

**Through the cracks:
An examination of women, homelessness and health care**

by

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ABSTRACT

This study provides a unique perspective on health care and emergency shelter services for older women dealing with homelessness as well as complex health care needs in the city of Toronto. Qualitative interviews with frontline shelter staff highlight the assumption that older women who are discharged from hospital will be cared for in an institutional setting such as an emergency shelter. Discussion focuses on how this assumption fails to adequately meet the needs of older women and how lack of adequate housing has a negative impact on their access to healthcare.

Key Words: homelessness, women, senior, health care, end of life, shelters

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DEDICATION

To all the women who find themselves at the intersection of homelessness and health care with no one listening.

And to Peggy, who I had the honour of meeting only briefly, but who inspired this entire project and changed who I am as both a practitioner and a person.

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1. Introduction

Homelessness is not a new phenomenon in the city of Toronto. As far back as 1999, the City of Toronto released an action plan to deal with the increasing number of people finding themselves without adequate shelter within the city (Report of the Mayor's Homelessness Action Task Force, 1999). Unfortunately within our neoliberal society the focus tends to put blame and responsibility on the individual. This can make it easier to both negate those who are homeless and also reduce our own responsibility regarding the systems that continue to marginalize these individuals.

For the purposes of this study, the 2012 Canadian Homeless Research Network's definition of homelessness will be used:

“Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing” (CHRN, 2012, p 1)

This definition includes those who are living on the streets, those staying in emergency shelters, those who are provisionally accommodated in places like hospitals, jails or couch surfing, as well as those who are at risk for becoming homeless due to precarious housing stability.

For women in particular, the experience of homelessness is never homogenous. A multitude of factors interact that contribute to women finding themselves without adequate or safe shelter.

These factors can include broad macro level societal issues such as lack of affordable housing, racism and discrimination, as well as micro factors such as an individual's physical health, mental health or substance use (Ontario Women's Council, 2002; Street Health Report, 2007).

The majority of services for the homeless have been directed towards men due to the larger number of men who are homeless (Kisor and Kendal-Wilson, 2002; Ontario Women's Council, 2002). Women's services have been adapted from these services but still fail to meet the unique requirements of this population. This study will examine the smaller subset of aging women dealing with homelessness and who require ongoing health care as an alternative to staying in hospital.

As the focus in health care shifts towards a more neoliberal model of health care services delivered in home as opposed to hospital (Local Health Integration Network, 2011), there exists the distinct exclusion of those who do not have a home to receive these services. While health care resources become increasingly scarce, those who are already marginalized within our society are left particularly vulnerable. Older adults in particular are underrepresented in research on homelessness (Ploeg et al, 2008), resulting in a distinct lack of policy around the specific issue of health care for older women dealing with homelessness and living in emergency shelters.

This study will initiate a dialogue of front line workers who work with older women dealing with health issues and homelessness. Particularly the access, or lack thereof, to home care

services when these service users are released from hospital into emergency shelters within the city of Toronto.

My personal connection to this study is that I am currently a frontline worker in a homeless shelter for women. As a graduate of Ryerson University's Bachelor of Social Work program, I have learned to critically locate, analyze and challenge institutional and structural oppression. In my personal life, I was a caregiver to my grandfather until his death. I have been consistently struck by the differences between the services available to people like my grandfather who owned their own home and had family supports, in comparison to the service users I worked with every day. I knew coming into this Master's program that I wanted to focus my research on this topic.

In my work on the front lines, I have witnessed the changes within the shelter system in regards to older women with complex health care needs being discharged into shelter. My first experience with watching a woman fall through the cracks of these two systems was at the beginning of my career with a client named Peggy (name changed to protect privacy). Peggy arrived at our shelter on a Friday night at 4:30 pm after spending the night sleeping on the streets in her wheelchair. She was an elderly woman actively dying of cancer but who no longer wished to stay at the hospital. Whether she was formally discharged or left of her own will was never clear. What had been made clear to her was that no more care would be provided for her. As she had been labeled a former addict, she was prescribed no pain medication by the medical professionals she encountered. This label prevented her from living her last days with proper pain control to alleviate some of her discomfort, almost as if a punishment for behaviour the

medical community deemed unfavourable. She was unable to take herself to the bathroom and my colleagues and I would carry her to the bathroom when needed. We spent the weekend warming up blankets to help keep her warm. By Monday, she had died. She was only with us for two and a half days; a short stay even by shelter standards.

A few days later, word came from a worker from an outside agency that Peggy had told her before she died that the treatment she received those two days at our shelter had been the kindest she had ever experienced. Those words had a tremendous impact on me. Professionally, I do not think I have ever felt so defeated as a social worker. The idea that this woman spent her last few days alive in an uncomfortable, busy shelter surrounded by staff that barely knew her was incomprehensible to me. The fact that for Peggy, it was the best treatment she had received made me unbearably sad. I have often witnessed the marginalization that happens to women experiencing homelessness but this was an example of a woman who had fallen so badly through the social service cracks that she was surprised by even the bare minimum of decency in treatment while she was dying.

Sadly, Peggy's is neither the first nor last situation to unfold the way it did. Senior women dealing with homelessness and complex health care needs are being failed by at least two large institutions: hospitals and emergency shelters. My goal in this Major Research Project is to highlight this phenomenon and begin the discussion around what is happening to women who find themselves falling through the cracks at the intersection of hospitals and emergency shelters.

2. Literature Review

i. Homelessness and Health Care

People dealing with homelessness are often living in crisis mode. The lack of stability that accompanies the lack of such a fundamental basic need as appropriate housing can wreak havoc on a person's health. Those who are dealing with homelessness face both an increased level of poor health as well as a higher risk of premature death compared to those who are not homeless (Hwang, 2001; Wen, Hudak and Hwang, 2007; Podymow, Turnbull, Tadic and Muckle, 2006).

Hwang (2001) contends that these higher risks have significant effects on both the individual's personal health and also the on the healthcare system at large. Research in both the United States and Canada contends that those who are affected by homelessness are more likely to use the emergency department as their primary source of health care (Hwang, 2001; Schanzer, Dominguez, Shrout and Canton 2007; Wen et al., 2007; Khandor, Mason, Chambers, Rossiter, Cowan and Hwang, 2011; Podymow et al. 2006). Khandor et al. (2011) found that the likelihood of having a family doctor decreased for every year an individual spent homeless in the city of Toronto.

One study out of the United States, found that health status increased when individuals entered emergency shelters (Shanzer et al., 2007). This was mainly attributed to increased access to health care and health insurance while staying in the shelter. Many studies looking at homelessness and access to health care are conducted in the United States and are usually

centered around access to health insurance which has little implication for countries with universal health care such as Canada (Khandor et al., 2007). Khandor et al., (2007) is one of the few articles that focused on the access to primary health care among Canadians dealing with homelessness without the variable of health insurance or lack thereof as seen in the American literature. Analyzed results from the 2007 Street Health survey were used along with interviews, but those who did not speak English were excluded from the interview portion of the study. Of the 34% of participants found to not have a health card, only 7% were not eligible for provincially funded health care. As those who did not speak English were not included in the interview portion, this study does not capture the experience of those who are not eligible for health care in Canada and who are also dealing with homelessness.

