

**BEING AND BECOMING A SPECIALIST PUBLIC HEALTH NURSE -
NET WEAVING IN HOMELESS HEALTH CARE**

**By
Maria Fordham**

**A thesis submitted to the University of Bedfordshire in partial fulfillment of
the requirements for the degree of Doctor of Philosophy**

October 2012

BEING AND BECOMING A SPECIALIST PUBLIC HEALTH NURSE: WEAVING THE NET IN
HOMELESS HEALTH CARE

MARIA FORDHAM

ABSTRACT

In this study, systematic reflection in professional practice is seen as a dynamic process towards socio-political action, negating a navel-gazing critique. Positioned within nursing, the pioneering narrative inquiry approach will be highly valuable in medicine, education and other health fields. When I embarked on this study, research to guide me in homeless health care was limited and there is, even yet, insufficient evidence to demonstrate the effectiveness of advanced nursing practice in England particularly with homeless people. Through its reflexive narrative nature that research gap is addressed in a profound journey that illuminates my transformation over a three year period of being and becoming a Specialist Public Health Nurse (homelessness). The methodology draws dynamically on an eclectic, philosophical framework which includes reflective practice/guidance, narrative inquiry, hermeneutics, aesthetics, critical social science theory, storytelling, performance-ethnography and ancient wisdom. The Six Dialogical Movements (Johns, 2009) provides coherence to the twenty-one practice experiences that adequately marked my transformation towards my practice vision. I used the Being Available Template (Johns, 2009) as a reflexive framework which became the metaphoric *net* of my practice, showing where and how homeless people *fall through the net* of care, and my role in weaving a stronger net. I also drew on the work of Belenky et al's (1986) voice perspectives to show empowerment in my specialist role. Within the narrative, each story illuminates complexity and brings new knowledge about homeless health care. The study tangibly links childhood trauma to adult homelessness; it illuminates suffering in homelessness, showing where and how mainstream health professionals contribute to suffering when they do not grasp their role within *the net*, perpetuating homelessness. *Appreciating precarious engagement in four quadrants*: health services, homeless services, the homeless person and my SPHN role, is a concept that illuminates the precariousness of *the net*. The study concludes with a SPHN Homeless Health Care Model. Towards an ensuing social action through dialogue, I use the term 'audiencing' rather than transferability of findings. Hearing stories from 'street to boardroom' - making the invisible visible - has been profound in health services as evidenced in the narrative.

Declaration

I declare that this thesis is my own unaided work. It is being submitted for the degree of Doctor of Philosophy at the University of Bedfordshire.

It has not been submitted before for any degree or examination in any other University.

Name of candidate: Maria Fordham

Signature:

Date: 20th October 2012

*I dedicate this PhD study to
my mother
Ellen Conroy (RIP)
her sisters
Mary (RIP), Frances and Bridget (RIP) McFadden
and my sister,
Kathleen Dean*

Contents

Page

1. Preliminaries

Abstract.....	1
Declaration.....	2
Dedication.....	3
List of Contents.....	4
List of Figures.....	8
List of Photographs.....	10
List of Appendices.....	11
Acknowledgements.....	12
List of Abbreviations.....	13

2. Text of the Thesis

Chapter 1: Background.....	14
<i>Forestructure of Understanding.....</i>	14
How I use the Forestructure of Understanding in this chapter.....	15
Fore-having.....	15
Concepts of Home.....	15
My Home.....	18
Personal Fore-having.....	22
Trauma.....	22
Resilience and Community.....	25
Professional Fore-having.....	28
Being a Midwife, Health Visitor and School Nurse.....	29
Fore-sight.....	31
Who are the Homeless?.....	32
Defining Homelessness.....	32
Local Homelessness.....	33
Family Homelessness.....	34
Single Homelessness.....	34
Local Health Services for Homeless People (2005).....	35
Fore-conception.....	38
Vision of Practice.....	38
Vision for Research.....	39
Addressing a Gap in Research.....	39
Chapter 2: Narrative Construction.....	42
Aim of the Study.....	42
Methodological Philosophical Framework.....	42
History of Johns's Narrative Approach.....	44
Narrative Inquiry.....	44
Narrative Plot.....	46
Self-Inquiry.....	47
Transformation.....	48
Empowerment Theory.....	48

CONTENTS	Page
Reflective Guidance	49
Reflexivity	50
Vision of Practice	51
Narrative Construction using the Six Dialogical Movements	53
1st Dialogical Movement:	
<i>Dialogue with self as a naive or spontaneous story</i>	54
Journaling	55
2nd Dialogical Movement:	
<i>Dialogue with story in a structured and disciplined way</i>	57
What is Reflective Practice?	57
Finding my own definition.....	58
A critique of reflective practice.....	59
Using the Model of Structured Reflection (MSR) (Johns, 2009)	60
Developing Insights	61
MSR cues	62
Dwelling with the Text to Gain Insights	67
Framing Insights	68
3rd Dialogical Movement:	
<i>Dialogue between tentative insight and other sources of knowing</i>	69
Integral Vision of Consciousness Model (Wilber, 1998, 2007)	70
4th Dialogical Movement:	
<i>Dialogue with guides and peers to develop and deepen insights</i>	73
The Process of Reflective Guidance	73
Why is Guidance Necessary?	74
The role of the Guide	74
Guidance to shift tension in practice	75
Guidance that challenges normal patterns of behaviour.....	76
Guidance to co-create meaning.....	76
Guidance as a resting and recuperative space.....	76
A Critique of Reflective Guidance	77
5th Dialogical Movement:	
<i>Weave a Coherent and Reflexive Narrative Text that Adequately Plots</i> <i>the Unfolding Journey</i>	78
Narrative Form	78
Writing style.....	79
The use of metaphor.....	80
Drawing on spirituality and ancient wisdom.....	80
Using art, poetry and photography.....	82
Narrative Plot	82
Feminist influences.....	83
Framing Reflexivity	84
Being Available Template (Johns, 2002).....	84
Women's Ways of Knowing: Development of self, voice and mind...	85
Coherence	87
Authenticity.....	88
Face Validity.....	89
Construct Validity.....	90
Rhizomatic Validity.....	90
Engagement and Performance Validity.....	91

CONTENTS	Page
Ethics	92
My Ethical Journey.....	94
Gaining Consent.....	95
6th Dialogical Movement	
<i>Dialogue with new experiences and with others to facilitate social action ...</i>	95
Social Action	96
Performance Autoethnography.....	97
Formalising the Performance Turn.....	98
Generalisability or Resonance?.....	99
Chapter 3: The Narrative - Falling Through the Net	100
Text 1 In this Space - Outreach clinic.....	101
Text 2 Winter Crisis - Multiagency meeting.....	109
Text 3 Despair and Delight - Outreach clinic.....	116
Text 4 Parallel Planning - Home visit.....	124
Text 5 All the King's Horses and All the King's Men - Hostel visit.....	132
Text 6 Connecting and Reflecting - Multiagency meeting.....	139
Text 7 Breaking an Offending Cycle - Home visit.....	145
Text 8 Torture - Hostel visits.....	151
<i>First Analytical Horizon</i>	160
The Being Available Template as The Net	160
Developing Practice	161
Homeless Person	162
Constructing an Effective Therapeutic Relationship.....	162
Recognising Suffering and Responding with Compassion.....	163
SPHN	164
Responding effectively to the spiritual needs of homeless people.....	164
Discerning my fear.....	164
Health Services	165
Attitudes.....	165
Preventing poor outcomes - services not engaging with homeless people..	166
Gaining evidence for a multidisciplinary team in homeless health care.....	166
Homeless Services	166
Appreciating the key role of homeless services.....	167
Managing contradictions in homeless practice.....	167
Appreciating Precarious Engagement - Being Mindful about the Net's Fragility..	168
Use of Voice	169
Text 9 Dancing with Dean - Hostel visits.....	171
Text 10 A&E Zero Tolerance - Clinic.....	177
Text 11 Invisible Health - Regional meeting.....	183
Text 12 Family Homelessness Networking - Health visitor and manager meeting....	186
Text 13 Turbulent Waves - Clinic and hostel contacts.....	192
Text 14 Department of Health National Award.....	200
Text 15 Balancing the Clay - Hostel visit.....	204
Text 16 Volcanic Eruption - Hostel visit.....	211

CONTENTS	Page
<i>Second Analytical Horizon</i>	217
Developing Practice in Year 2	217
Health Services	218
Attitudes by Mainstream Services.....	218
Learning to recognise oppression.....	219
HNA Report: insights towards a multidisciplinary team.....	220
Homeless Person	221
Complex trauma and entrenched homelessness.....	221
Childhood trauma as triggers into adult homelessness.....	222
Developing the Therapeutic Net.....	225
SPHN	226
Being courageous.....	226
Preventing vicarious trauma and burn-out.....	226
Supporting practice: art and spirituality.....	227
Homeless Services	227
Being a peace-maker.....	227
Collaborative working.....	229
Use of Voice	230
Text 17 Embracing the Leap - Strategic meeting.....	232
Text 18 Spaghetti Junction - Hospital discharge.....	238
Text 19 The Spider's Web - Mental health task group meeting.....	247
Text 20 A Can of Worms - Multiagency Panel meeting.....	254
Text 21 Tying the Knot- Clinical Commissioning Group.....	264
 <i>Third Analytical Horizon</i>	 273
Developing Practice	273
SPHN	273
SPHN: Weaving Strands in the Net.....	273
My Political Emergence.....	274
Being a Transformational Leader.....	275
Development of Voice	276
 Chapter 4 Weaving New Knowledge in Homeless Health Care	 278
Introduction	278
The Net	278
Transformation	281
The Being Available Template is 'The Net'	281
Vision	283
Overview of SPHN vision.....	283
Contextualise SPHN vision within national guidance and research.....	285
Contextualise SPHN vision with insights into homeless health leadership.....	286
Appreciating Precarious Engagement	287
Society	290
Homeless Person	292
Contextual overview 'Who are the Homeless?'.....	293
Working <i>with</i> the homeless.....	293
Being a peace-maker.....	294
Being with homeless women.....	295
Intellect/social class.....	297
Health Services	298
Awareness.....	288

CONTENTS	Page
Attitudes	299
Accountability.....	300
Multi-agency Partners	301
Voluntary services.....	301
Housing services.....	301
SPHN	302
Poise.....	302
Reflective Practice and Reflective Guidance.....	303
Development of Voice	304
Reviewing the Net in 2011/2012	306
Ten key messages for the Government	312
Chapter 5 From Being to Becoming a SPHN Homelessness	314
Narrative Construction - Contributing to Narrative Knowledge	314
Contextualised with other narrative approaches	314
Power in the research process	316
Benefits and Challenges of Narrative Construction	316
Becoming a mindful practitioner.....	317
Illuminating transformation in the process of becoming.....	318
Guidance and Co-creation.....	319
Guidance: managing the tension of challenge.....	323
Being a research practitioner.....	324
Will my narrative be heard?.....	325
Limitations	326
Ethics	326
Selection of Texts.....	326
Conflict of Interest.....	327
Audiencing	327
Implications for Practice	328
<i>Appreciating precarious engagement in homeless health care</i>	328
The ontology of homelessness and the patient experience.....	329
Helping mainstream services engage in mindful practice	330
Develops evidence for Advanced Nursing Practice.....	330
Future Research	332
Conclusion	332
List of Figures	
Chapter 1	
1.1 How I use the Forestructure of Understanding.....	15
1.2 Reflections of Home.....	19
1.3 Home Collage.....	20
1.4 Personal Fore-having.....	22
1.5 Professional Fore-having.....	28

CONTENTS	Page
1.6 Statutory and non-statutory Homelessness.....	32
1.7 Health Access points into Health Care for Homeless People (2005).....	35
1.8 Building Bridges in Homeless Health Care.....	38
1.9 Vision of Practice.....	39
Chapter 2	
2.0 Philosophical Methodological Framework.....	43
2.1 Limits and the Influences Grid.....	49
2.2 Vision of Practice.....	52
2.3 Narrative Construction Using Six Dialogical Movements.....	53
2.4 The Model of Structured Reflection.....	61
2.5 From Significance to Insights.....	61
2.6 Ethical Mapping.....	65
2.7 Framing Perspectives.....	68
2.8 The Dance of Sophia.....	70
2.9 The Four Quadrants Model of Consciousness.....	71
2.10 Creative Tension.....	75
2.11 Falling through the Net.....	82
2.12 Women's Ways of Knowing: Development of Self, Mind and Body.....	85
2.13 Coherence in the Six Dialogical Movements.....	88
2.14 Ethical Tension Within a Narrative of Self-Inquiry.....	93
Chapter 3 (Year 1)	
3.1 Outreach Clinic Health Models.....	102
3.2 Developmental Framing (1) - Bridge Building.....	108
3.3 Developmental Framing (2) - Bridge Building.....	115
3.4 SPHN Wheel Hub.....	120
3.5 Images of my net role.....	123
3.6 Developmental Framing (3) - Falling through the Net.....	131
3.7 Developmental Framing (4) - Falling through the Net.....	138
3.8 Developmental Framing (5) - Falling through the Net.....	144
3.9 Developmental Framing (6) - Weaving the Net.....	150
Analytical Horizon 1	
AH1.1 Being Available Template: The Net.....	160
AH1.2 Health and Homelessness Model - Adapted from Burford Reflective Model.....	161
AH1.3 Appreciating Precarious Engagement in Homeless Health Care.....	161
AH1.4 SPHN Role with Homeless Services.....	167
AH1.5 Appreciating Precarious Engagement in the Net.....	168
AH1.6 Year 1: Use of Voice in Precarious Engagement.....	170
Chapter 3 (Year 2)	
3.10 Developmental Framing (7) - Falling through the Net.....	176
3.11 Developmental Framing (8) - Falling through the Net.....	182
Box 1: Precarious Engagement: Advocacy versus Enablement.....	182
3.12 Developmental Framing (9) - Weaving the Net.....	191
3.13 Developmental Framing (10) - Falling Weaving the Net.....	199
3.14 Developmental Framing (11) - Weaving the Net.....	203
3.15 Developmental Framing (12) - Weaving the Net.....	216

CONTENTS

Page

Analytical Horizon 2

AH2.1 Being Available: Being Available - Year 1 Review.....	217
AH2.2 Appreciating Precarious Engagement in Homeless Health Care.....	217
AH2.3 Recognising Childhood Triggers into Adult Homelessness.....	217
AH2.4 Enablement and Advocacy in the Therapeutic Net: Appreciating Precarious Engagement.....	223
AH2.5 Evictions - Falling through the Net.....	228
AH2.6 Year 2: Use of Voice in Precarious Engagement.....	230

Chapter 3 (Year 3)

3.16 Developmental Framing (13) - Weaving the Net.....	237
3.17 Precarious Engagement - Multiagency Services.....	246
3.18 Developmental Framing (14) - Weaving the Net.....	272

Analytical Horizon 3

AH3.1 Being Available: Summary statement of Practice Development.....	273
AH3.2 Year 2: Use of Voice in Precarious Engagement.....	276

Chapter 4

4.1 The Net Rope: 3 Strands of Practice.....	280
4.2 SPHN: Being Available in Homeless Health Care Model.....	282
4.3 Advocacy, Enablement, Safeguarding.....	284
4.4 Appreciating Precarious Engagement in Society.....	289
4.5 SPHN: Homeless Health Care Values.....	290
4.6 Women's Homeless Health Needs Matrix.....	296
4.7 Mainstream Services: Attitudes the Contribute to Holes in the Net.....	300
4.8 Homeless Health Engagement Model: The Reflective Voice in Practice.....	305
4.9 A Representation of the Evolving Homeless Health Care Net: 2011.....	308
4.10 10 Key Health Messages for the Government.....	312

Chapter 5

5.1 Managing suffering through reflective guidance to sustain my practice vision.....	320
5.2 Cherry Tree Reflections: Homeless research and practice.....	322

Photographs and Collages

Chapter 1

Photographic reflections of my home.....	19
Collage of home.....	20
My parents wedding day.....	24
My sister and I, 6 months after the death of my father.....	24
DHS Tercentenary Celebrations 1706-2006.....	27

Chapter 3

Text 8: Mosaic coffee table.....	154
Peace in Pieces; peaces in piece.....	155
Rublev, The Trinity.....	156
Icon: Our Lady of Peace.....	156
Photographic expression of my experience.....	157
Collage: Reflecting on Rudi's Self-harm.....	195
Ask About Medicines Award, Westminster.....	200
Collage: Your Feelings - Self-Harm.....	207

CONTENTS	Page
Robinia Tree Reflections on mothering experiences.....	209
Spider's Web.....	247
 Chapter 4	
Cherry Tree reflection on research and practice.....	322
 Chapter 5	
McFadden's Well Straggraddy.....	333
 4. References	
Appendices	
1. Health Needs Assessment Report - CD.....	335
2. Email from Chairman of the Ethics Committee.....	336
3. Health and Homeless Leaflet	337
4. Information Letter: Night shelter Focus Group.....	338
5. Student's Poem.....	339
 Reference list	 340

ACKNOWLEDGEMENTS

I would like to offer my profound thanks to those who inspired and supported me during my thesis journey, especially:

Professor Christopher Johns whose development of reflective practice and guidance is globally recognised. The unique and noble knowledge held in nursing practice is most ably illuminated and developed through Narrative Construction. As a research genre, I look forward to its continued growth as its human caring significance becomes widely recognised.

The homeless people I met in practice, some of whom are represented in the study. I will never forget your suffering and courage, and your vociferous encouragement for me to complete this work "for the sake of others following behind us". I remain your witness to what I saw in practice.

