in the van?
  R: Yeah. …
  I: Tell me what it was like to try to get food and manage your diet when you were living in a van.
  R: You had to keep some ice. You can't keep anything in a hot car. I would have to have a cooler.
  I: Where did you keep your needles when you were in the van?
  R: Inside a bag inside the cooler and dry. That would keep them from bending. I had some needles that I would keep under the seat for a while and they would bend up.

A camper suffering from COPD and heart disease recounts the cold winters:

- R: How do I keep my albuterol inhaler from freezing? Even when I stick it in my pocket in the wintertime, I still have to pull the cylinder out and warm it up, and even that is a little out of the temperature range.
  I: What about checking your blood pressure?
  R: I don't think that would work very well at 20 below either [pointing to a blood pressure machine]. I think they are designed to work indoors, within certain temperature parameters and in a little less moisture.

The negative place effects of homelessness required participants to develop creative and adaptive strategies to manage their chronic diseases. However, some challenges such as extreme environmental conditions were impossible to overcome, leaving participants ill equipped and unable to adequately care for themselves.

Therapeutic Landscapes of Homelessness

Participants sought out therapeutic landscapes while homeless. Several accepted invitations from friends, to feel the comforts of home temporarily. Others found therapeutic landscapes in institutions of care. One man would deliberately get intoxicated when it was cold outside, so the police would take him to a detoxification facility. In detoxification, he says, "I would get my clothes washed. I'd get a warm bed. I'd get a couple meals." Another strategy was to go to the ER or hospital.

- I just wanted to escape and disappear. So I'd go to the hospital. That's the only way to go … I enjoyed being in the hospital because it was warm, I had three square meals a day, I had cable TV, and I wasn't worried about where I was going to sleep that night… One time I got frostbitten and stayed in the hospital eight days, and those were the best eight days of my life.

Campers remarked how beautiful the natural landscape was, especially during the summer and fall months. They fondly remember the smell of the woods, vibrant sunsets, and peaceful campfires. Others talked about the importance of finding therapeutic landscapes to escape the chaos of the shelters.

- I always walked from the shelter down to [main] street, because there's places, you know, they had benches and everything, and so I'd just go down there and read. It was just like because it was tough to read there at the shelter or do anything that, you know, for your enjoyment because it was always like if you read, someone was going to come, 'what are you reading?' You tell them, and they say 'what's is about?' So I'd go there just because there was no one.

Ironically, those who are not homeless also use public spaces as "places of escape" to be alone, to avoid the obligations of home, and for reflection (Cattell, Dines, Gesler, & Curtis, 2008, p. 552). Having had an occasional taste of these therapeutic landscapes while homeless, most participants were excited and anxious about discovering and establishing a permanent therapeutic landscape in their own home.

House Into Home: Becoming a Therapeutic Landscape

I think a home, rather than a house, anything can be a house. My campsite was a house, with the sleeping bag and cardboard box. A home to me should exude love, comfortableness. I'm not ashamed of my home.

Challenge of Matching Person to Place

The process of finding and making a house into a home, and having it become a therapeutic landscape, required time and work on the part of formerly homeless participants and their service providers. Several supportive service staff articulated the challenges of finding a place that suited their clients, essentially matching them to a place. It became a balance of determining what their clients desired in a home, what they needed for accommodations, and what they could realistically attain given their housing history, disabilities, and the current rental market. The physical structure of a place was also a consideration for clients with mental and physical disabilities, as well as for those with chemical dependency. Service providers note:

- For some folks, particularly the really mentally ill folks, the size of the building was a big factor. I know I had one person who was really challenging and had a tough time getting along with others, and so we somehow found her an apartment that had its own side entrance, which was gold, so then she didn't have to bother with anybody else, and it was really great …Physical disabilities are one consideration too. I had one person who had it really tough; she had a walker, and some back issues. Another person had a prosthetic, so they were able to navigate stairs, but not well, and I knew that in a few years they wouldn't be able to, so we tried to find something flat or with elevators.

- The other disability that didn't get talked about that we had difficulty with is brain injury. We had some folks that we soon discovered what apartments they could be in and those they couldn't … the first apartment we put this one individual in, he was on the second floor, and way on the other end of the building on the third floor there was a woman with a treadmill, and it just irritated him to the point where we finally had to move him out.

- With chemical dependency, I've found never to put someone in a garden level apartment because those tend to have a lot of traffic. It attracts a lot of business. People tend to lose their keys. They don't need a key, they have a window, no problem.

Some housing providers would move clients into a single room occupancy (SRO) unit first, to get them out of the shelter environment quickly and to have time to sort out their housing needs and the best housing location. Others moved clients into housing situations that were less than ideal because of their client's poor rental history or criminal history. Participants would often accept the first place offered to them just to get off the streets or out of the shelters, even though they did not particularly like the place. Describing his first apartment, one man stated, "that wasn't home to me; it was a stop off joint." Another commented that his first place was: "a bitch, but necessary. It was just a stepping stone, mainly to establish a decent rental history, so that I could move into a regular apartment, so I could really have my own home." Over half of participants (nine of sixteen) were living in their second apartment at the time of the interview, and almost all of these had had negative experiences with their first apartments. Participants did not appreciate slum landlords, loud and disrespectful neighbors, sharing bathrooms or kitchens, strict front desk personnel and rules, and having to share space in congregate settings with people who were suffering from alcoholism and depression. The words small, dark, and stuffy were frequently used to describe first apartments.

Service providers echoed the comments of participants, agreeing that their clients are not fond of first apartments for good reasons. However, they perceptively added that many have a difficult time with first apartments because they are learning how to live in a home after a number of years on the streets. One participant speaks of the process of letting go of the homeless mentality.

- In my mind, I'm still thinking I'm homeless. One thing people don't understand … after what you went through in the street; you still have that same frame of mind even though you're in a place. One thing they don't understand is that doesn't go away overnight; that takes time. People will be like oh, you're in an apartment, you should be doing this, you should be doing that, and you're just looking at them like what in the hell are you talking about. They just want you to automatically jump to

> things and do this, and do that, but one thing they don't understand is mentally, you're still in that same frame of mind. You're going to get over it eventually as you go, but it's not something that you can get rid of in one night.

It takes work to learn what one provider called "Housing 101." The responsibilities of housing include keeping the place clean, paying rent and bills on time, and being respectful to neighbors.

Negotiating Place and Social Identity

Another responsibility of housing that participants had to manage was the negotiation of their place with previous homeless friends, which in turn impacted their behavior and social identities. Gesler (1992) states that "place is a negotiated reality … there is a reciprocal negotiation between social groups and the places they inhabit" (p. 742). As a result, place "is neither neutral or passive" (Malone, 2003). When discussing the work involved in first apartments, a service provider observes:

- I think there's kind of two things that I think of … First of all, there's the persons arc of progress and their choice, you know the things they do the first time that they move in. What they do the first weekend that they move into their apartment might be the beginning of several long months of chaos and parties and invitations. This isn't everyone, but say there are groups of folks who have obligations to people on the street and now they have a place and so those obligations are coming due … They have to settle in the beginning for the place that is also accessible to friends, and so sometimes the first apartment doesn't work and the second apartment does because there are lessons learned along the way. The second thing is that because of their background they do get into a place that is dingier and more problematic and they build up some rental history so they can move into a better place. I have seen again and again, people living up to where they are. If you're at the rooming house where there's chaos and there's craziness every Friday and Saturday, and there's police calls all the time then that's how you'll keep going. If you move into a nice place with windows that's in better shape and you have your new furniture, all of a sudden the expectation by you is also different. So that's the other piece of it, what's available to them and how they behave …

It was difficult for many participants to navigate letting go of "old haunts and their old [drug] using friends." However, most recognized, or at least eventually learned, that allowing friends or other homeless acquaintances into their home would likely jeopardize their housing situation. As a result, they developed strategies to

negotiate their place. Some chose avoidance:

- I: How often do you find yourself going to the shelter or homeless service sites?
  R: I don't go there at all.
  I: You don't go there at all anymore?
  R: No.
  I: How long did it take you to stop going?
  R: To stop. That's interesting. It probably took me over a year, and then I completely shut the whole thing down and off.
  I: What made you make that decision?
  R: Well, because we had people come in here, and really they just came here to smoke crack, or to drink beer, and get stupid.
  I: So you wanted to cut off those people?
  R: I wanted them out of here. I was not willing to lose my apartment.
  I: That makes sense. So the places you've gone have changed and the people you see have changed.
  R: Very much so.
  I: You have a different group of friends now?
  R: Yeah. I don't have many, but they are different.

Others allowed old friends into their homes, but they learned to enforce strict rules about what behavior was allowed. One man placed a toy baseball bat near his door, as a symbolic reminder to him and his friends that he would get rough with them if they got rough in his home. Some participants deflected the responsibility of managing guests onto their service providers, or they deliberately chose housing with front desk staff and strict rules. In a similar vein, some participants chose apartments that were far away from their homeless lives, hoping a geographical barrier would keep people away. It became apparent that this process of letting go of old friends, old places, and old habits helped them not only to maintain their housing, but also their health.

- R: I worked intimately with my doc to reestablish reasonable health. It was not easy. Actually, it was very difficult because friends I have, the people I associated with are still drinking heavily and some of them are still smoking crack and things like that, and it's hard to say no when you are surrounded by that.
  I: What was difficult about getting your health back on track? Talk about your work on that, all that you had to do to get yourself to where you are now.
  R: The first health discipline I had to acquire was not to get drunk every day with my friends and that was difficult because I still enjoyed the company and it's hard to say no to a beer and a cigarette and the company, especially when you have a tradition of doing that with them.

Moving to a better place and stripping away previous social groups or norms allowed participants to assume new friendships and negotiate new social identities. Studies exploring the impact of housing on the homeless mentally ill uncover similar themes of "identity construction and repair" (Padgett, 2007, p. 1932) and improved social relationships after housing (Nelson, Clarke, Febbraro, & Hatzipantelis, 2005). Sixsmith theorizes, "the home, in terms of the kind of opportunities it affords people for personal and social action ... is one profound centre of significance contributing to a sense of place identity. Thus, places, and not least the home, may serve as 'contextual markers' for establishing one's social identity" (1986, p. 291).

Developing one's social identity and nurturing social networks is critical in the process of creating a therapeutic landscape. As noted in chapter two, ordinary places in the community such as the home become restorative by fostering therapeutic networks of care, which ultimately support the maintenance of health and healing. Those leaving inpatient alcohol treatment, for example, are better able to sustain their recovery if they have social support at home and in their communities (Wilton & DeVerteuil, 2006). Participants frequently spoke of how their homes allowed them to build or reestablish social networks of care. People often lack these supportive networks while they are homeless (Nelson et al., 2005). One man noted, "it's hard to have relationships when you are on the move from one place to the other." It was also difficult to build relationships when they were homeless because of shelter rules.

- Last night, [a friend] called me and asked me if I was hungry. It was ten-fifteen, and I said yeah. She needed somebody to talk to, so I was there, so we went down to a little, tiny Vietnamese restaurant over there. We went there, and we ate, and I came home ... I don't have a curfew; I can do whatever I want when I want to do it.

Housing also gave people the space and ability to have family and friends over.

- This is a beautiful dining room table, and I do like to entertain and things like that. That is not only a Native tradition; that was a family tradition from my mom and dad, so I like to entertain.

- R: I couldn't have my son stay over with me [in the shelter], so that was a big thing, that I wouldn't get to see him ... it was real hard on him too. He missed me.
  I: So have you had him stay over here?
  R: Yes, he comes every other weekend. He loves this place. That's what he always dreamt about, mom having her own apartment again. It would just be him and me, so that was really nice ... He really keeps me going, he's real concerned about me.

Service providers who helped people get and maintain housing were vital in participants' networks of care. For some, they were their only source of social support. Service providers spent a great deal of time with participants; shared activities included (but were certainly not limited to): bringing clients to health care appointments, taking those with disabilities to the grocery store, assisting people with health care and public benefits, and helping clients reintegrate into their communities by taking them to libraries, thrift stores, and food shelves. Time spent together became the foundation for relationships, accomplishments, and hope.

- I: You said when you moved into housing it gave you a purpose and brought your hope back. Why do you think that is?
  R: That would be difficult to answer. All I can say, once again, is if it wasn't for [my service provider], I don't know if I would have been able to accomplish what I have. We started building a trust, which is difficult, especially for a man like me, to trust anyone, let alone a social worker. I had to learn some new skills, of not just living indoors.

- The good thing about the program is there are people there you can talk to if you feel you need to talk. They don't just put you on your own and say you're on your own now. If you need support, there are people there you can talk to. Like [my case manager] and I have become close. I never lie to him; I talk to him about anything and he doesn't judge me. He doesn't judge me, we just sit down here [at home] and talk about it.

The home afforded privacy, and it literally became a foundation on which to build relationships and trust.

Setting and Keeping Up a 'Personal Home'

Just as participants created a certain social landscape in their homes, they also had to create and maintain a physical landscape. It was clear that participants had conceptions of what their homes should look like, so they set them up and kept them up

accordingly. A service provider illustrated with a story:

- My favorite story is actually a shared client of the homeless project. He was in the shelter forever and very mentally ill and vey dirty … the thought of him moving into an apartment we couldn't imagine, then we came to visit. You walked into his apartment and he had a fish tank set up and the place was spotless. I still don't really like to have him in my car, so personally he hasn't quite gotten the idea of it, but he has some idea of what his home was suppose to be like.

The PI noted time and again in her field notes how immaculate some apartments were. As evident by the spotless counters and common areas, as well as the organization of cupboards and shelves, most participants took great care at keeping up their home. They also decorated their apartments in ways that made these places feel 'homey', whether it was flowers on the kitchen table, hot coffee brewing for guests, or the sitting area arranged in a way that encouraged conversation. Of course, not all apartments were inviting. Four participants had messy, disorganized, or dirty homes. Interestingly, three of the four were first apartments, so perhaps these people were in the process of learning housekeeping skills. Providers confirmed that most people who move into a place after being long term homeless do manage, sometimes surprisingly, to set up and keep up their homes.

- I have been impressed with probably 95% of the people that move in seem to have - and some of them have been homeless for a long time - a very clear sense of how they want to live, how they want things to be arranged, what they do or don't want in their apartment, how they want to put things on the wall … I feel like they're very protective, they're very organized, they're very intentional and it really seems like they've had this vision for a long time and now they're just realizing it and I did not expect it. There have only been a couple people, there is one guy whose apartment was really sparse with nothing in it until it got really crazy and then it got trashed. That's really unusual though, so I've hardly ever had the experience where people can't seem to keep up a home, so I don't know if someone had a good home at some point or seen it on TV maybe.

It was clear that participants had some sense of what a home should look like and how a home should feel by how they described their first night in housing. Almost every participant experienced feelings of nervousness, excitement, or happiness; yet at the same time they also felt scared, uncomfortable, and out of place. One person

stated, “I felt like I was in somebody else’s bedroom.” Many linked feelings of discomfort and being out of place with having no belongings associated with a home such as a coffee maker, a television, pots and pans, and food. When asked about their first night in housing, many remembered having no belongings to set up their home.

- I: How did you feel your first night?
  R: I was happy, but then again, I was scared because I said, “Oh, shit, I’m getting ready to get an apartment. Is it going to be like that?
  I: Talk to me about that … like what?
  R: A little bit like, scary. I couldn’t see anything because I didn’t have my furniture, so I slept on a mat right here. And that lasted for two days. When I left [the shelter], I said “I don’t care, just let me go to the place and stay in here and when you’re ready to move my furniture, then it will be okay."

- I: Talk to me about what that first night was like for you.
  R: It was hard because I had a lot of my stuff in storage.

Others recounted how grateful they were when providers gave them supplies to make it feel like home such as a set of sheets; one even mentioned receiving a crockpot.

Not surprisingly, setting up their homes with furniture or personal belongings facilitated their attachment to home and helped participants develop a sense of ownership and strong sense of self. This is important because ordinary places like the home become therapeutic landscapes when people personalize them through deliberate physical and symbolic organization of the space (Smyth, 2005). Casey reflects, “because we have a body and are ensconced in a landscape, place and self alike are enriched and sustained” (2001, p. 690). One subject poignantly explains the significance of setting up his apartment:

- R: Then once I got the furniture in here … when I got it decorated, it really felt like home because [my case manager] and I went to Bridging and got the furniture, and we just loaded it up in the house. I told him he could leave. He was like, you don’t need help setting it up, and I said no, I got this. I set everything up.
  I: What was the significance of that day, getting all that furniture and being able to set it up how you wanted to?
  R: The significance? It was so fun because I got to move things around and set things up how I wanted them, versus having nothing. That meant a lot to me, too … it’s like an artist. He’s painting, he’s putting his masterpiece together, and then when he’s done with it, he stands back and he looks at it, and admires it. That’s

what I did when I got all this furniture. I set everything up, and then I stood back and looked at everything. I walked from the living room to my bedroom, just walking around making sure things were in place. That was satisfying to me, gratification I should say.
I: How did you know they were in place?
R: Well, because I already had it in mind how I wanted it set up; that's how I knew it was in place.

Some participants set up their apartments based on previous experiences of home. These experiences were "environmental pasts," or pasts "consisting of places, spaces and their properties which have served instrumentally in the satisfaction of the person's biological, psychological, social, and cultural needs" (Proshansky, Fabian, & Kaminoff, 1983, p. 59). Participants referred to former homes with nostalgia, and several arranged their homes as their mothers did when they were growing up. One man explained that his mother always had her dining room exquisitely set up as if guests were coming, though she never allowed anyone to sit at that table. He did the same.

- He had a small table set up for two in his dining area. It was adorned with nice chinaware, beautiful wine glasses, a vase with fake flowers, and neatly placed napkins and placemats. Seems he took great care in setting up this table, to remind him of a table in his mother's house. [Field Notes]

Pictures, artwork, and little knickknacks were carefully placed to remind participants of their love for family and friends. Others had adorned their apartments with dream catchers, altars, and religious symbols to nurture their spirituality. War medals and other memorabilia reminded participants of their work or military service. A service provider commented on how her clients personalized their apartments:

- I've seen some of my clients will go dumpster diving and they will find little treasures like dried flowers, pieces of furniture, actually, some pretty decent stuff that people have gotten rid of that they fill their house with, these little treasures. I think that makes it more home-like and personable.

All of these objects and visual displays made it clear that participants' homes were a reflection of who they were or where they came from. This idea that home is

constitutive of identity is a common theme in conceptions of home (Williams, 2002). The home has been defined as a "medium of self-expression and identity … portraying a person's individuality and their ties to society" (Sixsmith, 1986, pp. 281-282). Connections of home to the self and to society lead to feelings of security and psychological rootedness in 'place.' This is important because, as Williams states:

> The holistic model views a psychologically rooted environment as a component in the healing and/or health process. Such an environment is understood to be an individual's 'personal home,' providing an integrative network of physical, spiritual, and psychological factors merging together to promote the creation of a healing and/or health place (2002, p. 1198).

The work participants put into setting up their homes, or as one participant described, "establishing home," became a metaphor for the process of reestablishing their identities, apart from their previous identities as 'homeless persons.' This finding is not surprising, considering the home has been described as "a secure base around which to construct identities" (Kearns, Hiscock, Ellaway, & Macintyre, 2000, p. 389). This literal and figurative work of setting and keeping up home allowed participants to open the door to other therapeutic qualities of home.