A common theme in the literature of homelessness and health care is that many who are homeless ultimately feel discriminated against based on their status of homeless. Negative interactions with healthcare practitioners was cited in the interviews conducted by Khandor et al. (2011) as a motivating factor as a detriment to seeking health care. Wen et al. (2007) found that most participants in their study perceived unwelcomeness from health care practitioners as acts of discrimination. These negative interactions can prevent people from accessing preventative health care that may in turn increase disease severity and may explain the reliance on emergency departments as primary care options.

ii. Homelessness and End of Life Care

The experience of discrimination and negative interactions with service providers continues to be noted in a small but critical section of literature that delves into the end of life experiences of those dealing with homelessness. There appears to be an understanding that an aging population with normal aging processes combined with the higher than normal illness and mortality rates of those who are homeless, result in unique demands being placed upon the health care system, service users, and service providers (Chapleau, 2010; McNeil, Guirguis-Younger and Dilley, 2012; Song, Bartels, Ratner, Alderton, Hudson and Ahluwalia, 2007; Tarzian, Neal and O'Neil, 2005).

Tarzian et al. (2005); Song et al.(2006); and McNeil et al.(2012) all note that those who are homeless are more likely to be discriminated against while receiving end of life care. This discrimination can arise from systemic barriers such as socioeconomic status, racism and lack of developed services, but discrimination can also arise due to more personal factors such as mental health and addiction. Various literature concurs that many individuals dealing with homelessness are less likely to be accepted into hospices or long term care facilities due to substance use and behavioural concerns (Chapleau, 2010; Song et al. 2006; McNeil et al., 2010; McNeil and Guirguis-Younger, 2011). As most hospices operate under a no tolerance policy for substance use, this can produce feelings of judgment and further isolate those seeking end of life care, which can result in people dying on the street or in emergency shelters (Chapleau, 2010).

Literature on end of life care originates from the United States and focuses mainly on homeless individuals who are also substance users (Song et al., 2006; Song et al., 2007; Tarzian et al, 2005; Chapleau, 2010). Four of the studies reviewed took a qualitative, narrative approach to the research and enlisted speaking to service users and service providers. Three studies utilized focus groups (Tarzian et al., 2005; Song et al, 2006; Song et al., 2007) all of which contained themes concerning lack of respect from health care practitioners, barriers to accessing services, and discrimination. Song et al. (2007) noted what they termed a common theme of “fatalistic attitude” among participants with one participant comparing the act of dying to the act of becoming homeless:

“It’s just like dying, it happens. All of a sudden, I look up and I’m homeless; I’m in a shelter; I’m eating at the shelter; I’m dealing with other homeless people”
(Song et al., 2007, p429).

The acknowledgement that those who are homeless have a unique perspective on death and dying is both important and imperative to the research on this subject, something that is noted but requires further exploration.

A more recent study interviewed only two participants staying in a long-term residence specifically for those who are homeless and have been diagnosed with terminal illness in a large urban setting in the United States (Chapleau, 2010). This study had one male and one female participant, both of whom had been categorized as chronically homeless. Systemic issues such as poverty, lack of affordable housing and inability to access mental health services were noted but a strong emphasis was placed particularly on the personal factors contributing to the participant’s experience of homelessness. It should be noted that the female participant is

described as having an “anti-authority perspective” stemming from childhood abuse and being a survivor of rape (p 396). While the participant herself appears to have internalized the label of being “self destructive”, “impulsive” and “rebellious”, there should be a more in depth discussion around how her exposure to violence and abuse contributed to her homelessness and thus her end of life experience. Women specifically encounter unique and differing systemic barriers that contribute to homelessness, which will be further examined and discussed in this study.

Canadian research on end of life care notes that the palliative health care system is both underfunded and struggling to keep up with the ageing population (McNeil et al., 2012). Two studies in particular focus on the experiences of Canadian service providers who interact with those dealing with homelessness and end of care service delivery (McNeil and Guirgius-Younger, 2011; McNeil et al., 2012). Social service professionals included physicians, nurses, shelter directors, outreach workers, and personal support workers from six Canadian cities who dealt directly with palliative individuals who were also homeless. McNeil and Guirgius-Younger (2011) focused specifically on illicit drug use as a barrier to receiving end of life care and notes that this population seeks end services in various settings such as drop in centres, emergency shelters, meal services and emergency departments, where service providers may not be trained in end of life/palliative care. In particular, one participant noted that in a shelter environment, staff may not be prepared or equipped to deal with end of life issues or services. This is of significant importance as those who are homeless are regularly discharged to shelter settings from hospitals (Song et al., 2006; McNeil et al., 2012; Hwang, 2001; Chapleau, 2010).

The existing literature fails to adequately include those who do not use substances and find themselves dealing with end of life care and homelessness. The focus that existing literature places on those who use substances serves to distract focus from larger systemic issues such as the effect that gender, race, age, and socioeconomic status have on end of life care. It fails to include individuals who do not use substances but still find themselves struggling with homelessness while needing end of life care. By only examining substance users, the emphasis is placed on the individuals own barriers to health care instead of examining systemic structural barriers. While the literature is predominantly qualitative, sample sizes are small with an even smaller amount of female participants. While a portion of the literature references aging populations (McNeil et al., 2012; McNeil and Guirgius-Younger, 2011; Song et al., 2006), there is minimal exploration into the chronic illnesses that an older population faces that may not be palliative but would require ongoing care not normally found in emergency shelters or services for those who are homeless.

iii. Homelessness and health care and women

While men make up a significant amount of the homeless population in Toronto, there is a relatively large population of single women dealing with homelessness (Cheung and Hwang, 2004). Between 1992 and 1998 there was a 78% increase in shelter use among single women attributed to lack of affordable housing and cuts to social services (Ontario Women's Health Council, 2002). Single women dealing with homelessness have unique health issues when compared to single men and women with children (Cheung and Hwang, 2004). When compared to the general female population, single women who are homeless have higher

mortality rates, lower general health, higher rates of mental illness and substance abuse, and are more likely to be victims of violence (Teruya, Longshore, Andersen, Arangua, Nyamathi, Leake and Gelberg, 2010; Street Health Report, 2007; Ontario Women's Council, 2002). Women tend to be less visibly homeless, often moving from place to place or staying with friends and family (Street Health Report, 2007; Ontario Women's Health Council, 2002), which can affect their access to primary care and result in fragmented service due to the difficulty in maintaining primary care when transient.

There are far fewer studies examining women as a subgroup of the homeless population than their male counterparts (Kisor and Kendal-Wilson, 2002; Ontario Women's Health Council, 2002; Cheung and Hwang, 2004). The most comprehensive cross sectional study from the United States examining health and health care disparities among homeless women in Los Angeles examined the effects of race on both individual health outcomes and barriers to accessing health care (Teruya et al., 2010). The study found that white women were more likely to report decreased health and poorer health outcomes compared to their racialized counterparts despite the fact that women of colour experienced a greater level of poverty, discrimination, and had a harder time accessing affordable housing resulting in a disproportionate level of homelessness. The researchers attributed this to the differing ways in which women find themselves homeless but failed to specifically examine how the inherent privilege afforded to white women allows them to be able to freely report their experiences with poor health care.

As the majority of services for those who are homeless originated for the male population, many of the distinctive issues faced by their female counterparts are overlooked. (Ontario Women's

Council, 2002; Kisor and Kendal-Wilson, 2002). Women who are dealing with homelessness face increased exposure to both domestic and sexual violence. Women have the added responsibility of family planning, which can be difficult to access when living on the street or in shelter. The Street Health Report in 2007 suggests that the overarching need for women who are homeless is access to safe and stable housing where they are free from the threat of violence.

iv. Homelessness, older women and health care

There is little literature on older or elderly adult women who are homeless. Davis-Berman (2011) notes that women age 50 and up are more likely to be first time shelter users, have fewer social supports, and have more difficulty adapting to life in a shelter setting.