Dr Antje Diedrich, Dr Amanda Price and Dr April Noones who became co-guides, lifting nursing practice into performance - how privileged we were to work with you. My special thanks to Antje in her role as second supervisor.

My friends and colleagues: those in the Public Health team who supported me in my learning development and those who are on similar PhD journeys in reflective practice/guidance: Lou Jarrett, Lei Foster, Margaret Graham, Adenike Akinbode, Colin McCrae, Justin Harroun and Sylvina Tate. We have shared and co-created so much together in the golden dance of the fourth movement!

Father Fintan Crotty SS.CC. who journeyed with me as a dear friend and whose Congregation first stimulated my interest in working with homeless people. You all lit my way. Especial thanks to you, Fintan, and to the Daughters of the Holy Spirit, my teachers, and to their Associates who nourished and held me closely in prayer during my illness in the last months of writing-up.

Finally, to my dearest family Tim, Grace and Sophie, no words could acknowledge all that you have contributed to this thesis.....I will always remember your music in the background - the soothing and rocking rhythms of song, piano, guitar and flute, uniting me to you during the many, many hours of writing. I love you all so much - thanks for your enduring support, Ma!

ABBREVIATIONS

CAF - Common Assessment Framework
CAMHs - Child and Adolescent Mental Health Services
CMHT - Community Mental Health Team
CPHVA - Community Practitioner and Health Visitors Association
CPN - Community Mental Health Nurse
DH - Department of Health
DCLG - Directorate of Communities and Local Government
DWP - Department of Work and Pensions
ENB - English National Board for nursing
GP - General Practitioner
HNA - Health Needs Assessment (report)
HHI - Homeless Health Initiative
HV- Health Visitor
MDT - Multi Disciplinary Team
MSR - Model of Structured Reflection
NICE - National Institute of Clinical Excellence
NHS - National Health Service
NSF - National Service Framework
PCT - Primary Care Trust
QNI - Queens Nursing Institute
RN - Registered Nurse
RM - Registered Midwife
RHV - Registered Health Visitor
SPHN - Specialist Community Public Health Nurse

1 Background

Introduction

New to homelessness health practice when my research began, I have taken a narrative approach to illuminate my development in a journey of self-inquiry and transformation over a three year period in my role as a Specialist Public Health Nurse in Homelessness (SPHN). As you, the reader, journey with me into a homelessness landscape through this PhD study, new knowledge relevant to health professionals, academics and key partners in homelessness will be revealed from insights gathered through reflective practice and reflective guidance using Johns's (2009) methodology for narrative construction, outlined in Chapter 2.

In this chapter, I provide background knowledge from which the reader can interpret my narrative journey of self-inquiry and transformation towards realising my vision of homeless health care as a lived reality. Using Heidegger's (1962/2008) *Forestructure of Understanding*, I display personal and professional influences which shaped the way I understood the world, giving meaning to my practice experiences. In personal dialogue in reflective guidance Johns (February, 2011) stated,

Because of the narrative's contextual and subjective nature, it is necessary to position myself within an appreciation of where I am coming from, where I am at now, and where I am heading to, due to the inevitable partiality of my interpretation of experience. Any claim for objectivity would be false. Heidegger's concept of fore-structure gives structure to the positioning (Johns, 2011 - unpublished notes).

The Forestructure of Understanding (Heidegger, 1962/2008)

In *Being and Time*, Heidegger (1962/2008) advocates that appreciating a person's background is fundamental for interpreting their 'world' through which understanding is revealed. He writes,

Understanding always pertains to Being-in-the-world. In every understanding of the world, existence is understood with it, and vice versa. All interpretation, moreover, operates in the Forestructure. (Heidegger, 1962/2008:194)

His ontological, hermeneutic philosophy illuminates how Being-in-the-world is shaped by a shared culture, history, practice and language. Yet, my experience of the world is unique. Consequently, I use the *Forestructure of Understanding* to help the reader position me within the text given the narrative's subjectivity. I outline the three elements of *The Forestructure* which provided structure to this chapter in Fig1.1.

How I use the Forestructure of Understanding in this chapter

Fore-having 'In every case interpretation is grounded in something we have in advance – a fore-having'.	Fore-sight 'Interpretation is grounded in something we see in advance – a fore-sight'. (Heidegger, 1962/2008:191)	Fore-conception 'The interpretation has already decided for a definite way of conceiving it ... grounded in something we grasp in advance – a fore-conception'.
Personal and professional fore-having significantly contributed towards understanding how I thought, felt and responded in my practice. They include: <ul style="list-style-type: none"> • Concepts of home and homelessness • Personal experience - childhood influences and my spiritual formation • Professional experience - an outline of my career pathway 	My job description, local and national influences gave shape to my emerging role in homelessness: <ul style="list-style-type: none"> • An overview of local health services for homeless people in 2005 • Definitions of homelessness and other Housing perspectives in relation to health services • Local multi-agency initiatives in homelessness 	Through <i>fore-having</i> and <i>fore-sight</i> my <i>fore-conception</i> emerged as my 'Practice Vision'. <ul style="list-style-type: none"> • Metaphorically, I describe my practice vision as a bridge connecting people with services, and vice-versa. When bridges are constructed my role will eventually blend into the background • I identify the research gap which this study will address.

Fig 1.1

Fore-having

Concepts of Home

In this section, I explore my concepts of home as significant threads in understanding homelessness.

I have never been homeless, at least not without a physical home. As I read a reflective practice journal entry from autumn 2004 I feel the warm verve that I experienced when I first ventured into homelessness in a unique health role in the PCT. My practice *home* was based in the Public Health Directorate rather than generic Health Visitor services which had become almost exclusively child and family focused since the Hall (1989) report and subsequent editions (Hall 1991, 1996; Hall & Elliman, 2003). In my new SPHN role I felt I was returning to the traditional 'cradle to the grave' model of Health Visiting practice in which I was trained (CETHV, 1977). After my final home visit as a family Health Visitor my journal reflections captured the liminal threshold between home and homelessness practice,

22nd September 2004

A Call into the Homeless World - From Home to Homelessness

It is a warm September morning. I am on my way to a small farmhouse to greet Jodie, a first time mother and her three week old baby. On either side of me, yellow harvested fields spread out everywhere and an exquisitely clear, blue sky gently kneels down to greet them on the horizon. Half way along the farm track my phone rings. I pull over to hear an excited voice say, "Maria, I have good news. You've got the post ... I'm really looking forward to working with you." My heart leaps. This is a sunny day.

The phone call marks the end of twenty five years working as a generic Health Visitor in family homes and heralds a new journey specialising in homeless health care. What will it be like?

'Homelessness'
Such a stark word
Like naked branches
On a winter tree
Yet I feel so energised
To be entering into its world.
I feel my passion rise,
Like a strong sentinel,
Heralding dawn's sunrise
How shall I make my nursing post
Vibrant and visible
Uniquely contributing
To the growth of health care
For homeless people
In our town
And the UK?

To appreciate my new practice role, I found myself grappling with the concept of 'home'. Returning to Heidegger (2008/1962), he states "the way in which you and I am, the manner in which we humans are on the earth is bauen, dwelling" (p.145). He uses 'bauen', the old English and High German word for building, as dwelling. The Oxford Dictionary of English defines the word 'dwelling' as house, flat or other place of residence. Two general concepts of 'home' were forming: how I, or you, dwell in the world - our ontological being; and a physical living space, usually a dwelling, which is called home. van Manen (1990) elaborates,

The home reserves a very special space experience which has something to do with the fundamental sense of our being. Home has been described as that secure inner sanctuary where we can feel protected and be ourselves (Bollnow, 1960; Heidegger 1971). Home is where we can be what we are...we feel a special sorrow for the homeless because we sense there is a deeper tragedy involved than merely not having a roof over one's head. (van Manen, 1990:102)

van Manen articulates the often deeper tragedy underlying homelessness which affects the inner being. It was something I experienced in practice and unfolded in the narrative as I came to understand the fundamental association of home and homelessness with being.

Back on my practice *threshold* in 2004, I looked away from a familiar housed population with whom I had dwelled since entering nursing, and focused my gaze on an uncharted local landscape of health and homelessness. From Jodie's small farmhouse, I pondered on the natural world and, later that evening, weaved in literature to my reflections. O'Donohue (2000) notes,

The human person is the creature that changes the wildness of the earth to suit the intentions of his own agenda... One of the first ways this happened was by clearing trees to make homes' (p.141).

Clearing trees to make homes... Like most new UK infants, Jodie's baby was born into a family home. Homes seemed to be a natural right for all human beings, as The Universal Declaration of Human Rights (1948) appears to declare,

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (United Nations Universal Declaration of Human Rights 1948 - Article 25:1).

From the threshold of Jodie's farm, I believed that very few people in our town would be without a home - and if they were, they were likely to be 'housed' in a night shelter or a hostel. Maybe some people refused to inhabit homes (DCLG, 1999, 2003) or as I have frequently heard since in my homelessness post, they "*chose* a life style without responsibility".¹ Scanlon and Adlam (2008) observed this theme when exploring the complex reciprocal schism between the *housed* and the *un-housed*. They draw on Diogenes of Sinope who philosophically chose to live in a barrel. Others, including Alexander the Great, sought to house him but Diogenes believed it was society who lived shamefully, not him. Scanlon and Adlam note that "The view from Diogenes barrel was that neither was he a part of society, nor was he completely apart from it, and so was philosophically and socially in his proper place" (Scanlon & Adlam, 2008:531). This image of choosing homelessness was not the one that fuelled my passion, nor did it equate to my professional experience of homeless families, some emerging as war-torn refugees (Fordham, 2005). Most of all, the view seemed unsustainable as I was to find out in practice. On the threshold in 2004, these deeper issues were hazy as I pondered: what led people to homelessness, how did people recover from it and how effective could I be as Specialist Public Health Nurse?

¹ A former police inspector facilitating SOVA training (Safeguarding Vulnerable Adult), a psychiatrist attending mental health and homelessness training (2008) and mental health managers, all commented on this as if it was their over-riding perception of homelessness

My Home

To understand homelessness better, I reflected on my own home. The World Health Organisation (2004:6) states,

To live somewhere involves the development of a special relationship to space, time, luminosity, self and others. A house, in its concrete reality, brings support to certain aspects of individual psychological structuring – it is the central reference point of human existence.

In their deepest sense, my succession of homes had marked my life journey: a private rented house, a social housing flat, a family terraced house, nurses' accommodation, my own bungalow, my marital home - these were the *central reference points of my human existence*. In them, like many homeless people, I had successively been an infant, a child, a friend, a wife and a parent.

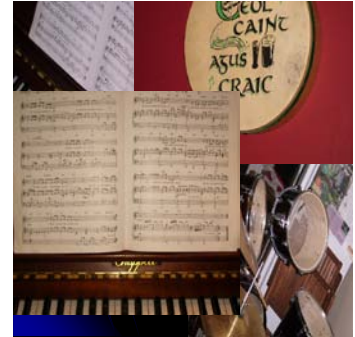
Following a reflective guidance photographic workshop,² I used photography and collage to reflect further. The camera became a tool for contemplative awareness (Farely-Hansen, 2001). Baudrillard (1997) sees photography as a mirror. Commenting on Baudrillard's reflective concept, Butler (2005) sees photographs as a "coming together, in which each part contains the whole" (p.9). Each of my photographs (Fig 1.2) had a history beyond its image, for example, the cassoulet pot - a wedding present - connected me with my husband and his family; at a deeper level it connected with countless meals past and present with family and friends. Globally, it reminded me of other people using cooking pots and linked me to those without them - the hungry and homeless. I thought of different tables that I inhabit - those in my office, my clinic, my home - and the people that surrounded them. My cassoulet pot, like other photographs, seemed to contain the whole (Baudrillard, 1997). Photography had raised awareness of my empathic connection with the world (Rifkin, 2010) and grounded me in 'home' as *the* place which provided me with the strongest identity of my selfhood (Hodgetts et al, 2007).

² PhD summer School of Reflective Practice (2006): Kay Goodridge, photographic artist, facilitated this workshop for reflective practice students on 25 October 2006 at University of Bedfordshire



Reflections of Home

- Cooking as homeliness
- Children to nourish
- Family to celebrate
- Nature to find rhythm in
- Music to harmonise with



Home as welcome and belonging

Home as recuperation

Home as memories



Home as space

Home as spiritual

Home where naked branches are dressed in dew

Photography by Maria Fordham

Fig 1.2

My reflections on home continued in a collage workshop on 'Intentionality and Healing' (Zahourek, 2006).³ Twelve nurses from across the globe spent an hour making collages from torn magazines; mine emerged as '*Home as Healing*' (Fig 1.3). An interpretation follows.

Fig1.3



Home as Healing Collage

Two red hearts sit juxtaposed, signalling beginning and end of a collage journey. The hearts represent love. The empty heart represents numbness, alienation or suffering; the 'full' one symbolises life, energy and recovery. The observing eye captures a willingness to look at one's own heart and acknowledge suffering in the life journey. Removal of defences to acknowledge suffering is represented by the nakedness of the woman in the shower. It may lead to a desert experience; the Landrover represents unexpected paths leading to healing. The reflective yoga pose represents the benefits of meditation to bring about balance, harmony and well being. Rich, meditative moments remind me that healing journeys like the four seasons of nature can-not be rushed. The garden represents wisdom to appreciate time. The busy kitchen mirrors daily living. Strength and vitality emanate from each person: meals are prepared, jokes retold, laughter ripples, the dishwasher fought about. It is a safe place to explore vulnerability when anxieties occur. 'Head stands' represent varied perceptions and world views to create deeper understanding. The open front door expresses individuality, a threshold which I freely passed through to work and study, set alongside my family role. Above the mantle, a picture of a lamb rests. It reminds me of God. Home, healing and belonging extend beyond the human family, into timelessness and space.

International Reflective Practice Conference, July 2006

³ Facilitated by Rothlyn Zahourek in 2006 at the International Reflective Practice Conference, Cambridge, England

Are reflections of home transferable to the 'homeless' world?

If concepts of home were significant to me as healing, love, family, belonging, space, nature, opening and closing a door, how were these experienced by homeless people? How, for example, were homeless people healed?

In this deepening awareness, I became conscious of an innate fear that I might ever be homeless. Violence, and the dirt and degradation of sleeping on the streets, were those I feared most. Later, I discovered photo-elicitation interviews in a study with twelve rough sleepers on their material and spatial considerations related to health (Hodgetts et al, 2007). Jean, a rough-sleeper, crystallised my thoughts,

I took these photographs because there is a man pissing... the steps and corners and crannies are often weed upon. So if you bed down at night, you know there's a big chance that somebody has weed on that spot....so you'd often lie in someone's urine....Yeah, that's what homelessness means it's dirty...filthy...horrible...degrading. How filthy is urine? (Hodgett's et al, 2007:716)

Dirt, neglect and the "inability to transcend the contamination of homelessness" (p.716) was significant for rough-sleepers in Hodgett et al's study and juxtaposed with the 'spaces of care' (Johnsen et al 2005:787) like Westminster's *The Passage*,⁴ which provided Jean's material and psychological comfort. 'Spaces of care' were places to 'be and belong' (Hodgett, 2007:716), providing communities of friendship and support. 'Spaces of care' were present in my home town (soup run, day centre, night shelter) and periodically I had responded to their financial appeals.

⁴ The Passage is set amidst Westminster Cathedral as a homelessness humanitarian facility offering food, shelter and health care.

Personal Fore-having

An overview of my personal fore-having is shown below (Fig 4.1).

Personal Fore-having		
<p>Family</p> <p>Married to Tim, a solicitor</p> <p>We have two daughters: Grace and Sophie</p>	<p>Profession</p> <p>RGN RN RHV Nurse Prescriber BA (Hons) Health Care</p> <p><i>See Fig 1.3</i></p>	<p>Community Leadership</p> <p>School governor/ Playgroup chair person.</p> <p>Eucharistic minister, Baptism preparation leader, Mothers' prayer group founder/leader.</p>
<p>Illness</p> <p>Hospitalised with pneumonia, aged 6 yrs.</p> <p>Endometriosis: partial bilateral oophrectomy (aged 24)</p>	<p>Childhood Trauma</p> <p>My father's death from Tuberculosis occurred when I was six months old; my sister was three</p>	<p>Housing</p> <p>Social housing triggered by my father's death - a small, damp flat</p> <p>Aged 11, we moved to a our own terraced house beside a park and river. It was a palace to me.</p> <p>I live in a leafier suburb in the same town. I feel a sense of continuity with the past</p>
<p>School Experience</p> <p>Early education marked by free meals, free bus passes and free uniform.</p> <p>High absence: asthma and pneumonia Experience of being bullied Integrated well in upper school – after moving out of social housing</p> <p>30 (homeless) boys from St Francis Children's Home attended same school</p>	<p>Personal Feminist influences</p> <p>Raised in an empowering, caring female household. My mother was a natural family leader and homemaker.</p> <p>Heroic stories born from my aunt's nursing experiences in Africa and war torn Glasgow.</p>	<p>Culture and Religion</p> <p>Catholic Irish roots</p> <p>Active in two organisations: Daughters of the Holy Spirit (DHS) Sacred Hearts' (SSCC)</p>

Fig 1.4

Three themes emerged through my personal Fore-having which I draw on in practice. They are:

- Trauma
- Resilience
- Community

Trauma

In the narrative, a history of trauma is evident in all texts concerning homeless people. The aetiology of the word trauma emanates from the Latin word for wound (Walsh, 2007). Frank (1995) and Nouwen (1979/2005), self-proclaimed 'wounded' storytellers, describe how their

woundedness became a source of empowerment, moving them from passivity to an activity of service and healing (Frank, 1995). Walsh (2007) identifies certain types of loss as trauma: violent death, sudden death, prolonged suffering, ambiguous loss, unacknowledged stigmatised loss (e.g. HIV/AIDS), past traumatic experience. One type of traumatic loss, *untimely death*, is evident in my personal Fore-having (Fig 1.4). Walsh notes that,

Untimely losses are hardest to bear. The death of a child or young spouse seems unjust and robs future hopes and dreams. The loss of parents with young children requires reorganisation of the family system (Walsh, 2007:209)

The Death of my Father

Each Christmas, my elderly aunt reminds me that as a six month old infant I, with my sister and mother, spent our last Christmas day with my father when he arrived from hospital with an oxygen cylinder to spend a few hours at home. His eleven month journey with Tuberculosis culminated in his death shortly after midnight on New Year's Day. He was 32. His death had rippling effects on my life which significantly affected other parts of my childhood, including our housing status. It was a trauma from which we as a family had to surf, survive and recover.