Keys: Opening the Door To …

Keys were hugely significant, as almost every participant referenced them at some point during the interview. The actual physical experience of using, feeling, and possessing keys seemed incredibly enjoyable.

- The idea to reach in your pocket and grab your own keys. When I first got my apartment I was showing them off to all my so-called friends and telling them I got a place … I was showing them off saying to look at these brand new keys. They're huge keys too … They're great looking keys. They were shinier back then, they got kind of worn in, but they're good looking brass keys, they're tough Schlage keys.

- I'm just looking at them [the keys] like I got a thousand dollars in my hand. I'm just sitting there looking at the keys like wow, so I'm shaking them … I do the keys

like this - [shaking the keys]. Everywhere I went for the first month, I'd take my keys and [jingles keys]. I don't know why, but I guess I was excited to have some keys. For me, this was a big thing, so I'm walking around like I'm the stuff.

On a deeper level, their keys apparently symbolized a number of psychological attributes of home. One simple attribute, frequently mentioned when asked what their keys represented, was *happiness*. This is a word the general population associates with home as well (Sixsmith, 1986). Participants also felt their keys represented *peace*, which by definition conveys a sense of freedom from disturbance and violence. For the formerly homeless, it was a freedom and relief from the chaos and dangers of the shelters and streets, the rules imposed on them by shelter staff or society, and the stress of needing to find basic necessities.

- I love the simple fact I get to come in, relax, nobody bothering me, nobody telling me I have to go. I get to come stick my key in the door, God, I love that - unlock the door, come in, lock my door, and I'm totally safe. I get to kick my shoes off, kick my feet up, relax, and watch TV. I can do that in peace without somebody seeing me sitting somewhere for so long, saying hey, you got to go, you can't sit here. It was really hectic. I don't have much stress anymore. My stress level is way down.

- I: What was it like to get those keys?
  R: A blessing out of heaven … like a big weight off, like I got the monkey off my back. I can't stress myself out no more. I can't worry about too much, and it's just like I'm happy that I got this place.

One participant, when asked what it means to have keys in hand, succinctly and assuredly stated, "*empowerment*," which became a prevailing theme throughout other interviews. Keys literally and figuratively bestowed the power to make choices about when to "come and go when I want" and also, as alluded to in the theme of negotiating place, about whom to admit or decline entry into their homes. Home was equated with the ability to choose in the ordinary tasks of life like deciding what to eat for breakfast, and in even more important areas like deciding to tend to health.

- I love the comfort of watching your own television program, or taking a shower when you want to. Going to bed when you want to. I don't think I'd ever be able to live with someone again because of what I've been through. I love my own space, my quietness.

- I think that is what being given a home helps you do. You are in your home. You know you've got to make this phone call. You know you've got to go to the hospital … to get this done or that done … your home gives you that independence. You do it, and the only reason you can't do it is you won't allow yourself to.

Service providers discussed the importance of respecting the autonomy that comes along with a home, of being sensitive to clients who may have felt disempowered for many years.

- Most people, first they're going to figure out how much I'm going to make them do, like a big conversation is them asking if they have to go to this meeting, or do this and they're trying to test to see what the rules of how much it really is their life and how much we're running it.

A *sense of belonging* was another attribute participants associated with home. This concept is frequently referenced in literature exploring the meaning of home (Sixsmith, 1986) and in the therapeutic landscape literature (Gastaldo, Andrews, & Khanlou, 2004). Participants felt that this sense of belonging, of having a place to come home to, was heightened for them because they had lived so long without it.

- I: What are some specific features of housing that you think a person who's never been homeless would take for granted?
  R: The bathroom, a refrigerator, a stove, a window, a chair. There are so many things.
  I: What do those represent to you?
  R: They represent a feeling of belonging. Growing up, I've been in foster homes and stuff like that, and then always taking a vacation in the summer and living on the streets, or in bathrooms … I never would unpack and never felt anything was mine. That lasted into my adulthood. For a while there, when I had my business, I felt at home, I had my house and everything, but when I left that life, then I went back to what I was doing when I was a teenager-I wouldn't unpack when I moved, nothing really felt like it was mine. Here, for some reason, I unpacked.
  I: Was that almost the first time?
  R: In years.

- I like my life better than I liked it when I was homeless. I like it now because I got somewhere to go, I got a key. I can turn the lock and I can walk in the building and say, 'this is my apartment,' and then going back to where I was. I just think if I didn't have this apartment, I'd still be on the streets right now, got nowhere to go.

The physical amenities of home were certainly important for participants, but just as important were the intangible feelings of security and connectedness to a place. Kearns

& Smith ponder if "it is the rooflessness or rootlessness that is the more pressing problem in homelessness" (1994, p. 420)?

A sense of belonging and rootedness has been equated with what environmental psychologists, sociologists, and human geographers call 'place identity.' One identifies with a place, and forms place identity, when the particular place is experienced over time and fulfills biological, social, psychological, and cultural needs. As these needs are satisfied, and as positive memories form, a person develops feelings of attachment or belonging. These feelings, in turn, foster a sense of meaning and purpose in life. The home is central in conversations about place identity because "without exception, the home is considered to be the 'place' of greatest personal significance in one's life" (Williams, 2002, p. 145). As noted, participants nurtured attachment to their homes by setting and keeping them up in ways that reflected their sense of self. Attachment was also strengthened by pleasurable sensory experiences they had within their homes.

Entertaining the Senses

Participants spoke fondly of the sensual experiences of home. They highlighted the comforts of home that brought them ***tactile*** pleasure such as luxuriating in a hot shower or bath, putting on fresh clean clothes, cuddling up in a cozy bed, laying down on a real mattress, settling into a comfortable couch, spreading out in a spacious room, and feeling a gentle breeze coming in through the windows.

- I didn't have to shower behind all these people [in the shelter]. I got to have my own private shower, and I could stay in there as long as I liked without people rushing me, knocking at the door. It was hectic. Those are the things that made it feel like home.

They also enjoyed the ***visual*** stimulation in and around their homes, many of which were connected with animals and nature. These included the sunlight pouring into a room, home decorations like beautiful red tile or curtains, adorable dogs walking by the front porch, the woods across the street teeming with wildlife, the variety of

animals at a nearby zoo, and a huge water fountain in the middle of a housing courtyard.

- The blooms, the crabapple trees, are in full bloom. I get to look over the south courtyard with all the plants, and I feel secluded. I love my view … The tulips are beautiful and they bring life back to people. I wanted to create something for people to go out there where they can just either relax or calm themselves, get life, feel excitement, whatever it is they need at that particular moment, like a sanctuary, with different colors. He has allowed me to do that [plant tulips], and I can do it at my own time.

- The view is very nice because I never thought that I could live on a 12th floor, and then it was my first time living 12 floors up and I could see all the buildings that there is to see in downtown, and that was a very breathtaking view that I have, and it's very nice that a person that came from the street could have a breathtaking view. That was a surprise to me at first, and then to have that view, I'd like to keep it that way. It's a good experience.

The ***olfactory*** pleasures of home included candles and cleaning products. Most smells reminiscent of home, however, were associated with cooking such as the smell of fresh brewed coffee and pot roast.

- One guy bought a crockpot and it was the greatest thing, and he'd talk about coming home, and his little place would smell like roast beef, and it was so wonderful, he could put it in the fridge and keep it for however long it lasted, and that was big for him, because he could store food.

Lastly, the ***auditory*** enjoyments of home helped participants create an ambiance of relaxation. Sounds of nature including birds chirping and the whistle of the wind were frequently mentioned. Other sounds to fill the quiet included television noise, "pendulum" clocks, and a fountain in a common courtyard.

- I have a fountain inside the building that sounds like a waterfall, which is very soothing. When I get bored inside my apartment, I can just go out and hear the waterfall.

- You wake up in the morning, you open your windows, and you see the sun's out there and you can hear the birds and it's to live for.

The PI frequently entered apartments that had quiet music playing in the background. One gentleman not only played recorded music, but he was also a musician and could play music on the keyboard for his own and others enjoyment.

- R: My music is so special to me it's hard for me to even put it in words. It's just creating music. I would say that whatever it does to non-musicians to make them feel good, multiply that by about a hundred times and that's how it makes me feel. Through my music I can share who I am inside with other people without having to get into vernaculars, and all this other stuff because you either like the song or you don't. If you like the song, which I wouldn't do if you didn't, it's a special communication.
  I: Did you have music outside?
  R: With great difficulty because CD players don't work in snow banks when it's twenty below. They don't work very well in rain storms either, and batteries cost a fortune; there's no way to recharge them.

Service providers agreed that it was important for clients to fill their homes with sound. They added that part of the function of sound for the mentally ill is to silence the voices they hear in their heads. For others, the sounds of a fan, radio, or television are used to drown *out* the silence. Since formerly homeless people usually become accustomed to the constant clamor of homeless environments, it can be difficult for them to settle into a quiet apartment.

- We as providers make sure right away that even those who don't have TVs will have some kind of noise machine, a radio or TV because of the fear of isolation, the lack of community, being in an empty apartment.

As one would expect, not all sensations of home were positive. When describing first apartments, participants spoke of dark basement rooms, noxious smells associated with shared living spaces, and annoying noises coming from the neighbors. Interestingly, a man who had camped outside for years told of how he had to get used to "indoor sounds" such as the refrigerator turning on and the "pop and bang" of cabinet wood that was expanding. By and large, however, the home was a place of entertainment for the senses and mediated their sense of attachment to home.

Related to this theme is a concept called topophilia, which was explicated by the humanist geographer Yi-Fu Tuan (1974). Topophilia, literally translated 'love of place', connotes the feelings of affection and attachment that people have for certain places,

often as a result of direct sensory experiences (Williams, 2002). Structural equation models suggest that topophilia includes four domains. The first is *cognitive challenge*, meaning the complexity and visible coherence of an environment. The second is *environmental familiarity,* which includes the identifiability, spaciousness, and privacy of a place. The last two domains are especially relevant to this discussion. They are: *ecodiversity,* composed of things like animals, flowers, mountains, water, and trees; and *synesthetic tendency*, or the colors, smells, sounds, light, and tactile sensations of a place. All of these domains work together to create a therapeutic landscape, and they have been significantly associated with improved physical, mental, and social quality of life (Ogunseitan, 2005). Participants in this study were clearly refreshed and restored by their home environments, enhancing their lives and their health.

Providing Time and Space to Achieve a 'Normal' Life

Whether it was the restoration that came from living in a place they loved and identified with, the empowerment they felt along with the freedoms of home, or the new social identities and networks of care they created, participants spoke of having somehow found feelings of normalcy and an eagerness to achieve more in life.

- R: I see things from a different perspective now. When I was living on the street, my thinking was real fast. Not real fast smart-wise, but I have to do this, I have to do that. I wasn't really paying attention to the world then when I was on the streets. Now that I'm in housing, I'm starting to focus, like binoculars, when they're blurry and you focus them.
  I: How does housing help you do that?
  R: Well, for the simple fact that I feel like I have a life now; I feel like I've achieved something, which is housing, and I'm starting to achieve other things; like my volunteer work and the things I like to do. I guess I feel normal now. I don't feel like some bum.

- I: How has housing changed you, or your ways of thinking?
  R: It gives me a sense of … I don't know what normal is, but it gives me a sense of being normal. It gives me a sense of having a place to go. I can take a bath. I can eat. I can pick up the phone and call a buddy. But having a place changed me because I want to help somebody.

- R: I'm not drinking as much, I still have a few cocktails; I'm not going to lie to you and say I totally stopped. I'm not drinking as much, and my drug usage is down.
  I: What about having a home do you think has helped you reduce your drug and alcohol use?
  R: For the simple fact I feel like I have a life now. I feel like I have something to look forward to. Like the stuff in here, I bought most of this stuff, and I was pretty impressed with that, because normally when I get money, I'd go buy drugs. I have food in the refrigerator. I'm starting to do the right things.

The home afforded participants the time and mental space to give back to society and to focus on their futures. Several participants were regularly volunteering at local church communities or within supportive housing programs. Others shared a desire to start volunteering, or to pursue further education and employment opportunities. These findings echo a former study that uncovered "the existential 'what's next?' question that can emerge after leaving the survival mode of the streets and having the 'luxury' to contemplate the future" (Padgett, 2007, p. 1932). For participants in this study, the home was healing because, like many therapeutic landscapes, it gave them an opportunity to clear their minds from the stress of their previous homeless lives.

Therapeutic landscapes can also provide space and time for therapeutic physical and social activities (Milligan, Gatrell, & Bingley, 2004, p. 1783). Simple hobbies and recreational activities were especially enjoyable to participants because most were not able to do them while homeless.

- R: I make certain outfits that have leather materials, and I am able to work on it by having a place and take my time and decide what goes on it, and it's very time consuming … I attach leather material on it with different colors, different pictures and art … it really totally occupies my mind.
  I: What hobbies did you have while you were homeless?
  R: I didn't have any hobby because I was constantly worried that I would get profiled and where to be, be asked to move, so I could not focus on any hobby because I didn't have a permanent place to work on.

One man was using his entire living area to sew the sail for a sailboat he planned to make. It was clearly a time-consuming and meticulous undertaking, but he spoke with great joy and pride at having accomplished a good portion of the work. Numerous

other hobbies were mentioned including crocheting, making bead jewelry, writing, building model cars and ships, watching TV and movies, reading, drawing, practicing spirituality, gardening, fishing, and playing cribbage. These activities helped relieve stress and improved mental health; when discussing hobbies two participants noted:

- I'm a newspaper nut, so I'll go and get a newspaper, get my little walk in, my little exercise in, then I work my crossword puzzles and give my mind a chance to celebrate, rather than dwell on my crap.
- Occupying my mind, I need to be able to, you know, to deal with my stress because my medical problem is causing me to stress out and constantly worry and have anxiety about my health problems … it's taken its toll on my head sometimes.

People often seek out therapeutic landscapes, like retreat centers or spas, to get away from the daily grind and to find time to 'work on' or take care of themselves. In a similar way, the home can function as a place for retreat, as it offers the "space in which individuals are free to do as they please" (Mifflin & Wilton, 2005, p. 405). In this study, participants were finally free to do the work of caring for themselves and their health. Wanting to care for themselves was linked to their hopes of achieving more in life.

- R: To tell you the truth, I really didn't care about my health when I was on the streets.
  I: Why not?
  R: Because I'm on the street, I'm trying to survive. I know it sounds corny, but I really didn't have time to think about my health … Now that I have a home and things to look forward to, I really don't want to die, because at this point, I really feel like life is just starting to get started for me.
- I take care of myself a whole lot better now because there are things that I have to be alive for.

Many participants, when asked why they did not attend to their chronic illnesses or take their medications when they were homeless simply stated that they "didn't care" about themselves. Thus, having a home and feeling normal imparted a *desire* to care about oneself. Just as importantly, it gave people the *ability* to care for themselves. Service providers reached a consensus that this desire and ability to finally care for themselves manifests itself in self-care activities like getting a haircut, grooming facial

hair, and going to the dentist or receiving dental work.

- R1: People can start to care for some of their medical and dental issues, and that's huge because I don't know the number of people who have gotten partials and dentures over the last five years that before was not a possibility.
  R2: That's something that really marks you as not normal in this culture, if you don't have all your teeth … I feel like dental stuff is a big struggle that most people have neglected and that's a huge not normal thing.
  R3: It's such a big, big piece, and I think of all the people that come back into [the shelter] and I haven't seen them in years, and they'll be grinning at me, and I'll be like okay, what's happening, and then I'll realize. They'll point at their mouth and I'll say oh, that looks great because I forget they didn't have teeth before, because it's normal, as you say.

Obviously, attaining housing and caring for themselves directly impacted participants' self esteem and sense of dignity.

- When I was homeless, I didn't care. I didn't even say hi … This has something to do with self-esteem. The reason why I say that is because I was feeling low, rotten about myself, because I didn't have a home, I didn't have anything, or anything to look forward to. Now that I'm in an apartment, thanks to the program, my self-esteem has risen. I feel good about myself; I sit there in the mirror and brush my hair for an hour.

- One person said, "God you are looking good." You hear that and that's a motivator to think 'I'm looking good; I can go on tomorrow.' Get my clothes washed today and go on tomorrow, and that's what I do.

In addition to contemplating the future, pursuing hobbies, and maintaining self-care, participants associated normalcy with the day-to-day routines of life, as one would expect of an "average" person.

- I: What were you looking forward to?
  R: To have a home like normal people and have a life like normal people.
  I: What do you mean by normal?
  R: Like what average people do in the way they live, in other words, a real life.
  I: What does that life look like?
  R: An opportunity to further achieve the things I set my mind to. One of them is living a healthy life with chronic conditions.

Routines and the more "mundane practices" in life are critical in developing a sense of place, as "space becomes a place when it is used and lived" (Cresswell, 2009, p. 2). Additionally, being able to establish daily routines is indicative of a sense of ontological security, which has been defined as a "vague and deep concept about people

having confidence in the social order, in their place in society, in their own right to be themselves, and a belief that their self-realization can be achieved" (Kearns, Hiscock, Ellaway, & Macintyre, 2000, p. 388). A previous study has demonstrated that the home, as a place to carry out "routines of daily life," improves ontological security in the formerly homeless, mentally ill population (Padgett, 2007, p. 1931). The present study confirms these findings.

The home as a place of routinization played a critical role in participants being able to manage their chronic illnesses and for their recovery efforts.

- Working on myself-doing a lot of work on myself. I've become a very independent person, but making it feel like my home, I guess, was a process. I don't even know how to explain it. Like I've said, nobody that uses can come here, I have my structure, I have my boundaries. I get up early in the morning, and I do my meditations, I read my Twenty-four Hours a Day, I read my self-esteem book called Believing in Myself, I say my prayers, and I go take a shower, get cleaned up, and go to work. When I'm on my way home, in my mind I say I'm going home. This is home for me. It's very comfortable.

The actual structure of home allowed them to build structure into their lives, in a way they were unable to do when they were homeless. Daily or even hourly tasks like checking blood sugar levels, monitoring blood pressure and weight, and taking medications became a part of participants' routines. Conveniently, these health care activities were often sandwiched between other tasks like having their morning cup of coffee and brushing their teeth.

- R: I've got a Walgreen's in there. I take a lot of pills, I take seven or eight in the morning, and then I take a handful at night.
  I: How do you remember to take them?
  R: I take that thing out [pointing to a medication reminder box]. See, it shows I've already taken my morning meds; then I take that med; and when it's done, I put it in there, but I take out the next day's and I put it up top. I put them right there so I know; that's my system.
  I: Do you have a system throughout the day?
  R: Yeah, I guess … I get up and I wash up and do stuff that I do, and then I test my blood sugar, and then I drink some coffee, and if I get hungry, I get Meals on Wheels.

- I: How do you remember to take your medications?
  R: The same way you do … when you get up in the morning and you remember to brush your teeth.

A nurse describes how helpful, and potentially life saving, it was for a client with a traumatic brain injury to get into a home and be able to develop a routine.