Cheung and Hwang (2004) examined the rate of mortality for homeless women in Toronto and found that younger women were at higher risk of premature death but only examined women aged 18-64, which completely excludes elderly women who are homeless. While the current research shows that those who are homeless are more likely to be discharged from hospital to an emergency shelter (Ontario Women's Health Council, 2002; Song et al., 2006; McNeil et al., 2012), there is limited literature on older women who are homeless and in need of ongoing health supports.

Examining older women who are homeless is essential as the population ages. Age can already be considered a mitigating factor for older women who tend to live on a fixed income, have longer life expectancy (which may surpass savings or pensions), and have difficulty accessing social supports (Kisor and Kendal-Wilson, 2002). The addition of the greater health burden and

risks associated with homelessness cause older women who are homeless to face significant barriers that urgently need to be addressed.

There is a significant gap in the literature in relation to older women who are dealing with ongoing health issues while trying to navigate the emergency shelter system. The aim of this major research paper is to start the conversation about current practices and realities that leave older women marginalized while at the intersection of homelessness and health care.

Specifically, how appropriate is it for hospitals to discharge older women with health issues into emergency homeless shelters? How does the availability of resources affect their stay in shelter? Are emergency shelters in Toronto capable of dealing with the needs of this unique population? This major research paper will begin to examine these questions in order to highlight the reality that currently exists within the shelter system.

3. Theoretical Framework

My personal understanding of anti-oppressive theory has been influenced strongly by critical, anti-racist, queer, postcolonial and post structural theories. These theories inform my understanding of anti-oppressive theory in both my research and my practice. I have spent the last five years working from an anti-oppressive framework on the front line in an emergency shelter for single women. While my workplace is a large institution, I believe it is imperative to bring a critical lens to this work. In order to further social justice, one must challenge the dominant discourses that exist in what can be an oppressive and neoliberal space for marginalized individuals attempting to access shelter.

Silva, Smith and Upshur (2013) note that the intersection between public health policies and social justice will become more important for marginalized individuals who face barriers to accessing health care as the majority of our society continues to age. As this study will examine, it is already imperative that this intersections be explored The Ontario Local Health Initiative Network (LHIN)'s Home First policy is an example of older homeless women being placed as the 'other' within our society. In order to conserve hospital resources, this policy relies solely on the concept that all individuals who are hospitalized should be prepared to be discharged home as soon as medically feasible. It completely ignores the very idea that not all individuals have adequate housing to even be discharged. Not only are their health care needs not being served by this policy, older women who are homeless and ill are ignored altogether. The emphasis is on conserving resources and money, not on access to healthcare.

A feminist perspective can be used to deconstruct the dominant, neoliberal ontological assumptions that currently inform practice and policy that surround housing, healthcare, and emergency shelter. To do this, we must examine how the political climate affects the reality of these women. Current public policy that aims to cut resources from social program, housing and health care creates the perfect storm that leads older adult women finding themselves discharged from hospital to shelter and falling through the cracks. The overall lack of health and social services, the lack of safe and affordable housing results in the continued discrimination of older women with disabilities, older women of colour, and older Indigenous Women who find themselves homeless and sick. Women are distinctly and irrevocably affected by the feminization of poverty (Pearce, 1978) and this is particularly true for the women this study aims to examine. A hierarchy exists between women who have access to adequate housing and healthcare and those who do not.

A feminist post-modern framework allows us to deconstruct the current dominant discourse of “the bag lady” that surrounds older women dealing with homelessness (Kaiser and Kendall-Wilson, 2012). The imagery of the bag lady conjures up visions of mental illness, hoarding and dirtiness which positions the older woman on the margins of society. For those women that I work with on the margins, this preconceived imagery means that they often find themselves ignored. At times you see people cross the street to avoid having to contemplate the very existence of the “bag lady” or how they have come to get there. On a daily basis these women face being ignored by the general population, many of the professionals they come in contact with and the public policies that affect them. Our society has been conditioned to think of homelessness as a result of undesirable personal characteristics such as mental illness or drug

use rather than as a result of political and social structural oppression. This major research paper will focus on highlighting the lack of attention, resources and support available for older women who are homeless and dealing with illness.

4. Methodology

The purpose of this major research project is to explore the topic of older women dealing with homelessness and health issues through the experiences of frontline workers and key informants within the city of Toronto. This qualitative phenomenological exploratory study utilizes qualitative interviews with three front line workers and key informants who have first-hand experience working with this population. These interviews provide an initial examination of the topic within the scope of the Major Research Project. This qualitative data provides a unique perspective on health care and emergency shelter services for marginalized women who are dealing with homelessness as well as complex health care needs. This qualitative research project aims to provide an initial discussion with those workers on the front line who work directly with women trying to navigate two large systems within the city.

Potts and Brown (2005) suggest that three fundamental principles that inform anti-oppressive research: anti-oppressive research is social justice and resistance in process and outcome; anti-oppressive research recognizes all knowledge is socially constructed and political; and anti-oppressive research is about power and relationships (p.259). These are important foundations that seek to challenge the dominant positivist construction of knowledge. The qualitative interviews in this study allow for a more thorough examination of the relationships between front line workers and service users. Participants were asked to locate themselves within the research while sharing their experiences from their personal perspective.

Qualitative, anti-oppressive research proposes that knowledge should come from those who experience the reality and not those who have political or social control (Creswell, 2013; Moosa-Mitha, 2005; Potts and Brown, 2005). It should be noted that front line workers are inherently placed in a position of social control, which was acknowledged by both researcher and participants. This does not discount the experiences of frontline workers but the inherent power differentials between frontline workers and service users must be acknowledged and examined throughout this major research paper. Positivist epistemologies place the researcher in the position of power and the creator of knowledge. Anti-oppressive and critical research seeks to dismantle that paradigm and shift the focus to creating and co-constructing knowledge with those who are marginalized. To that end, participants were informed that they could have as much or as little involvement in the research as they were comfortable. Our knowledge as anti-oppressive front line workers is created through our work with those who are marginalized but our knowledge does not speak for them. Participants were not asked to speak for their service users but rather share their experiences and stories from working with those who are marginalized.

This is a small, qualitative study that examines the lived experiences of frontline emergency shelter workers that work with older women dealing with complex health care needs. As such, only three qualitative interviews were conducted. This method was chosen as there was limited research regarding the topic of women, homelessness and health care. Consequently, I wanted to examine the topic through initial discussion with front line workers to ascertain a better understanding of the issue. As the scope of this major research project is limited, the small sample size cannot be extrapolated to speak for the experience of all front line shelter workers.

As both a researcher and a front line worker, I was in the unique position of wearing two hats during this Major Research Project. I was genuinely curious, both as a researcher and a front line worker, if the things I was seeing in my experiences were being noticed by other front line worker in other shelters. I was very aware that I came into this researcher with my own professional experiences and it was important to the research that my own experiences not influence the data. It was both important and imperative that while drawing on my own experiences as a front line worker that I maintained confidentiality. This was something that I continually informed my entire research process.

i.Design

Recruitment was done through purposive sampling. Three potential participants who had self identified as front line workers, verbally indicated their interest in participating to the researcher. All three participants were previously known to the researcher through interactions within the professional community. Two participants expressed interest in participating after hearing about the researchers intention to conduct this major research project and one participant was directly approached verbally by the researcher. They were given copies of the flyer (Appendix A) and communication was done through phone to set up the actual interviews.