As a result of his death, our family system re-organised (Walsh, 2007). We moved into council housing (social housing). Our mother juggled retail and cleaning work to be 'there and care' for us with the help of her sisters, one of whom was a nurse/midwife. Listening to my aunt's war stories of nursing inspired by imagination and guided my career path. A degree of poverty was part of our childhood. Practical assistance made a significant difference; one day, a brilliant white twin-tub washing machine, encircled with a large, red, taffeta ribbon arrived at the door of our upstairs flat. I remember our delight. My mother had won it in a raffle and its arrival meant she no longer had to trample the weekly washing in the bath, carry the wet load down the concrete staircase, along a narrow long footpath to reach our garden; a substantial haul with two young, children. The twin-tub became part of our family's recovery.



24th July, 1954

My parents, Ellen and John, on their wedding day.



Summer 1959

My sister Kathleen and I six months after my father's death.

The social housing area that we moved into remains in the top 2% deprived areas in our local area (Public Health Report, 2010). Some of the flats are designated temporary accommodation properties for homeless people.⁵ Living now in the least deprived area of our town, the average life expectancy for women is 83 years, five years more than the deprived area around my childhood home (Public Health Report, 2010). The five year gap arises in less than a five minute car journey. Strikingly, the same gap for men is eleven years. In the Government's extensive report on Health Inequalities, Sir Michael Marmot (2010) illuminates,

In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods. Even more disturbing, the average difference in disability free life expectancy is 17 years. So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability (Marmot Review, 2010:16).

My experience of living in neighbourhoods where health inequalities arise due to inequalities in the conditions of daily life, has enabled me to appreciate hardship caused by deprivation. Nothing, however, could have prepared me for the deprivation I was to witness in homelessness where the average age of death for rough sleepers has been estimated to be between 40 and 44 years of age (Halligan, 2009; DH, 2010).

Resilience and Community

Landau (2007) and others, cite resilience as an alternative to vulnerability following trauma. Drawing on her work as a clinical psychologist, she defines resilience as an,

Inherent capacity, hope and faith to withstand major trauma, overcome adversity and prevail with increased resources, competence and connectedness (Landau, 2007:352)

My Fore-having is filled with community activity demonstrating resilience. Resilience is fostered through belief systems, organisational patterns and communication processes reducing vulnerability which may present as: anxiety, depression, family violence, addiction, relational conflict and family cut-off (Landau, 2007; Walsh 2007). Resilience manages trauma and facilitates post-traumatic growth (Landau, 2007). It is engendered not simply by an individual's own disposition but also by families and communities who foster connectedness and act as agents for change. Landau cites families as the essential unit for negotiating successful transition towards resilience, wherein hearing ancestral stories of surviving trauma and simply connecting to family once a month, reduced risk-taking behaviours like sexual risk and subsequent exposure to HIV. My Fore-having illuminates how family and community fostered my resilience. Yet, for homeless people family and community is a complex area to be negotiated as the narrative shows. Nevertheless, the premise on which resilience is based is that people who have experienced loss are transformed when they discover new strengths which they had previously been unaware of

⁵ Local authority temporary accommodation (TA)

(Lefebvre et al, 2006:349). Additionally, in his document on health inequalities, Marmot (2010) endorses resilience - conceptualised as social capital - as critical to health and well-being.

Social capital describes the links between individuals: links that bind and connect people within and between communities. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental well-being. (Marmot, 2010:16)

Roman Catholicism

My resilience and social capital was partly forged within a Catholic community; a global community filled with music, symbols, story, colour, reflection, transformation, performance, actors, audiences and family. Christian theology and Christian iconology deepened my reflective understanding of joy, love, suffering and compassion, and my response to it. Some examples are illuminated in the narrative. On suffering, the Catholic spiritual writer Nouwen (1979/2005:72) writes "who can take away suffering without entering into it?" The challenge in my health practice has always been to be open to the suffering of others as a principle of humanitarian solidarity. In his encyclical letter on Social Concern (*Sollicitudo Rei Socialis*), Pope John Paul II (1987:38.2) wrote,

When interdependence becomes recognized ... the correlative response as a moral and social attitude is solidarity. This then is not a feeling of vague compassion or shallow distress at the misfortunes of so many people ... it is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all.

Poignantly, in the same encyclical, he noted,

The lack of housing...should be seen as a sign and summing up of a whole series of shortcomings: economics, social, cultural or simply human in nature. Given the extent of the problem we should need little convincing of how far we are from an authentic development to peoples (*Sollicitudo Rei Socialis* 1987:17)

Catholic Social Teaching (CST) and the principles of justice and peace informed my practice. Commitment to the 'common good' is a moral philosophy of social concern which is nourished through my affiliation to two religious orders:⁶

- **The Congregation of the Sacred Hearts of Jesus and Mary (SS.CC)**

The SS.CC congregation is a global missionary order. Our town's 'soup-run' for the homeless was initiated by the SS.CC priests at the parish church I attend and they were co-founders of the homeless day centre. In October 2009, I attended the Vatican for the

⁶ The common good embraces the sum total of all those conditions of social life which enable individuals, families, and organizations to achieve fulfillment ([The Common Good and the Catholic Church's Social Teaching A statement by the Catholic Bishops' Conference of England and Wales 1999](http://www.catholic-ew.org.uk/The%20Common%20Good%20and%20the%20Catholic%20Church) accessed 31.12.10 www.catholic-ew.org.uk/The Common Good and the Catholic Church)

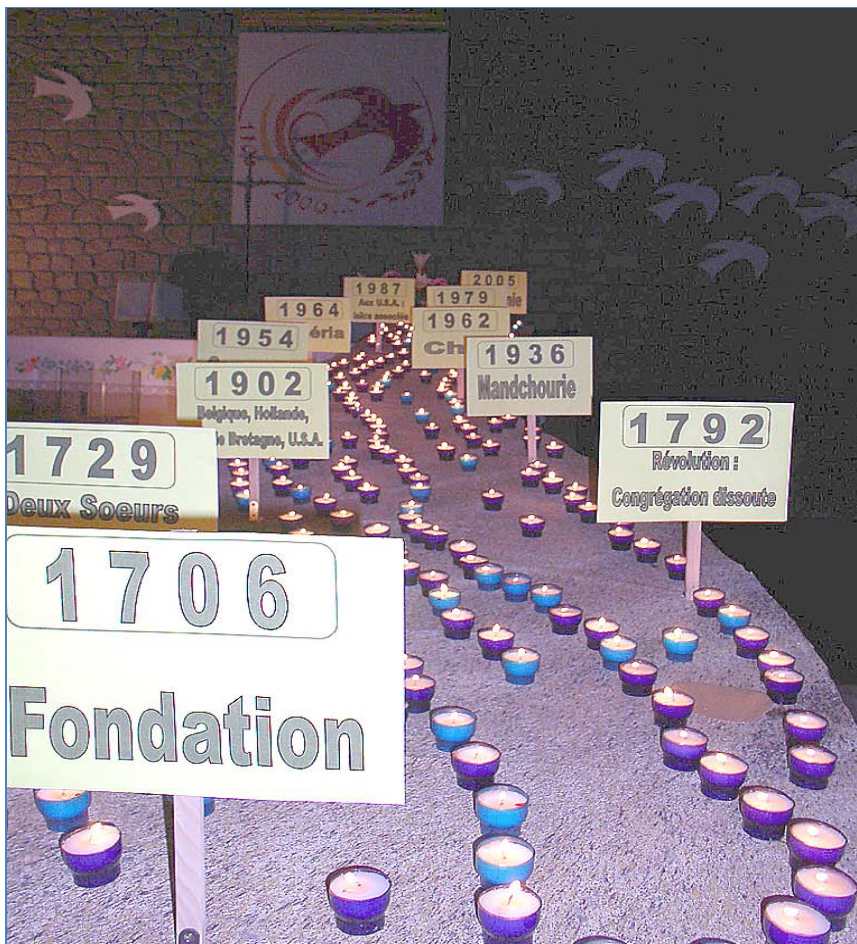
canonisation of Saint Damien De Veuster, an SS.CC priest who lived and died on the leprosy colony of Molokai, having devoted his priesthood to those marginalised by leprosy.

- **The Daughters of the Holy Spirit**

In 2000, following two years formation, I became an Associate of the Daughters of the Holy Spirit Sisters and am currently the Justice and Peace UK provincial representative.⁷ The sisters are aligned to people living in poverty. They work in nursing, medicine and teaching, often in third world countries. My work in homelessness and their work with marginalised communities resonate with Marmot's report on addressing health inequalities (Marmot, 2010:34),

Social justice is a matter of life and death ... we can all easily recognise the health inequalities experienced by people...for whom absolute poverty is a daily reality.

DHS Tercentenary Celebrations 1706-2006



The 'Daughters of the Holy Spirit' arrived in Britain in 1902. This image was created for the tercentenary celebrations (2005) of their global presence emerging from their early origins of nursing and teaching in Plerin.

Sister Ann (DHS), a retired Health Visitor, prepared meals at the day-centre where I held my weekly clinic for homeless people

⁷ The religious order was formed in Plerin, Brittany in 1702 when two married women, Marie Balavenne and Renée Burel committed their lives to the sick, the poor and children. Current Justice and Peace issues include child trafficking and global warming.

Professional Fore-having

My career pathway is illuminated below: (Fig 1.5)

Clinical Practice/ Qualification	Professional Experience
Student Nurse RN	1976-1979 Enjoyed theatre, A&E, gynaecology
Student and Staff Midwife RM	1980 -1982 Training consolidated in a busy unit (5,000+ births per annum).
Community Midwifery Sister	1982-1984 Busy urban/rural practice mix. 5 home births.
Health Visitor student RHV included 1 year counselling certificate pilot project	1984-1985 Health Visitor/School Nurse training. Rural area. High rates of post-natal depression/maternal isolation. 'Neighbourhood study' published in Health Visitor journal ⁸ .
Health Visitor/School Nurse: ENB 998: Teaching and Assessing	1985 – 1990 Market town: 'cradle to grave' HV practice: high caseload of single mothers, high safeguarding need/children on 'child protection' ⁹ register, fathers in prison, children with severe disabilities, parental and child bereavement, 75 year old elderly assessments and bereavement visits. School Nurse to 3 local schools.
Health Visitor (1 year maternity leave) ENB: HIV/AIDS	1990 -1994 County town: women's refuge and Life hostel visits. High BME caseload. Safeguarding needs. Professional lead 'Care of the Next Infant' (CONI) following sudden infant death, (training and support to Health Visitors and families). Facilitator: NHS Child Minding Project
Part-time Health Visitor (1 year maternity leave)	1994 – 1997 Rural area: Professional/farming families. A&E/ Neo Natal Unit liaison cover.
Part-time Health Visitor	1998 -1999 Town centre practice. Initiated post-natal depression support group (PETALS). Neo-natal liaison. Experienced significant conflict with colleague
Health Visitor BA Hons - Health Care; ENB A29 Reflective Practice; Nurse Prescriber	2000 – 2004 High case-load of refugees. High safeguarding needs. County Foster Panel member (2003-2005).
Part-time Specialist Public Health Nurse - Homelessness MPhil/PhD begins 2005	2004 – 2009 Clinical/strategic homelessness role in Public Health Directorate

Fig 1.5

⁸ Conroy, M. F. (1986) An Approach to the Neighbourhood Study - a framework for Health Visiting Practice *Health Visitor Journal* 59 (11) 333-334

⁹ 'Safeguarding' was previously referred to solely as 'child protection'

Being a Midwife, Health Visitor, School Nurse

My professional Fore-having is set against a background of universal and targeted health promotion programmes for children and young families (DH, 2004; DH, 2007; SEU, 2006), as well as preventative health to support children and families for those in most need (NSF DH 2004, DH 2007, SEU, 2006). Latterly, this includes those who are homeless or living in temporary accommodation, and those who have fragile social networks (DH 2007). At its core, is my experience as a Health Visitor (HV) supporting young families. The Queens Nursing Institute (QNI) emphasized the qualities which HVs hold,

Health visitors, arguably, face a wider range of changes and influences than other groups of nurses. This is because of their holistic view of health and prevention and their position at the interface between the NHS and local authority, nursing and public health, general practice and children's centres (QNI, 2007:11).

'The Four Pillars of Health Visiting' (CETHV, 1977) were key principles for my homelessness role embracing prevention, holistic practice and multiagency collaboration. They are:

- The Search for health need
- Stimulation of an awareness of health need
- Influencing policies affecting health
- Facilitation of health enhancing activities

These pillars became my mantra - an apt Health Visitor model of practice to use in a role where I felt like a pioneer in homeless health care.

Family breakdown is a major cause of homelessness and strengthening families to prevent it was highlighted in a recent (The) Fabian Society report (Smith, 2010),¹⁰

For the majority of homeless, addicted or offending adults their problems did not start in adulthood - the risk factors were evident much earlier. Around half of all prisoners ran away from home as a child, almost a third were in local authority care, half were excluded from school and two thirds have a numeracy level below that of an 11 year old child. Similarly, up to a third of rough sleepers were in care, 40 per cent of homeless young women were sexually abused as children and family conflict is the main immediate cause of homelessness for at least two thirds of young homeless people. We also know that substance abuse correlates strongly with the experience of family breakdown and dysfunction amongst young people (Smith, 2010:19).

Being a Health Visitor, School Nurse and Midwife acutely alerted me to homelessness prevention as insights in practice emerged.

¹⁰ Family breakdown - a main cause of homelessness, collected by Local Authority housing departments for the collation of national statistics

Being with woman; being with child

The central theme of my experience as a midwife and Health Visitor (HV) is 'being with women and children'. *Being with women* opened my mind early on, to the complexities of life: a young mother in an incestuous relationship with her father, giving birth; red writing alerting me on clinical records to strict confidentiality about the fathers non-paternity on the labour ward; being with a young teenager as she 'handed-over' her infant for adoption. Such experiences raised my consciousness of complex life journeys from birth onwards.

In a study by Plews et al (2005) *Being there* is one of six themes which clarify the unique contribution HVs make to the well-being of clients, compared with other agencies.¹¹ *Being there* similar to *being with* meant *being available* to discuss problems with mothers where mothers felt something special about speaking to a HV, "... a willingness to discuss anything, not being patronized, experiencing genuine interest" (p.795). *Being available* is a key theme in my homelessness practice.

Contrary to research which found that HVs were not meeting the public health needs of women (Pritchard, 2005) whether as single unsupported mothers (Knott & Latter, 1999), in domestic abuse (Frost, 1999, Peckover, 1999), with postnatal depression (Higgins, 2001) or with prostitutes (Lazenbatt et al, 1999) I was drawn to these areas of high need in Health Visitor practice as Fig 1.5 illuminates. I sought to support mothers to attach appropriately to their infants (Cassidy & Shaver, 1999) and to navigate emotional tensions as they arose in parenting, illness or development delay - key elements in my role. I was intrigued to understand more about homeless women who may or may not be mothers and how *being with* them would unfold in practice.

The marginalization of men's health was noted in a study of HV practice (Williams, 1997), although a more recent study by North Staffordshire Health Visitors shows the effectiveness of male-friendly 'MOTs' for men in deprived areas (Linnell & James, 2010). My *Being with* men as a Health Visitor included single parenting, bereavement counseling and men's health promotion events. It was an area of health which I believed would be significant in single homelessness practice.

County Foster Panel

'Looked After Children' (LAC) features strongly in homelessness. One study cites between a quarter and a third of rough sleepers as being 'looked after children' (Social Exclusion Unit, 2001).

¹¹ Themes relating to the unique contribution of Health Visitors included: Feeling bad, She knows what she is talking about, Other people, Being there, Lifting a weight, Safety net (metaphorically links into my narrative plot described in Chapter 2).

As the health representative on the County Foster Panel, I reviewed medical reports that accompanied legal papers, providing a health perspective on needs of foster carers, parents and children. The role of the panel was to approve and review all fostering arrangements. When I initially realised that safeguarding concerns arose within fostering placements - something I had not anticipated when attending child protection meetings to safeguard children as a HV - I was alarmed.