- She didn't know how to take her medications because she would lose them, so people would think she was med-seeking. When we finally got her into housing, we were able to get her a TBI waiver, and she was able to establish a routine, and so now she's doing amazingly well. A traumatic brain injury doesn't go away, but the fact that she's had a routine is incredible and she functions. She's very high-functioning, she's very smart, and she was able to reconnect with her family … She's re-established those relationships … It's incredible what she's done. It took a while for her to figure out who can come over and who can't come over, but she's doing great. She probably would've died; I'm sure she would've died-hit by a car, frozen to death-if she hadn't have found housing, because she didn't know where she was going, literally.

The processes by which the home becomes a therapeutic landscape for formerly long-term homeless adults with chronic illnesses take time to evolve, and they require both literal and figurative work. Matching people to places they love and identify with is not easy; it involves navigating and negotiating complicated physical, social, psychological, geographical, and political systems and barriers. Once these barriers are overcome, however, participants are able to create and sustain homes that reflect who they are and where they came from, support their social networks of care, entertain all of their senses, and allow them to 'open the door' to freedom and the hope of a 'normal' life and promising future.

Place Effects: Home Essentials for Health

The home as a therapeutic landscape contributed to participants' overall sense of well being. By directly affecting their psychological and social selves, it aided in their health and healing in important, yet more intangible or indirect, ways. This next section will unpack the 'black box' of housing as a health care intervention by articulating the place effects of a home on health. Though place effects are often investigated at macro levels of neighborhoods and populations (Macintyre, Ellaway, & Cummins, 2002), this study examines place effects at a smaller or micro scale. In addition, the negative place effects of home on health have been described previously (see Matte & Jacobs, 2000 for a thorough description). This discussion explicates the largely concrete features of home that positively impacted participants' health, health care utilization, and ability to care for themselves. Staring with the obvious, the following features are literally home essentials for health.

Water, Shelter, and a Private Bath

The home gave participants immediate and constant access to these basic necessities of life, which had an obvious impact on their health. Nurses agreed, saying:

- R1: They're able to be in a warm place out of the elements. They're able to get more rest. Even their immune systems improve with these added things … I just think, overall, [housing] improves their immune system … it's safer, so there's less stress. They're able to get better, deeper sleep, have more immediate access to food and fluids and their medications. I think overall, it's huge.
  R2: I do too. I think housing's the most important factor. It's the groundwork for everything else.

Macintyre, Ellaway, and Cummins (2002) suggest that any discussion of place effects on health should include Maslow's hierarchy of human needs (Maslow, 1968), which begins with unpolluted air, clean water, nutritious food, and adequate shelter. Upon remembering their homeless lives, several participants told stories of suffering because of a lack of shelter from the elements, water, and a bathroom. Frostbite and

dehydration were shared complaints. Frostbite often leads to severe consequences such as infection and loss of extremities, but the consequences of dehydration should not be overlooked either, especially for those with chronic illness. They include altered mental status, lethargy, a risk of falling, nausea, vomiting, diarrhea, and electrolyte imbalances (Bottomley, 2001).

Participants told of how embarrassing it was to experience vomiting and diarrhea, without ready access to a bathroom. One man suffered terrible diarrhea as a side effect of his HIV medications, and when he was homeless he "would be walking down the street going to the bathroom, it was that bad." In many cities, it is virtually impossible to find a bathroom open to the public. As a result, people who are homeless often are forced to urinate in public, leading to what some consider the criminalization of homelessness (Foscarinis, 1996).

- One of the [St. Paul] cops says it all the time, 'I gave this guy a ticket and said you shouldn't be peeing outside, and the guy said fine, where can I pee, you find me a place and I'll pee there' He said he thought and thought, and thought, and couldn't think of anything.

Having access to a private bathroom was particularly important for those who required a urinary catheter bag after surgery, and for those who had frequent urination as a result of a urinary tract infection, poorly managed diabetes, and prostate cancer treatment. A private bath made diagnostic and screening tests easier as well. One woman tells of the difference between collecting a 24-hour urine in the shelter versus the home.

- R: To collect urine, even though they gave me one of those hats to put on the toilet, the toilets are not residential size, so the hat would fall into the toilet after I went, so I'd lose urine. If I was able to save the urine, there was nowhere to put the bottle, to set it down to pour it in.
  I: Was it embarrassing?
  R: It was very embarrassing. You talk about a challenge-something very simple was made almost impossible.
  I: Do you think that having a home makes it easier?

R: Oh yeah … for one, I have some place to set the bottle down. Two, I have more privacy to collect it the way I'm suppose to collect it … now I have one that fits the toilet that I am on …the thing is, being in one of those stalls, and you didn't want to use the last stall, because that one was usually disgusting, and that's the handicapped one. You're in one of these stalls, you're trying to juggle stuff around, you're dropping things, there's nothing to set anything on, and you're setting it on that dirty floor. There's nothing to hang anything on in the stall, like those hooks.

Service providers noted that several clients had agreed to a colonoscopy after entering housing.

- Having your own bathroom when you're sick, whether chronic sickness or whatever, it's ridiculous to try and imagine being sick [sounds of agreement]. All the average ages of my clients are 49 or 50, so year after year they have to come get dropped off for a colonoscopy, but being able to deal with that preventative care.

Almost more than any other feature of home, participants spoke of their appreciation for a safe, clean shower. In the shelters, showers were often dirty from the previous person, and their showering time was limited, making it hard to shave or set up the bathing area to accommodate disability. Having a private shower, and at times a bathtub, was both a hygiene and safety issue.

- I honestly think the thing that would probably stand out the most, and it sure did with me, was the shower. I can take a shower every day. Can you imagine that? I got that bath tub here, and I don't trust my balance so much, so I'll take a bath most of the time and that is so good. I can just lay there. It's deep and it's so good.

Hygiene, defined as "protection from infectious or contagious disease and from toxins and pollutants," is also at the top of Maslow's list of human needs (Macintyre, Ellaway, & Cummings, 2002, p. 133). One's place directly affects the ability to attain hygiene and cleanliness. As noted in an earlier discussion, hygiene was difficult for participants to maintain when they were homeless. Simple amenities like toilet paper and sanitary pads were hard to come by. Campers had exceptional challenges.

- That's another thing you can't do outside. Your hygiene is lacking, but I would do as much as I could, like use Wet Ones, Fresh Wipes, or whatever. You can at least use that and then put some deodorant on … then there is brushing your teeth. You will learn to conserve on water when you've got to carry the shit because water is heavy.

The nurses noted that those with chronic illnesses are often more susceptible to contagious disease due to weakened immune systems, so living in and keeping up a hygienic environment is critical. Avoiding skin infections by bathing is also important. One nurse commented:

- Certainly hygiene improves [after housing]. For people with wounds, their hygiene is better, which helps them heal and they have access to water.

Hygiene certainly impacted participants' self-esteem, which in turn influenced their health care utilization. Compounded by feelings of being unwelcomed by health care providers, several participants avoided health care settings when they were homeless for fear of embarrassment. When asked why he did not let health care providers monitor his blood pressure when he was homeless, one man explained:

- Probably weakness, probably I'm not going to let anybody else ... and probably feeling so dirty that no one will want to touch me to take it.

As a result of their homeless histories, many deeply appreciated these most basic and necessary comforts of home.

One's Own Bed for Sleep and Recovery

Few would dispute that it is easier to get adequate sleep on a comfortable mattress rather than on a thin mat on a tile floor. A service provider exclaimed, "getting up and down from a shelter mat is awful ... you may as well be sleeping on a piece of paper." Equally important to sleep is having the security and familiarity of being at home in one's *own* bed.

- Now that I'm in housing, I don't fear anymore. My sleep is so good, because I know that I'm in my bed, I'm in my house, my doors are locked, my windows are locked; I know I'm safe.

Getting 'good' sleep is critical to health. Sleep deprivation has been shown to weaken the immune system, complicate chronic illnesses, impair the ability to manage stress, and may even accelerate the aging process. People who are homeless are particularly

vulnerable to sleep deprivation, resulting from a variety of factors like anxiety about safety and meeting basic needs, substance use and mental illness, uncomfortable and noisy sleeping conditions, and shelter rules about curfew and wake times (Bottomley, 2001; Davis & Shuler, 2000). Not surprising, service providers all agreed that those who received housing and their own bed showed immediate improvements.

- Even having just enough sleep, that's the biggest difference that you notice even in a couple weeks, and it's not in everyone because some people are anxious because they're isolated or alone, but everyone who doesn't have that, just having enough rest by itself makes such a huge difference for people's demeanor.

Chronic conditions, their symptomologies, and associated medication regimens also significantly impact sleep or a person's need for sleep (Bottomley, 2001). In this study, having one's own bed was helpful for those with headaches or migraines, chronic orthopedic or arthritic pain, and for those who needed to take naps due to the side effects of medication and altered sleep cycles.

- The other thing with medications is the side effects with homeless. If they get drowsy they don't want to take a medication because it sets them up for too much physical violence. If they have a place where they can sleep it off, they're fine.

- I like when I be sick here [at home] because I can go lay in the bed, drink my hot tea, take my cough syrup, take my Alka-Seltzer Plus Night tablets and go in there and lay on the bed till the cold goes away.

- I have a lot of people whose sleep schedule is either they sleep in a 24 hour basis where they'll nap, but they won't really sleep in any way that I think is normal. The shelter though enforces a very circadian rhythm, which was very unnatural and this one guy said that he loves 'this napping thing.'

Lastly, a bed allowed people to stay in bed during the day and recover from significant surgeries or illnesses. Having a place to recover was a prerequisite for elective surgeries, often put off during homelessness.

- There are definitely a lot of people who come to our [Housing Program] with medical goals, that they’re going to get their shoulder surgery or hip replacement or their kidney transplant. That is a big thing that we hear a lot, that people are looking and doctors won’t do certain things until they have housing or even allow them to have a certain procedure. I’m really shocked at how many people are

> walking around in so much pain every single day, waiting to do this thing that most of us would do right away.

It is clear that having one's own bed is necessary for getting a good night sleep and being able to properly recover from sickness or surgery.

Kitchen Amenities

Participants relished having a kitchen and a place to prepare their own meals. They were able to improve their diets and even their relationships with food by having their own kitchens. One man who struggled with obesity described how his "eating habits are getting more leveled:"

- Now it's more like I have food in the fridge and it's my choice if I want to eat a spaghetti dinner and I won't be home gorging. I don't have to eat all of it … or chow down because it's the last meal that you're going to get. It's not like that anymore, it's like you just have some. I put the rest away in the fridge. That's what I do.

Participants spoke of finally being able to prepare, eat, and store fresh fruits, vegetables, and meat. They appreciated having immediate access to food when hungry. This access was essential for diabetics; one had several hypoglycemic seizures in the shelter because he did not have ready access to food. Another diabetic commented:

- Now my diabetes is almost normal. I've been an on and off diabetic, but while I was in the shelter, it was horrible because of the food. I tried cooking myself, but it was worse, because the food you could buy with food stamps and eat that day, those are usually very high-calorie foods, and high-carb, so I stopped cooking [on my own] and I just ate downstairs [in the shelter cafeteria].

They were able to comply with the other special diets recommended by their health care providers such as low fat and low sodium diets. A man who required a renal diet stated:

> I: How were you able to make diet changes in the shelter? Or were you able to?
> R: I wasn't able to because I just take what I get. Beggars can't be choosers, so there was a time I wasn't able to eat because it was just that bad. I just skipped meals because the condition of my flare-up was just totally getting in the way, and I wasn't able to drink when I want and eat when I want and not have to worry about feeling so tight in my stomach because I was swelling. It was hard … Now, I cook my own

meal, and that was very important for me to get proper nutrition in being able to deal with my health issue.

Vegetarians and those with irritable bowel syndrome (IBS), lactose intolerance, and food allergies were also better able to regulate their diets. A woman with IBS told of how when she was homeless she was "skinnier than a rail" and that she would "either not eat, or eat something that would irritate my stomach."

Service providers, while granting that they noticed an improvement in many of their clients' diets, made sure to mention that not all participants availed themselves of the opportunity to cook for themselves and improve their nutrition.

- I think meal making is a larger challenge than housekeeping, I think that's a really hard thing for people to do - budget their money. There are so many pizza's delivered on the first of the month. Then there's so much desperation by the end of the month, and people don't really know how to plan their food and people tend to think that food is optional. Within [congregate housing] that's one thing where those who do have food end up helping each other out a lot, cooking for each other.

Other amenities of the kitchen, besides food, enabled participants to better manage their chronic illnesses. As expected, diabetics commented that a refrigerator was a necessity for the proper storage of insulin. Additional features included the freezer, which was used to make ice for injuries and scrotal swelling after prostate surgery; the microwave, used to heat up hot pads for sore muscles; and magnets on the fridge reminded participants of important clinic, pharmacy, and triage numbers.

Electrical Outlet

Certain health care equipment required an electrical outlet. Continuous positive airway pressure (CPAP) machines for sleep apnea, congestive heart failure, and COPD require electricity. Electricity is needed to charge electric scooters and wheelchairs, which allow people with walkers to use this equipment. Vaporizers, air conditioners, and nebulizers also improve respiratory function.

- We've had folks with asthma. One fellow used to say it's really tough to do a nebulizer at [the drop in center], but it's a little easier when you have your own place. He still doesn't quite know how to do the inhalers, but we're working on it. I think some of those chronic health conditions become easier.

Lastly, blood pressure machines and exercise equipment required electricity.

Four Walls

Interestingly, participants used their walls to hang up items that became necessary for health and health care utilization. Clocks and calendars reminded people when they had medical appointments and when to take their medications, and 'to do' lists were tacked up that had reminders to call doctors and go to the grocery store.

- I put it [a calendar] up there and I mark all the days off and things like that. It's just something to do and also to keep up with the days … as a matter of fact, I wrote down my doctor's appointments. I have one Friday.

A diabetic also had put up several educational posters about nutrition and managing diabetes, as she had not been eating well. The poster was a visual reminder to her of how many carbohydrates she could eat.

Certainly, four walls became a structural barrier from communicable diseases. An asthmatic who had repeatedly suffered from bouts of pneumonia and bronchitis when she was homeless reported that she has not been diagnosed with these respiratory conditions since entering housing. Four walls were also a barrier from other people, offering privacy and a sense of security. One man with HIV credited his compliance with his medications to being able to take them without people watching him. Another participant noted:

- You can just be more diligent about your doing the things you need to do when you have your own apartment and you don't have people just milling around you. Sometimes if you're not feeling really good or something like that, at least I'll say with me, I can get testy. I mean when I had those migraines and I would have a real bad one, I'll tell you, you did not want to be around me.

A woman with severe depression explained the difference between managing an episode of depression in her private apartment versus the shelter.

- It's easier, and I also believe it's easier to get out of … when you're depressed, you're not in the mood for the bullshit that goes on. You really don't have a place where you can go and just be by yourself, and not have to deal with other people's craziness and mental illness. I can lay here and work through it, and I'm noticing that my depressions are not lasting as long anymore.

Space and Place for Health & Medications

Physical space and specific places within the home were necessary for participants to maintain their health and health care activities. Housing provided space for exercise and exercise equipment like yoga mats, balls, and arm weights. Space was also used to store medical equipment like CPAP machines, oxygen, and walkers. While homeless, one respondent had to keep his CPAP machine put away at a bar because he could not physically carry it around all day. Now, he appreciates that he can put it in a convenient spot.

- I can put my sleep apnea machine on top of those shelves. It's even lower down and even with the bed, so I could put a drink up there.

Specific places within the home were designated for certain items, which helped participants keep track of belongings, and in some cases, important medical information.

- Things go in the dresser, and I wanted a place for everything. I have these two little junk drawers out in the kitchen that I use for miscellaneous paper. If I don't know where something goes, I just slip it in there, just so long as I have it. I put mail in another drawer, like old mail and old hospital bills or stuff that is not a bill. I save things like messages from [service provider organization], like reminders for my appointments. Those are little pink papers, like the ones that say 'While you were out', I save those too. It's just kind of nice to have a place you can throw things in.

Some participants deliberately placed items to accommodate physical disabilities and chronic illnesses. One reason, suggested by researchers investigating the significance of home for home care, is that "a major contributing factor to the comforts of home is the consistent location of furniture and useful items so that deliberation is not required in the conduct of daily activities" (Angus, Kontos, Dyck, McKeever, & Poland, 2005, p.

173). Strategies in this study included putting a table with nebulizer equipment close to the bed, clearing the common areas of clutter to get through with a walker, and putting a TV in the bedroom for entertainment during recovery. One woman, after complaining about how she had to walk a distance to get to the bathrooms in the shelter, stated:

- You need to lie down, and here, or when I am at home, the bathroom is only so many feet, and you don't have to go all that distance. When you have your own home, you can set things up the way you need them so that you can recover, because it takes weeks and months.

Medication compliance was hugely improved after housing, mainly because participants had a specific place to put them. One woman explained that with housing "you're able to take your medicine; you don't have to keep hiding it." Keeping medications "in sight" was a shared strategy. Though some participants did use their medicine cabinets in the bathroom, it was more common to see participants' pill bottles sitting on a shelf or on the kitchen table.

- When I get them [medications], I put them right there on the kitchen counter, because every morning when I get up, I come straight to the kitchen for some water, or something like that, and I look at them and I take them.

- [Nurse] Clients, too, are better with taking their medications. When they have their own place to remind them, they can set their meds by their toothbrush to take them at night. They don't have to worry about their meds being stolen.

Unquestionably, taking medications on a more routine basis had direct impacts on participants' physical and mental health. Two diabetics knew their A1Cs (a measure of diabetes control) before and after housing. They went from eight and nine, a level indicating diabetes has been uncontrolled for a long time, down to around six, which indicates good control. Due to increased medication compliance, an epileptic man went from being in the ER two or three times per month when he was homeless down to zero times since being housed. A man with hypertension recounts how his doctor was in disbelief when his blood pressure stabilized.

- I: Has the doctor or anybody in the clinic said that your health has improved?
  R: Yeah. He couldn't believe it. He usually has the nurse take my blood pressure … It was right on the button of perfect … The doctor says he can't believe it so he wanted to do it again. He did it again, the old fashion way.
  I: He couldn't believe it?
  R: Yeah, and then before I left he wanted to do it again just to see and record it into his computer stating that that was my blood pressure.

HIV medication regimens require strict adherence to be effective. Supporting the research demonstrating that housing reduces viral load and immunity (Sadowski, Kee, VanderWeele, & Buchanan, 2009), respondents in this study reported that their viral loads were undetectable since being in housing and taking medications regularly.

Place for Pets

Those who were allowed to have pets in their homes expressed direct impacts on mental health and even their ability to sleep. One respondent had to hear his cats breathing at night because he had grown so accustomed to people breathing around him in the shelters. The following quotes illustrate the health benefits of pet ownership.

- R: I thank God every day [for my pet]. I talk to my cat because he came from a shelter too … he's really helped with my depression, he's got mental health issues too.
  I: That's funny, what are his?
  R: I'd say that he's bipolar. He's got PTSD too from the shelter life.
  I: So he's been therapeutic for you?
  R: Very much so. He's got some issues, so we kind of match.

- [Service Provider] That comes into choosing apartments, too, and we've actually had a fair amount that cats have seemed to help, because otherwise they feel kind of lonely when they've been in group dynamics for a long time.

Pets also assisted participants with the difficult process of reintegrating into neighborhoods and with social interaction.