As required by the Ryerson University Research Ethics Board, which approved this research project, participants were informed of the nature of the study, specifically that they would have a chance to speak directly about their experiences working with marginalized women who have

been discharged from hospital who require their ongoing health care needs to be met while staying in an emergency shelter. Participants were informed of steps being taken to ensure confidentiality prior to the beginning of the interview. They were provided with a copy of the consent (Appendix B) and given a chance to read and make any inquiries they had regarding the consent. After explaining the participatory nature of the interviews, each person was asked to sign the consent. All three participants agreed to participating and signed the consent. All three participants also consented to audio record the interviews.

One hour in depth interviews were separately conducted with each participant. The location of each interview was as agreed upon by the participant in a private location of their choosing. The interview was guided by semi-structured interview questions approved by the Ryerson Ethics Board (Appendix C). Questions posed to participants were meant to gather the lived experiences of frontline workers and key informants in the shelter system within the city of Toronto. The aim was to allow participants to reflect on their unique experience providing services for older women dealing with homelessness and ongoing health care support within the shelter system.

Each interview was set for a one hour period. Interviews were recorded and the audio from each recording was transcribed. The transcripts were then analyzed for emergent themes based on identical or similar content. Each theme was initially colour coded until all transcripts were analyzed. These themes were then categorized into the following headings: gender, access to health care resources, age, staff issues and shelter resources. Analysis focused on each distinct theme as it's own topic followed by an examination of possible relationships between themes and how they may influence one another. This will be further discussed in the Findings chapter.

ii. Participants

Participants were given the opportunity to choose a pseudonym that would be unique to them. All participants self identified as female and have worked in a front line capacity within homeless shelters within the city of Toronto.

Mya - Mya has worked with women experiencing homelessness for over ten years. She has worked with men, women, women with children and refugees dealing with homelessness. She currently describes her role as being a service system manager.

Keisha Ray - Keisha Ray began her career working with youth experiencing homelessness. She has worked directly with women experiencing homelessness between the ages of 24-100 for the past eight years.

Callie - Callie has over twenty years experience working with homelessness within the city of Toronto. She previously worked in a detox setting within a hospital and has worked directly with men and women experiencing homelessness.

iii. Benefits

Potential benefits include participants having the chance to voice their observations regarding working with this unique population while also being able to express any concerns or possible solutions so they may identify from their experience.

iv. Ethical Considerations

This Major Research Paper (MRP) is intended to be of minimal risk to participants as every effort will be made to keep identifying information private. Participants were asked to relate their experiences working with clients who require specific health care services while staying within the shelter system. While there is some risk of clients being identified, every possible effort was made to keep the identification private of both participants and any third party of which they may speak. All named shelters and shelter users, both male and female, were redacted in the transcripts to prevent identification. Participants were informed from the onset of the interview that any names or identifying information would be removed from the transcripts by the principal investigator. Participants were informed that this is a voluntary research project and that they were free to withdraw from the study at any time should they wish with no consequences.

5. Findings

While the interview guide partially directed the nature of the interviews, several themes emerged that will be discussed in this section.

1. Lack of Attention to the Needs of Homeless Women

As all participants identified as working with women experiencing homelessness, gender was a theme woven throughout the interviews. Consistent with the literature, all participants noted that women find themselves entering the shelter system later than men and are more likely to have experienced violence and trauma before entering the shelter system.

They don't get as much attention as men do in the sense that there aren't as many of them in numbers. They are coming in at a much more later part of their life where they are more complex. (Mya)

The fact that women are coming in at later parts of their lives is directly relevant, as this study aims to examine the intersection of homelessness, age, gender, and health. The complexities for older women dealing with health issues and homelessness are compounded by the fact that there are no services directly designed to address the issues of these service users.

i. Discrepancy between services by gender

Currently there is a significant discrepancy between the services offered to men with complex health care needs who are dealing with homelessness and their female counterparts. A large downtown male shelter offers services for men who are dealing with health issues and/or end of life care. No such unit exists within the women's sector.

.....they actually have that unit where this is the only type of clients that are there. We don't have that for the women's shelters. This is it, basically right now. There is a lot more available out there for men currently right now. (Keisha Ray)

The supports are there for men, not even that great, but at least they are there and they are not there for women. (Mya)

Mya and Callie noted that the larger number of men who experience homelessness directly affects how and what services are generated and for whom. While there may be a higher number of men dealing with homelessness, the discrepancy between the overall number of people requiring services based on gender does not lessen the impact of the situation for women. Participants found that the smaller number of women dealing with homelessness face higher marginalization as they do not receive the same policies or programs as men because they are smaller in number.

ii. Barrier to accessing health care

All three participants acknowledged barriers for women dealing with homelessness while trying to access adequate health care. These barriers significantly impact women's ability to navigate

the healthcare system, particularly once they have become hospitalized. Language, cognitive difficulties, emotional and mental health were all barriers listed by all three participants. The inability for women to communicate their needs with healthcare providers was cited by all three participants as the most significant barrier to accessing appropriate health care for homeless service users. Callie specifically spoke regarding the point of entry into the health care system as significant for women experiencing homelessness to express their needs. An inability to communicate the level of urgency they may be experiencing can result in not being able to access appropriate services from the onset of their journey through the health care system.

The complexities of dealing with mental health and addiction issues was cited by each participant as a barrier to accessing proper health care. Specifically, this was seen as a barrier to being able to communicate with health professionals. Previous negative experiences within the mental health care system were seen as having a negative correlation on the willingness to seek health care services :

...especially senior women have lived through a time when support for mental health care may have not been so friendly, so there are plenty of women who experienced their mental health care in a very negative way through institutionalization, through over-medication; a variety of things that could have made them have a bad experience. So that would definitely be a barrier for them. There can be language barriers, there might be cognitive impairments where they can't explain the help that they need and they are vulnerable at times. They may not want to speak up which makes them have inadequate health care (Mya)

Issues of mistrust with professionals within the health care and social service systems is not an uncommon response for those who have been marginalized by large institutions and have felt the direct result of neoliberal practices. For women, this is particularly tied to their health outcomes. A women that has avoided accessing primary health care services for fear of prejudice may only seek medical attention once their health becomes too precarious to deal with themselves, which may result in the need for higher medical intervention and result in poorer health outcomes.

iii. Lack of attention in hospital discharge planning

The experience of the participants in this study was that older women who are homeless experience substandard discharge planning from hospital and find themselves discharged to emergency shelter settings without adequate resources to meet their health care needs. This considerable gap in service appears to stem from the incongruity between hospital discharge planners perceptions of ‘medically stable’ and the reality of being medically stable enough to stay in an emergency shelter setting. For those individuals who have adequate and appropriate housing to go to from hospital, discharge planning is centered on their ability to navigate within the home. Changes and adaptations to the home can be made in order for it to be more accessible. The discharge plan is individualized for them. The very fact that an older woman is homeless seems to be where the marginalization of discharge planning occurs.

All three participants believed that homeless shelters being staffed institutions meant that a large part of discharge planning for those particular service users is overlooked or ignored. The expectation seems to be that the person who is homeless is going from one form of institution to

another so any issues that arise will be taken care of by staff at the shelter. Callie specifically linked discharge planning assumptions to the expectation that a shelter has staff that can provide support.