Fore-sight

My *Fore-sight* evolved from national and local guidance and from my job description, grounded in the following words spoken by Louise Casey, Head of the Rough Sleepers Unit,

It is clear that many Primary Care Trusts and GPs have had limited contact with housing departments, little or no involvement in the development of homelessness strategies and may not view housing providers as the natural partners of health. This underlying situation is likely to limit health agencies understanding of the potential role they can have in preventing homelessness and of how housing and support agencies can reduce demand for health care services... the review and strategy process appear to have been useful in making clear to local authorities the complex nature of homelessness and how important close joint working between statutory agencies is, in order to reduce it. (Casey, 2003:16)

Casey's (2003) message was *the* siren for health professionals to grasp their role in preventing homelessness by working collaboratively with multi-agency services, promoting access to health services for homeless people. Raising awareness of homelessness in mainstream health services was crucial clinically; strategically, I was responsible for facilitating the health actions in the first homelessness strategy, a statutory evolution from *The Homelessness Act 2002*. PCT responsibilities were:

- Jointly, identify gaps in service provision in the priority areas which impact on homelessness.
- Review hospital discharge procedures to ensure that discharged patients without access to accommodation receive appropriate assessment and support.
- With the Council, implement joint solutions which will meet needs.
- Jointly, investigate access to health and other services of families in temporary accommodation

My role would culminate in the production of a HNA report with recommendations for developing health practice (Appendix 1). I have contextualised my role further within local services in the following section.

Who are the Homeless?

In this section of Fore-sight, I will:

- Define homelessness
- Provide a local overview of single and family homelessness
- Show local health access points for homeless people in 2005
- Provide an overview of my SPHN role

Defining Homelessness

The most common definition of homelessness in the UK originates from the *Housing (Homeless Persons) Act 1977*. In its simplest form, Williams et al (2002:315) defines homeless people as those "Lacking secure accommodation, free from violence, or the threat of violence". The *Housing (Homeless Persons) Act 1996* requires local authorities to categorise people who present as homeless into three areas:

- Unintentionally homeless and in priority need¹²
- Intentionally homeless and in priority need
- Housed in temporary accommodation pending enquiries and a homelessness decision, or housed under discretionary power

There is an additional responsibility to identify statutory and non statutory homelessness (Fig 1.6). A duty of care by Local Authorities is provided to those in the statutory homelessness category only.

<p>Statutory Homelessness</p> <ul style="list-style-type: none">• Those who are in priority need i.e. have dependent children or are an older person, household, or vulnerable.• Those who are <i>not</i> classified as <i>intentionally homeless</i>• Those without the right to access secure accommodation for that night, are not legal tenants of any property, nor own property anywhere• Those whom may be classed as about to lose their dwelling within 28 days• Those who have a local connection to the area
<p>Non-statutory homelessness:</p> <ul style="list-style-type: none">• Non-statutory homeless are those to whom the local authority has no obligation to house either because they are deemed <i>intentionally homeless</i>, or are not in priority need categories. These include single homeless, many of whom happen to be young people of both sexes and in the larger cities of different ethnic groups as well as older white men (Smith, 2003)

Fig 1.6

¹² 'Priority need' categories are a key are to health services as they include: families with children, older people aged 60 years and above, those vulnerable on account of mental health issues, learning difficulties, physical health young people at risk, ex-members of the armed forces, those who have been in prison as set out by Smith (2003) from Housing Policy and Community Research Institute in a review of the impact of legislation on the definition of homelessness and on research into homelessness in the UK.

Pertinent to health services, Crane & Warnes (2001a) in their report on the responsibility of health care for single homeless people noted:

- There is only a *statutory* obligation to keep homelessness statistics on those who are *in priority need*.
- *Non-statutory* homelessness particularly affects single homeless people who are then not registered as homeless with Local Authority housing departments and do not appear in homelessness statistics. They are more likely to be unserved by statutory services and fall between housing, health and social services (Crane & Warnes, 2001).

The Local Picture: Family and Single Homelessness

Homelessness can be divided into single homelessness and family homelessness. Sixteen to seventeen year olds threatened with homelessness are included in family homelessness (DCLG, 2008a). I shall briefly outline the local issues in the following section.

Family homelessness

In 2005 the majority of homeless people were families living in temporary accommodation (TA) or people staying with relatives or friends reflecting the national picture (Cook et al, 2004). Homeless families have complex and inter-related health, social and educational needs which often results in increased multi-agency working.¹³ In a key strategic document for health service development of family homelessness, Cooke et al (2004) drawing on Greenhill and Redican (2002) highlights how families moving into TA are often in crisis, arriving without medication and with outstanding health needs.¹⁴ Locally, I identified accommodation units for 130 children experiencing family homelessness.¹⁵ Homeless families were required to access health services in the same way as the general population. Without a notification system in place between housing and the PCT, some were potentially unknown to health services (Cook et al, 2004). I benchmarked other models of practice to senior managers and included them in my HNA report (Appendix 1).

¹³ Detailed in the Health Needs Assessment Report - Appendix 1

¹⁴ See Vostanis, P. (1999) *Homeless Children*. London: Jessica Kinglsey; Jenkins, M. & Parlo, C. (2011) Evaluation of health services received by homeless families in Leicester *Community Practitioner* 84(1): 21-24; HNA (Appendix 1).

¹⁵ The Local Authority informed me that they had met the government target of no children placed in B & B but accommodation for 20 families from out of area was provided in our locality.

Single Homelessness

- *Rough sleepers*: In 2005, housing managers informed me that under the Government criteria statutory counts¹⁶ were unnecessary because only three rough sleepers were officially known about in our area even when 'anecdotal' evidence from local homeless services illuminated eight further rough sleepers. This confirmed Crane and Warnes (2001a) findings that rough sleeping counts significantly underestimate levels of rough sleeping. I pondered: how could health services commission health services when accurate data on rough sleeping was not provided?
- *Night shelter*: Forty-two different people used the eighteen bedded unit in Nov 2005. Six people were regularly turned away when it was full.
- *Hostels*: Nine hostels offered accommodation to young (16-25 yrs) and older (25+) homeless people. One rural site also offered employment.
- *Day Centre*: The centre had between seventy and eighty vulnerable people attending in the winter of 2005.

Newly in post, I was alerted by the Local Authority to a report by the housing charity Crisis (2002) on an exploratory visit to our town.¹⁷ It contained focus group findings from homeless people about their disconnection to GP and mental health services locally - even in the face of suicide attempts.¹⁸ This correlates with recent DH (2010) report on single homelessness where research, also by Crisis (2002), show homeless people being forty times more likely to be unregistered with a GP than the general population. Barriers include (DH, 2010:17):

- Proof of identity required for GP registration
- Homeless people generally have poorer engagement skills and chaotic lifestyles, making it difficult for them to book and keep appointments
- Presenting when illness is critical because other needs are more critical

The Crisis report also stated that locally, "There is lack of willingness to listen carefully to those receiving services and to make improvements" (Crisis, 2002a:13).

To improve health access and address health inequalities in homelessness, the local issues I needed to address were substantiated in a report by the Government's Rough Sleepers Unit (Griffiths, 2002):

¹⁶ In 2005 rough sleeper counts were performed if three or more rough sleepers were known about. It took place for one hour, on one night of the year.

¹⁷ Crisis (2002) *Exploratory Visit of Crisis to (anonymised) Report* 12th September 2002. London: Crisis

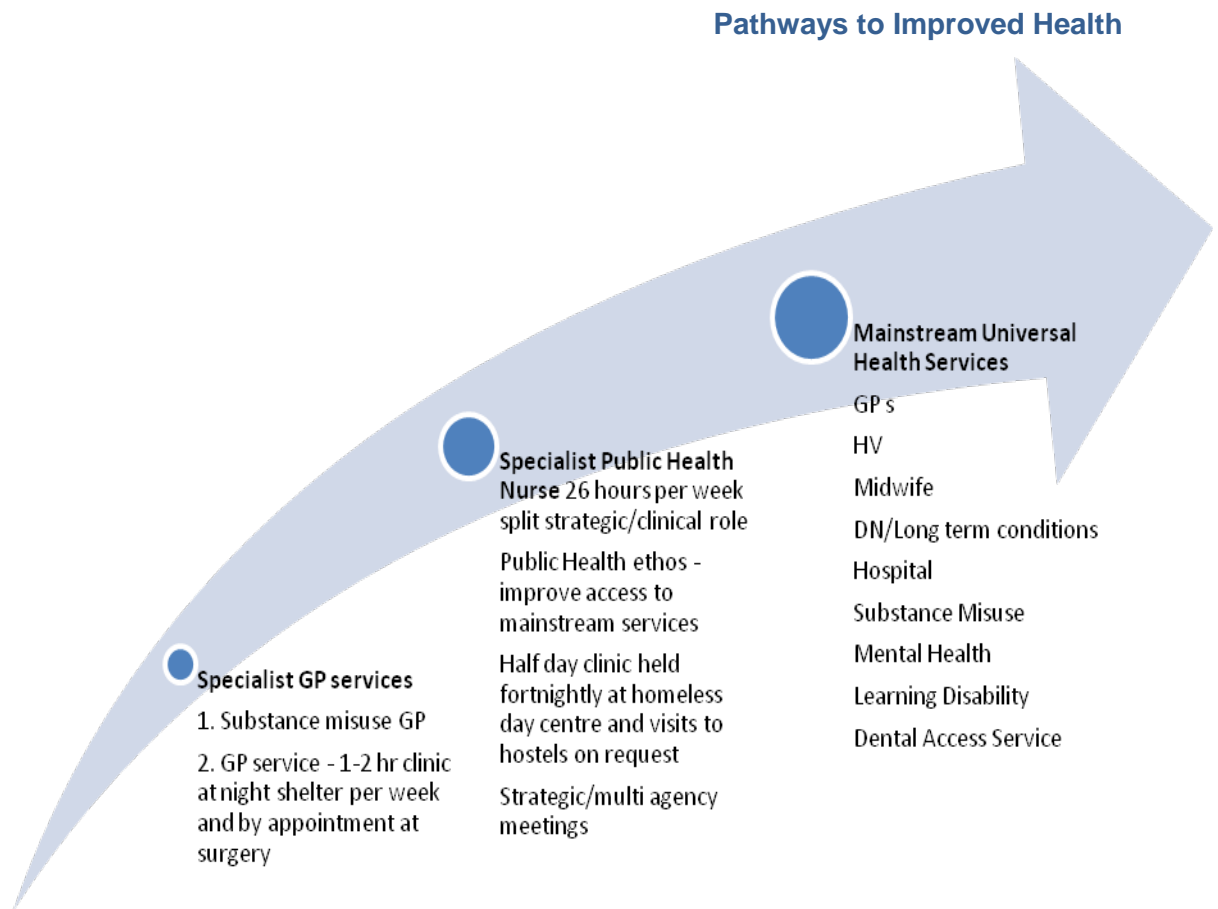
¹⁸ In my focus groups (2006-7) the GP at the night shelter was very well regarded by homeless people who were respondents.

- Listening to the voice of the homeless
- *Being available* to homeless people to engage them in health services

Both were significant for developing my practice vision as discussed later under Fore-conception in this chapter.

Local health services for single homeless people in 2005

Health access points for homeless people in 2005 include my new clinical role are shown in Fig 1.7



Health access points into health care for homeless people

Fig 1.7

- **Medical Models**

Two small, separate medical models of health care for homeless people were provided: A GP held a weekly clinic at the night shelter; a specialist substance misuse GP provided a weekly

clinic at the day centre.¹⁹ Neither service had funding for computerized medical records for outreach clinics.

The general ethos at that time was that all GPs should be accessible to homeless people, to share 'the burden'.²⁰ This synchronized with a Public Health momentum towards inclusion of homeless people in mainstream services. A tension existed about creating a dependency culture in homelessness through specialist services preventing homeless people using mainstream services. However, to reduce health inequalities and the subsequent high burdens of ill-health caused by extreme exclusion the need for specialist consideration (DH, 2003) was necessary. I met the two GPs independently from each other at their outreach clinics. It was agreed that I would deliver clinical services at the day centre and hostels, promoting where necessary mainstream access.²¹ This set a clinical pattern which continued until 2008.

- **Substance misuse services and mental health services**

Focus group respondents described local drug services as 'brilliant' but mental health services were a key concern to homeless people and to homeless services. Additionally, the mental health assertive outreach team only accepted referrals for people registered with a GP. Nationally, Homeless Link's Survey of Needs and Provision (SNAP) report (2009), reviewed the clients of homeless services and found 43 per cent had *mental health* problems and 59 per cent had *multiple needs* (including dependency and physical health problems).

- **SPHN Role**

This is organised as:

- Role overview
- Working with the voluntary sector
- Homeless Health Needs Assessment report
- Health alignment and support

Role overview:

How would my role be perceived by the homeless? Power et al (1999:23) noted,

There is a common assumption that homeless people have made a conscious choice to disengage from helping services. Moreover, it is often assumed that they are so socially alienated and disengaged from normal expectations that they will have no interest in improving their health.

¹⁹ In my later focus groups with homeless people, the GP service was highly valued by homeless people

²⁰ Initial conversation about access to health services with night shelter GP

²¹ People from the night shelter could access my day centre clinic and I would support night shelter staff on health and homelessness through access to training, information etc.

Would they engage with me? The WHO (2000) quote from the Munich Declaration provides an awning to contextualize my role,

We believe nurses and midwives have a key and increasingly important role to play in society's efforts to tackle public health issues of our time; as well as ensuring the provision of high quality accessible, equitable, efficient and sensitive services which ensures continuity of care and address people's rights and changing needs. (World Health Organisation [WHO] 2000:1)

My role was divided into five main areas:

- *Public Health*: Produce a Health Needs Assessment (HNA) report of the needs of homeless people
- *Strategy*: Multi agency partnership work (E.g. multi agency hospital discharge policy)
- *Clinical*: Facilitating access to health services for homeless people, providing a clinic to single homeless people and providing consultative clinical advice to health visitors
- *Education*: Provide education and training on health and homelessness to NHS staff and homeless services
- *Consultation*: Support mainstream health care staff by providing expert advice on health and homelessness

I held a financial budget of £2,000 per annum.

Working with the voluntary sector

A vibrant voluntary sector existed locally, meeting strategically as the housing forum, comprising of statutory and voluntary services. Latterly, I was a member of the executive committee. The multi-agency development that I was involved with occurred largely through the forum, for example I brought my concerns about evictions to the forum and local authority partners. Subsequently, eviction processes were improved as the narrative illuminates.

Homelessness Health Needs Assessment report (HNA) (Appendix 1)

As I began the PhD narrative, I was collecting data for the HNA, a gaps analysis and benchmarking tool on Health and Homelessness for directors and senior managers in the Public Health Directorate but also for health practitioners.²² The narrative illuminates the development and dissemination of the report with my recommendations to senior health managers, commissioners and multi-agency partners.

²² The term Health Needs Assessment (HNA) has come to mean an objective and valid method of tailoring health services, evidence based approach to commissioning and planning health services (Perkins, et al 2005).

Health alignment and support

Based in the Public Health Directorate, my line manager was a Public Health manager. A named Health Visitor manager declared she knew nothing about homelessness, and met me infrequently. My clinical support came from two key areas:

- Nationally, I travelled to UK venues to attend the Homeless Nurse Group UK (HNGUK) which became the Homeless Health Initiative (HHI) under the umbrella of the Queens Nursing Institute.
- Locally, in the PhD School of Reflective Practice which ultimately guided and developed my practice as research.

Fore-conception

Emerging through Fore-having and Fore-sight, Heidegger (2008/1962) identifies Fore-conception as 'something to grasp' as the final stage in the Fore-structure of Understanding. 'Something to grasp' is my practice vision as I began my research journey. O'Donohue inspired me,

The way you see things makes them what they are.... Your vision is your home. ...life comes to embrace us and lead us into the pastures of possibility (O'Donohue, 2000:170)

Vision of Practice

My practice vision remained foggy for six months until I attended the International Reflective Practice Conference in Reykjavik in June, 2005. There, mellow sounds of Simon and Garfunkel singing Bridge over Troubled Water mesmerized me during Jonasdottir (2005) paper on her reflective practice research with women receiving treatment for breast cancer. Poignant lyrics - *Down and out, on the street, falls so hard, and comfort you* - captured an emerging vision: I would become a bridge in homelessness health care (Fig 1.8).

BUILDING BRIDGES IN HOMELESSNESS



Fig 1.8

With this metaphor in mind, I was able to articulate a vision statement to fulfill its function in detail (Johns 2002), (Fig 1.9).

Becoming an expert practitioner and strong voice in the PCT on homelessness

Space will be created for therapeutic clinical encounters where appropriate care reduces the suffering of homeless individuals and families. Timely clinical interventions will ease their journeys through homelessness and provide optimal opportunities for improved health. In turn, this will enhance opportunities to obtain and sustain suitable accommodation.

A core value will include the development of services across the PCT so that access to health care is equitable bearing in mind the specific needs of homeless people. To facilitate this, clinicians and all health care staff will be educated in the particular needs of homeless people so that stigma is reduced and discriminatory practices challenged where they exist.

The SPHN accepts responsibility for creating opportunities for the voice of homeless people to be heard so that their health needs are known. This may be through clinical encounters or in the participation of multiagency groups in homelessness. In this way homeless people will be empowered to contribute to the development of local health and other services in which policy, procedures and recommendations are made and multi-agency strategy is effective.

The SPHN shall collaboratively work with homeless service providers whose vital work often remains hidden. In this way homeless people should be offered quality care where the impact of health issues are understood by homeless service providers and evictions minimised. Referral systems to health care will be formalised and health care training facilitated.

By influencing national and local policy the SPHN aims to reduce homelessness. To this end the responsibility of becoming politically effective is accepted. Contributions to the national and international knowledge of homeless nursing will be an integral part of the role (*through conferences, publications*).