- There was a time that I didn't want to be seen by the public. I used to feel uncomfortable walking out of my home. I always try to stay clean. I always try to address people properly with how are you … on the streets I didn't have to worry about that. I was grubby and nobody gave a damn how I looked, but I did. Then when I got a home, then I got to thinking how am I going to respond to someone out there that sees me. What helped me a little bit, and I was doing it and I was

> getting very comfortable with it … people would walk by with their dogs. I would have my windows open and my cat would be out there. People would stop and say, look, you've got two pretty kitties, aren't they just beautiful, and then we'd start communicating, just lightweight stuff. And I would say you ain't no different from anybody else, but because you lived so long, and I lived on the streets hard … I was pretty hard out there, mostly hard on me, and it took me a very, very – and I still struggle with it and probably will till the day I die – but it took me an awfully long time to feel comfortable in my own skin, but I'm better now than I was a year ago.

Geographers are becoming increasingly interested in how animal geographies intersect with human geographies, as there are "complex entanglings of human-animal relations with space, place, location, environment, and landscape" (Philo & Wilbert, 2005, p. 4). This study demonstrates that animals can play a vital role in geographies of health.

Address and Telephone

Having an address and telephone were essential for communicating with pharmacies, clinics, emergency and support services, mental health crisis lines, and health care providers. An answering machine or voicemail was important for receiving automated appointment reminders, and an address was needed for the delivery of health care equipment. A service provider told a maddening story of one gentleman in the shelters who had severe COPD and desperately needed continuous oxygen. The medical equipment company refused to deliver oxygen to someone without an address, and the shelter would not let him store oxygen on site, which resulted in countless ambulance rides from the shelter to an ER only one block away. Once housed, he received his oxygen and has not been back to the ER since. The following quotes further illustrate the consequence of having an address and telephone.

- It's hard when you ain't got no apartment because you got to have an address and phone number for your doctor and them when they give you pills and stuff. If you tell them you're at the shelter, then it's going to be more hard. When my doctor's going to call me, wants to talk to me, tell me how my test results went, I'm like, oh, I got a phone number, got an address!

- When you're homeless, you can use [the shelter or drop in center] phones, but you've got a bunch of people around you, and they're all talking, and it's hard to hear what they're saying, and really, some of the stuff I'm talking about to a nurse

over the phone is not really something I want to be overheard. There's no privacy. It's easier to take care of these things here.

A phone and address were equally important for mental and emotional health, as they made it possible for participants to connect with networks of support and care, including family and friends. One participant enjoyed sitting down at her kitchen table with a cup of tea and writing them letters, and another would call them up to "deal with loneliness." Having a phone also allowed participants to slowly rebuild trust with estranged family members.

- I: Were you always in touch with your family when you were homeless?
  R: No, I wasn't in touch with them for years … I'd see them once in a blue moon … every like five years.
  I: When did you reconnect with them?
  R: Quite a bit of it came from when I moved in here.
  I: What about being in here made it easier?
  R: I had a phone, and they never knew how to get a hold of me anyway. I was out in the woods, you know, and I didn't really want them to talk about it.

- I had no contact with my family for a long time. My daughter, when I first came back from [Maine], told me straight up I've decided that the only way I can talk with you is over the phone, because I don't trust you, so having a steady phone. That was the other thing, too; when I was homeless, I might have throw-away phones, but half the time I'd lose them. It's family. I have reconnected with every one of my family.

As noted earlier, support service personnel were included in these networks of care. A previous study evaluating supportive housing also found that the phone was an important "lifeline" to support services (Jost, Levitt, & Porcu, 2010, p. 13).

- If something is frustrating me, it gives me an opportunity to get on the phone and call [case managers]. [One case manager] has given me the freedom to 'call me anytime you want to call,' and that is a pretty good freedom.

Instead of going into a clinic or ER, participants with nurses on their support teams would often first call their nurse with health concerns. Expectedly, case managers were called for a host of reasons such as help with benefits, housing or landlord concerns, or when they simply needed someone to talk to.

Neighborhood Effects

Though the impact of surrounding neighborhoods was not explicitly addressed in this study, they certainly had an impact on participants' health, self-perception, and behaviors. Researchers confirm these phenomena, as the perceived reputation of a place affects residents' self-esteem and overall morale. They propose "the possibility of 'pull up' or 'pull down' effects on health of adjacency to different types of people or places" (Macintyre, Ellaway, & Cummins, 2002 p. 129). Several participants explained the impact of nice areas.

- R: This is a very nice area to live in … a [VanBuren] Avenue address has a little prestige with it, and I have said this before, living up here has stopped some of my habits. In the past, I might go digging through someone's ashtrays left around looking for cigarette butts, or I would panhandle. This is not the area to do it in. It's made me want to do better.
  I: That's amazing, what other habits have changed?
  R: Well, the drinking and drug use, of course, changed.

- R: To boil the whole thing down, it's decent people. There's nothing but decent people around here from what I've seen, and from my point of view, I wasn't a decent person. I'm thinking this place looks too classy.
  I: Has this place, living here, changed that perception of yourself?
  R: Yeah, it changed a whole lot. I'm a decent person now, according to my eyes.

Others appreciated the nearby amenities of their neighborhoods that directly impacted their health and health care utilization including a YMCA, local library, public transportation, clinics, and pharmacies.

- I: Why did you choose this place?
  R: Because it was in a good neighborhood, because they had the light rail train, rapid transit. You have Super Rainbow, Cubs, Target, Radio Shack, Blockbuster Videos, you got the library, plus I got my Lake St. doctor's office up the street, so all that's in a good neighborhood so I can walk.

Not all comments about local neighborhoods were positive. One man, who was still living in his first apartment, complained that it was in a dangerous area with crack addicts, rival gangs, and frequent gunshots. Interestingly, another respondent reported 'pull up' effects of living in chronic inebriate housing, which one would assume would

pull a person down. He stated that living there made him feel like a "lowlife," so he decided to reduce his drinking and move into a nicer apartment.

These findings on the place effects of home make a substantial contribution to the homeless and housing literature. Elucidating the "mechanisms by which place [in this case the home] might influence specific aspects of health" is a necessary first step in developing targeted health and health care interventions (Macintyre, Ellaway, & Cummins, 2002, p. 135). Nurses who work with this population should apply these findings. Though they may not be always conscious of it, their clients' environments, and the places they move and live, directly impact the type of care nurses are able to provide (Andrews and Moon, 2005b). A nurse in this study certainly understood.

- I know some of the outreach or homeless clients that I see and work with, versus clients that we've gotten into housing, it's a different type of nursing that I do with each. The homeless clients are more in a survival mode, so me talking to them about getting a primary medical doctor and getting their blood pressure checked, it's not very realistic. When they're homeless it's, 'OK, do you have any immediate healthcare concerns we can deal with?' It's probably less preventive medicine that I focus on, versus when somebody is housed. They're in less of a survival mode, so we can talk about setting up a primary, or when was your last dental exam. They can actually set up appointments and keep them. Then we can talk preventive medicine. 'Can I meet with you once a week to check your blood pressure?' I can meet with them on a regular basis to help them with getting their meds refilled and setting them up. I'm able to do much more effective nursing and preventive medicine when they're in an apartment, versus homeless.

The following section explores in greater depth the 'place' that nurses have on housing teams and the roles they assume when working with those who have been homeless.

Nursing's 'Place' on Housing Teams

Nurse as Trusted 'Stepping-Stone'

Nurses are highly regarded by the public, as nursing is one of the most trusted professions (Donelan, Buerhaus, DesRoches, Dittus, & Dutwin, 2008). Participants in this study echoed these sentiments. Their perceptions of nurses on homeless and housing teams were consistently positive. Helpful, caring, honest, compassionate, knowledgeable, and trustworthy were among the adjectives used to describe nurses. One participant noted: "People love them [nurses] because they are people who care." As a result, nurses were sometimes the first or only person homeless participants would trust to help them out of their circumstances. They became, in a sense, like stepping-stones out of homelessness. This inherent trust allowed nurses to engage people in a unique way, unlike other 'helping' professionals such as outreach workers or social workers. Service providers reflected:

- R1: When I did street outreach to women in prostitution, we would infer either to the men that were around, or sometimes them, that it was healthcare. We'd almost try to get the rumor out that we were nurses, because people aren't threatened by that.
  R2: Yeah, to get that trust and respect.
  R3: And everybody has to talk to a nurse no matter what your status in life. We don't all have case managers or outreach specialists.
  R4: And maybe nurses aren't going to push you in some ways to get out of prostitution, or to do other things, like a social worker would.
  R5: They take your blood pressure.

This idea that nurses are focused on tasks like taking blood pressure, and on physical health, made nurses seem non-threatening. The physical aspects of health became a place for nurses to start conversation. A severely anorexic woman, for example, refused to talk to anyone on a crisis team except for the nurse, and she only wanted to learn about the physical consequences of her disorder. These initial conversations built trust and opened up opportunities to address other issues related to service resistance, chemical dependency, and mental illness. One service provider

describes how nurses become stepping-stones to mental health treatment.

- A nurse is a stepping-stone, too. We had a guy who is schizophrenic, but will not take any medications ... He'll talk to the nurse, and he'll deal with his physical needs and medications, but he won't go with any mental health medications. He was at first hesitant about the nurse, but then he agreed to have the nurse come just to deal with blood pressure medications. Now they're starting a conversation about anti-psychotics and that kind of stuff ... He did a lot better when he was on medication, but he has a lot of paranoia about that, so it's kind of a first step. The nurse is a critical part of that.

Nurses also became trusted stepping-stones into health and health care. As discussed in the introduction, those who have experienced homelessness are often incredibly distrustful of health care institutions and providers. It is common for people who are homeless to feel stigmatized, ignored, and unwelcomed in health care settings (Wen, Hudak, & Hwang, 2007). Participants in this study shared similar experiences, causing them to avoid hospitals and primary care clinics. However, nurses who reached out and were able to provide care in homeless settings or participants' homes (in their 'places') were often, through trust and rapport, able to convince participants to establish or reestablish a relationship with a clinic provider. One respondent told the story of a woman who was very sick with Hepatitis C but refused treatment, until a nurse became involved.

- She'll only now go to the doctor with the nurse on the team. She doesn't trust the rest of us to know what we're talking about. We're like, whatever, the nurse will go. Now the medical stuff has become so important to her that she wants to know.

Because of nursing's professional knowledge of health and illness, participants were more open to take health advice from a nurse.

- Something about having the title nurse, even practical, common-sense stuff ... You [a service provider] can say something fifty times, and they [nurses] come in and it's like what's your job? I'm a nurse. Oh, well. You probably shouldn't smoke. Oh, wow, ok. You're beating your head against the wall behind them, but it's true.

- [Formerly Homeless Participant] I think a lot of it rests in the comfort that they are there. I'm receptive to them in the sense that I know what they are talking about or I think they know what they are talking about or they wouldn't say it to me.

The foundation of trust, and the freedom that participants gave nurses to become their stepping-stones toward improved health, allowed nurses to assume another important role, that of a health and health care navigator.

Nurse as Health and Health Care Navigator

Few would disagree that the American health care system is complex and difficult to navigate. Participants in this study certainly found this to be the case. Frustration with this so-called 'system' of health care was a common theme during interviews. Much of their frustration was centered on the health insurance industry. Complaints included confusing enrollment requirements, bills they could not understand, and needed tests or treatments that were not covered by insurance. These barriers within the system caused some to avoid it altogether. One respondent was a Vietnam vet and thus qualified for Veteran's Administration health care benefits. He refused to use their services, however. His reason:

- Because I have a bad attitude with the VA because I fought with them. I filed a claim against them for many years because my PTSD is service connected. They kept denying, and denying, and denying.

Another man told of how he did not understand clinic restrictions on a certain type of health insurance, and therefore received a bill for going to a clinic that the hospital itself had recommended to him.

- They [the hospital] said that I had to get a primary doctor and I never followed up, through with that, because I didn't know where to go. He said there were a bunch of clinics I could go to and they gave it to me and I went to one doctor at the clinic called [City Clinic]… I went to that one a couple different times and then the clinic told me not to go there anymore because I had [a certain type of health insurance]. They said I couldn't go see my Doctor anymore because I had to pay my bill first. I said, to heck with that.

Nurses who came along to help participants navigate this complicated health care system were a welcome relief. As health care professionals, they had unique expertise and experience with the system, allowing them to better advocate for the needs of their

clients. Much of nursing's navigation work involved centralizing their clients' care, which was often very fragmented before housing. They would assist clients in applying for benefits, choosing a health care plan and primary care clinic, and setting up their medications and refills at a nearby pharmacy. One nurse describes the importance of her health care navigation work:

- They stick with the same pharmacy once they leave, nine out of ten times. Whereas before, we have clients that come in with several different medications from several different pharmacies, or at least a couple different pharmacies. Now, we've not only done medication teaching with them, but I certainly explain the importance of having one pharmacy, just like having one medical doctor, so they can be better followed for continuity of care.

Other care navigation work included taking on the insurance industry and advocating for needed transportation, medications, and medical equipment. This was not always an easy task, which is likely why many participants gave it up so quickly. It often took nurses time and great patience to get approval. One participant recognized a nurse's effort to get him an insulin pump.

- She [the nurse] was told many times that it was not covered, but then she worked with Dr. [Daniels] and got the pump after a couple months of calling.

Nurses also helped participants navigate their chronic illnesses. Having nurses on supportive housing teams to assist clients in this type of navigation work was especially helpful to service providers, as several clients were facing chronic health issues for the first time and support service staff were not always knowledgeable about or comfortable with chronic illnesses.

- R1: Probably the most untalked about is the chronic and medical conditions that people have. We all know about mental illness and we all know about chemical dependency, but it's just not talked about.
  I: Not talked about like you don't bring it up?
  R1: Not talked about, like when we talk about long-term homeless people we talk about MI and CD [mental illness and chemical dependency]

Many individuals did not engage the health care system when they were homeless, so connecting with a primary doctor resulted in new diagnoses. Service providers explain:

- R1: Sometimes people aren't ready to deal with them [physical health problems], or don't know about them until they get housing and get to the doctor.
  R2: And then it surfaces.
  R3: Yeah, there's been cancer, but they haven't been to the doctor.
  R1: We have, I think especially in the single adult population, folks who have had a lot of time to really wreck themselves, and you can't 'unwreck' a lot of them.

To ensure that clients became confident with the management of their chronic illnesses, nurses provided a great deal of education. One woman newly diagnosed with diabetes expressed how thankful she was to have a nurse on her housing team, so she could receive further education.

- I'll talk it [diabetes] over with her [the nurse]. She's coming this Wednesday, so we'll sit and chat about it. I'm also going to my doctor tomorrow, because the clinic sort of just told me this and that was it. I feel like I was thrown to the wolves. The [clinic] nurse came in and said this is how you do it, prick your finger, and I went through a whole vial of strips because I couldn't get it right. Not telling me when your blood sugar's high, you should do this or do that - nothing. I haven't even met with a nutritionist.

Nurses provided education about medications as well, and both housing team nurses had facilitated health 'topic' groups with clients to discuss relevant health issues like sleep hygiene and nutrition. It was not always easy for nurses to break old health care habits that clients learned while homeless. As an example, one individual who was on about twenty medications would put all of them into one bottle when she was homeless because she did not want to carry around a huge bag of pill bottles. Now that she is in housing, her nurse explains, "She takes them and dumps them into a bowl, so she has a bowl of all these different colored pills that she picks through to take her meds."

Part of navigating a chronic illness is learning when to seek help and how to utilize the health care system appropriately. As noted earlier, several clients would call nurses on their housing support teams when they were experiencing unfamiliar side

effects or symptoms. The nurses, in turn, would triage these acute health problems and teach clients if, when, and where to seek further care. One respondent, who had a nurse on his team, sounded surprised that most housing teams to do not have nurses. He noted how having a nurse to help navigate and triage illnesses, especially initially, is critical for the formerly homeless population.

- When some of us come into housing, we don't have a primary care person… Whomever [nurse] you are with you can call that person and say I'm just not feeling right; something's going on with me. To me that's one of the most vital roles they can play. I thought that, sure, all of these programs had nurses. They don't have!

Service providers agreed that nurses would be a welcome addition to their housing teams, as they often have to shoulder the responsibility of determining if and when to seek care for their clients.

- Even if the nurse could not actually do anything to treat them, if the nurse could explain their condition to them so they knew what they were dealing with, for some of them that would make a big difference.

- I think that if I could pick one skill to magically be given, it would be the ability to triage people's medical stuff. I hear breathing, and it sounds really bad to me, but is it really bad or is it just chronic lung disease?

Those who did have nurses on their teams expressed amazement at how clients had become health literate since becoming housed, and they assumed it was because of their nurses. One reason nurses on housing teams are successful in engaging and assisting clients with their health is because they have the ability to become literally and figuratively close to their clients, and thus to learn and share each person's unique story.

Nurse as Proximal 'Story' Teller

The theme of nurse as proximal 'story' teller builds on concepts introduced by Malone, who suggests that there are three types of "nested proximities in nursing" that are "not merely spatial, but temporal as well" (2003, p. 2318-20). These concepts also have a moral weight, as they were inspired by Liaschenko's (1994, 1995) work on the

moral geographies of nursing. The first and foundational proximity is physical proximity, which to Malone is achieved when nurses touch and physically care for patients' bodies. It is expanded upon in this discussion to include physical nearness, absent of 'hands on' care work. (Nurses in this study did perform physical care like changing dressings, but most of their time was spent 'being with' clients.) Over time, physical proximity becomes the catalyst for narrative proximity, or closeness that results from hearing a patient's 'story' and truly knowing their 'place' or situatedness in life. Nurses often share these stories, to compel other caregivers to action. Moral proximity, couched in an ethic of care, is the last to be realized (Peter & Liaschnko, 2004). It occurs when "nurses are able to begin to appreciate the moral significance of issues for [the patient] and to act accordingly on his behalf when he/she is unable to do so" (Malone, 2003, p. 2319).

Nurses who do not achieve proximity to their patients often become distal caregivers. Being distal has become an increasing phenomenon in this technological and virtual age, as some nurses never interact with actual physical bodies (Sandelowski, 2002). Distal nurses likely see their patients as no more than a set of tasks or a set of diagnoses. Their work is constrained by demands of managers and institutional mandates about efficiency and reporting. Changes in health care, and the off-loading of physical 'body' work onto lesser skilled personnel, reduce the time nurses can spend with their patients, resulting in distal environments that make physical proximity difficult or next to impossible. Ultimately, under these conditions, nursing loses its ability to meet its moral obligation to patients and to their unique life stories (Malone, 2003).

The tension between distal and proximal nursing was evident in this study. Service providers reached broad consensus that homeless and housing teams required

proximal nursing to be effective. They need nurses who will take the time to get to know clients in their environments, and who will acquire an intimate understanding of the barriers they face in achieving health and receiving health care. This conversation underscores the difference between distal and proximal nursing.