I don't feel like they are being assessed properly. I think it's just based on "Oh, okay you're homeless? We've got nowhere for you to go, we need the space in the hospital so we're going to put you in a shelter and then hopefully at the shelter they're going to make the appropriate referrals where ever you have to go. (Callie)

The experience of finding themselves homeless is traumatizing for women, particularly senior women. At the point where they find themselves homeless and ill, they may not have family that can advocate for them upon discharge and ensure that what needs to be in order is in place. When a referral is made from the hospital into a shelter and staff and service users play catch up once the person has already left the hospital setting.

All three participants stated that they have encountered instances where an older woman dealing with health issues was prematurely discharged from hospital into an emergency shelter setting. While there is an understanding that hospitals are working with limited resources, the perception was that this lack of resources contributed to older women being discharged to shelters prematurely.

2. Shelters as a Destination for Convalescing Service Users

While each of the participants expressed concern that women were being discharged prematurely from hospital to shelter, concern focused both on the appropriateness of the discharge plan and the ability of the shelters themselves to meet the needs of these individuals.

i. Inappropriate shelter environments

Communicating the lack of resources shelters have to assist clients who have ongoing physical health care needs can be very difficult for frontline staff:

One of the frustrating things is trying to relay to outside agencies the fact that a shelter is not a place for a senior or a person coming out of hospital that needs more care. The assumption is that shelter workers can do it all, (that) it's a one-stop-shop-all and it's just not. (Callie)

A person being deemed medically stable from a hospital system perspective does not necessarily demonstrate that the person is healthy enough to be able to navigate the intricacies of living in a shelter setting. The busy, transient nature of shelters was cited as prohibitive for older women recovering or dealing with illness.

...in a homeless shelter you're mixed with a population of people with a wide range of ages, dealing with addictions, dealing with language barriers, dealing with so many other issues it makes for a very very very busy environment that isn't therapeutic or helpful for somebody who is convalescing or should be convalescing depending on whatever it is they had to deal with in the hospital

*setting. So again, it's an injustice to the client because of the environment itself.
(Callie)*

While the predominant aim of emergency shelters is to provide a safe alternative to sleeping on the street for those dealing with inadequate housing, the very set up of the shelter setting causes inequity for older women dealing with illness. For older women who are discharged into a shelter setting while trying to deal with an illness, sharing a room with four or five other people or perhaps even more in a dormitory setting is very different from being in their own home. The lack of privacy and personal space while ill can be particularly jarring. Some shelters have rules that require service users to leave the building during daytime hours, which would preclude the ability for women to rest when needed.

There is particular dilemma around end of life care within a shelter setting and the ability of women's shelters to meet the needs of those who are dying. As there are no designated shelters or spaces for older women who are homeless and facing end of life care, they access the same services as women dealing with very different issues altogether.

This shouldn't be the last place for them to be and I think that, you know, women should, actually, if they are ill and they are passing away, it shouldn't be here. It should be somewhere comfortable" (Keisha Ray)

Each participant shared an experience of working with a service user through end of life care and expressed frustration at women having their needs and comfort ignored at the end of their lives. Keisha Ray described the inhumane back and forth that can happen between hospitals and

shelters in an example where a woman was sent to shelter from hospital when there was no longer any treatment options left, only to be sent back to hospital from shelter once the active dying phase began and the shelter was unable to cope.

ii. Overwhelmed and Undertrained staff

All three participants acknowledged the heavy burden on front line staff trying to assist older women with complex health care issues. It is important to examine how staff deals with this burden as frontline shelter staff have an enormous influence on how service users with health care issues experience their stay in shelter.

The need for appropriate training was central topic for each participant. Training has a direct impact on how staff react to situations and therefore the direct experience of the service user. Training has failed to keep up with the changing needs of shelter users, particularly older women with complex health care needs.

...they are not equipped to handle health care situations or meet the needs of women who need health care supports, especially end of life care. And it takes a toll on staff. They never knew. They didn't sign up for this. They didn't know they were signing up for this and are now caring for people at the end of life and have no training or resources to cope with that themselves in order to give good services to the people that need it. (Mya)

We need more training to be able to deal with the aging population, especially in the shelter system. We do have some training, for sure, we do have some knowledge and learning through situations that come up...but I don't think there

is a formal current training for elderly people living in a shelter and what to expect and how to move forward. Especially end of life stuff (Keisha Ray)

Shelter staff appears to be dealing with these situations as they arise on a case by case basis.

This lack of formal policy or training can negatively impact the relationship between staff and service user as the demand on front line workers increases and they find themselves unable to cope with varying demands. The combination of lack of training, lack of resources and increased work load can be transferred into negative interactions and experiences for service users.

If it's like cleaning up feces, doing all kinds of stuff, they might get a lot of backlash, staff is not as eager to assist. And so, they aren't as eager to assist so they might have to wait longer, they might have to see staff looking annoyed because they actually have to help them wash and so forth and staff is basically saying "this is not my job" - you know what I mean?- "I didn't go to school to be, you know, showering and cleaning people" "I'm not a nurse, I'm not a PSW" or whatever the case may be. (Keisha Ray)

What unfortunately you probably see most, especially in shelters that don't normally deal with complex health care needs, unfortunately the resident is seen as a burden. I don't believe it's because staff are malicious, I think it's that staff aren't equipped so now they see this resident as a burden, something difficult: "we don't want to deal with that", "why do I have to deal with that?" "I don't know how to deal with that", um, so they could be treated negatively by shelter staff because it's almost like a burden. And you can see that in family settings where someone, their health care needs become so complex that it's a "burden" to the family. I think it's very similar in a shelter setting. Staff deal with a variety

of needs in the shelter with the residents so in some shelters you have front line staff doing things like making the dinner and doing case management for the clients so they are also quite stretched. So, for example, in a single staff setting on an overnight shift, if somebody is, has health care needs that need to be attended to, the only staff is solely taken. The resources are all on that one person when there could be a house full of people. So, it can be taxing. The staff can end up treating someone negatively. (Mya)

All participants felt that front line shelter staff were not properly prepared for the demands now required of them in regards to assisting service users with complex health care needs. This seemed to be most prominent when discussing personal care needs, in particular dealing with cleaning of bodily functions. The combination of the type of work being asked and the lack of resources to handle that work appear to be the biggest contributors to negative staff-service user interaction.

Not all staff interactions were seen as negative. All three participants emphasized the empathetic nature of some shelter staff when dealing with service users facing complex health issues and needs. Keisha Ray noted the humanity of front line workers when faced with vulnerable service users at the end of their lives. She felt that staff “lead with their hearts” no matter what their level of training or their willingness to do the tasks required. Social service workers and social workers working frontline in shelters are required to be flexible in a hectic, constantly changing environment while maintaining empathy for those they work with in order to best serve their needs. Frontline shelter staff are accustomed to dealing with a scarcity of

resources and this appears to be another example of staff and service users endeavour to make the most of a situation with the least amount of resources.

This ability of frontline workers to adapt and be flexible when faced with shrinking resources may not be as ideal as it might seem. While there are worthwhile benefits to service delivery, there are negative ramifications that emerged in the interviews. Mya highlighted that while staff may go out of their way to assist a service user with complex health care needs, the lack of training and resources may wind up taking away from other service users who also require attention.

iii. Limitations to CCAC supports within shelters

...having CCAC services is vital but the way it's being delivered right now? I think our women are underserved in that area. (Mya)

Currently, follow up supports for people discharged from hospital to home are provided by local Community Care Access Centre (CCAC) agencies. A referral is made to CCAC from the discharging hospital and CCAC conducts an in-home assessment to determine services. These services range from nursing, to personal support (PSW) care, social work, physiotherapy, and occupational therapy. Eligibility determines the amount of hours allotted for services that are then provided in a person's home.