Fig 1.9

This vision is developed throughout the narrative.

Vision for Research

Addressing a Gap in Homeless Health Research

In late 2004, when I set out in health and homelessness practice, there were few qualitative interpretative studies for me to draw meaning from on the way people in the United Kingdom experienced ill health when homeless, or how they felt ill health had contributed to being homeless, despite a plethora of research indicating poor health compared to the rest of the population in single homelessness (Bines,1994; Citron et al, 1995; Connelly et al, 1997) and family homelessness (Cook et al, 2004; Vostanis,1999). There was substantial literature on why homeless people may have difficulty in participating in research, including distrust of authority

(Breaky, et al 2001, Smith et al, 1991), chaotic lifestyles (Power et al, 1999), inadequate collection methods related to participants literacy skills (Power et al, 1999) and prioritisation of addiction needs over research engagement (Hills, 2003). Consequently, to inform my practice and provide evidence for the systematic review of health services in the Health Needs Assessment report (Fordham, 2007), I led focus groups interviews with homeless people as I was beginning this study in 2005/6. I found the engagement process to be highly successful, contrary to the literature cited. Homeless respondents reflected and articulated to me how the focus group dialogue contrasted with the dehumanizing experience of repeated attempts to access health services (p.122). This initiated my own transformation in practice as my insights developed about the way people who were experiencing homelessness wanted to constructively influence local health service development (p.130-132). Inspired by my own transformation whilst listening and reflecting on the voice of homeless people, I felt affirmed that a reflexive narrative study would ably plot my practice journey.

More recently, there have been a number of nurse-led, participatory, qualitative studies describing the perceptions of homeless people about the health care they received (Daiski, 2007, Crocombe, 2008). The studies used semi-structured interviews with single homeless people in public settings (e.g. city parks, car parks, streets drop in centre etc) but did not include the health professionals' perceptions of working with homeless people. Echoing the theme of the Munich declaration (WHO, 2000) used earlier in this chapter Daiski (2007), a nurse educator, urges the nursing profession to "return to the roots of nursing as practiced by Nightingale who was a social reformer" (p.279). Despite her recommendation, she does not expand knowledge about negative attitudes that respondents perceived from health professionals towards them. Crocombe's (2008) study does show that specialist health services *can* be easily accessed by homeless people as opposed to mainstream health services. She concludes that ultimately homeless people should be supported into mainstream health services as their health improves.

Poulton et al's (2006) study also uses semi-structured interviews with a SPHN and her manager. It incorporates a case study design to explore the effectiveness of the specialist nurse in working with single homeless people in Northern Ireland. The study outlines the nursing skills required to meet the health needs of homeless people and evaluates the role as innovative, highly skilled to the level of Advanced Nurse Practitioner and very cost effective, but the authors conclude that "formalized multi disciplinary teams for the homeless population are probably required" (Poulton et al, 2006:145).

It is precisely at this juncture that I make a unique entrance to the contribution of new knowledge in health and homelessness. My study plots my transformation as I flow from significance to

insight (Johns, 2010) using reflective practice and reflective guidance in homeless health care. The narrative does not flow in a neat linear fashion but hovers amidst the complex issues that I faced each day. Fitzpatrick (2006) seems to be the only other researcher who has grasped the need for a coherent study which explores homelessness at the intersections of multiple and complex need (Fitzpatrick, 2006:4). Dovetailing with her identified gap in homelessness research, my study is a unique nursing contribution in academic homelessness literature which will inform others, particularly clinicians and health commissioners about homelessness and the role of the Specialist Nurse. Its appeal will extend beyond nursing, as I weave the methodology through varied philosophical frameworks which mark my transformation as described in Chapter 2. The gap in knowledge which the study will fill can be summarised as:

The reflexive narrative study will address a gap in homelessness research at the intersections of complexity in nursing practice to illuminate my journey of transformation as I develop clinical and strategic practice, working collaboratively with multiagency/multi-disciplinary services to improve the health of homeless people.

Through the vista of the nurse's lens, the study will demonstrate the way professional knowledge, gained through reflective practice and guidance, has implications for the effective delivery of homeless health care in England, including homelessness prevention as health triggers into homelessness are illuminated.

Summary

In this chapter, I have used the Forestructure of Understanding to enable the reader to contextualize my transformation in nursing practice by interpreting the narrative with this background knowledge. Such transparency in narrative construction is necessary.

In Chapter 2, I describe how I constructed the narrative using Johns's reflective practice methodological approach.

2 Narrative Construction

Introduction

In this chapter, I tell the story of how I constructed the reflexive narrative as a coherent account that illuminates my practice journey of transformation in homelessness health care - a challenging and creative academic endeavour of studying my nursing practice. The methodology and method for reflexive narrative draws strongly on the work of Professor Christopher Johns, a nurse academic. My woven narrative, displayed in Chapter 3, was developed from significant practice experiences written as story texts which evolved into reflective texts through systematic reflection and culminated in a substantive narrative text consisting of twenty-one practice experiences. The method for achieving this is laid out the Six Dialogical Movements which is explained in this chapter. Key to Johns's narrative construction is reflexivity wherein I mapped my learning through looking back over experiences to see self emerge - the concept of transformation from being to becoming the practitioner I desired to be. Johns's reflective guidance research template was set out in Guided Reflection (Johns, 2002, 2010) and used by Jarrett (2009) in her PhD research of Being and Becoming a Specialist Nurse in Spasticity Management. Guided by their footsteps, I have sought to establish my own narrative path in being and becoming a SPHN (Homelessness).

Aim of the Study

The narrative serves two purposes:

- To inform the reader of the reflexive journey
- To open the space for the reader to reflect on their own experiences, and on perceptions of homelessness, opening the possibility of dialogue towards transforming people and transforming the world

I begin by introducing the methodological approach based on Johns's (2009) eclectic framework. The philosophical influences are subsequently weaved into the Six Dialogical Movements to show narrative construction as a coherent process (p.53)

Methodological Framework

I used Johns's philosophical framework (Fig 2) as a practical rather than ideological concept for self-inquiry towards transformation. The quilt-like bricolage framework enabled me to "work between and within competing perspectives and paradigms...which connect the part to the whole"

(Denzin & Lincoln, 2005:6). Each influence served my overarching guiding methodology: narrative inquiry as a journey of self inquiry and transformation towards appreciating and realising my vision of homelessness health care as a lived reality. Used as a methodological map, the framework will guide readers to the varied philosophical concepts within the Six Dialogical Movements of narrative construction.

Philosophical Methodological Framework (adapted from Johns 2008 – in class)		
Narrative Inquiry [pp.44,78] Storytelling [p.79]	Autoethnography [p.47] Autobiography [p.47] Performance Ethnography [p.91]	Empowerment theory: Critical Social Sciences [p.48] Feminist theory [pp.83,85,86]
Reflective Theory [pp.49,57,60,73-78,84]	Narrative as a journey of self-inquiry and transformation	Aesthetics: Photography, Collage [p.82]
Nurse Theory [p.83] (other than reflective theory)	Hermeneutics [p.53,62]	Ancient Wisdom and Philosophy [p.80]

Fig 2.0

In the complex decisions to represent my narrative most faithfully, I drew on different influences to varying degrees. For example, to help weave the narrative into a coherent whole (fifth dialogical movement) I used practice insights drawn from feminist theory, particularly Belenky et al's (1986) theory on women's perspectives of voice, mind and development. This key influence illuminates my transformation as an empowerment process through voice. In the same dialogical movement, I was mindful of storytelling (Okri, 1997) and performance ethnography (Richardson & St Pierre, 2005) so that I could write a narrative that would effectively engage the reader in my practice experiences. However, the reader may find me less authoritative when I use peripheral influences (e.g. Charles Dickens) that move me beyond my own centre of nursing experience compared to reflective practice theories, critical social sciences and nursing theory - all of which are extensively explored in the Six Dialogical Movements. Such nuance in narrative construction makes my narrative unique. The reader may appreciate a history of the development of Johns's approach to contextualise the philosophical influences further.

History of Johns's Approach

The major influence on the development of Johns's methodology has been a reflexive understanding of guided reflection. Johns initially termed his narrative approach as a 'critical, reflexive phenomenology' developed in his PhD study (Johns, 1998). His concept of reflective guidance developed over an 18-month period when he was mentoring a staff nurse, new to holistic nursing methods, at the unit which he managed in Burford Hospital. To gain insights about Gill's practice, his philosophical framework (Fig 2.0) enabled them to understand the embodied forces that constrained Gill's realisation of desirable practice (Johns, 2002:5). It is this ethos, understanding embodied forces in health and homelessness practice, which I drew on in my narrative research.

To provide context to the reader in this particular genre of narrative inquiry, four key concepts are initially introduced. They are:

- Narrative inquiry
- Self-inquiry
- Transformation
- Vision of practice

These concepts are expanded on in the Six Dialogical Movements which I will discuss afterwards.

Narrative Inquiry

Humans are storytelling organisms who, individually and socially, lead storied lives. Thus, the study of narrative is the study of the ways humans experience the world. (Clandinin & Connelly, 1990:2)

In narrative inquiry, experience marks the beginning of inquiry, not theory; theory is weaved in through the narrative process (Clandinin and Connelly, 2000:42). As a practice-researcher, its approach aptly facilitated learning in my PhD journey of inquiry where insights about health and homelessness arose through practice experience. Narrative enabled me to present a meaningful, practical and reflexive way to research self in my journey of transformation towards my practice vision. Riessman (2008), building on her earlier seminal work on narrative inquiry (1993), emphasizes a mushrooming in this field of inquiry because of its nature to influence others by being "strategic, functional and purposeful" (p.8), concepts which I utilize below:

- **Functional:**

As a method of exploring and illuminating the practice field, narrative has been used in nursing (Sandelowski, 1991; Benner, 1984; Tilley, 1995; Johns, 2002 & 2006; Fredriksson & Lindstrom,

2002) and other health fields, particularly psychotherapy (Polkinghorne, 1988; Etherington, 2004) and anthropology (Bateson, 1994; Mattingly, 1994). My narrative communicated identity and community (Charon, 2006) where locally, and to a certain degree nationally,²³ my role was pioneering. Captured in narrative form, the cultural and social features of people experiencing homelessness, homelessness services and health services and my role within it were illuminated to facilitate deeper meaning, showing where health services were - or were not - linked into homelessness.

In so doing, pathways in and out of homelessness became tangible, facilitating awareness of health's role in prevention and intervention strategies.²⁴ This has not previously been demonstrated by nurse researchers and consequently this study informs homelessness health practice development. It also addresses a research gap wherein the transient and chaotic nature of homelessness, means that longitudinal research on pathways in/out of homelessness is under-researched (Fitzpatrick & Christian, 2006).

Moreover, reflecting on patient-physician communication and the suppression of narratives of resistance in health care, Mishler (2005) challenges health researchers as a social justice concern questioning the,

... vast amount of research demonstrating a strong relationship between morbidity and mortality rates...(with) very little reference in studies of patients stories in clinical encounters to their daily experiences of living under condition of poverty, oppression or social exclusion. How is this possible? (p.438).²⁵ (my italics)

My research meets Mishler's challenge. My transformation began from clinical dialogue with homeless people, listening to their stories, studying my interaction with them; some of their stories sat alongside mine. A criticism maybe that such stories are filtered through my nursing lens yet, as a functional tool, my narrative research recovers, at least partially, resistance narratives in order to recover patient care. Through a reflexive narrative of self-inquiry my research contends the strong categorization rules that may keep patients voice out of the conversation of health and illness. In so doing, as Mishler suggests, my research upholds an ethic of social justice which is further explored in the Six Dialogical Movements (p.53).

²³ Health care models for homeless communities differ throughout the UK. Other nurses working in homelessness are unlikely to have a triple role (clinical, public health and commissioning) but may work as Community Matron (Warrington PCT) or in primary care health teams (Three Boroughs [London], Leicester).

²⁴Terms used in housing statistics as reasons for homelessness, provide limited guidance to connect health professionals to detailed homelessness prevention. Drawing on my previous work as a family Health Visitor, I link 'childhood disturbance' (Crane, 1997), 'Looked after Children' or 'family breakdown' to illuminate childhood stories which led to adult homelessness, as they emerged from practice experience.

²⁵ Mishler uses the term 'narratives of resistance' to describe a subculture within health care which silences patients story of what some health professionals call 'non-compliance'. In his notes he states that "the important task is to use such stories to enlarge and complicate our analyses and interpretation of patients' ways of responding to their illness and treatment recommendations." (p.445)

- **Strategic:**

Increasingly characterised by partnership working since the *Homelessness Act 2002*, my role was strategically as well as clinically positioned. Through narrative, meanings in homelessness health practice were interpreted in relationship to significant others, not just health services, reiterating Hegel's notion that society is compared to a living body which stands in relationship to other units and becomes "much more than its parts" (Polkinghorne, 1983:135-137).²⁶ Narrative descriptions of clinical practice were written in a rich text to "show and tell" as appropriate to narrative form (Clandinin and Connelly, 2000), evoking intellect and senses (Pinar, 1981) to influence strategic 'others'.

- **Purposeful**

A reflexive narrative was the only way I could show learning that adequately marked my reflective growth in homelessness health care (Johns - reflective guidance, June 2010). Patricia Benner (1984) drawing on a Dreyfus & Dreyfus (1986) model used narrative to reveal stages of nurse development from 'novice' to 'expert'. Illuminating the distinctive skills and behaviors which were unique to each area, she was able to reveal tacit knowledge of the 'expert' nurse which was a landmark in understanding the evolution of nursing practice. Narrative enabled my experiences to be assembled like links in a chain, as Dewey (1933) remarks, in a way that adequately told my journey in homeless health care towards my vision becoming a lived reality.

Narrative Plot

Traditionally narrative was seen to have a plot with three distinct phases: a beginning, middle and end. Polkinghorne (1998) notes,

A plot is able to weave together a complex of events to make a single story. It is able to take into account the historical and social context in which the events took place and to recognise the significance of unique and novel experience. (p.19)

Whilst my narrative plot was constructed around the metaphor 'Falling through the net' to illuminate where, why and how homeless people had fallen 'through the net' of services and my developing role within it, I remained sensitive to criticism of a neatly ordered masculine 'Hollywood plot' ending (Clandinin & Connelly, 1990) where my role became the answer to homelessness! I applied plot lightly to bring meaning to the flow of events (Ricoeur, 1985; Polkinghorne, 1983; Johns, 2006), where for the first time in health and homelessness research, stories from 'street to boardroom' were weaved together to show my transformation in practice. Inspired by feminist theorists who dispute plot and value a textual narrative form which "starts on all sides, starts twenty-nine times" (Cixous, 1995:175), I wrote reflective texts that mirrored the unfolding drama of practice.

31 For example, Local Authority systems: Housing, Social Services, Benefits Agency, Health agencies – hospital and community trusts, homeless services, Regional homelessness, Homeless Health initiative

In the Six Dialogical Movements, I show how I lightly applied the plot to heighten awareness of *the net* as an environment which I could influence, and as a marker of my development.

Self-Inquiry

Johns's genre of narrative inquiry is unique in its transformative intent through the process of self-inquiry towards developing practice insights; it is not simply a retrospective account of my practice. Here, I address self-inquiry as it relates to autoethnography and autobiography but later I look at Critical Social Science (CSS) theory (p.48) and hermeneutics (p.54), also central to the concept of transformation.²⁷

Self-inquiry in the narrative is deeply but not exclusively autoethnographic. Spry (2001) defines autoethnography as,

(A) self narrative that critiques the situatedness of self with others in social contexts...the autoethnography text emerges from the researcher's bodily standpoint as she is continually recognizing and interpreting the residue traces of culture inscribed upon her from interacting with others in contexts...in autoethnographic methods the researcher is the epistemological and ontological nexus upon which the research process turns. (Spry, 2001:711)

As I looked at myself critically, the notion of self-inquiry, I developed insights about what it means to *be* a specialist public health nurse in homelessness (ontological) and what it means to *do* homelessness public health nursing (epistemological). Reflective practice became *the* connection upon which the research process turned, linking episteme and ontology. Self-inquiry, through reflective practice, was the means which created space for me to dialogue towards shaping social change, a feature of autoethnography (Holman-Jones, 2005:763). Although social change was not a direct focus of the study - meeting the health needs of homeless people was - the plot became one of action towards change. Equally, self-inquiry is not a cultural study, although appreciation of culture informed my practice. Neither is autoethnography transformative; instead it focuses on the situatedness of self in the lived experience (Holman-Jones, 2005).

Self-inquiry draws on autobiography. Pinar (1981) writes,

What we aspire to when we work autobiographically is not adherence to conventions of a literary form. Nor do we think of audience, of portraying our life to others. We write autobiography for ourselves... we cannot see movement in others nor contribute to it. In this sense we seek a dialectical self-self relation (Pinar, 1981:184)

²⁷ CSS arises from self-inquiry; hermeneutics develops within the process of self-inquiry in the critical hermeneutic circle held within the Six Dialogical Movements (Johns 2009) (p.53). Hermeneutics is the interpretation of texts where-in the reading of its parts brings about a deepening awareness of the whole (Gadamer, 1996/2000). In CSS theory I utilize Brian Fay's work as discussed on (p.48)

The main focus of autobiography is greater understanding of self (Pinar, 1981), rather than Spry's premise on autoethnography as written to influence others. Autobiography and autoethnography tend to be a retrospective looking back and making sense but the author may gain insight that changes their life subsequently... yet it doesn't have that transformative intent.

Self-inquiry draws on these research genres; its uniqueness lies in its approach towards the process of transformation.