- R1: I think visiting nurses are great, but what I find with the nurses that I work with [is that they] are so overworked and rushed that they don't have time to talk … I feel like it's almost like a doctors appointment where they don't really have time to spend. They do get to see the person in their environment and that really helps. There's the woman with the medications all over the table in and out of the bottle and you can see that the chances that she took all these meds is really small when there's some in her purse and some over there. I would walk in the apartment and I think she would just take handfuls at different times of the day and I never really knew what. The nurse that came in and got to see that, saw something that the doctor in the office never got to see, which was that this person was very random … I feel like the nurses were so rushed and they had so little time. We had a colleague who left to become a nurse and she said that she's just run off her feet …

  R2: We saw her tonight and she said she had 18 people to see tomorrow and that's in different location …

  R3: How can you see eighteen people in a day?

  R1: Some people quit … she gets paid by the person so there's that pressure. There's going to be a lot of money, but it's going to be a lot of work.

  R4: The thing about having the embedded nurse [on the team], and this is not to say that the other nurses aren't helpful, but they really take the time to understand the individual person. These are people whose barriers are pretty high already.

  R5: I think it's the type of the nurse that's critical too, because if you have an institutionalized nurse who's focused on illness and just says that you really need to see your doctor that's not going to be helpful. But if you have a nurse who's not just focused on illness, but is focused on health and is able to support people's health along with treating or triaging the illness, that's more helpful. The nurse that we had was not helpful, he was more focused on signing off on medications and he was not proactive and out there engaging people. That ability to engage people in talking about their health and triaging them is helpful, but the other is not helpful.

This theme that nurses on housing teams were unique because they were 'proximal' was reiterated by both participants and the nurses themselves. A nurse commented on how participants did not appreciate 'distal' nurses.

- I got this nurse to come out and meet with her [a client]. I don't believe the homecare nurses follow the same "meet them where they're at" philosophy. I think they have stricter charting and requirement guidelines because this client, very shortly after, fired this homecare nurse, so then it was back to me beating my head against the wall trying to work with her.

One participant was well positioned to comment, as she had had experiences with both the nurse on her housing team and a nurse from another agency. She seemed to have an inkling about the differences between distal and proximal nurses.

- [The agency nurse] would come every other week, or every week, and fill up the pills, and I got the feeling that perhaps she wasn't really used to working with people like me. I'm not sure. I don't know, we just didn't fit, but I knew [Mary, the housing nurse], so we did fit. Mary does outreach nursing; she goes to campsites and stuff like that.

The last part of this quote was insightful. She knew that she 'fit' with nurses who had acquired knowledge about the past and present places in her life. Nurses who were familiar with the geographies of homelessness were better able to understand the barriers people faced in housing. Those who had physical proximity - spending time with participants in their homes and in their day-to-day routines like going to the doctor, cooking food, and taking medications - achieved narrative proximity as well.

Proximal nurses act as "hearers and bearers of the patient's story" (Malone, 2003, p. 2321) and become 'story' tellers. It is a frequent research theme that nurses carry the responsibility of being the eyes and ears of doctors and other health care providers (Liaschenko & Peter, 2004). In this study, nurses were storytellers to supportive service staff and other health care professionals involved in their clients' care, to ensure that important aspects of clients' stories were not missed. These stories provided support for nursing recommendations related to needed referrals, lab work, and medications.

Nurses explained:

- I'll do a lot of intervention over the phone by calling the office and talking to the doctor's nurse, *letting her know what we're seeing, what the client is experiencing*,

if there are side effects to medications … when clients go into a medical appointment they take this medical referral with them … there's a place for me to write, or the client, some of the things that they need addressed.

- I think advocating for them is huge, and *just shedding light on different things that might not otherwise be seen or heard*. It affects their treatment and it affects how aggressively other people work with them, and sometimes how people respond to them. It seems like sometimes the homeless aren't taken seriously or they're brushed aside unless they have someone representing them, whether it's to get housing or to get their health care needs met.

There was evidence that nurses on the housing teams felt a sense of moral proximity to their clients as well. They told detailed stories of how they felt compelled to go 'the extra mile' for clients if they felt it was needed, calling them on their day off or visiting them on Christmas day. They spent hours in hospitals and ERs advocating for clients who could not advocate for themselves. This final story is about a man who was discharged from the hospital into a dangerous home situation. It illustrates how being physically 'in place' with clients reveals a larger story and incites moral action.

- His apartment was a mess. He had his refrigerator door open with food in the refrigerator. There was spilled food on the floor. He had his medications strewn all over the floor. He had his box of Lovenox injections there. He knew nothing about when he needed to get it, if he had given himself any. While I had been there for not quite an hour, he tried to give himself two injections. He thought he had gone from morning to night and he needed another one. Obviously, a very unsafe situation. He refused to go in, so I did call 911 on him. He was swearing and cursing the case manager and me out. Sometimes you have to forget harm reduction. You have to save their life.

Just as clients' stories have encouraged nurses to act on their behalf, findings of this study should spur health care and housing providers, educators and researchers, and public policy makers to support housing as a health care intervention.

Chapter Five: Discussion

The painfully obvious lesson for me has been the futility of solving this complex social problem solely with new approaches to medical or mental health care. After two decades of doctoring to the homeless poor, I believe that I could best improve the health of my patients by assuring access to housing and supportive services as core components of their treatment plans … I dream of writing a prescription for an apartment, a studio, an SRO, or any safe housing program, good for 1 month, with 12 refills (O'Connell, 2007, p. 202).

- *Dr. Jim O'Connell*
  Boston Healthcare for the Homeless Project

Dr. Jim O'Connell leads the nations largest and most innovative health care project for homeless individuals. He has access to state-of-the-art medical technologies, allowing him to 'doctor' the homeless poor in ways that most outreach healthcare providers could only dream. Despite these advances, he humbly admits learning the 'painfully obvious lesson' that his efforts are futile unless he works to secure housing for his patients. In a sense, he has recognized his need to 'doctor' the place where the homeless poor reside. Findings from this study confirm this realization that housing is a first line intervention to improve the health and lives of people experiencing homelessness.

Key Findings

As revealed in the stories of those who have lived long term without a home, the places and spaces of homelessness are not conducive to health and healing. The disease-ridden shelters and extreme environments of the streets demand creative and adaptive strategies from those who are chronically ill. A fitting example was the participant whose blood sugar machine did not work in the cold, so he used solving a Rubik's cube as an indicator of low blood sugar. Homeless populations also face extreme social environments. They are required to share their space with people they do not know or trust. As a result, they live constantly on guard, and those with chronic health conditions are forced to expose their health vulnerabilities to strangers. This

makes the management of health problems practically and psychologically difficult, as many do not want to bear their illnesses to those around them. Having no place to put health care belongings like medications compounds the challenge of managing illness while homeless. Lost, misplaced, and stolen items are a frequent occurrence. Additionally, save a friend's home or hospital bed, there is little time or space for respite if one becomes acutely sick or experiences exacerbation of chronic illness. Geographic exclusion from public areas necessitates perpetual movement from one place to another, causing physical exhaustion and allowing no time for recovery. Ultimately, people suffer from feelings of despair and feelings of literal 'home'lessness.

Having lived for so long without a place to come home to, it was no surprise that people described their first nights in housing as exciting but uncomfortable. It was especially difficult for those who moved into an empty room, without items like towels or linens to personalize the space or make it feel 'homey.' The transition into housing was a challenge for those who still had connections to the people and places from their homeless lives. The figurative work of closing the door on homelessness involved negotiating their home space with previous social groups, and finding a place that matched their needs and desires. This work took time. Consequently, participants did not experience great therapeutic benefits from first apartments.

The home, often the second place they moved, became a therapeutic landscape through a variety of means. Once carefully negotiated, the home became a stable base for new social identities and networks of care. These networks included trusted service providers, nurses, family, and friends. The process of setting and keeping up housing in a way that made it feel personal and homelike (according to participant perceptions of what a home should be) also nurtured attachment to home. Participants purposefully placed pictures of loved ones, important memoirs from the past, and

reminders of their spirituality to create a therapeutic environment. Sensual pleasures of home such as a hot shower and nice smelling candle added to the therapeutic qualities of home. People came to love their homes for all of these reasons, and because their homes (and the actual keys to these homes) represented opportunities for happiness, peace, empowerment, and a sense of belonging. The home also offered time and space for achieving a sense of normalcy. Participants came to feel 'normal' again by developing day-to-day routines, pursuing the hobbies they had loved but lost while homeless, and giving back to the community through volunteer work or employment. Feeling normal in turn fostered self-esteem and the *desire* to care for themselves.

In addition, the home literally gave participants the *ability* to care for themselves. Concrete physical features of the home, called place effects of home, were necessary for health and the maintenance of chronic disease. The kitchen provided space for the preparation and storage of food, which was especially helpful for those who required special diets, those who were vegetarian or lactose intolerant, and those with gastro-intestinal problems like irritable bowel syndrome. A private bathroom and shower, along with running water, were necessary for proper hygiene and for health care interventions such as colonoscopy preparation or 24-hour urine collection. The bedroom allowed for safe sleep and recovery, and it had electrical outlets for equipment such as C-PAP machines. The physical structure of home gave shelter and security, as well as the space and a place for health care equipment and medications. On its four walls hung calendars, clocks, health posters, and important phone numbers. The home also provided the stability for a phone and address. All of these were important for the appropriate utilization of care and networks of care. Being able to have pets improved mental health and facilitated integration into the surrounding community. Lastly, the neighborhoods surrounding their homes offered amenities important for health such as

public transportation, community clinics, pharmacies, and libraries. Neighborhoods with prestigious reputations presented the added benefit of helping participants hold themselves in high esteem.

Nurses had an important place on housing teams, and they too nurtured participants' desire and ability to care for themselves and manage their chronic illnesses. As a highly trusted profession, nurses became figurative stepping-stones out of homelessness and into health care. Most people are required to talk to a nurse at some point in their lives, but not all have to interact with a social worker. Thus, nurses engaged people who were homeless and formerly homeless in a unique way, unlike other homeless professionals. They were not perceived as a threat. Nurses were also rightly viewed as highly knowledgeable about health and health care systems. They became health and health care navigators for both participants and service providers, off-loading some of the burden of disease management and triage. This navigation work was particularly important for the newly housed, as they entered primary care for the first time and faced new and complicated diagnoses. Lastly, the home gave nurses on housing teams both the time and space to truly 'be' with participants. This physical proximity gave them an intimate knowledge of how clients' places impacted their health and health narratives. Nurses then shared these narratives with other care providers to advocate for client needs and, if necessary, to encourage moral action.

Integration of Results

Findings from this study echo previous research on the impact of housing on health. More importantly, they add to this body of knowledge by elucidating certain processes and mechanisms by which housing influences health outcomes. Participants reported improvements in depression and anxiety after housing, as found in other studies (Clark & Rich, 2003; Fichter & Quadflieg, 2006; Mares & Rosenheck, 2009;

Wolitski et al., 2010). They did not, however, link these outcomes to connection to psychiatric care or adherence to medications. Though these certainly could have influenced mental health, participants cited the therapeutic qualities of housing such freedom from the stress of homelessness as reasons for mental health improvement.

As supported by both quantitative (Mares & Rosenheck, 2009; McHugo et al., 2004; O'Connell, Kasprow, & Rosenheck, 2008) and qualitative (Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; Padgett, 2007) studies, participants spoke of marked gains in quality of life. This was not surprising, as those with poor physical health have been shown to experience the greatest benefits of housing in terms of quality of life (Wolf, Burnam, Koegel, Sullivan, & Morton, 2001). One likely explanation, as noted in findings from this study, is that housing has direct and immediate place effects on health for the chronically ill homeless population. It is also hypothesized that housing enhanced quality of life because it became a loved and enjoyed therapeutic landscape. As demonstrated, the sensual pleasures of a place can significantly improve physical, mental, and emotional health (Ogunseitan, 2005). Having a home also improves quality of life because it restores self-esteem and a sense of identity. Interestingly, one study states, "like those who are chronically ill, the former identities of those who are homeless become questioned, undermined, or negated" (Boydell, Goering, & Morrell-Bellai, 2000, p. 36). Thus, those who are both chronically ill *and* homeless experience a compounded loss of identity. Housing and the subsequent ability to improve chronic illness can help individuals regain a sense of their former housed and healthy selves.

Results mirrored previous research demonstrating that people may (O'Connell, Kasprow, & Rosenheck, 2008; Fichter & Quadflieg, 2006; Larimer et al., 2009) or may not (McHugo et al., 2004; Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, Gulcur, & Nakae, 2004) experience a reduction in alcohol and drug use after housing. One

participant in this study did report a significant reduction in alcohol use. Interestingly, when asked how he was sure of his decreased use, he explained that he collected his beer can tops and put them in a jar. He noted that it took much longer to fill the jar after he was housed. His story illustrates an important point. Several previous studies investigating alcohol use over time employed only self-reported measures of alcohol and drug use or addiction severity (Larimer et al, 2009; O'Connell, Kasprow, & Rosenheck, 2008; Clark & Rich, 2003). Objective measures of chemical use such as quantity or episodes of public intoxication may provide improved accuracy and sensitivity in this area of research. This study is notable because it sheds light on why people reduce their alcohol and drug use after housing. Participants noted a reduction in chemical use due to the following: improved self-esteem and empowerment, not needing a place to stay inside away from the harsh winters (which detoxification facilities offered), the ability to pursue other enjoyable activities and hobbies, and as a result of new sober networks of care. Other participants commented on the continued struggle of chemical addictions. As indicated in previous research, however, no one reported an increased use of drugs or alcohol after housing (Petroskas, 2011).

Robust research demonstrates that providing supportive housing to homeless adults encourages appropriate utilization of health care institutions, reducing societal costs associated with emergency rooms, hospitalizations, and other public institutions such as shelters and jails (Aidala, Lee, Abramson, Messeri, & Siegler 2007; Culhane, Metraux, & Hadley, 2002; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). Not surprisingly, all participants in this study had a similar experience. Many had fragmented care and utilized only emergency or acute care when they were homeless. They were able, however, to reconnect to primary care and centralize their care after housing. They also finally received important preventative care such as health

screenings (e.g. colonoscopy) and elective surgeries because they could be discharged to a home to recover. This study expands on the former findings by identifying how and why health care utilization may improve after housing. As noted earlier, certain features of the home made accessing and following up with care much easier: an address and telephone, nearby primary care clinics, accessible public transportation, and visual reminders in the home like a calendar or 'to do' list. Nurses and service providers assisted clients with connecting to and navigating health care institutions, and the therapeutic qualities of home directly impacted participants' desire to access care. They could finally make health care a priority and no longer felt ashamed or embarrassed when visiting health care institutions.

Only a few studies have investigated how housing impacts markers of chronic physical conditions, and those that do exist are limited to studying only the homeless population living with HIV and AIDS. Housing has been shown to reduce viral load, improve immunity, and increase overall survival (Buchanan, Kee, Sadowski, & Garcia, 2009; Wolitski et al., 2010). Two participants with HIV in this study did report a reduction in viral load. Beyond this, however, several participants told of other chronic conditions stabilizing over time. Two diabetics, with obvious health literacy, knew that their glycosylated hemoglobin had normalized after housing. Those with chronic hypertension reported becoming normotensive, and several with chronic respiratory conditions (e.g. COPD, asthma) noted vastly improved lung function. Qualitative reports of improved physical health after housing are not sufficient evidence to conclude that housing is etiologically linked to these outcomes. However, gathering qualitative data is often the first step toward building a robust research base (Polit & Beck, 2008). The following section will discuss this and further suggestions for research, practice, and policy.

Direction for Future Research, Practice, and Policy

Research

Findings from this study should spur quantitative investigations into how housing influences the trajectories and symptomatologies of chronic illnesses such as hypertension, diabetes, COPD, and asthma. However, quantitative studies must go beyond gathering self-reported data on physical health outcomes. As noted in this study, those recently housed may be connecting to primary care for the first time and facing illnesses that went undiagnosed while homeless. This could foreseeably result in self-reported measures that are worse after housing. Researchers should collect data on objective physiologic markers of disease processes before and after housing. These could include blood pressure, glycosylated hemoglobin, pulmonary function tests, and measures of incentive spirometry. Valid instruments measuring symptoms or illness burden associated with common chronic conditions could also be useful in demonstrating housing's impact on physical health and health related, or disease specific, quality of life (Guyatt, Feeny, & Patrick, 1993). Since research influences housing policy, as evident in the creation of housing for people with HIV/AIDS (i.e. HOPWA Program), we may someday witness the creation of housing opportunity programs for homeless people with other chronic illnesses.

Much of the literature exploring the impact of housing on the health of homeless adults compares one housing *type* against another. Examples include: board and care homes versus community housing (Fichter & Quadflieg, 2006), group housing versus independent apartments (Caplan, Schutt, Turner, Goldfinger, & Seidman, 2005), and community residences versus supported housing (Siegel et al., 2006) (see Table 3 for a summary of housing types). An extensive review of literature on housing for persons with severe mental illness concludes that most housing research relates outcomes to

these housing types, but it fails to pay much attention to other crucial components of housing such as philosophical model of care, actual service delivery, and housing environment. This last feature, housing environment, comprises location, quality of housing, and living arrangements (Waegemakers-Schiff, Schneider, & Schiff, 2007). In addition to these features, this study demonstrates that housing environments can include: physical arrangements of place and space, sensual pleasures that foster attachment to and love of place, and items that deliberately personalize one's place and contribute to a sense of belonging. Rog & Randolph (2002), in an evaluation of supportive housing, call researchers to examine and measure the "key ingredients of housing" and how they are linked to specific outcomes (2002, p. 70). Because there is no definitive answer as to which housing *type* best improves health outcomes (Kyle & Dunn, 2008), future qualitative and quantitative research should explore other components of housing (including environment and place) that influence health and quality of life for formerly homeless individuals.

Another recommendation for research is to enhance the transferability of this study's findings by expanding the scope to other populations and contexts. Though the formerly homeless sample for this study was demographically diverse and represented a wide range of homeless locations (e.g. streets, shelter, camps), the sample consisted of single homeless adults confined to a specific geographic area. Clearly, geography matters when discussing issues of health. Future studies could focus on a specific population in a specific area for greater insight into how housing and place impact health and health care utilization. For example, researchers could employ a phenomenological approach and deliberately focus on the lived experiences of homeless diabetics living in rural areas who recently received housing.

This study had a relatively small representation of nurses, which was expected since there are very few nurses in this line of work (Wallace, O'Connell, & Frisch, 2005). Expanding the study to include more nurses in other geographic areas or across sites would add to the knowledge of nursing's place on homeless and housing teams and in community support services for homeless individuals. Additionally, time matters as much as place. Both are often neglected but nevertheless key variables in health and nursing research (Henly, 2003; Sandelowski, 1999). Therefore, researchers could conduct in-depth interviews before housing, immediately after housing, and follow-up at different time periods after housing. A grounded theory or ethnographic approach may be well suited for this type of investigation into the meaning and experience of home (Mallett, 2004). An across-time study such as this would elicit rich detail about the thoughts and behaviors of those who are chronically ill and receive housing. Furthermore, qualitative methods are critical because they allow for "conversing *with* rather than just *about* 'them' [participants]," giving formerly homeless individuals a real voice and presence in research (Kearns, 1994, p. 112).