In terms of shelter support, CCAC provides cluster care supports to certain shelters and regular one on one supports to those shelters for which they do not have a cluster care arrangement. As

opposed to having one worker assigned to each service user, cluster care allows a single worker to attend to the needs of several service users within the shelter. Rather than have ten PSW's coming in to assist ten residents with showering and personal care, one or two PSW's will be assigned to that particular location to see to the needs of those ten residents within a prescribed amount of time.

While the assistance of CCAC as a larger part of the service delivery puzzle was viewed as a positive by participants, there were limitations to the effectiveness of this collaboration. Participants felt that supports were not available outside of normal business hours which is incompatible with the 24 hour a day, 7 day a week reality of an emergency shelter.

CCAC workers are put on a schedule. And they are allowed so many hours to go into each facility. People don't get sick on a schedule. So if they are getting sick, or having their issues of defecating or incontinence, or whatever type of situation they are having medically; their wound is oozing or something that needs to be cared for by that CCAC worker, it doesn't happen on a schedule. So now, it could be 1:30am and they are gone and you've got, how many clients in a shelter? Other things are going on at the same time. This one client could take up an hour, even longer, where you could also be dealing with people in crisis, who have addictions, who have mental health, who have anger management stuff going on plus just the regular running of a shelter. You're taking away two staff, maybe even more, away to take care of this person. Yeah, you have CCAC in there but guess what? It wasn't on their scheduled time. How do you do that? It's a big expectation on the staff and it's an injustice to that poor person who is in need of more professionalized and direct services." (Callie).

While all participants were highly appreciative of the relationship between CCAC and their shelter it was clear that services require improvement to meet the needs of shelter residents.

For those women who do not stay in shelters that have access to cluster care, the process of obtaining CCAC services following discharge from hospital can be fragmented and difficult to navigate. Once they have been assessed by the local CCAC and services set up, it is incumbent on that service user to maintain those supports. Given the transient nature of emergency shelters, this can be a hardship on service users. If a woman finds herself discharged from shelter for not following rules, she may be transferred to a shelter in a completely different CCAC catchment area. The services she was receiving do not automatically follow her. A new referral is made and she must then go through that local CCAC's intake process. The process is cumbersome and oppressive to those already dealing with the trauma of being homeless and sick

3. Barriers to accessing Long Term Care

When a person is no longer able to meet their own health care needs and requires significant levels of care, they may be referred to a long term care facility. All three participants perceived that there were several factors that contributed to their service users not being able to access long term care facilities when needed. A qualifying requirement for long term care is the need for 24 hour a day assistance. Homeless women who fall anywhere beneath that threshold and can manage some form of their own care are discharged into shelters.

Not having legal status in Canada was primary example brought up by each participant when discussing barriers to health care and long term care facilities. Keisha Ray gave an example of how having no legal status affects access to Long Term Care:

...I know for instance there is a client who has a lot of different medical issues going on. She has the dementia piece, she has the whole age piece, she is not able to care for herself anymore. This is not the setting for her to be in at all, right? This is the place, this is supposed to be transient. Like you are actually supposed to be able to move into your own home. It's not a place to be sitting and waiting to see what will happen but because she has no status she is not able to access long term care. So now this has become her long term care, which is not appropriate (Keisha Ray)

Not having legal status in Canada prohibits Keisha Ray's service user from accessing the same health care as citizens who are deemed "legitimately" entitled to health care. In practice, this means that an older woman who requires medical intervention sits in a busy shelter when a more appropriate place to meet her needs would be a long term care facility.

For those who are lucky enough to be deemed legitimately able to access health care, there are other barriers that may prevent them from moving from shelter into an appropriate long term care facility:

.... Or there's people who do fully meet the criteria of long term care and fully need to be there but for whatever reason are not accessing it, such as they have behaviours that prohibit them from being in long term care. (Mya)

Mya raises the argument that long term care in the current capacity may not meet the needs of service users accessing shelters, particularly older women with ongoing health care needs with concurrent mental health issues or substance use. Keisha Ray described an example where a service user was automatically disqualified from long term care because of her history of setting fires. The decision was made on past behaviour and not on the need of the woman involved.

6. Discussion

Prior to conducting this research, my employment working front line in an emergency shelter exposed me to many of my own experiences of working with older women dealing with complex health care needs while homeless. My experience of working with Peggy in the vignette in the introduction of this paper is what has guided me to explore this topic more in depth. While undertaking my literature review, I was both surprised and disheartened to find that this topic has not been examined in more depth. The reality is that there are women being discharged from hospital into homeless shelters that are neither prepared nor able to meet the needs of these service users. The tug of war of responsibility between the two institutions has real life implications on older women dealing with homelessness and illness.

i. Medically Stable versus Shelter Ready

The incongruence between a service user being ‘medically stable’ for discharge from hospital and ‘medically stable’ for a shelter setting appears to be a major contributing factor in the dispute between hospitals and shelters. The data in this study shows that shelter workers understand the resource demands on hospitals and their motivation for freeing up beds. The concern from workers is that it appears that a person’s ability to navigate the shelter is not a primary focus for hospital discharge planners. The assumption that older women who are discharged from hospital will be cared for in an institutional setting such as an emergency

shelter, contributes to substandard care that frontline staff are witnessing and the continued marginalization of older women who are homeless.

This study is not an examination of the functioning of discharge planning from hospital to home but it is important to acknowledge the key concepts in order to highlight the discrepancy for older women discharged into shelter. There are many obstacles and little ability for the physical space of a shelter to be changed to be more accessible for one individual. Shelters, on principle, are designed to fit the maximum amount of people within a space as an alternative to someone having to sleep on the street. As noted in the findings, some shelters require that residents be out during daytime hours, which would prohibit the ability to convalesce as needed. This is not a barrier that someone in their own home would have to face. Women who are homeless are beholden to the rules and regulations of the institutions in which they seek shelter. They suffer a loss of autonomy directly related to their homelessness that is not felt by their appropriately housed counterparts.

The lack of communication between hospital and emergency shelters has substantial impact on service users who are caught between two institutions with their own policies and procedures. It is clear in the findings that the lack of communication between hospitals and shelters directly impacts service users who find themselves caught between the two systems. Navigating the complex health care system while ill can be overwhelming even without the added burden of dealing with homelessness. This lack of cooperation between hospitals and shelters sacrifices the comfort and stability of those women caught in between. This sad reality was illuminated in Keisha Ray's example of a dying service user being shipped from hospital to shelter and back to

hospital because she failed to fit into either system's purview of service. Instead of living her last days in comfort, she was physically moved from place to place as if unwanted and unwelcome because she did not have access to appropriate shelter while sick.

ii. Feel free to stay, as long as you follow the rules

While it is clear from the findings that shelters are attempting to meet some needs of older women discharged from hospital, the rules and regulations that contribute to the transient culture of shelters is not conducive for those who are recovering from illness or who are actively at the end of life stage. Not following rules may result in a service user's discharge to another shelter, regardless of health status. This, compounded with any behavioural or mental health issues, creates a revolving door of women moving from shelter to shelter once being referred from hospital.

It should be noted that substance use, behavioural, and mental health issues are not only inherent to those who struggle with being homeless. While these factors may contribute, they are not the sole reasons why older women find themselves without adequate housing. It is important to recognize the political, and systemic factors that contribute to homelessness for women (Ontario Women's Council, 2002; Street Health Report, 2007). There are people who deal with substance use, behavioural, and mental health issues that are able to do so in the privacy of their own home. Those women are not subjected to the same rules and regulations regarding their actions or lifestyles as those who find themselves living in a homeless shelter.