Transformation

What is transformation - chrysalis to butterfly; water into wine? In the poem 'Grandeur' by Gerald Manly Hopkins, nature transforms him as he sees it for the first time in a new and vital way. Gadamer (1996/2000:379) draws on dialogue to bring about transformation. He writes, "To reach an understanding through dialogue.... one's own point of view is transformed into a communion in which we do not remain what we were". In essence, I practiced differently at the end of my research to the way I did in the beginning as insights changed my understanding.

My transformation was developed from practice insights using empowerment theory (Fay, 1987), reflective guidance and reflexivity (Johns, 2002) which I introduce below.

Empowerment Theory

In defining CSS, Fay (1987) writes,

In the broadest terms, critical social sciences is an attempt to understand in a rationally responsible manner, the oppressive forces of a society such that this understanding stimulates its audience to transform their society and thereby liberate themselves (Fay, 1987:4)

He describes '3 Es' that bring about social change:

- *Enlightenment*: To understand why things as they are. E.g. growing knowledge on why access to health services is difficult for homeless people
- *Empowerment*: Having awareness, ability and courage to take appropriate action towards change
- *Emancipation*: The realisation of change towards transformation

These key areas of transformation are written into Johns (2009) definition of reflective practice.²⁸ In the Six Dialogical Movements, I explain in more detail how they contributed to the narrative. In essence, homelessness practice is chaotic, vital and shifting and the '3 Es' influenced my actions both implicitly and explicitly.

²⁸ See p.58

Pre-reflective states to rational change limit transformation. Fay (1987) describes these as:

- *Embodiment*: Our conscious and subconscious development
I interpreted this to mean the way I thought, felt and responded in the world of homelessness. E.g. I removed jewelry on my first visit to the night shelter, fearing that I could be mugged.
- *Force/authority*: Power used to appropriate self determination
I interpreted this as the way power and force were used to construct and maintain oppressive relationships in health and homelessness.
- *Tradition*: The setting in which human-beings partially define their identity whilst rejecting other parts.
I interpreted this as the customs, norms and prejudices that I and others had, including habitual practices in health care and housing.

Reflective Guidance

CSS theory is embedded in reflective practice and reflective guidance. Fay's limits are woven into Johns's (2009) Influence Grid (Fig 2.1), illuminating how reflective guidance tunes into practice tension, shifting its nature towards achieving the practice vision. Fay does not identify as Johns does, that *theory* when used exclusively as evidence based practice, is a limit - whilst reflective practice is not. All limits are pre-reflective states, woven into the fabric of large organisations like the NHS (Johns, 2009).

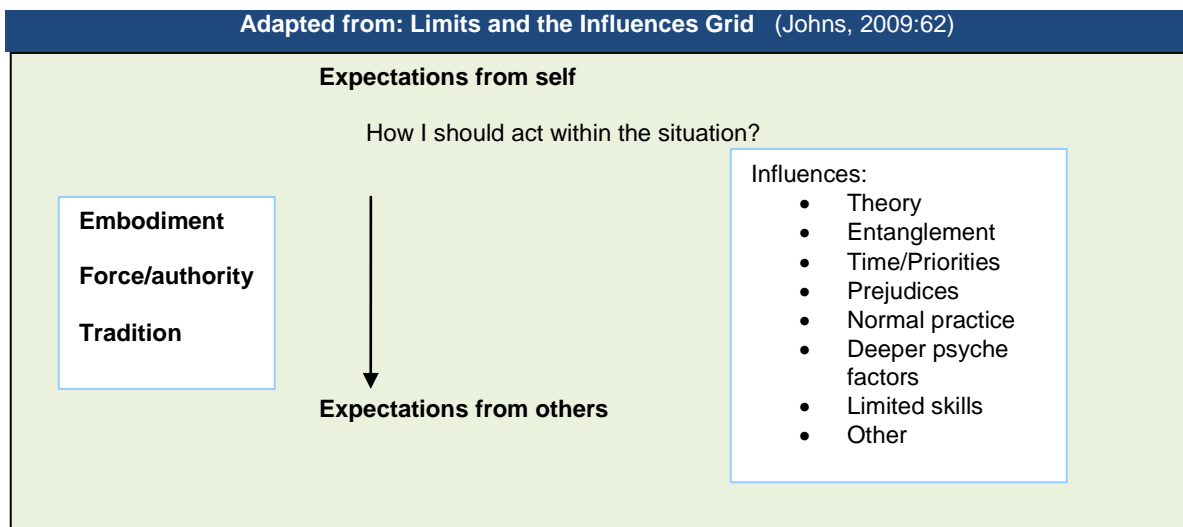


Fig 2.1

The Influences Grid (Fig 2.1) facilitated my growing appreciation of factors that could limit my becoming the practitioner I desired to be. In the Six Dialogical Movements (second dialogical movement) the feelings cue - ***'What factors may constrain you acting in new ways?'*** in the

Model of Structured Reflection²⁹ (Johns, 2009) - helped me confront fear as tensions to take action on (Texts:4,7). Senge (1990) calls this 'creative tension' which is built into Johns's definition of reflective practice.³⁰ In creative tension, 'limits' emerged as feelings of discomfort between my values and my practice. Through reflective guidance I learnt to identify the gap between the current reality of practice and my practice vision. Reflective guidance is methodologically developed within the fourth dialogical movement (pp.73-78). It remains key to this genre of narrative inquiry.

Reflexivity

Whilst researchers agree that reflexivity develops knowledge and understanding of practice (Johns, 2002, 2010; Frid et al, 2000; Koch & Harrington, 1998) definitions of reflexivity differ. Koch & Harrington (1998:887) describe reflexive research as an ongoing self-critique and self-appraisal where the researcher has positioned self in moral and sociopolitical contexts allowing the reader to travel easily through the world of its participants via well written texts. Etherington (2004:36-37) cites seven concepts of reflexivity including: self-awareness seen as a vibrant and transparent process throughout the research stages; being conscious of own ideology, culture and politics and that of participants and audience; exploring the liminal space between objectivity and subjectivity to represent the more blurred genres of experience. I relate Etherington's concepts to being mindful in practice, noted in Johns's definition of reflective practice.

The notion of reflexivity as self-inquiry towards transformation in practice is unique to Johns's narrative approach. He defines reflexivity as a "Looking back over a series of experiences to see self emerge" (Johns, 2009:102).

Marking my reflexivity

Two key frameworks reflexively marked my transformation in the narrative. I briefly summarise them below:

- The Being Available Template [BAT]: I used BAT as the prime reflexive framework to show my role development in practice - it became 'the net'. My core therapeutic with homeless people was to *be available* to prevent them falling through the net of services. Johns's (2002:51) 'core therapeutic' of *being available* is to work with the person, enabling them to find meaning in the health event, and make good decisions about their lives, taking action to meet their health care needs. Insights that emerged through the Model of Structured Reflection [MSR] (Johns 2009) were positioned within Framing Perspective³¹ (Johns's 2009), illuminating BATs development. BAT is explored further in second and fifth dialogical movements.

²⁹ See p.61

³⁰ See p.58

³¹ See Framing Perspectives p.68

- Belenky et al's (1997) model of development of self, mind and voice, marked awareness of my use of voice in practice. The perspectives Belenky et al define are: silence, received knowledge, subjective knowledge, procedural knowledge, constructive knowledge. My use of the framework is outlined in fifth dialogical movement (p.85).

Vision of Practice

In Chapter 1, I outlined my emerging vision of practice (p.38). Later in the narrative, I wrestled with Senge's (2006:208) critical questions on vision applying them to my practice: What should the future picture of homeless health care be? Why did I want it to exist like that? What was the core values needed for the vision to be realised? I also drew on the precision of Johns's (2009:30) concept of a viable clinical and moral vision which addressed three cornerstones of practice:

- The nature of caring – the meanings I gave homelessness practice in terms of my therapeutic response and health outcome
- The internal environment of practice – promoting a culture in health for my vision to be realised
- Social viability – social and professional issues that develop the significance of homeless health care within society.

My vision incorporated four key areas of inclusive health for homeless people (Fig 2.2) which became a constant focus of reflective inquiry as I flowed with the current reality of practice and tensions held within it.

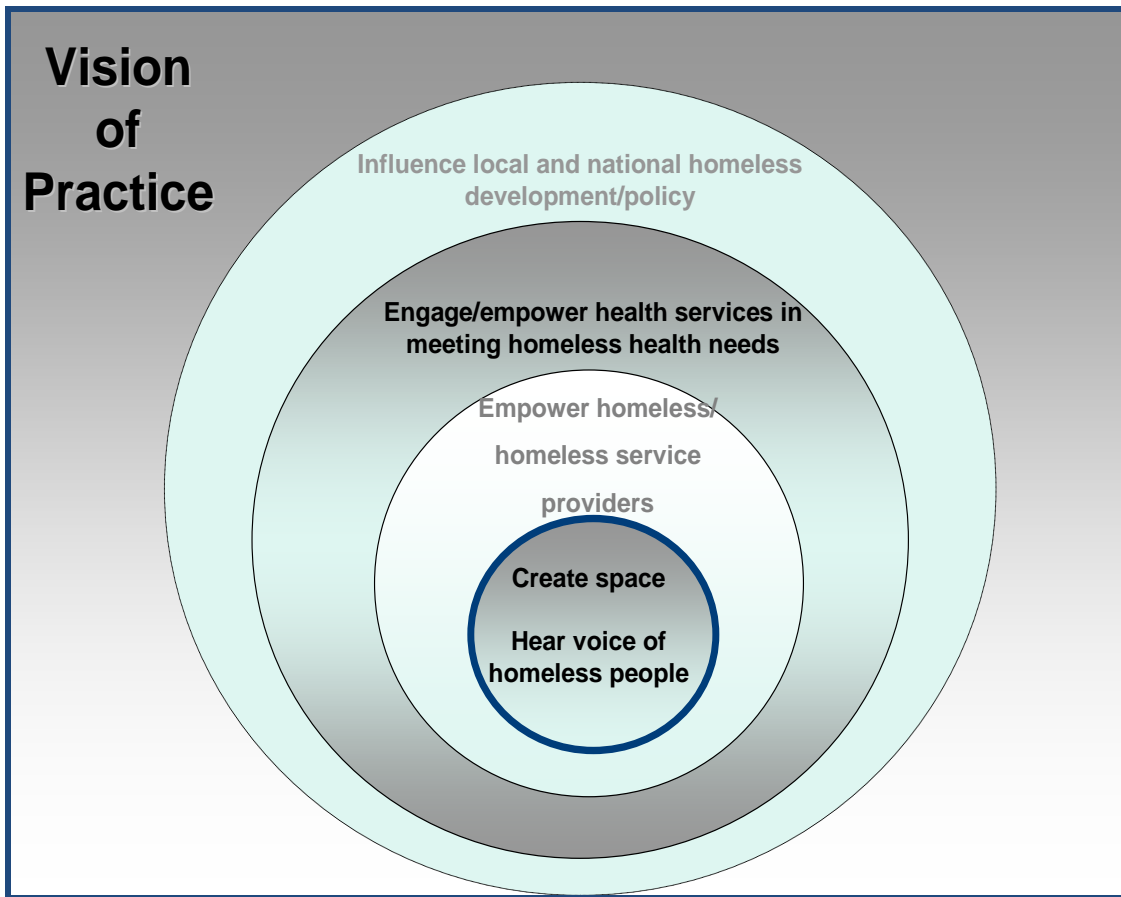


Fig 2.2

Development of my practice vision is constructed in three analytical horizons contained in Chapter 3.³² By the narrative's end, a redefined BAT became my SPHN vision for Homeless Health Care.

I turn now to the Six Dialogical Movements - key to Narrative Construction (Fig 2.3).

³²For successive Analytical Horizons see p.160, p.217 and p. 273



Fig 2.3

Johns terms the dialogical flow towards meaning in the Six Dialogical Movements, as the 'critical hermeneutic circle'. The Heideggerian notion of the hermeneutic circle is described by Dreyfus (1995),

In interpreting a text one must move back and forth between an overall interpretation and the details that ...stand out as significant...the new details can modify the overall interpretation which can in turn reveal new details as significant, the circle is supposed to lead to a richer and richer understanding of the text. (Dreyfus, 1995:36)

The key premise held within the hermeneutic circle and within Six Dialogical Movements is dialogue. In each dialogical movement, moving between texts and the whole, interpretations formed that led to practice insights.

Dialogue

Formulating the principles of dialogue within the framework, Johns draws on the work of Bohm (1996). The word *dialogue*, derives from the Greek word 'dialogos': 'logos' meaning 'the word' and 'dia' meaning 'through' (Bohm, 1996). Bohm describes dialogue as 'a stream of meaning flowing among us and through us and between us' (Bohm, 1996:6). He distinguishes *dialogue* from *discussion* by illuminating how dialogue may bring about communion rather than making a particular view prevail to 'win points'. The spirit of dialogue is different. He states,

Perhaps in dialogue, when we have this very high energy of coherence, it might bring us beyond just a group that could solve social problems. Possibly it could make a new change in the individual.... Such energy has been called communion. (Bohm, 1996:54)

I felt a sense of *communion* in the PhD community of inquiry which Johns formed in 2005 in the University of Bedfordshire. Dialogue took place either individually or in groups where we were mindfully challenged. Drawing on Bohm, Johns identifies six rules of dialogue for reflective practice (Johns, 2009:13) all of which can be viewed as mindfulness:

- Commitment to work with others towards consensus for a better world
- Awareness and suspense of one's own assumptions and prejudices
- Proprioception of thinking
- To be open to possibility and free from attachment to ideas
- To listen with engagement and respect
- To have a mutual appreciation of dialogue

To show how I constructed the narrative, I now turn to each of the Six Dialogical Movements.

The First Dialogical Movement - Dialogue with Self

In this section I discuss:

- The process of journaling
- Journals as therapeutic spaces
- Journals as private documents

Journaling

The process of journaling

Each evening, I wrote a full, descriptive and spontaneous account of a practice experience, paying attention to detail to produce a *story text*. The inherent value I found in this activity is captured by Manjusvara (2005),

In reality there has never been a day in our lives...when something happened that did not eventually lead to significant results. In the onward rush of events it is usually hard to see these patterns...In developing our writing practice – we have a better chance to find order in the apparent chaos that surrounds us. Moreover, the decisions we make during this process - for example the things we choose to omit or include when describing a journey tell us a great deal about ourselves. In an important sense they are what turns a series of events into a story and eventually, detail by detail, not just a story but our own life story (Manjusvara, 2005:4).

Ten used reflective journals sit on my desk. Picking up the one marked 2006, I open a page. I see myself like a gush of wind upon the homeless health landscape: arranging an urgent case conference to challenge an inappropriate hospital discharge;³³ attending a homeless forum to give updates on three new NHS projects;³⁴ witnessing and challenging stigma at a health professionals meeting.³⁵ My practice is vivacious and energetic. Words like *happy* and *fulfilled* leap up from the pages challenging *inner discomfort* as a trigger in reflective practice (Boyd and Fales, 1983:106). Conversely, I see phrases like 'shock ripples through' me on other pages. Emotive language acting as powerful indicators to what I was witnessing where feelings about practice became key triggers towards my transformation (Johns, 2009). Weather conditions connect me tangibly to those sleeping-rough.

In the vast but relatively uncharted landscape of homelessness health care, the dilemma of selecting events which Manjusvara (2005) posits, became 'what chose me?' Many experiences made me want to write: women's journeys into homelessness; experiences that exposed complexity; human suffering; or simply how people *fell through the net*. Moreover, in reflective guidance I was encouraged to capture the mundane – people I might subconsciously pass-by in practice. In this way, I explored unknowing in my homelessness role. Munhall (1993) cites unknowing as an addition in nursing theory to patterns of knowing (Carper, 1978).³⁶

³³ A mother of three was being discharged by psychiatrists to the night shelter. Her mother was temporarily looking after the children during her illness. She was considered homeless by health staff because her husband did not want her to return home.

³⁴ The first annual Health and Homeless Fair, Focus groups with Homeless people for the Health Needs Assessment and the Admission and Discharge policy

³⁵ Stigmatizing a marginalized group, a Health Visitor inappropriately asks a visiting police officer 'Do we have to visit gypsy sites?'

³⁶ Carper's (1978) empirical, aesthetic, personal and ethical patterns of knowing in nursing, as types of theory representing knowledge, evidence and enquiry in nursing practice.

Initially, I wrote prose across the journal page. Guided by Johns (2002), I used the left side only so that developing insights could be placed on the right. As reflective skills increased, I wrote short lines with carefully chosen words where prose often shaped into poetic form, succinctly capturing feelings about my practice experiences. By early 2008, I 'caught' metaphors used in practice and used them evocatively to hold and communicate meaning and insights. 'Opening a can of worms' (Text:20), for example, illuminated fear voiced by health professionals of delving too deeply into homelessness. Storytelling flowed eagerly towards deeply reflective texts that same evening, with minimal journaling.