Finally, despite common assumptions, homeless populations are heterogeneous and include individuals across the lifespan. Research generally describes three groups of homeless populations: single homeless adults, homeless youth, and homeless families (Hwang, 2001). Research estimates that 5 to 7.7 percent of youth in the United States experience homelessness each year (Robertson & Toro, 1998). Families make up almost 50% of the homeless population in the United States, and there are 1.35 million homeless children in these families (Culhane, 2004). Each of these sub-groups of the homeless population has unique health and health care needs and reasons for becoming homeless (Hwang, 2001). As such, the impact of housing on their health and health care utilization should be examined separately in future place-based research.

As evident in this study, place-based research can offer significant contributions to on-the-ground practice.

Practice

It is critical that homeless service providers - including therapists, case managers, social workers, and nurses - understand the places of those they work with and how these places impact health and healing. If they are aware of these relationships, they can apply their knowledge "in positive ways to develop therapeutic places that actively promote health and well-being" (Smyth, 2005, p. 494). Ultimately, putting this research into practice means deliberately making the home into a therapeutic landscape for formerly homeless clients and consequently fostering their attachment to home. Mifflin and Wilton assert, "being housed is not the same as being 'homed'" (2005, p. 406). If providers can help their clients through the process of making house into home, a place identity is formed. This is crucial for achieving and maintaining housing; those whose sense of identity is figuratively 'wrapped up' in their home place will not want to lose their housing. If they did, they would be losing a part of themselves and a piece of their identities.

A fundamental goal for formerly long-term homeless adults with chronic illnesses is achieving housing stability and housing tenure. Attendees at the 2011 National Health Care for the Homeless Conference were quick to point out that keeping people in their housing is a primary aim for service providers as well. This is a laudable goal for both groups, since this research study demonstrates that housing has vital 'place effects' on health. The structure and amenities of housing, or the "physical attributes of home" (e.g. heat, bathroom, water), are necessary for the maintenance of health and management of chronic illness (Walsh, Rutherford, & Kuzmak, 2009, p. 306). Housing retention is also important for this population because, as discussed in chapter two, it

leads to improved mental, physical, and emotional quality of life. It reduces societal costs associated with homelessness by improving utilization of health care and reducing use of detoxification centers, jails, and homeless shelters. Considering these reasons, it is not a surprise that most research in this area focuses on housing retention and reducing time spent homeless (Nelson, Clarke, Febbraro, & Hatzipantelis, 2005).

This study reveals concrete ways that service providers can nurture place attachment and increase housing retention. Matching a person to a place that meets their needs and desires is critical. Other studies confirm that finding a home environment with a good fit or match to a person's preferences and needs directly impacts outcomes related to health and housing stability (Anucha, 2005; Coulton, Holland, Fitch, 1984; Lipton, Siegel, Hannigan, Samuels, & Baker, 2000; Moore, 2000; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005). Regarding the fit between a person and their environment, Ridgway, Simpson, Wittman, and Wheeler comment:

> If people live in environments that do not meet their definition of home, they will remain unsettled. When people feel a subjective sense of satisfaction with a setting, they are more likely to function better, be healthier, and settle in. (1994, p. 414).

As such, service providers should offer a variety of housing types and avoid a one-size-fits-all approach (Kresky-Wolff, Larson, O'Brien, & McGraw, 2010). They should be especially mindful of the physical layout for those with chronic health issues, as it can hugely impact the ability to maneuver and manage independently. If the housing is in a multi-unit building, providers should consider how room placement influences mental health and necessitates or hinders social interaction (Evan, Wells, & Moch, 2003; Ridgway, Simpson, Wittman, & Wheeler, 1994). It has also been shown that "fitting in can be influenced by a combination of variables, including the match between the

ethnic/racial makeup of the neighborhood and the housed person, and the match between the individual's values and the neighborhood's" (Yanos, Felton, Tsemberis, & Frye, 2007, p. 705). This study also uncovered the importance of neighborhood, as nicer areas had 'pull up' effects on participants. Thus, service providers should, if they are able, place clients in high quality housing and in neighborhoods where clients will feel comfortable.

Matching a person to the right place is often a challenging and time consuming process, resulting from a variety of social, physical, and political factors. Examples include: overcoming barriers to housing such as a poor rental or criminal history, letting go of homeless 'places,' and identifying structural needs in light of physical or cognitive disabilities. Service providers must be patient with this process and encourage their clients to be as well, since strong place attachment might not happen until the second or third apartment. Nevertheless, providers should make efforts to create a home-like environment in first apartments, especially for the first night in housing. Small gestures like putting sheets on the bed, food in the cupboards, and hand-towels in the bathroom alleviate feelings of discomfort and anxiety for clients exiting homelessness after many years.

Service providers can actively work to facilitate the attachment process to home and create a therapeutic landscape in the home. They can assist clients with the careful negotiation that is required to prevent previous homeless friends from jeopardizing housing. This may include putting clients, especially those with active and serious chemical addictions, in housing that has a front desk monitor. Recognizing the potential loss of previous friendship networks, service providers should encourage clients to reestablish or establish new networks of care. Providers become a part of clients' networks of care, yet their involvement should not hinder or replace evolving

friendships. Goering et al. (1992) note this "delicate balance between meeting needs and creating needs, and, at the same time, nurtur[ing] development of friendships" (p. 213). Estranged family members may also reenter clients' lives, so single adult housing programs should be prepared to integrate families into their scope of practice. One study found that mentally ill participants, when asked what was important to their housing stability, most frequently mentioned relationships with family, friends, and service providers (Thompson, Pollio, Eyrich, Bradbury, & North, 2004). These relationships are foundational to enhancing the therapeutic qualities of home.

Place identity is strengthened when clients find a home they love and personalize. Service providers should explore their clients' previous experiences of home, to discover what they loved about these places. Careful attention should be paid to the sensual pleasures of home. Providers can also encourage clients to set up their homes in ways that reflect positive home experiences and their self-identities. In this study, possessions used to personalize home space included pictures of family and friends, reminders of spirituality, and knick-knacks that reflected interests and hobbies. Some even set up their homes in a manner similar to their mother's homes. An ethnographic study exploring the meaning of home and possessions with homeless women revealed that homelessness "greatly constrains the accumulation of [special] material possessions," thereby damaging ones identity and sense of self (Hill, 1991, p. 299). The women in the former study had three types of possessions: small symbolic possessions they kept *despite* homelessness, possessions acquired *during* homelessness that inspired hope, and important possessions that had been *lost* as a result of homelessness. Service providers should encourage their clients to integrate special objects such as these into the construction of their new homes in order to instill a sense of pride and place identity, and to create a more home-like environment (Hill, 1991).

Participants in this study emphasized that housing helped them feel normal, which in turn led to increased self-worth and a desire to care about themselves and their health. In another study, it was *service providers* who noted the importance of normalcy on participants' health and recovery. One provider explained that the work involved in moving someone into mainstream housing "is about trying to make people's lives as close to normal as possible" (Kresky-Wolff, Larson, O'Brien, & McGraw, 2010, p. 218). To help clients achieve a sense of normalcy, service providers should encourage them to establish day-to-day routines, particularly those that incorporate health care activities such as medication administration and monitoring. They can support their pursuits of activities such as hobbies, volunteer opportunities, and employment. They should assist them in acting on newfound concerns for health by helping them connect to primary, mental, and even oral health care.

Policy

Housing policy makers and program advocates who serve formerly homeless individuals, especially those suffering from multiple chronic morbidities, should include positive health and quality of life outcomes in the larger body of evidence on the benefits of housing with support services. Results from this study can help advocates articulate the specific mechanisms by which housing improves health. Arguments for supportive housing have been made from fiscal to human rights standpoints, yet they should also be made from health care and health systems perspectives. Health care policy makers and administrators need to include supportive housing in their collection of prevention and treatment interventions to improve the health of this vulnerable population. As noted in the introduction, policy makers too often take a highly medical approach to health problems, focusing on individual health behaviors while losing sight of the social determinants of health.

Access to care, though certainly important, is mistaken as the sole solution to health disparities. Lantz, Lichtenstein, & Pollack (2007) elaborate on this point by saying:

> When health vulnerability and disparities are medicalized, health care access becomes overvalued and overemphasized as the most promising policy path. It is also an easier path, politically, than are fundamental social and economic reforms. The result is our current situation, in which an estimated 95 percent of U.S. health services spending goes toward direct medical services, and only 5 percent is invested in population or community approaches for prevention and health status improvement (2007, p. 1255).

These statistics are unfortunate, as only about five of the thirty years Americans have gained in life expectancy during the twentieth century were a result of improved medical care (McGinnis, Williams-Russo, & Knickman, 2002).

The worlds of housing and health care, and their associated funding streams, should be fully integrated to meet the needs of homeless populations. There are models of these types of partnerships across the country. In 1998, San Francisco's Department of Public Health began managing the city's Direct Access to Housing (DAH) program, which consists of at least 13 supportive housing facilities. All of these facilities have medical and/or nursing staff on-site, and primary care is offered at each housing site to residents through the Housing and Urban Health Clinic. This highly innovative model, which begins with housing people as the first act of care, is funded in part with health care dollars (Direct Access to Housing Program, nd). Unfortunately, most supportive housing programs are not able to do the same, as each state has its own policies around Medicaid allocation. State Medicaid directors and policy makers should follow San Francisco's lead and begin to leverage federal healthcare funding for homeless housing, support, and nursing services. They should also advocate for the

creation of housing opportunity programs, like HOPWA, for people with chronic diseases such as diabetes, COPD, cancer, and asthma. For example, two highly innovative programs that integrate housing and health care worlds are Common Ground's *Street to Home* and *Hospital to Home* programs. These models target the most vulnerable homeless populations and high users of hospital systems and place them immediately into housing (Jost, Levitt, & Porcu, 2010; Kanis, 2007)

A clear and consistent finding in this study was that in order for participants to make their homes into therapeutic landscapes and benefit from the place effects of housing, they had to find a place that suited both their needs and desires. Having a choice in where they lived was key. Housing choice, however, is perhaps one of the greatest challenges in implementing a supportive housing intervention. Affordable apartments are incredibly difficult to find, not to mention that lack of affordable housing is one of the fundamental causes of homelessness (Lozier, 2006). Individuals who are fortunate enough to have acquired an affordable housing unit (i.e. public or Section 8 housing) usually do not move out of their housing units, making vacancies scarce (Rog & Randolph, 2002). It is also difficult to find housing in the current market because a minimum wage income cannot keep up with rising housing costs. Federal and state governments have offered housing subsidies to homeless individuals, so that they do not pay more than 30-40% of their income for rent, but these subsidies are limited (National Alliance to End Homelessness, 2007). Even enrollment in supportive housing studies has been delayed because researchers were not able to provide timely housing options or obtain a sufficient amount of housing subsidies (Rog & Randolph). Access to mainstream or supportive housing can be difficult when policies exclude people who have criminal histories, previous evictions, behavioral or psychiatric issues, and problems with chemical dependency. Therefore, policy makers

should advocate for strategies that promote housing and housing choice. These can include: reducing barriers to supportive housing affordability and access, increasing stock of a variety of housing models, creating housing subsidies, increasing opportunities for employment, and raising the minimum wage.

The creation and provision of housing is important for the homeless population, especially those who experience multiple morbidities, but not all housing is created equal. The place effects of unhealthy and unsafe housing have been discussed at length in housing and public health literature. Lead-based paint, pollutants and allergens in old carpets and drapes, humidity and moisture that result in harmful mold, rodents and insects, and inadequate heating and plumbing facilities have all been identified as public health housing hazards (Matte & Jacobs, 2000). These negative place effects should not be ignored. When making the case for housing, policy makers and advocates must remember that only safe and healthy housing, in safe and healthy neighborhoods, is health care for homeless adults.

Nursing Research, Practice, and Policy

The metaparadigm of nursing includes person, health, and environment. These three concepts simply and succinctly describe the whole of nursing's work. As the essence and core of nursing, they unify the discipline and focus its inquiry (Donaldson & Crowley, 1978). The relationships between these concepts, however, are incredibly complex. Place-based research, particularly through the lens of health geography, can help unpack these dynamic relationships. As demonstrated in this study, a person's place and lived environment are central to their health, quality of life, and experience of care. Despite their importance, care environments remain nebulous in nursing practice and theory (Andrews and Moon, 2005b). Patients are often 'displaced' when they encounter nurses in clinics and hospitals. They are cared for outside of their day-to-

day environments, making it challenging for nurses to truly understand how their patients' 'places' matter for health. Since nursing offers a unique perspective that "evolves from the practical aim of optimizing of human environments for health," nurses should be deliberate about place in both practice and research (Donaldson & Crowley, 1978, p. 119; Andrews, 2002). Even Florence Nightingale underscored the importance of not only nursing patients but also 'nursing the room' (Andrews, 2003b).

Nurses who work on homeless outreach and housing teams are well positioned to understand homeless geographies, as they both figuratively and literally meet people 'where they are at.' Mental health nurses have learned to do the same, since their care work has shifted from institutions to the community and into the home (Högberg, Magnusson, & Lützén, 2006). Taking time and coming into the client's space builds trust and a lasting relationship. This work is the foundation to place-based care and reveals more complete life and health narratives, which are used by nurses to advocate for patient needs. One study that analyzed psychiatric nursing interventions in the formerly homeless, mentally ill community found that 70% of nursing interventions were conducted outside of an office, and of these interventions, 71% involved "complex relationship building." Not surprising, the most frequent activity that the nurses associated with relationship building was being "available for visits/contacts in any location" (Wallace, O'Connell, & Frisch, 2005, p. 487). If homeless and housing nurses want to become trusted stepping-stones out of homelessness and into housing and health care, they must have the time and freedom to become 'proximal' and get to know clients and their 'places' in life. Administrators and program managers should allow nurses both the time and the space to nurture these critical relationships.

Nurses have unique bodies of knowledge and holistic perspectives on health, so they can face barriers in the health care system head on and advocate for systems

change in ways that are different from other professionals. They can play an integral role in networks of care and on housing teams, relieving homeless and housing service providers of the burden of complex triage and care navigation. Those who administer and manage supportive housing programs, especially those that currently do not have nurses, should recognize the huge contributions nursing could make to their clients and teams and work to securing funding for these positions.

When dealing with vulnerable populations, nursing and health care navigation cannot happen over the phone or at a distance, as is commonly practiced by health and managed care organizations (Hatton, 2001). As demonstrated, nurses must meet people where they are at and in person; they must physically 'be' with them when they are facing their struggles. As such, nursing outreach should be a component in any health care home, accountable care organization, or managed care organization. People who are uninsured, vulnerable, or rightly distrustful of our 'system' often do not want to come into or engage our health care institutions. If nurses do not reach out to them, these populations will remain invisible and continue to suffer from injustices and inequality.

Nurses should be aware, however, that entering "home spaces … require[s] far deeper engagements with their clients' lives" than they may have in other health care settings (Bender, Andrews, & Peter, 2010, p. 1073). Intimate relationships, though foundational to care, can become emotionally taxing. Furthermore, in environments of little support and scarce resources, closeness to clients can lead to moral distress. Peter and Liaschenko remind nurses "that while proximity calls nurses to act, it can, in some circumstances, lead them to turn away, to abandon … proximity can be perilous" (2004, p. 219). This impulse to turn away likely results in situations where a nurse wants to help a client in need but lacks the means and power to do so. People who are

homeless suffer the greatest societal and health care injustices, and they often have incredibly complex and demanding social and physical needs. Nurses could easily feel powerless when facing the political, social, structural, and systemic barriers that hinder their clients' well being. Administrators and managers need to be mindful of the perils of proximity and ensure that adequate resources are available to meet client needs, that front-line staff have an opportunity to advocate for systems' changes, and that the nurses doing this work are fully integrated into a supportive housing or outreach team. Strong collaboration between members (i.e. housing specialists, social workers, nurses, case managers) is necessary to prevent moral burdens from falling on one person and to alleviate moral distress (Peter & Liaschenko, 2004).

Findings from this study support the assertion that "the condition of homelessness, and not simply traits of homeless individuals, influences risk behaviors and service utilization" (Shubert & Bernstine, 2007, p. S178). Not all nurses and health care professionals are aware of the place effects of homelessness on health, however, leading to negative and blaming attitudes that become significant barriers to homeless populations seeking care (Wen, Hudak, & Hwang, 2007). Researchers suggest that as long as people who are homeless "perceive themselves or are perceived as second class, [health care] interactions will remain infrequent, episodic, and costly" (Ugarriza & Fallon, 1994, p. 27). Therefore, nursing instructors should encourage service learning, an effective model for building a social awareness and providing community health education (Gerberich, 2000). Interaction between nursing students and people who are experiencing homelessness must, however, move beyond students providing short-term or skill oriented care. The ultimate goal of service learning should be that nursing students acquire an intimate understanding of the 'stories' and geographies of homelessness. This understanding can come through comprehensive health

assessments. Questions should explore not only physical health status, quality of life, chemical dependency use, and mental health symptoms, but also thoroughly assess housing stability and living conditions.

As evident in the geographies of homelessness, many people who are sick on the street have no place to recuperate or recover. Nurses should be involved in developing and providing respite or recuperative care, which is recognized by the National Healthcare for the Homeless Council (NHCHC) as "care for homeless persons who are too ill or frail to recover from a physical illness or injury while living on the streets, but are not ill enough to be in a hospital" ("Medical Respite Care", 2007, p. 1). Hospitals are discharging people sooner than ever before and with higher acuity rates (Neal, 1996), which takes a heavy toll on those who have no home to recover. Homeless respite and recuperative programs provide 24-hour care and a safe place for homeless persons to heal immediately after discharge, or during an episode of acute illness or injury not requiring hospitalization. Many programs are based in a homeless shelter, where clients often have to share their space with several people. This research supports a model of respite care, however, that would include quiet, private rooms. This model would give people some sense of home and a real respite from shelters and the conditions of homelessness. Quite literally, it would look like 'home' care to people without a home.

This dissertation would be remiss if it did not call nursing to advocate for structural and 'place-based' interventions, like respite care and housing, that improve the health of homeless populations. Helping people secure and maintain housing can be a first-line nursing intervention. Florence Nightingale and Lillian Wald, two of history's most influential and visionary nurses, understood the responsibility of caring for place and recognized the importance of the social determinants of health. They

acted tirelessly to improve living conditions among the poor. In presenting a history of public health street nursing, Hardill makes a plea to nurses:

> We must guard against embracing strategies that do not address basic health determinants … and reject those strategies that may, albeit inadvertently, result in little more than glorifying nurses who 'tend the poor' such as media stories that make governments look progressive for funding street nurses in shelters while poverty continues to grow and poor people continue to die prematurely (2006, p. 96).

Nurses have an imperative to make their patients' environments conducive to health. Therefore, they should play an integral role in homeless and housing research, and can be strong advocates for supportive housing at practice, programmatic, and policy levels.

Conclusion

At the 2011 National Health Care for the Homeless Conference, attendees received bumper stickers that boldly stated *Housing is Healthcare - and Both are Human Rights*. This catchphrase has ended up on countless cars and buttons, and homeless advocates, researchers, policymakers, and healthcare practitioners alike have all used it in their discussions on the importance of housing for people who are homeless. It has become a definitive answer to the question, "Is housing healthcare?" Because the statement is so frequently used, however, the profundity of these words is at risk of being lost. This study proposed a deeper question, "How is Housing Healthcare?," and sought its answers from those who live them every day. Their stories reveal how ones 'place' deeply impacts health and healing. They bring to life the profound changes that can occur in someone's life when they move from a landscape of despair into a landscape of healing. Hearing their voices, we are challenged to stop and ponder the great truth that housing is indeed healthcare.