This policing of homeless woman once again places them in the margins of society and contributes to the feminization of poverty (Pearce, 1978).

iii. “People Don’t Get Sick on a Schedule”

All three shelter staff in this study were quick to acknowledge gratefulness for CCAC services that assist those who are discharged from hospital to meet ongoing health care needs while in shelter. The professional alliance between CCAC and shelters is an important relationship to maintain and expand upon. The addition of cluster care to all shelters would greatly lessen the administrative barriers currently faced by those requiring CCAC supports while navigating the transient nature of shelters.

Perhaps the largest obstacle to tackle within the existing collaboration is how best to use resources within a 24 hour, 7 day a week shelter setting. As Callie so succinctly stated: “People don’t get sick on a schedule”. The lack of round-the-clock services results in staff resources being stretched very thin. This in turn affects all service users within the shelter, not just those discussed in this research.

There is no doubt that having CCAC supports in place is beneficial to both the service user and shelter staff. Participants felt that it was a matter of when and how much support is available. While having a Personal Support Worker (PSW) assist during the day can lessen the burden on staff, the reality is that personal care needs can arise at any time of day. The strict requirements for accessing long term care mean that women who fall even a few hours short of the threshold

of needing 24 hour a day care are staying in shelters. Women do not have incontinence and bowel issues only between the working hours of 8:00am to 5:00pm. They may be able to manage self transfers to and from the bathroom during the day with the benefit of planning and time, but in the middle of the night when they have to navigate through the dark, while half asleep, around a roomful of other people, their ability to manage is drastically diminished.

Even when an older woman does require 24 hour care, they can be ineligible for the appropriate long term care based on lack of legal status or because they have exhibited certain behaviours that automatically exclude them. This is consistent with the findings earlier in the literature review that found that those who are homeless face systemic barriers to accessing appropriate long term care or palliative care (Chapleau, 2010; Song et al. 2006; McNeil et al., 2010; McNeil and Guirguis-Younger, 2011). The prohibitive rules and regulations that prevent access to long term care for certain people based on social constructs of right and wrong is both punitive and demeaning. The current system of eligibility for long term care fails to appropriately address the needs of older women who are homeless.

iv. Staff - are we ready?

As a self-identified frontline worker in the shelter system, I was not surprised that staff issues were identified as an emergent theme in this study. As a social worker coming from an anti-oppressive theoretical perspective, I believe that there are always ways in which front line staff can improve the experience of service users in the shelter setting. I am also acutely aware of the

demands placed on shelter staff working in an ever changing, poorly resourced, 24/7 environment.

Perhaps the key finding for examination is the link that participants made between the workload of frontline staff, their level of training, and the effect on the relationship with the service user. This was consistent with the findings earlier in the literature review that questioned the lack of training for shelter staff in an Ottawa shelter (McNeil and Guirgius-Younger, 2011) Mya's insight into the reaction some staff have to providing health care services normally provided by a PSW or a Nurse is of particular note:

... "we don't want to deal with that", "why do I have to deal with that?" "I don't know how to deal with that". (Mya)

This directly links the negative reaction of staff towards assisting older women with an inability to deal with the situation. With the increase in older women with complex health care needs entering the shelter system, the skill requirements of staff has changed. Proper lifting of people and the procedures of proper hygiene care are not things normally taught in most social work or social service classrooms. It is no surprise that staff find themselves unprepared for these tasks. Linked back to the previous discussion around the availability of PSW supports only at certain times, it is clear why these tasks fall to frontline staff. The expectation that all staff are able to adjust to these demands is problematic. While none of the participants felt that frontline workers are deliberately malicious towards older adult women with complex health care needs, there appears to be varying levels of care that workers are comfortable with or are able to cope with.

7. Future Considerations

i. Implications for Practice

The reality in shelters is that there are service users who will die. As the population ages and more older women find themselves forced to live in shelters, the frequency of this reality will grow. Many of the women seen in shelters have little to no outside support from family or friends. At times, the relationship between staff and resident can serve as the only link to the community at large. This can make end of life situations difficult for both staff and service user. Staff may not know how to cope with seeing someone through the end stages of their life and residents may not wish to leave the shelter setting because their only connection is with the staff that have been caring for them.

It would not be out of the realm of consideration to note that some frontline staff may be resistant to caring for women with complex health care needs by undertaking tasks normally associated with PSW's and nurses, and not social work practice. I think it is important to note that Mya, Callie, and Keisha Ray all acknowledge that their experience was that staff also come from a place of caring. Personally, I have witnessed staff carry women to the washroom when they have been unable to get there themselves. There have been numerous times when myself or my colleagues have physically cleaned and changed a resident because the PSW was not coming back until 8:00am the next morning and in good conscience, we could not let someone sit in dirty sanitary products until then. This does not serve to excuse, detract or justify negative interactions that service users encounter with front line shelter staff. It is imperative for front line staff to acknowledge that they hold a significant position of power providing care and

services to some of the most vulnerable women in our city. This study highlights that this responsibility should be respected and fostered by providing front line staff with the proper training and education to give them the tools to best work with service users.

ii. Implications for AOP Social Work

I believe that AOP social work can play a very significant role addressing the service gap for women dealing with homelessness while faced with health issues. As AOP practitioners we have a responsibility to acknowledge the marginalization that is occurring and advocate for change.

A large part of this study talked about the experience of frontline staff and the demand and stress placed on them to perform duties that they might not be properly trained to deal with or feel comfortable performing. It is important that we acknowledge our limitations as practitioners while also ensuring that we are taking steps to learn the skills we need to best assist those with whom we work. On a broader level, perhaps there is a place in AOP classrooms to discuss the changing demands placed on frontline workers by ever shrinking resources contrasted against our fundamental commitment to helping others.

While the demands placed on staff are important to acknowledge, it should not overshadow the burden that is placed on women falling through the cracks of both shelters and health care services. Having to depend on professionals for health and self care needs can position already vulnerable women into a further place of powerlessness. This is particularly distressing when examined in conjunction with statistics that show women are more likely to have suffered

trauma prior to entering the shelter system. AOP social work must challenge the dominant rules and regulations within these large systems that serve to marginalize, oppress and ignore women who find themselves homeless. Practically, this may involve advocating from the front lines for individual service users to be treated with dignity and respect. It could be challenging rules and regulations of our workplaces that penalize service users and contribute to the transient nature of shelters. It should involve confronting team members or healthcare professionals when we encounter judgements being made on certain behaviours or choices made by our service users. On a larger, more political level, AOP social work should be advocating for older women dealing with homelessness and complex healthcare needs to receive proper access to resources and ensuring they have access to their health care while being adequately housed.

iii. Implications for future research

The question as to whether or not shelters should even be providing this level of care is one that needs to be further explored through research. Preferably, this will be AOP research which will aim to capture the voices of older women who are discharged from hospital into a shelter setting. Future research should also explore possible benefits and practicalities of changing the composition of front line shelter staff to include PSW's and nurses in order to better serve the changing needs of service users.

iv. Limitations

While this study found that there are discrepancies in services available by gender, there has been no specific research on whether the current health care programs offered in the male shelters for men would fit the unique needs of older women experiencing homelessness and complex health care needs.