Journals as therapeutic spaces

In the relative clinical isolation of homelessness practice, my journal became a confidante. Rather than time consuming (Burnard, 1995; Burrows, 1995) it was valuable time relearning creative writing skills. As a therapeutic process (Johns, 2009) it neither produced anxiety (Hulatt, 1995; Cotton, 2001) nor difficulties in writing (Jarrett, 2009). Holly (1989:71) notes that, "writing taps the unconscious; it can make the implicit, explicit, and therefore open to analysis". Re-reading a mid-winter journal entry, I recall my deep introspection about the nature of suffering which I had witnessed so much of, that week. My thoughts turned inwards as I dialogued with myself about my own healing processes arising from childhood:

Tuesday 24 January 2006:

I am reading Rothlyn Zahourek's paper on Intentionality and Healing³⁷. She says intentionality 'holds and molds healing and is therefore the matrix of healing.' I am instantly connected to mum's serene 'suffering' (and ours) in my childhood and how prayer was 'intentionality' - vital to our family's healing and happiness - maybe even survival and existence. I am conscious now that 'survival' and 'existence' is the language of homelessness. Is this transference - or am I just connecting more compassionately to their suffering? What is it that holds and molds me as I explore the nature of suffering? How well do I ease it for those I meet? What else can I do?

Like gazing into a mirror (Johns, 2006) my journals were fertile places to dwell, where self and deity were located. I established "...continuity of self with past, present and future self" (Boyd and Fales, 1983:111). Through journal writing, I came to know "who I am so I could refine and sharpen this tool for therapeutic work" (Johns, 2006:37).

³⁷ Zahourek R. P. (2005) Intentionality: Evolutionary Development in Healing. A Grounded Theory Study for Holistic nursing. *Journal of Holistic Nursing* 23 1 89-109

Journals as private documents

In my MPhil/PhD transfer seminar (August, 2010), I was required to defend the 'calling-in' of journals by examiners who may wish to question how I interpret my practice experiences; a question related to methods of surveillance. I drew on the concept of hermeneutics³⁸ within the Six Dialogical Movements, noted as a critical concept of reflective practice (Gilbert, 2001; Mantzoukas and Jasper 2004; Mackintosh, 1998). My journals were personal documents which I had not previously agreed to disclose. As a tool, they captured spontaneous and authentic accounts of complex practice, which alerted me to self; they did not display my conscientization (Freire, 1970) as linear markers for examiners to critique. Instead, they acted as a space to begin a deeper, invisible process of hermeneutic interpretation, the "...backward and forward shifting between the whole and its parts" (Geanellos, 1998:159). The emerging interpretations were formulated in reflective texts. An examiner could only effectively critique my journal entries of homelessness health care from their own perspective of being-in-the-world (Heidegger, 1962/1980) – not mine.

Second Dialogical Movement - Dialogue with the Story

The Model of Structured Reflection (MSR) was developed by Johns through analysis of patterns in supervision relationships, framed theoretically using Strauss and Corbin's (1990) paradigm model in grounded research. In this movement, I describe how I used MSR to dialogue with the story text in my journal as an objective and disciplined process to gauge emerging insights (p.60). I also discuss how insights were framed using Johns's Framing Perspectives.

To contextualize the eighteen MSR cues and how I used them in practice, I will initially explore and critique concepts of Reflective Practice.

What is Reflective Practice

The growth in reflective practice began with the crisis of confidence in professional knowledge applied through traditional scientific 'technical rationalism', and its mismatch to practice experience (Schon, 1983:14). Schon, an educationalist, recognised that the crisis arose when professionals confined themselves to the high ground of empirical theory, rather than acquiring knowledge gained in practice, wherein lay 'the most important and challenging problems' (Schon, 1983:42). This particularly resonated with homelessness practice where increased health needs lay parallel to poorer access to health services (ODPM, 2004; DH, 2010) and scant nursing research.

³⁸ The hermeneutic process is concerned with interpreting texts to find meaning (Gadamer 1975/2004) which began as I dialogued with myself during the process of journal writing. van Manen (1990:180) says, 'to interpret a text is to understand the *possibility of being* revealed in the text' – a grasping of my being or an attempt to grasp the being of another, perhaps a rough sleeper or someone 'you wouldn't care to sit next to' (Okri, 1997:41).

The educationalist, John Dewey (1933), distinguished reflective action from routine action where changes in perception do not occur. Reflection begins a process of understanding something in a different way (Dewey, 1933:190). Atkins and Murphy, (1995:32) affirm that reflection is "a complex and deliberate process of thinking about and interpreting experience in order to learn from it".

I resonated strongly with Johns's (2009) definition of reflective practice as 'mindfulness', a metaphoric mirror, watching ourselves in practice,

Being mindful of self, either within or after experience, like a mirror in which the practitioner can view and focus self within the context of a particular experience, in order to confront, understand and move towards resolving contradictions between one's vision and actual practice. Through the conflict of contradiction, the commitment to realise one's vision, and understanding why things are as they are, the practitioner can gain new insights into self and be empowered to respond more congruently in future situations within a reflexive spiral towards developing practical wisdom and realising one's vision as praxis. The practitioner may require guidance to overcome resistance or to be empowered to act on understanding. (Johns, 2009:12)

As noted earlier, Johns accommodates an appreciation of CSS theory within his definition, exploring Fay's (1987) '3 Es'.³⁹ He also includes the Buddhist concept of mindfulness, acknowledging it as an ultimate expression of reflective practice. Mindfulness is a quality of presence which notices what is present, without interference or judgment (Goldstein, 2002). It resonated with my Christian perspective of awareness of God in the present moment (Christian-Buddhist retreat Turvey Abbey, Bedfordshire 2006).

Finding my own way - a definition of reflective practice that I use in homelessness health care:

Johns's understanding of reflective practice seemed like a 'coming home' where strands of my existence harmoniously merged through reflective practice,⁴⁰ not only towards my practice vision but within my nursing career and my life. I weaved his definition of reflective practice into my vision of homelessness:

In reflective practice I am mindful of being with the other, weaving my vision towards better health care for homeless people - knowing that their health is greatly disadvantaged by being homeless. In the reflective space of practice experience I sense, see, hear and tell. I watch and wait, holding the space, holding the silence of knowing and not knowing to let knowing unfold either within or after the experience. I shape homelessness practice so that my words, my voice, sit beside those of others towards the co-creation of knowledge. I weave in my own ways of knowing and being towards a holistic health perspective. When creative tension appears I harness it, acting

³⁹ Enlightenment, Empowerment, Emancipation

⁴⁰ van Manen (1990:102) describes home as a fundamental place of our being 'where we can be what we are'. My existence included my values, beliefs and life experiences formed from being in the world

on it or bringing it to mind afterwards in order to explore and transcend it. I seek out wise guides from different communities: academic, peer researchers, homeless people, colleagues and spiritual mentors to be my light at times of unseeing – or disturbance – towards another stage of co-creation. Reflective practice is my hermeneutic circle which transforms me towards transforming the health care experiences of homeless people.

A Critique of Reflective Practice

With a critical eye on reflective practice, I am drawn to two areas in the literature. The first is the vulnerability of the reflector (Hargreaves, 1997; Rich & Parker, 1995; Burton, 2000) and the second is the value attributed to knowledge gained through reflective practice (Mantzoukas & Jasper, 2004; Mackintosh, 1997).

When deep-seated coping mechanisms are disturbed through the process of reflection, practitioners may be vulnerable to psychological morbidity (Rich & Parker, 1995). Student nurses have described reflective practice as painful (Durgahee, 1996; Bellman, 1996) and disturbing despite an increase in critical thinking and self concept (Durgahee, 1996). Burton (2000:1014-1015) noted that reflective practice could "increase anxiety rather than reduce it". Johns argues that, perhaps they were not taught it well enough (personal communication, January 2011) Potentially harmful effects like these, arising from reflective practice, concerned me as I ventured into a seven year study period. I felt uneasy when a key-note speaker at a conference told the audience that he suspected his depression may have been a side effect of reflective practice despite a familial history of depression.⁴¹ I did cry in homelessness practice, something I had never done before which is illuminated in the narrative, and elsewhere (Fordham, 2008). Was it homelessness that made me cry, or being a reflective practitioner? Was my tearfulness a symptom of emotional entanglement, or a natural reaction to sad situations? Johns (2009) uses the term 'emotional entanglement' when working as a reflective guide with Trudy, a nurse in palliative care. He comments,

We all need to experience emotional entanglement, because only then can we recognise the place. Perhaps entanglement is an inevitable consequence of holistic relationships because it's so hard to resist the suffering of another...that's where reflection can help us. (Johns, 2009:258)

This illuminates why reflective guidance has been cited by some as necessary in reflective practice (Burton, 2000; Rich & Parker, 1995) but nurses have identified social and peer relationships as equally effective (Durgahee, 1996).

⁴¹ Steven Brookfield - Key note speaker, International Reflective Practice Conference, Iceland, June 2005

Based in a Public Health Directorate with a strong positivist approach for scientific, evidence based research, I was alert to the critique that reflective practice lacked value. Internal markets in health care with a focus on cost efficiency and financial constraints may challenge the philosophical approach to reflection (Naughton & Nolan, 1998). Nurses leave the profession because of it (Burton, 2000). Equally, reflective practitioners have been viewed as being "outside the norm" (Mantzoukas & Jasper, 2004:932) and marginalized from the dominant nursing group. In practice, I was challenged by more 'powerful'⁴² people who required control through 'objective' (positivist) means, resistant to deeper meanings in health experience which qualitative research provides. Even today (August, 2010), as I presented focus group data on health experience from our local Immigration Removal Centre (IRC)⁴³ the voice of detainees in the report was treated by a senior commissioner with suspicion and accusation - beyond research bias - to 'fabrication', illuminating how qualitative research may be challenged. Reflective practice gave me the skills to rapidly disempower the accuser, moving the debate into healthier dialogue. Setting seeds towards a growing holistic research culture within Public Health is gradually progressing. To develop the discussion in this study on competing claims for truth, I use Wilber's (1998/2007) Four Quadrants Model of Integral Consciousness in the third dialogical movement (p.70).

Using the Model of Structured Reflection (MSR) - Edition 15A

Johns (2009) significantly develops the process of reflection through the MSR as a systematic process towards emerging insights in practice as shown in the narrative. Whilst there is a variety of reflective models to choose from (Gibbs et al, 1988; Boyd and Fales, 1983) I was intuitively practicing many MSR cues before I knew about Johns's model. The cues provided a systematic navigation of experience, central to developing insights in homelessness health practice research (Fig 2.4). I internalized them as a natural way of *being* a mindful practitioner.

⁴² I refer here to commissioners and managers who hold substantial budgets

⁴³ Fordham (2010) *A Health Needs Assessment Refresh Report on Adults detained in Yarl's Wood*. Bedford: NHS Bedfordshire

The Model of Structured Reflection Edition 15A (Johns, 2009)

- Bring the mind home
- Focus on a description of an experience that seems significant in some way
- What issues are significant to pay attention to?
- How do I interpret the way people were feeling and why they felt that way?
- How was I feeling and what made me feel that way?
- What was I trying to achieve and did I respond effectively? (aesthetics)
- What were the consequences of my actions on the patient, others, myself?
- What factors influence the way I was/am feeling, thinking and responding to this situation? (personal)
- What knowledge did or might have informed me? (empirical)
- To what extent did I act for the best and in tune with my values? (ethical)
- How does this situation connect with previous experiences? (personal)
- How might I reframe the situation and respond more effectively given this situation again? (reflexivity)
- What would be the consequences of alternative actions for the patient, others and myself?
- What factors might constrain me responding in new ways?
- How do I NOW feel about this experience?
- Am I more able to support myself and others better as a consequence?
- What insights have I gained?
- Am I more able to realise desirable practice? (Framing Perspectives)

Fig 2.4

Developing Insights

The etymology of the word insight comes from 'inner sight' or wisdom and is defined as "The capacity to gain an accurate and deep understanding of someone or something" (*Oxford Dictionary of English* 2006:896). Insights are enfolded within significance which lies on the surface of experience. *Significance* is an idea; *insights* reflect the changed self and represent new knowledge. Using the MSR I reflected on the significant parts of the experience towards deepening insights - the notion of the hermeneutic circle (Fig 2.5).

From *significance* to *insights* using the MSR



Fig 2.5

MSR Cues

Bring the mind home

This cue begins reflection and reminded me of meditation for inner stillness. Eckhart Tolle (2005:18-20) explains this perfectly,

Your mind is an instrument, a tool...the present moment holds the key to liberation...All true artists, whether they know it or not, create from a place of no-mind, from inner stillness. The mind then, gives form to the creative impulse or insight.

From the point of inner stillness, I honoured the practice experience.

What issues are significant to pay attention to?

Standing back from the text, I attended to significant issues, contemplating individual words, phrases, spaces or connections. It was similar to my Christian hermeneutic practice of Lectio Divina, noted as,

... 'Feasting on the Word.' ... first taking a bite (Lectio), then chewing on it (Meditatio). Next savor the essence of it (Oratio). Finally, the Word is digested and made a part of the body (Contemplatio). (Holdaway, 2008:109)

In Text:1 about my clinic experience with Pamela, a rough-sleeper, a particular word was significant. It opened up the space for me to consider the first five cues of the MSR:

9 January 2006

Reflective Diary 2

'The cold, clinical surroundings become insignificant; I fully engage in her presence'.

- I chew on the word *presence* – *what do I mean by it?* Was I really present or did I simply think I was?
- I reply to myself: *Presence – being in the moment of practice* I open to Pamela *and* Pamela opens to me, engaging with health care and with her traumatised self. *Presence* is cathartic. Her tears flow. In *presence* I hold and tentatively shape the practice experience with her as she tells her story. *Presence* is a shared process wherein I develop empathic inquiry.
- *Presence* opened a healing space at a time when Pamela had disengaged from other health professionals. I was therapeutically present at a time of crisis for her and the homeless service providers who were supporting her.

I reflect further on *presence*, deepening my understanding through theory (third dialogical movement),⁴⁴ and reflect again with my peers and mentors (fourth dialogical movement). Insights feel like fog lifting towards a clearing for future practice - 'Wow' moments! Gadamer (1975/2004) enlightened me further,

The task of hermeneutics is to clarify this miracle of understanding, which is not a mysterious communion of souls but a sharing in a common meaning. (Gadamer 1975/2004:292)

In this particular exemplar I used the cues: ***What issues are significant to pay attention to? How were others feeling and what made them feel that way? How was I feeling and what made me feel that way?*** I continue below with the remaining cues:

What was I trying to achieve and did I respond effectively?

Grasping health and homelessness issues towards responding skillfully as an effective practitioner illuminates my aesthetic response throughout the narrative. In my public health role, I travelled to Leicester and Northampton to see how others 'did it' and searched for scant documents that benchmarked health and homelessness. In clinical practice, I drew on my health visiting, midwifery and nursing experience, cultivating aesthetic ways of knowing (Carper, 1978; Johns, 1995) towards effective action. Johns (2009:61) views aesthetics as four movements:

- How I appreciated the situation
- How I made clinical decisions (phronesis or practical wisdom)
- My skilful response
- My reflection on consequences

In each practice experience, I sought to bring my own uniqueness, weaving in other 'patterns of knowing': empirical, moral (ethical) and personal knowledge, (Carper, 1978:17) responding to Carper's request that nurses should grasp their own 'personal knowledge' towards seeing patients as people.

Reflexivity, noted earlier (p.50), involved looking back over the experience to see self emerge (Johns, 2006) to facilitate 'knowing' where I compared 'desirable' practice with actual practice. This is explored further in the fifth dialogical movement (p.84).

⁴⁴ In the third dialogical movement I move freely into theory savoring *presence* using a quote from Senge (2005:13), "The core capacity needed to access the field of the future is presence.... presence (first) as being fully preconscious and aware in the present moment....then as deep listening, of being open beyond one's preconceptions.... of letting go of identities and the need to control...ultimately leading to a state of letting come... when this happens the forces shaping a situation can move from recreating the past to manifesting or realizing an emerging future."

What were the consequence of my actions on the patient, others and myself?

I used the Influences Grid (Johns, 2009) (p.49) to analyse *creative tension*. Emotional tension, for example, developed when snowballing occurred from effectiveness in my practice role. Henderson (2001) draws on the concept of emotional labour and nursing as an under-appreciated aspect of caring work. She states,

In relation to the emotional labour of nurses, it is clear that nurses not only experience strong emotions in the context of work but also consciously use those emotions to hone, refine and improve their practice. This is a high-level skill and one which requires great honesty, tenacity and perseverance. Not surprisingly, such a high degree of personal investment can have both positive and negative effects (Henderson, 2001:135).

As I juggled strategic and clinical tensions in my role (E.g. Text:19), I linked it to time/priorities on the Influence Grid to gain insights for future practice, acting congruently with my vision.

What knowledge did or might have informed me?

The demand for evidence based practice is critical but it was the philosophical influences used as a methodological framework in this study that guided my transformation most effectively - it dealt with the tension between theory and practice that always plagues nursing. Theoretical knowledge came from diverse sources: Department of Health white papers, DCLG housing guidance and legislation; Voluntary sector publications: Crisis, Homeless Link, Shelter, YMCA; Professional organizations, Queens Nursing Institute, Homeless Health Initiative, which latterly I contributed too.⁴⁵

To what extent did I act for the best and in tune with my values?

In Nichomachean ethics, Aristotle describes the process of reflection as "deliberation to attain a good goal" (Aristotle 1934). I ethically deliberated on my actions to recognise moral knowledge which Carper refers to as ethical knowing. Drawing on Heidegger (1962), Logstrup (1997) offers two ways of responding to the ethical demand of a patient coming into (my) care: the authentic caring response or inauthentic 'destroy or ignore' response (Kirby & Slevin 2003:243). Kirby & Slevin (2003) state,

As nurses we can determine how we will respond to those who are delivered into our hands, by calling upon consequentiality, deontological or relational approaches or indeed by choosing an inauthentic position that ignores the ethical demand. But what we cannot do is deny the existence of this demand. (p.243)

Both responses are seen in the narrative: I acted through fear [inauthentic] (Text:12) and with growing political courage [authentic] (AH3).