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Appendix A

Table 1. *Quantitative Evaluation Tool Adapted from Whittemore (2005)*

Citation #	1	2	3	4	5	6	7	8	9	10	11	12	14	15	17	18	19	20	21	22	23	24	25	26
Sample																								
Inclusion & Exclusion Criteria well defined and appropriate	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Health, demographic, SES, & other confounders controlled	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Sample Size Justification	√	√	√	√		√		√		√	√	√	√	√	√	√	√	√	√	√	√	√		√
Study Protocol																								
Study procedures systematic and well specified	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Measurement																								
Choice of outcomes appropriate	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Data collection specified and systematic		√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Measures demonstrate adequate reliability and validity		√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
Attrition																								
Withdrawals, dropouts, or other losses from study identified and accounted for	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Threats to Validity																								
Confounders and bias carefully considered and controlled	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√

Citation #	1	2	3	4	5	6	7	8	9	10	11	12	14	15	17	18	19	20	21	22	23	24	25	26
Statistical Analysis																								
Statistics appropriate and well described	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Levels of significance or confidence intervals reported	√	√		√		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Intention-to-treat analysis for longitudinal data				NA	√	√		√	NA	√	√	√		NA	√		√	√	NA	NA	√	NA	√	√
Discussion																								
Conclusions supported by results with biases/limitations considered	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Intervention (if applicable)																								
Detailed information about treatment, setting, and interventionist provided	NA	NA	√	√	√	√			√	√	√	√	√	√	√	√	√	√	NA	NA	√	√	√	√
Efforts undertaken to ensure treatment integrity	NA	NA	√						√		√	√			√				NA	NA				
Randomization of subjects to treatment and control group	NA	NA		NA	√	√			NA	NA	√	√	√	√		√	√	√	NA	NA	√		√	√
Evidence of study group comparability at baseline provided	NA	NA		√	√	√	NA	√	NA	√	√	√	√	√		√	√	√	NA	NA	√	√	√	√
Quality Assessment: Acceptable (A) & Limited (L)	L	A	L	A	L	A	L	L	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A

Table 2. *Qualitative Evaluation Tool Adapted from Checklists in Fink (2005)*

Citation #	**13**	**27**
Data Collection		
Methods described/appropriate	√	√
Researchers qualified/trained	√	√
Data Analysis/Results		
Agreement between researchers/external reviewers	√	√
How categories were chosen is explained	√	√
Deviant cases presented	√	
Results valid/trustworthy	√	√
Design		
Described/appropriate	√	
Triangulation		
Sampling		
Description/Justification	√	√
Consent obtained		√
Conclusions		
Transferability	√	√
Limitations	√	√
Quality Assessment: Acceptable (A)	A	A

Table 3. *Summary of Articles on Housing and Health or Health Care Utilization*

#	Citation	Design	Sample & Sampling Method	Housing Type* & Support	Health or Health Care Utilization Related Results (sg.=significant; ns=not significant)	Quality Assessment	Housing Retention Rates
1	Aidala (2005) National Multi-Site Primarily Urban	Secondary Data Analysis 6 - 9 mos.	Persons living with HIV/AIDS (PLWHA) N=1095 Non-randomized: Propensity Scoring	Homeless vs. Unstably Housed vs. Stably Housed Low demand housing programs with varied support services	**Hard Drug Use:** (sg. reduction for those with housing improvement (HI) vs. no change (NC) – odds 54% lower) **Hard Drug Use, Needle Use, and/or Needle Sharing:** (decreased 11.4% with HI vs. 3.8% with NC) **Unprotected Sex:** (sg. reduction for those with HI vs. NC – odds 63% lower) **Sex Exchange:** (sg. Increase for those with housing worsened vs. NC – odds 411% higher)	Limited – Loss to follow-up for longitudinal analysis	53% for follow-up study (Total N=2149; comparable attrition group)
2	Aidala (2007) New York City	Secondary Data Analysis 12 yrs. 1994-2006	PLWH over 20 yrs. N=1661 60% M 40% F 53% AA 33% Hispanic 75% Substance Abuse Two stage stratified probability sample – 3 cohorts	Homeless vs. Unstably Housed vs. Stably Housed Varied support services	**Receipt of Appropriate HIV Medical Care:** (sg. reduction for those with housing needs (HN) – 26% lower) **Entry into Appropriate HIV Medical Care:** (sg. improvment for those who received housing assistance (HA) – 79% higher) **Entry into Any Medical Care:** (sg. reduction for unconnected persons (UP) with HN compared to UP without HN – 50% lower; sg. Improvement for UP who received HA compared to UP who did not – 104%) **Retention in Any Medical Care:** (HA strongest associated variable: AOR – 1.2)	Acceptable	85-88% of cohorts

3	Clark (2003) Florida	Prospective 12 mos.	Homeless with severe mental illness N=152 52% M 48% F 77% CA 20% AA Propensity scoring and assignment to stratum	Supportive Housing with Case Manage-ment vs. Case Manage-ment Only	**CSI, Days of Alcohol and Drug Use:** (improvement over time for all groups and strata – changes between groups and strata ns)	Limited – Limited information on health related changes; no p-values reported	71% available for one follow-up interview
4	Culhane (2002) New York City	Retrospect-ive Cohort 2 yrs. before & after housing	Homeless adults with severe mental illness N=3338 Matched-pair control group	NY-NY Housing – Independent Housing with Support & Community Residences: Integrated Support vs. No Housing Control Group	**Psychiatric Hospital Days:** (sg. reduction [49.2%] for NY-NY – ns for control group) **Inpatient Hospital Days:** (sg. reduction [21.2%:No Medicaid 24.4%:Medicaid] for NY-NY) **Outpatient Visits:** (sg. increase [75.9%] for NY-NY – ns for control group) **VA Hospital Days:** (sg. decrease [24.4%] for NY-NY)	Acceptable	NA
5	Dickey (1996) Boston	Prospective 18 mos.	Homeless adults with MI N=112 70% M 30% F 72% Substance use	Evolving Consumer Household vs. Independent Apartments	**Institutionalization, Medication Visits, Therapy, Day Programs, & Crisis Visits:** (ns over time or between groups)	Limited – Limited baseline data on services used	92% for entire 18 mos.

6	Caplan (2006)	Prospective 18 and 48 mos.	disorder (SUD) 75% Homeless > 1yr. Randomized	Both with Intensive Case Manage-ment (ICM)	**Perseverations:** (sg. improvement for those without substance abuse in ECH/deteriorated for IA) **Logical Memory, Continuous Performance Test for Attention:** (sg. improvement for both groups)	Acceptable	81% at 18 mo. and 59% at 48 mos.
7	Fichter (2006) Munich, Germany	Prospective 3 yrs.	Homeless adults N=129 84.5% M 15.5% F 70.2% SUD 80.9% Axis-1 disorder Non-randomized: High and low risk for deterioration groups	Board and Care Home vs. Therapeutic Board and Care vs. Community Housing	**Alcohol Consumption**: (sg. decrease for high risk group: 245g/d to 154 g/d) **Emotional Lability, Interpersonal Sensitivity, Depression, Anxiety, & Global Severity Index:** (sg. improvement over time for both groups) **Obsessive Compulsive Symptoms, Interpersonal Sensitivity, Depression, Anxiety:** (sg. group/time interaction for high risk group)	Limited – Limited information on housing & support interventions	73% for all three follow-up interviews (Baseline, 1 yr., 3 yr.)
8	Kessell (2006) San Francisco	Retrospect-ive Cohort 2 yrs. before & after housing	Homeless adult applicants to a supportive housing program N=249 73.5% M 24.9%F 1%T Non-randomized	Enrolled into SH vs. Usual Care (not enrolled in SH programs)	**Acute Health Services (i.e. ER, inpatient hospitalization) & Ambulatory Health Services (ie. outpatient clinics, community mental health):** (changes between groups ns)	Limited – No data on housing status of usual care group, or subset of SH group	93.5% (6.5% died during study period)

9	Mares (2009) 11 States	Prospective 12 mos.	Chronic Homeless Voluntarily Chosen N=734 76%M 24%F Avg. time homeless=8 years; 67% disabling medical condition	HUD Housing, Primary Medical Care, Mental Health & Addiction Services Support Services & Case Manage-ment Available	**Usual Health Care Provider, Number of Preventive Procedures, Number of Health Behaviors Discussed:** (sg. increase from baseline at 12 mos.) **Variable Change in Service Use Over Time** **QOL:(**sg modest increase) **SF-12 Mental Health, Psychological Distress (BSI):** (sg improvements over time) **Physical Health Function & Substance Use (ASI):** (ns changes over time) **Crack, Cocaine, & Marijuana Use:** (sg decrease in use over time 28-50%)	Acceptable	89% at 12 mos.
10	Martinez (2006) San Francisco	Retrospect-ive 2 yrs. before & after housing	Homeless adults with MI,CD, and/or HIV/AIDS N=236 73%M 27%F 100% Homeless > 8mo. Randomly chosen through lottery	Permanent SH – Low demand Support services available	**Emergency Service Use:** (sg. reduction over time, comparing 1 yr. before and after SH, for ER visits [53% to 37%]; total visits [457 to 202] **Medical** [378 to 154 visits] **Psychiatric** [79 to 48 visits] **Inpatient Admissions:** (sg. Reduction over time, comparing 1 yr. before and after SH, for number of admissions [19% to 11%]; total number [80 to 44]	Acceptable	NA

11	McHugo (2004) Washington DC	Prospective 18 mos.	Unstably housed adults with severe mental illness N=121 48%M 52%F 82.6%AA 85.1% Homeless Randomized Groups	Integrated - with CM on-site vs. Parallel - with mobile Assertive Community Treatment Team	**Service Use, Alcohol and Drug Use:** (ns) **QOLI, CSI, Interpersonal Violence:** (sg. improvement over time in both groups) **CSI:** (sg. Improvement for integrated) **QOLI:** (sg. gender/group interaction – males less satisfied with parallel)	Acceptable	84.3% over 18 mos.
12	Milby (2005) Birming-ham, Alabama	Prospective 12 mos.	Homeless adults with cocaine dependence and non-psychotic mental illness N=196 75% M 25% F Randomized Groups	Day Treatment – No Housing (NH) vs. Housing Contingent on Abstinence (HCA) vs. Housing Not Cont. on Abstinence (NACH)	**Abstinence Prevalence at 6 mos. and Treatment Attendance:** (sg. increase for HCA and NACH compared to NH)	Acceptable- Missing data on abstinence outcomes after 6 mos	66.7% HCA 62.7% NACH 42.4% NH

13	Nelson (2005) Toronto and Hamilton, Ontario	Qualitative Interviews: Narrative Analysis	Homeless adults with severe mental illness recently placed in supportive housing N=20 11M 9F Purposive Sample	Varied SH Models (independent and group living with support and rehabilitation services)	**Three Domains: Personal, Relationships, Resources:** (overall improvement in three domains after SH compared to youth and adult life before SH)	Acceptable	NA
14	O'Connell (2008) San Francisco, San Diego, New Orleans, Cleveland	Retrospect-ive 5 yr.	Homeless adult veterans who had psychiatric and/or substance use disorder *who were housed after baseline* N=392 95% M Randomized Groups	HUD-VASH: Section 8 Voucher - ICM vs. ICM only vs. Standard Care - with short term CM	**ASI Drug and Alcohol Subscales:** (sg. decrease for HUD-VASH compared to ICM) **QOLI:** (sg. improved for HUD-VASH compared to ICM and SC)	Acceptable	95% 1 yr. 85% 2 yr. 72% 3 yr. 58% 4 yr. 38% 5 yr.
15	Cheng (2007)	Retrospecti-ve Using Multiple Imputation Technique	Homeless veterans who had psychiatric and/or	HUD-VASH: Section 8 Voucher - ICM vs. ICM only vs. Standard	**ASI Drug Subscale, Days of Alcohol/Drug Use & Intoxication:** (sg. decrease for HUD-VASH compared to SC) **Days in Institutions:** (sg. decrease for HUD-VASH compared to ICM)	Acceptable	Complete cases HUD 41% ICM 27% SC 19%

		3 yrs.	substance use disorder N=460 Randomized Groups	Care - with short term CM			
16	Pollio (2000) St.Louis	Retrospect-ive 24 mo.	Homeless with mental illness N=113 Matched Groups	Stably Housed for 24 mo. vs. Not Housed	**Use of Health Services:** (ns) **Service Use:** (sg higher for housed group)	Unacceptable – no information on type of *health* services used – matched only on one variable.	
17	Siegel (2006) New York City	Prospective 12 mo.	Homeless or unstably housed adults with MI N=139 Propensity scoring and assignment to stratum	Community Residences (CR): with intensive support services and treatment, sobriety contingent vs. Supportive Housing (SH): Services separate from housing	**Crisis Service Use:** (sg. decrease over strata and over time for those *retained* in sample N=80 in SH compared to CR)	Acceptable	80% 12 mos.

18	Tsemberis (2004) New York City	Prospective 24 mo.	Homeless adults with Axis I diagnosis N=206 79% M 21% F Randomized Groups	Continuum of Care (CoC): Contingent on treatment & sobriety	**Alcohol and Drug Use:** (ns) **CSI**: (ns) **Substance Treatment Utilization:** (sg. increase for CoC)	Acceptable	88% 6 mos. 87% 12 mos. 84% 18 mos. 78% 24 mos.
19	Gulcur (2003)	24 mo.	N=225	vs. Housing First (HF): Not-contingent on treatment & sobriety	**Proportion of Time in Psychiatric Hospitals:** (sg. reduced for HF group especially those recruited from psychiatric hospitals – 50% lower at 12 mos.)	Acceptable	96% 6mos. 94% 12 mos. 90% 24 mos.
20	Padgett (2006)	48 mo.	N=225	Support services for both housing models	**Alcohol and Drug Use:** (ns) **Substance Treatment Utilization:** (sg. increase for CoC at 36 mos) **Psychiatric Services Utilization:** (sg. increase for CoC at 48 mos.)	Acceptable	87% 4 yrs.

21	Wolf (2001) Los Angeles	Prospective 16 mo.	Homeless adults N=249 Targeted sample	Exit to - Independent Housing (IH) vs. Dependent Housing - i.e. nursing home, prison vs. No Housing	**QOLI:** (sg. improvement for IH) **Post Exit From Homelessness Satisfaction & QOL:** (sg. increase for those who reported poorer health status at baseline) **Overall Life Satisfaction:** (exit from homelessness ns predictor)	Acceptable	Subset of larger sample N=502 84% with one f/u interview
22	Wong (2002) Northern California	Prospective Varying follow-up 3 mo.–1yr.	Homeless adults with and without severe mental illness (SMI) N=548 78% M 22% F Stratified Random Sample	Exit to - Own Home – i.e. apartment, home, or private room vs. No Housing or temporary arrangement	**CES-D:** (sg. reduction in distress for those with no mental/chemical diagnosis in their own apartment)	Acceptable - varying follow-up times	81% for follow-up interview

23	Wolitski (2010) Baltimore, Chicago, LA	Prospective 18 mos. "Housing & Health Study"	Homeless/Unstably Housed PLWHA N=630 Majority male, AA, >40 yrs., unemployed Randomized	HOPWA Housing vs. Customary Care (CC) Case management provided to all	**CES – D & PSS:** (sg. earlier improvement for HOPWA) **SF-36 (Physical Health):** (sg. earlier improvement for CC) **CD4 & Viral Load:** (ns improvement in intent-to-treat; homelessness sg. associated with detectable viral load in as-treated) **High Risk Sexual Behavior (e.g. 'sex trading'):** (improvement over time for both groups p=.07-.08) **Medical Care Utilization:** (sg. reductions over time) **HAART Utilization & Adherence** (ns changes)	Acceptable Higher % housed in CC than anticipated	At 18 mos: 82.5% HOPWA 51% For CC
24	Larimer (2009) Seattle, WA	Prospective Quasi-Experimental 6 mos. (control) and 12 mos. (housed)	Chronically homeless adults, highest users of alcohol-related services N=134 94% M Wait list control, propensity scoring	Housing First, no treatment requirements, on-site case managers	**Medical Center, EMS, & Sobering Center:** (sg. reduction in contacts over time for those placed in housing) **ASI/90-R TimeLine Follow Back** (In housing first group, 2% decrease per month in daily drinking, sg. decrease in days intoxicated over time)	Acceptable – attrition analysis conducted only on those who died while in the study	No mention of housing retention rates
25	Buchanan (2009) Chicago, IL	Prospective, Randomized Controlled Trial 12 mos.	HIV positive homeless adults N=105 Randomized	Permanent Housing (PH) with intensive case management vs. Usual Care	**Survival with Intact Immunity:** **(**sg. increase in PH - 55% in PH vs. 34% UC; 63% relative increase in survival) **Median Viral Load:** (sg. reduction in PH group - 1356 vs. 10,417)	Acceptable	No mention of housing retention at 12 mos.

26	Sadowski (2009) Chicago, IL	18 mos.	Single homeless adults with chronic medical illness being discharged from the hospital N=405 Randomized	Permanent Housing (PH) with intensive case management vs. Usual Care	**ER Visits, Hospitalizations, Hospital Days:** (PH group had relative reduction compared to UC – 24% ER, 29% hospitalizations, 29% hospital days) **Quality of Life:** (both groups reported improvement in physical and mental health over time)	Acceptable	66% of PH group housed at 18 mos.
27	Padgett (2007) New York City	Grounded Theory Analysis: Two life history interviews	Purposive sampling from previous housing study (Tsemberis et al., 2004) N=39	Housing First vs. Control Group	**Emergent Themes:** Control and self-determination, routines of daily life, privacy and freedom from supervision, identity construction and repair, and 'what's next' of having a home	Acceptable	N/A

* The following are general descriptions of the above housing types. See specific references for a full description of housing type and service model.

Low Demand Housing: Focus is on access to housing and services with minimal requirements such as treatment participation or sobriety. Conditions of tenancy are limited in their demands.

Permanent Supported(ive) Housing:Tenants retain all housing rights and responsibilities, and they can remain in their housing as long as they abide by the conditions of their lease. Services are offered to clients, but they are usually located off-site.

Integrated/Community Residences:Housing that has integrated services on-site. Community residences usually have congregate living arrangements, intensive services, and often require treatment attendance or sobriety.

Board and Care Homes: Congregate (i.e. multi-unit) residences with on-site management/supervision; usually offers a range of services and meals. Generally for those not 'ready' or able to live independently. Tenants usually receive one room and share common areas.

Parallel Housing: Permanent supportive housing where a mobile Assertive Community Treatment (ACT) team follows tenants. Services are 'parallel,' not integrated into, housing.

Evolving Consumer Households: Households where tenants live in community. This model begins with extensive on-site staff support and ideally 'evolves' into a self-sustaining community (without staff support).