8. Conclusion

Peggy, the service user from the opening vignette, is a quintessential example of a woman who found herself at the intersection of health care and homelessness and fell through the cracks. Her health prevented her from obtaining adequate housing and her lack of adequate housing prevented her from receiving the health care she needed. She either left or was asked to leave a hospital setting due to not following the rules regarding smoking on premises. There are a multitude of reasons why service users are not willing, or able, to follow rules in large institutions such as hospitals or shelters. What stands out about Peggy is that she turned smoking into her act of resistance. She had been labeled a substance user and was subsequently denied pain control because of external judgment of previous actions she had taken in her life. Her choice to stay on the street was her way of trying to retain her autonomy in the face of rules imposed on her by the dominant discourse of the health care system. In her final days of life, she chose to sleep on the street in her wheelchair rather than submit to the rules of an institution that judged her for her choices and failed to assist her when she needed it.

Homelessness is a significant social justice issue within our city. The contexts within which women find themselves homeless are complex and diverse. This study examined the experiences of three frontline workers in emergency shelters who have encountered older women who are homeless and discharged from hospital into emergency shelters within the city of Toronto. This topic is increasingly relevant as our aging population places more demands on the already resource drained health care system and increasing cuts are made to social services.

A considerable service gap exists at the intersection where health care and homelessness meet for older women. Older women experience barriers to accessing adequate health care both prior to hospitalization and following discharge from hospital to emergency shelter. The experience of all three participants in this major research paper highlight the difficulty faced by women trying to get their health care needs met while in an emergency shelter, and the lack of preparedness of shelters to deal with this vulnerable population.

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APPENDIX A



Everyone Makes a Mark

SCHOOL OF SOCIAL WORK
FACULTY OF COMMUNITY SERVICES
Accredited by The Canadian Association for Social Work Education

PARTICIPANTS NEEDED

Do you work with women over the age of 60 experiencing homelessness in Toronto?

Do you have front line experience with women over the age of 60 who have been discharged from hospital into an emergency shelter?

Would you be interested in sharing these experiences for a research study examining the experiences of front line workers?

If you answered yes to these questions, please contact me at aeastrom@ryerson.ca to be part of a small study being completed as part of my Master's degree in Social Work at Ryerson University. A \$10.00 Tim Hortons card will be provided to all participants.

The actual interview process will involve a 1 to 1.5 hour tape-recorded interview conducted in person. All information shared will be confidential and no names or identifying information will be published or shared in any way. Participation is entirely voluntary and you can choose to end your involvement with the study at any time. I particularly welcome the participation of those who identify themselves as Aboriginal, people of colour, immigrants and refugees, and other equity seeking groups

Thank you,

Ashley Comrie
MSW Candidate

APPENDIX B

The Use of Home Health Care Services in the Emergency Shelter System in Toronto

You are being asked to participate in a research study. Before you give your consent to participate, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigator:

Ashley Comrie - Master of Social Work Student

Supervisor:

Lisa Barnoff PhD – Associate Professor, Ryerson School of Social Work

Purpose of the Study: This study will use qualitative interviews of front line staff working with homeless women to gather an overview of the existing issues specifically faced by women over the age of 60 living in an emergency shelter in the Greater Toronto Area with complex health care needs.

The Research shows that adults over the age of sixty (60) encounter more difficulty trying to exit the shelter system while also facing more complex health care needs. With the current focus in health care relying on sending people to live in their homes while receiving in-home support care for physical health issues, there is little data on what that looks like for women who are under-housed or living on the street.

Use of Data: The information participants share in interviews will be used for the purpose of a supervised Major Research Paper submitted to Ryerson University in partial completion of a Master of Social Work degree. The findings of this data may be used for publication in the future.

Description of the Study: The data collected during this study will involve a one-on-one interview in a location of your preference. The location can be in a private room at Ryerson University or a private space mutually agreed upon by both parties. You will be asked to participate in a digitally recorded, approximately 1-1.5 hour interview, that will ask you to reflect on your experience as a self identified employee of an emergency shelter setting. Topics will include: Access to resources, availability of resources, personal experience dealing with older adults accessing both the health care system and shelter system,

Risks or Discomforts: Every effort will be made to maintain confidentiality. All names will be changed to protect the identity of study participants. Only the Principal Investigator and Study Supervisor will have access to the data collected. All data will be stored in a locked safe. You may experience discomfort during the interview because of the length or because of the emotional nature of the discussion. You may choose not to answer any questions that make you feel uncomfortable. Please note that you can stop the interview, take a break, or withdraw at any point during the interview process or after it has taken place. If you decide to withdraw, all data collected from you will be destroyed and will not be included in the study, and nor will there be any negative consequences for withdrawal.

Benefits of the Study: I hope that this study will help identify gaps that older adults with complex health care needs may face when receiving home health care support while living in emergency shelters within the city. I cannot guarantee that you will directly benefit by participating in the study.

Confidentiality: Only myself and my supervisor will have access to the data collected. The data from interviews will be audio recorded and transcribed. All identifying information will be removed from transcripts and pseudonyms will be used to ensure confidentiality. Transcripts and electronic recordings will be password protected, stored at Ryerson University and deleted after one year.

Voluntary Nature of Participation: Participation in this study is voluntary. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time before the final report has been written. At any point in the study, you may refuse to answer particular questions or stop participation with no fear of repercussions.

Future Contact: If you consent to be contacted for the purpose of sharing the study findings, you will be contacted when the study is complete at your last known previous address.

If you have any questions regarding this research in the future, or should you wish to notify researcher of a change in address, please feel free to contact:

Principal Investigator:

Ashley Comrie – aeastrom@ryerson.ca

or

Study Supervisor:

Lisa Barnoff - (416) 979 5000 x 6243 lbarnoff@ryerson.ca

If you have questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for information:

Research Ethics Board

c/o Office of the Vice President, Research and Innovation Ryerson University

350 Victoria Street

Toronto, ON M5B 2K3
416-979-5042 / rebchair@ryerson.ca

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement. You have been told that by signing this consent agreement you are not giving up any of your legal rights.

Name of Participant (please print)

Signature of Participant

Date

Please indicate with a signature below if you give your consent to have this interview audio taped:

Name of Participant (please print)

Signature of Participant

Date

Please indicate with your signature below if you give your consent to be contacted regarding the study results:

Name of Participant (please print)

Signature of Participant

Date

Appendix C

Interview Questions

1. How long have you worked with women who are experiencing homelessness?
 - a) How long have you worked specifically with women dealing with homelessness?
 - b) Does your experience include working with other populations dealing with homelessness? If yes, please describe.

2. Do you feel there are barrier for homeless women to access adequate health care?
 - a) if so, can you describe some of those barriers?

3. Have you ever felt that someone was prematurely discharged to a shelter setting from hospital?
 - a) If yes, please describe the situation and why you felt this was the case

4. Did you feel that your workplace was able to meet the needs of these individuals?
 - a) If not, please explain why this was the case
 - b) If yes, please explain why this was the case

5. Have you ever felt that a service user's health care needs could be better served in a long term care facility rather than an emergency shelter?

a) If yes, please describe why you felt this was the case

6. Do you have any professional experience working with any Community Care Access Centre services while in a shelter setting?

a) if so, how would you describe the availability of these services to your service users?

b) If not, do you believe that these services could be of help to the service users at your work place

7. Do you feel that service user's with complex health care needs are treated different by front line shelter staff because their level of care may be different than others living in the shelter?

a) If yes, how do you believe this affects their stay in the shelter? Please describe.

8. Do you feel that the services required by homeless women with chronic health care needs in any way affect their ability to obtain stable long term housing?

a) if yes, why?

b) if no, why ?

9. Is there anything about your experience that you would like to share that I have not asked that you feel is important to my understanding of your experience?