Table 4. *Housing Providers and Associated Organizations*

Housing Provider	Organization
COHR (Collaboration of Housing Resources)	Spectrum, St. Stephens, Simpson Housing and the American Indian Community Development Corporation
Delancey Street	Guild Incorporated
Project Homeward	Mental Health Resources
Project SAIL (Support and Advocacy for Independent Living)	People Incorporated
Housing First	Catholic Charities
Homeless Assertive Community Treatment	Hennepin County, People Incorporated
Spectrum Homeless Project	Spectrum Community Mental Health
Women's Housing Partnership	Simpson Housing Services
Lydia Apartments	Spectrum Mental Health & Plymouth Neighborhood Foundation
St. Stephen's Street Outreach	St. Stephen's Human Services
Metropolitan Homeless Outreach Services (MHOP)	Hennepin & Ramsey County, People Incorporated
Frequent Users Service Initiative	St. Stephens
Redeemer's Arms Supportive Housing	Wilder Foundation

Table 5. *Description of Formerly Homeless Participants (N=16)*

Demographics						
Age	Gender	Race	Education	Marital Status	Veteran Status	Income
36-70 Range	11 M (69%)	Caucasian n=6 (37.5%)	Some High School n=2 (12.5%)	Single n=9 (56%)	Veteran n=4 (25%)	Temp. Work n=2 (12.5%)
50 Years (Avg.)	5 F (31%)	African American n=6 (37.5%)	High School or GED n=6 (37.5%)	Divorced n=6 (37.5%)	Non-Veteran n=12 (75%)	General Assistance n=4 (25%)
		Native American n=3 (19%)	Associates Degree n=4 (25%)	Engaged n=1 (6%)		SSI n=5 (31%)
		Asian n=1 (6%)	Some College n=4 (25%)			RSDI n=4 (25%)
						Social Security n=1 (6%)

Homeless History				Housing History			Health History	
Homeless as Child	Years Homeless	Primary Location	Years Housed	Housing Type	Primary Chronic Diagnoses	# of Meds	Primary Mental Health Diagnoses	Chemical Dependency
Yes n=6 (37.5%)	2-5 n=5 (31%)	Shelter N=5 (31%)	< 1 n=3 (19%)	Scattered Site n=9 (56%)	Diabetes n=5 (31%)	2-5 n=8 (50%)	Depression/ Anxiety n=6 (37.5%)	Alcohol n=8 (50%)
No N=10 (62.5%)	6-10 n=4 (25%)	Camp/ Car N=5 (31%)	1-3 n=9 (56%)	Congregate n=7 (44%)	HTN n=9 (56%)	6-10 n=5 (31%)	Bipolar n=3 (19%)	Hard Drugs n=4 (25%)
	10-15 n=3 (19%)	Street N=4 (25%)	3-5 n=4 (25%)		Cancer n=3 (19%)	11-20 n=3 (19%)	Schizophrenia Atypical Psychosis n=2 (12.5%)	None n=4 (25%)
	16-20 n=1 (6%)	Sub-standard n=2 (12.5%)			HIV/AIDS n=2 (12.5%)		PTSD n=1 (6%)	
	Over 20 N=3 (19%)				COPD/ Resp. n=6 (37.5%) Other (1 for ea.) Seizures, Kidney Disease, CHF		None n=4 (25%)	

Table 6. *Description of Service Provider Participants (N=11)*

Age	Gender	Race	Highest Education	Position	Years Relevant Experience	Care Model	Housing Model
28-64 (range)	2 Male (18%)	Caucasian n=11 (100%)	Bachelors n=6 (54.5%)	Case Manager n=5 (45%)	3.5-9 n=3 (27%)	Harm Reduction and/or Housing First n=7 (64%)	Scattered n=5 (45%)
45 (avg.)	9 Female (82%)		Masters n=4 (36%%)	Director or Manager n=4 (36%)	10-15 n=3 (27%)	Intensive Case Management n=2 (18%)	Congregate n=3 (27%)
			Doctoral n=1 (9%)	Registered Nurse n=2 (18%)	>15 n=5 (45%)	Sober Site-Based n=2 (18%)	Scattered & Congregate n=3 (27%)

Appendix B

Capacity to Consent Screening Tool

Assigned Study Number: _____

1. Is this research study voluntary? YES NO

2. If you choose not to be in the research study, will this change your regular care? YES NO

3. Once you begin the research study, are you free to stop at any time? YES NO

4. Is the research study guaranteed to help you? YES NO

5. If you drop out of the research study, will this change your regular care? YES NO

6. One of the potential benefits of the research study is:

   a) longer life
   b) an opportunity to reflect on your housing, health and health care
   c) free medications for pain
   d) a winter coat

7. One of the risks of the research study is:

   a) becoming physically ill
   b) you will have an emotional response to talking about homelessness and health care
   c) having to change doctors
   d) having to change housing service providers

Appendix C

Consent Form for Formerly Homeless Adults

Homelessness, Housing, and Health Geography

You are invited to be in a research study that will explore the impact of housing on the health and health care use of formerly long-term homeless, chronically ill adults. You were selected as a possible participant because you have experienced long-term homelessness and have been in housing for more than six months. We ask that you read this form carefully and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Dawn Petroskas, RN; Joan Liaschenko, PhD; and Dianne Bartels, PhD of the University of Minnesota School of Nursing and Center for Bioethics.

Background Information

The purpose of this study is:

To understand how your place of housing has impacted your health and health care use, and how your home has become a place of healing. The study will also explore your experiences with nurses during your transition into housing and after you were housed. Part of this study involves interviewing your housing and service provider about their perspectives on these issues.

Procedures:

If you agree to be in this study, we would ask you to do the following things: Participate in one individual interview in your home. This interview will be digitally recorded and transcribed verbatim. It is expected to last 2-3 hours. *You can answer all, some, or none of the questions*.

Risks and Benefits of being in the Study:

The study has one risk: You may experience emotional distress talking about the issues surrounding your time while homeless or about your health care experiences. The researcher will be sensitive to your feelings and stop the study if needed. Please let the researcher know if you become uncomfortable.

There are no guaranteed benefits of participating in this study. It *may* be helpful for you to share your feelings about these issues.

Compensation:

You will receive $20.00 cash compensation for your time upon completion of the interview. You will be asked to sign a receipt to receive this compensation.

Confidentiality:

The records of this study will be kept private. If any report is published, all information that will make it possible to identify you as a participant will be removed. All identifiers in the transcripts, such as names and places, will be omitted. All research records, tapes, and transcripts will be stored securely and only researchers will have access to them.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota, your housing provider, or your health care agency. **If you decide to participate, you are free to not answer any question or withdraw at any time without affecting these relationships**.

Contacts and Questions:

The primary researcher conducting this study is: Dawn Petroskas, RN. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at the University of Minnesota by calling 612.625-9396 or by email at deexx017@umn.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650 or email address: irb@umn.edu.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature:_____Date:_____

Signature of Investigator: _____Date:_____

Consent to Audiotape:

My signature below indicates that Dawn Petroskas has my permission to produce an audiotape of the individual interview in which I will participate. In this interview, I will be asked to share my impressions of how housing has influenced my health, and about my experiences with nursing.

The investigator of this study may utilize my comments in publications or presentations describing the study. Such presentations will not identify me.

Signature_____

Date_____

Appendix D

Handout for Service Providers

Homelessness, Housing, and Health Geography:
The Impact of Housing on the Health of Chronically Ill Homeless Adults

What's Known:

- Housing improves health - mental health, quality of life, chemical use, markers of HIV, risk behaviors
- Housing improves utilization of services – hospitals, ER, shelters, corrections

What's Missing:

- How/if housing improves chronic diseases
- The voices and stories of these people and their service providers/nurses

My Project:

- Qualitative – interviews with ~20 formerly homeless adults; 3 focus groups
- Through the lens of the academic discipline, Health Geography
- Funded by Minnesota Nurses Association Foundation

Recruitment Criteria:

- Able to give informed consent
- Formerly long-term homeless adult (>21; homeless for 1 yr. or 4x in 3 yrs.)
- English speaking
- In housing for >6 months but not more than 5 years
- Safe for me to interview privately

- **Has one of the following chronic illnesses:**
  - **High blood pressure, diabetes, seizures requiring medication**
  - **History of stroke or blood clotting issues**
  - **Renal disease**
  - **Heart disease (history of heart failure, heart attack, arrhythmias)**
  - **Asthma or lung disease requiring ER/hospital visit in the last 3 years**
  - **Cancer**
  - **Gastrointestinal bleeding, disease**
  - **Pancreatitis**
  - **HIV/AIDS**

- **Willing and able to reflect on their housing/health experiences for 1-2 hrs.**

<u>What I Need From You:</u>

- **Identify 1-2 people who would be good for me to talk with**
- **Introduce the study to them in a neutral way – give them handout**
- **If they are willing, set up a time for me to meet with them**
- **Participate in one focus group at my house – 2-3 hours**
- **Timeline: Interviews (April-June) – focus groups after**
- **Get your nurses involved**

Appendix E

Flyer to Recruit Participants

- You're Invited to participate in the –

Health & Housing Study

A nursing student at the University of Minnesota is interested in hearing your story.

You were homeless for a long time and then got housing …

What is it like having a place to call home?

How did getting housing impact your health and chronic illnesses?

Have you seen a doctor or a nurse since you've been housed – What was this experience like for you?

These are a few of the questions she would like to ask you.

Dawn Petroskas is a nurse at the University of Minnesota who is conducting a research study to see how housing impacts formerly homeless adults with a chronic illness. You were given this handout because you would be eligible to participate in the study. If you agree to participate, she would interview you at your home for 1-2 hours.

For your time, you will be given $20.00 cash.

Dawn's co-investigators at the University are Joan Liaschenko, PhD and Dianne Bartels, PhD. If you would like to contact Dawn or her advisors,
call: 612-624-9440 or
mail: N504 Boynton 410 Church St. SE
Minneapolis, MN 55455

Thank You!

Appendix F

Consent Form for Nursing and Non-Nursing Housing Service Providers

Homelessness, Housing, and Health Geography

You are invited to be in a research study that will explore the impact of housing on the health and health care use of formerly long-term homeless chronically ill adults. You were selected as a possible participant because you have assisted a formerly long-term chronically ill homeless adult with the acquisition or maintenance of housing. We ask that you read this form carefully and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Dawn Petroskas, RN; Joan Liaschenko, PhD; and Dianne Bartels, PhD of the University of Minnesota School of Nursing and Center for Bioethics.

Background Information
The purpose of this study is:

To understand how the place of housing impacts the health and health care use of formerly long-term, chronically ill homeless individuals. The study will also explore how the home becomes a place of healing for formerly homeless adults, as well as how nurses support the acquisition and maintenance of housing. Part of this study involves individually interviewing formerly homeless adults about their perspective on these issues.

Procedures:
If you agree to be in this study, we would ask you to do the following things: Participate in one focus group. The focus group will be digitally recorded and transcribed verbatim. It is expected to last 2-3 hours. *You can answer all, some, or none of the questions*. You are invited to talk with the researchers after the focus group one-on-one, if you wish to further elaborate on any issues discussed, but this is not required.

Risks and Benefits of being in the Study:
The study has two risks: (1) You may experience emotional distress talking about the issues surrounding homelessness, health, and healthcare use. The researcher will be sensitive to your feelings and stop at any time during the focus group. (2) You will be sharing personal information in a group setting. Though the researcher will ask all members to maintain confidentiality, there is a risk that group members will divulge the information you share to others.

There are no guaranteed benefits of participating in this study. It *may* be helpful for you to share your feelings about these issues.

Compensation:
You will receive a one-time payment of $50.00 for your time upon completion of the focus group. You will be asked to sign a receipt to receive this compensation.

Confidentiality:

The records of this study will be kept private. If any report is published, all information that will make it possible to identify you as a participant will be removed. All identifiers in the transcripts, such as names and places, will be omitted. All research records, tapes, and transcripts will be stored securely and only researchers will have access to them.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota or the housing provider you are affiliated with. **If you decide to participate, you are free to not answer any question or withdraw at any time without affecting these relationships**.

Contacts and Questions:

The primary researcher conducting this study is: Dawn Petroskas, RN. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at the University of Minnesota by calling 612.625-9396 or by email at deexx017@umn.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650 or email address: irb@umn.edu..

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature:_____Date:_____

Signature of Investigator: _____Date:_____

Consent to Audiotape:

My signature below indicates that Dawn Petroskas has my permission to produce an audiotape of the focus group in which I will participate. In this group, I will be asked to share my impressions of how housing has influenced the health and health care of formerly long-term homeless adults with chronic illnesses, and about how nursing supports the place of housing as a health care intervention.

The investigator of this study may utilize my comments in publications or presentations describing the study. Such presentations will not identify me.

Signature_____

Date _____

Appendix G

Structured and Semi-Structured Interview Guides for Formerly Homeless Interviews

1. Age:
2. Gender:
3. Ethnicity/Race:
4. Marital Status:
5. Veteran Status:
6. Educational Status:
7. Employment:
8. Income:
9. Children:
10. City of Residence:
11. Homeless History:
    - How many episodes of homelessness –
    - How long was each episode –
    - What caused you to become homeless –
    - History of child homelessness –
    - Location of homelessness –
    - Type of homelessness (e.g. street, shelter, camp) -

12. Housing Type:
    - Housing Choice (i.e. Did they get to choose where they live) –
    - Housing Integration in Community (i.e. Scattered site vs. congregate housing) –
    - Housing Rights (i.e. Housing secure even if they do not comply with the program) –
    - Service Choice (i.e. Do they have a right to refuse services) –
    - Services Separated from Housing (i.e. Are support staff on or off site) –
    - Referrals to other Services (i.e. Are referrals to other services available)

13. Health History:
    - Chronic Illnesses –
    - Mental Illnesses –
    - Chemical Dependencies –
    - Disabilities –
    - How often do you use health services –
    - Where do you receive services –

Research Questions	Interview Questions
How do formerly long-term homeless adults with chronic illnesses describe the place effects of housing on their health and healthcare utilization patterns?	**In terms of your health and (insert chronic illness), what about housing has been good or bad for you? Why? How does it do …?** • How has housing influenced your health? If housing has not influenced your health at all, why do think that is? • How does housing help you take care of yourself? Has it made it easier or more difficult? • How has housing changed your feelings about yourself or others? • What are specific features of housing that you think people who have never been homeless would take for granted?
How do the places and spaces of homelessness impact the management of illness?	• What health concerns or fears did you have before getting a home, what about now? • Tell me about what was like to manage a chronic disease while you were homeless? What is it like now? • Many people find that going to the clinic is hard when they're homeless, what do you think? How has housing made it easier or more difficult to go to the clinic, take your medications, or stay out of the hospital?
How does a home become a therapeutic landscape for formerly homeless adults with chronic illnesses?	**I imagine it would be quite a change from being homeless to having a home. Tell me your story – how did this change take place for you?** • How you were able to move into housing? • Who helped you make that transition? • What was that transition like? • Tell me what life is like for you now, compared to when you were homeless. • What makes this place your home, and how did you make it feel like your home? • Tell me about what this place means to you? • What is it like to have a place that you can call home?
What are the ways nursing supports formerly long-term homeless adults with chronic illnesses in their homes?	**The last thing I'm curious about is your experiences with nurses. Tell me about some of these experiences, while you were homeless and after getting into housing.** • While you were homeless, what were some of your encounters with nurses like? Did they ever talk to you about housing? • Have you ever had a nurse help you get settled into housing? • If there is a nurse on (team name), what does he or she do for you? • What are your perceptions of nurses? • How have nurses demonstrated to you that they understand homelessness and the importance of housing?

Appendix H

Structured and Semi-Structured Focus Group Guides

1. Age:
2. Gender:
3. Ethnicity/Race:
4. Marital Status:
5. Veteran Status:
6. Educational Status:
7. Agency/Years of Employment at Current Agency:
8. Relevant Past Experience (i.e. in homeless or home care field):
9. Agency/Supportive Services & Housing Type:
    - Brief history of mobile support team (i.e. when it started, funding, etc.) –
    - Who provides support services –
    - Average case load –
    - Particular care model –
    - Housing Choice (i.e. Did they get to choose where they live) –
    - Housing Integration in Community (i.e. Scattered site vs. congregate housing) –
    - Housing Rights (i.e. Housing secure even if they do not comply with the program) –
    - Service Choice (i.e. Do they have a right to refuse services) –
    - Services Separated from Housing (i.e. Are support staff on or off site) –
    - Referrals to other Services (i.e. Are referrals to other services available)

Thank you all for coming. Just to recap a bit about the study – I have interviewed 16 folks about how housing has impacted their health, and what the transition was like for them to get into and 'settled' in to housing. They've had some amazing insights, and I plan to share some of them with you as we go along. For this group, I would like us to have a conversation kind of in sequence with *before* housing (what that's like), then how your folks get *settled in* to housing (if they do), and then the bulk of the discussion will be around how their life, and specifically their chronic health, changes *after* housing.

Before Housing:

1. Describe the process of 'picking a place' for your clients? How do you decide where folks are going to live? (for those on-site – talk about assigning a room)

2. How are the places they end up a good, or not a good, fit for them?

Transition: - "after what you went through in the street; you still have that same frame of mind even though you're in a place … it doesn't go away over night; that takes time"
(ex: scary but happy 1st night, often it's the 2nd place that works out best)

1. What is it like for your people to transition into housing?

2. How do your clients make their places into their homes?
   (what do their places tell you about them)

After Housing: - "when I was living on the street, my thinking was real fast. Not real fast smart-wise, but I have to do this, I have to do that. I wasn't really paying attention to the world then when I was on the streets. Now that I'm in housing, I'm starting to focus, like binoculars, when they're blurry and you focus them. I: How does housing help you do that? R: Well, for the simple fact that I feel like I have a life now; I feel like I'm a person. I feel like I've achieved something, which is housing, and I'm starting to achieve other things … I guess I feel normal now."

1. How do people's lives change after housing?
   Physical Appearance
   Chronic Health
   Mental Health

2. Do your clients ever talk about what housing means to them? What do they say?
   (how about their keys)

3. How do the places they go, the people they see, the things they do, change after housing?
   - New hobbies
   - New friends
   - Reconnect with families

4. Think back to your sickest clients, tell me about how they take care of themselves and how they manage their health, now that they have housing.
   - Have you witnessed changes in their health and health care use?
   - Changes in their health literacy?

5. How do service providers support their health and health care use?

6. Assuming that you've gone to appointments with clients …
   - How are you able to direct a person's plan of care, having a sense of where they live and come from? How is place significant to their care?
   - How does knowing a person's day-to-day lives and the places they live make it easier to care for people?

Nursing

1. What are some of the things that nurses on your team do to care for your clients?
   To support their physical health, chronic disease management.
   To support their mental health.

2. How could nurses be used in your housing programs, if they are not already?

Nursing Specific Questions for Focus Group

Nursing

1. What are some of the things you do to care for your clients?
   To support their physical health, chronic disease management?
   To support their mental health?

2. What is your ultimate goal for your clients once they get into housing?

3. Assuming that you've gone to appointments with clients …
   - How are you able to direct a person's plan of care, having a sense of where they live and come from? How is place significant to their care?
   - How does knowing a person's day-to-day lives and the places they live make it easier to care for people?

4. Talk about what it is like as a nurse who practices harm reduction? How do you balance your desire to see the ideal versus the real?

5. Have you witnessed a change in people's "health literacy"?

6. What is it like being able to practice nursing independently, versus taking an order from a doctor about the plan of care? Would your work change if you had medical oversight?