⁴⁵ HHI (2009) Guidance on Family Homelessness

The ethical demand in homelessness health practice is pronounced and urgent; I used Johns's (2009:65) Ethical Mapping grid (Fig 2.6) to guide practice.

Ethical Mapping (Johns 2009:65)		
Patient's/family's Perspective/other patients	Who had authority to make the decision/act within the situation	Doctor's perspective
If there is a conflict of perspectives/values, how might these be resolved?	The Situation/Dilemma	What ethical principles inform this situation?
The nurse's perspective	Consider the power relationships/factors that determined the way the decision/action was actually taken	The organization's perspective

Fig 2.6

Ethical mapping lit the practice experience; an empowering framework as a way of exploring 'partial views'. It challenged my own view of the situation, particularly those involving health access (Texts:3,13), eviction (Texts:8,9) or hospital discharge (Texts:6,18), significant for service development. Key ethical issues were autonomy (empowering homeless people, homeless service providers and health service staff) and use of health service resources as illuminated, for example, in *Journeying with Heidi* (Text:8) and *Spaghetti Junction* (Text:18).

'Looking Forward' Cues

The following journal entry illuminates my first visit to the night shelter. Afterwards, I show how the MSR 'looking forward' cues 'opened-up' the text for me to recognise my effectiveness and limits, providing a learning space to cultivate phronesis in my future practice.⁴⁶

⁴⁶ Aristotle (1934) firmly links phronesis to reflection, which he terms deliberation to attain a good goal. Phronesis or practical wisdom is the ability to think about how and why we should act in order to change things (Fordham, 2008)

First Visit to the Night Shelter
Friday 27th January 2006:
Focus Group Information Event

I am frightened of going there...images of the woman punched in the eye, who came to see me at clinic flash into mind. I must take my personal alarm! I give Tim my engagement ring – just in case! 'They' won't want to engage with me, if I'm wearing expensive jewellery!

I scoop up the consent forms and patient information letters before I leave. It's freezing outside! Jenny – in her early 20's - greets me. She is so gentle and quiet! I'd assumed a strong, 6' man would be in charge.

The smell of two huge lasagnes wafts out from the kitchen. It's homely here. Staff welcome a stream of street guys - and two young 'gals'! I recognise others from clinic: Will and Pamela (both living on the streets).

How do I relate to them? I am so keen to do something about homelessness. There is a passion within me but how effective am I? I don't feel like a nurse – more like a social worker...although I'm shown 'trench foot' - and plastic surgery on a wrist! He jokes 'it's from injecting' – or is he serious? Then, he laughs and says he doesn't 'do' drink or drugs!

In the kitchen there's a guy eating - his hands rise strangely into the air. Is he mentally ill? ...I don't approach him...not this evening...this evening, I'm here to do the consent forms and patient information letters.

Just before I go, I see Will. In a serious tone, he says 'I have things to say on Monday about health services which aren't good' and then adds, 'it's not personal though.'

'That's all right, Will – that's why I'm here - to improve health services for homeless people!'

I leave, feeling much more like a researcher than a nurse.

Using the looking forward cues, I considered how I might act in a similar situation:

How might I respond more effectively? Delighted at the way the night shelter residents engaged with me I achieved a successful information event prior to the focus group. When I penetrate the surface of this cue, I recognize my limits: fear around criminality and engagement with mental health issues.

What would be the consequence of alternative action for the patient? This cue prompted me to be less self critical as I negotiated tensions between my strategic and clinical role. I wasn't there to assess individual health needs.

How do I now feel about the experience? The event paved the way for a successful focus group. Recognising my clinical 'limits' (Fay, 1987) provided me with further strategic direction as I reflected on mental health professionals being part of a homelessness team.

Am I more able to support myself and others better as a consequence? Yes, creative tension developed practice insights in homelessness as noted in the previous cue. Generally, reflective guidance and other support systems revitalized my practice and research.

Dwelling with the Text to Gain Insights

In dialogical movement two, I have shown how I stood back from the story text, dwelling with it to gain insights like scrolling down a screen to identify 'unknowing' within the experience as already illuminated. Winterson (2001:120) explains this well,

The one life we think we know is the only window that is opened on the screen
The big window is full of detail
Where meaning is often lost among facts.
If we close that window...what we find is another view...
The window is emptier
The cross references are cryptic.
As we scroll down it, looking for something familiar
We seem to be scrolling down to another self
One we recognise but cannot place.
The coordinates are missing
If we move further back
Through a smaller window that is really a gateway to measure ourselves by
We are coming into a dark region
A single word might appear
An icon.

Through each dialogical movement dwelling with the text was a constant and creative movement towards weaving the narrative in the fifth movement.

Framing Insights

I framed emerging MSR insights using Framing Perspective grid (Fig 2.7) developed by Johns (2009). This helped me to focus on particular aspects of practice to deepen my insights and position myself within theory.


Framing Perspectives Johns, 2009:78 (adapted)		
Philosophical framing Confronting and clarifying my beliefs and values that constitute desirable practice	Role framing Clarifying my role boundaries and authority within my role	Theoretical framing Drawing on extant theory and research to make sense of my knowing in practice
Developmental framing Becoming more effective through learning outcomes and research from the experience		Reality perspective framing Understanding the barriers of reality yet empowered to act in congruent ways
Parallel process framing Connecting learning processes in guidance to clinical practice	Temporal framing Awareness of how the situation connects to past experiences to inform future experiences	Problem framing Identifying, focusing on a problem towards its resolution

Fig 2.7

How I used the Framing Perspectives

Generally, at the end of most texts, I used *developmental framing* to illuminate *role* and *philosophical (vision)* framing and to highlight future action contributing to my development. In post text figures, the *reality framing perspective* sits between role framing and philosophical. I briefly discuss how I used these three framing perspectives below:

- **Philosophical Framing (Vision)**

As insights emerged I challenged myself - how effective had I been: had I worked towards a greater sense of social justice to change the lives of homeless people by engaging effectively with them? Had I challenged health managers who dominate service delivery to think differently about whose interest were being served? These issues hinged on empowerment theories (Fay, 1987; Freire, 1970/1993; Belenky et al, 1987). As the narrative evolved I recognised that to achieve my practice vision I had to become politically effective. Johns and Freshwater (1998) emphasize the political dimension of reflection,

This ability to become critically conscious is far removed from simply examining an event to see what should be done differently. There is an implicit political dimension, linked to critical awareness, which enables assumptions inherent in ideologies to be challenged. (Johns & Freshwater, 1998:152)

Becoming more aware of my unique role and my transformation within it, I confidently made political challenges in health and multiagency meetings to shape the practice environment (Texts:20,21).

- **Reality Framing Perspective**

This perspective enabled me to explore limits to my practice vision. For example, I experienced 'walls of resistance' by some mainstream health professionals towards homeless people. Theory, for example the categorization of deserving and undeserving patients (Kelly et al, 1982; Shaw, 2007), enabled me to grasp this reality perspective. As insights deepened, the nature of my role changed. For example, nurse education became a key aspect in my role towards inclusion of vulnerable people in the developing net of care (Appendix 5 and 6).

- **Role Framing**

In narrative Text 1 (p.101) I am seen to struggle about the nature of my role: would a CPN, counselor or spiritual advisor be better placed than me to meet the health needs I am presented with? In the unfolding text my unique contribution as a SPHN in homelessness is clearly seen as an emerging insight. By the end of the narrative the insights that emerged about my role enabled me to create a SPHN model of care.

Deepening insights were incorporated into BAT (p.84) in three analytical horizons which are discussed in Narrative Form in the fifth dialogical movement (p.78). Woven by insights the narrative form shaped into a coherent process. In this second dialogical movement I was moving from significance in practice to insight as a key feature of self-inquiry. Seeing new knowledge emerge about my practice was exhilarating.

Third Dialogical Movement - Dialogue between Tentative Insights and Other Sources of Knowing

In this movement, I dialogued with the text using other sources of knowing. Tentative insights were substantiated in order to:

- Position my insights within a wider community of knowledge.
- Deepen the insight
- Develop new insight

Johns (2009) names this *informed text*. He situates this movement within the 'Dance of sophia' which I illuminate below (Fig 2.8). Afterwards, I will show how emerging insights are situated within Wilber's (1998, 2007) Integral Vision of Consciousness Model.

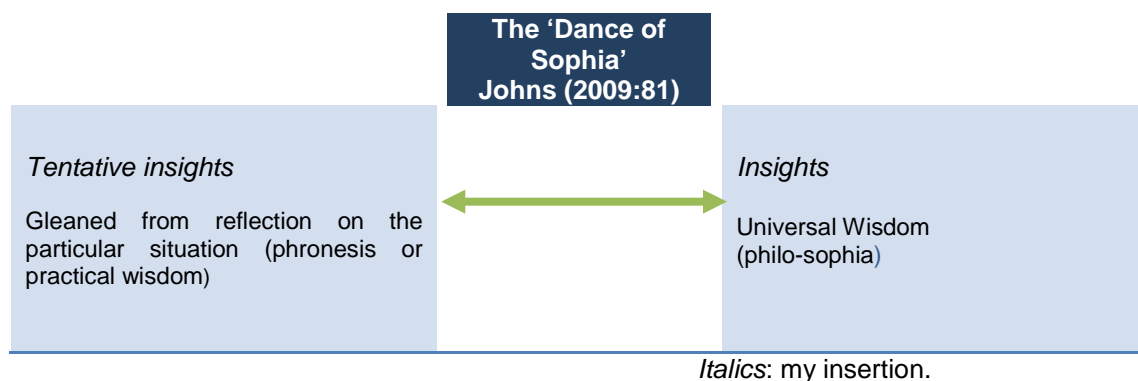


Fig 2.8

The concept of sophia or theoretical wisdom, developed by Aristotle (1934), leads to universal truths; it differs from phronesis which he defines as practical wisdom or prudence.⁴⁷ Reflecting on tentative insights is a process towards universal wisdom. Hansen (2008) links sophia to the,

Existential (not epistemological and scientific) attempt to understand ourselves in the moment and our relation to Being. (Hansen, 2008:38)

Being in homelessness practice ...Hansen challenges me to think about how I learn about the existential and ontological dimension of practice not simply as intuitive yet not prominently epistemological, rational and intellectual. Theory was not a superior knowledge force (Dewey, 1963/1938) but something which enriched the text and provided me with deeper meaning as insights unfolded. Each contributed to the development of universal truths, particularly about the nature of caring, peace and justice (Aristotle, 1934). Moments of insight did not necessarily arise immediately but often later as I reflected again on what it means to be a SPHN working clinically and strategically in homelessness health care.

Integral Vision of Consciousness Model (Wilber, 1998, 2007)

I used the Integral Vision of Consciousness Model (Wilber, 1998, 2007) to draw holistic insights as a coherent process. Within a deepening hermeneutic circle I could only meaningfully dialogue with new knowledge from my own experience. This is the 'I' quadrant which Wilber (1998) expresses in the Four Quadrant's Model of Integral Consciousness.

⁴⁷ See Building Bridges in Homelessness– phronesis in nursing practice (Fordham, 2008)

Wilber (1998) notes that we experience the world in "universal deep features and local surface features" (p.288), wherein, the world is relational, dynamic and unpredictable but holds patterns of universal truths. Some features are subjective realities, experienced by the individual; others are objective realities known in the world. Both have an individual or collective fit as shown in the Four Quadrants Model (Fig 2.9). Each paradigm offers valuable knowledge about the world, either individually or as a collective whole. By integrating them, "none can be reduced by the others" (Wilber, 1998:12).

The Four Quadrants Model of Consciousness

	SUBJECTIVE (left hand path)	OBJECTIVE (right hand path)
Individual	<p><i>Upper left</i></p> <p>I Self and consciousness Reflection on experience Authenticity-integrity-sincerity</p> <p>Truthfulness</p>	<p><i>Upper right</i></p> <p>It Brain and organism Empirical Knowledge Reflective Guidance</p> <p>Truth</p>
Collective	<p>We Cultural and worldview Patterns of relationship in the everyday world e.g. cultural acceptance or derogation of homelessness</p> <p>Justice</p> <p><i>Lower left</i></p>	<p>Its Social systems and environment Social systems such as the NHS, Housing, Voluntary organisations</p> <p>Functional</p> <p><i>Lower right</i></p>

Adapted from the Integral Vision of Consciousness: The Four Quadrants Model (Wilber, 1998) and Quadrants Focused on Humans (Wilber, 2007)

Fig 2.9

In Wilber's model, the dominance of empirical science based paradigm (objective) which overshadows experiential knowledge (subjective) is challenged so that upper right quadrant of traditional empirical knowledge in this model is viewed in context *with* the other quadrants. The model gave context to my practice experience, integrating partial views of myself, as outlined below:

Upper left: Individual subjective view

The subjective 'I', evoked the head, heart, hand (Cope, 2001) concepts of how I was thinking, feeling and responding within the experience to draw deeper meaning from surface signs as I reflected on practice. Authenticity, integrity and sincerity (Wilber, 1998) provided coherence in the research process and emerged from truthfulness of practice accounts that is required for self-inquiry. If truth had not been present, distortion itself would be a subject of reflection (Johns, 2002).

Aesthetic knowledge sits in this upper-left quadrant. On its own it is insufficient. Reflective knowledge, incorporating all of Carper's (1978) ways of knowing as noted in MSR cues (p.63), is more accurate - it contains more than aesthetic knowledge.

Upper right: Individual objective view

Empirical scientific based knowledge is situated in this quadrant, identified as an 'it' fit by Wilber i.e. the objective facts of an event, extensively used in medical models. I used extant knowledge to deepen insights through a variety of data sources. Reflective guidance brought further objectivity through my guides who challenged me to objectively explore emerging insights.

Lower left: Collective subjective view

This view enters the 'we' fit where cultural norms, revealed as patterns of relationship, structure the everyday world. I appreciated how I was influenced by them through reflection. Issues of justice such as health inequalities, rightness and mutual understanding fit into this quadrant. When I first began in homelessness practice, the invisibility of profound health and housing needs is situated in this quadrant.

Lower right: Collective objective view

Reflection empowered me to think beyond cultural norms towards the way health services, housing and voluntary organisations 'fitted' or failed to fit together in homelessness practice. This quadrant embraced organisational theory.

Rules for Injunction

My narrative may be threatened by an empiricist creed (Johns 2002), where objective truth is viewed as supreme through 'evidence' based grounding. But Wilber's (1998) model elicits the varied modes of knowing available through experience. He argues that evidence is "...brought forth by valid injunctions" (p.84). This concept places narrative in a paradigmatic perspective where each quadrant has its own rules for injunction or method. Wilber has developed these as 'eyes of knowing': those of the flesh (body), the mind (mind) and of contemplation (soul). Each discloses a different type of experience where the integrated model unites the whole. Wilber (2007:267) suggests that valid knowledge has the three major strands:

- An injunction (paradigm, exemplar, experiment) which is an active form of knowing, "if you want to know this, do this"
- An experience (awareness, tuition, apprehension) which illuminates the phenomena brought about by the injunction
- Communal confirmation/rejection which is checking the results with others who have completed the first two strands

Arising from being in the homelessness world (injunction) I was the only person who could adequately apprehend my practice experiences - they could not be observed by another person, hence my learning and understanding fitted into the individual subjective view but flowed into the four quadrants through reflection. Guided reflection was *the* pathway for 'integrating the four quadrants from the direction of the subjective "I" (Johns, 2002:8) so that my experiences brought body, mind and soul into a coherent whole.

Fourth Dialogical Movement - Dialogue with Guides and Peers to Develop and Deepen Insights

In this movement I dialogued with my guides and research peers to check-out and deepen my insights and develop new insights by co-creating deeper meanings in homeless health care.

The Process of Reflective Guidance

The academic community of inquiry consisted of other nurse practitioners and nurse educators undertaking similar PhD work with Professor Christopher Johns as our supervisor/guide. As we listened to each other's texts, we mutually become both actors and guides within the process of reflective guidance. The group met every four weeks from 2005-2008. In 2008, three theatre lecturers joined this unique narrative research genre and became co-supervisors where performance, performance theory and performance ethnography became part of the transformative process.

Over three years, I shared 42 reflective/informed texts in the group, pre-posted on the Google 'narrative group'. 45-60 minutes were allocated for dialogue. I developed 21 texts into the narrative. Guidance felt like 'camp fire teaching' (Johns, 2002; Bolton, 2005); a painted 'stick man' gardener on our teapot became a metaphor for inspiration: seeds planted, watered and ripened in our imaginations (Okri, 1997). Our different disciplines and perspectives became like a shared consciousness as reflections of practice connected. On a number of occasions, uncannily, similar themes were presented. I began to understand the reality of Okri's (1997:22) poetic words to our group,

The spirit warms. Memory burns brightly. The fires of intelligence blaze away and self consciousness evaporates. Then – wonderfully – the soul finds the sea; and the usually divided selves function luminously as one.

As we connected to each other's reflective journeys, I felt empowered and affirmed in my nursing practice. The significance of dialogue was palpable in the process of self-inquiry as we dwelled in the value of nursing experience, knowledge and extant theory to inform and deepen insights.

Why is guidance necessary?

In a paper presented at the 11th International Reflective Practice Conference (Fordham, 2005), I described reflection as looking at my own image on a still pond – no matter how much I gazed, I would never fully see myself as others see me for my reflection is a reversed mirror image. In her keynote address at the 16th international reflective practice conference Kathy Armour⁴⁸ introduced the word ‘Doxa’, used more frequently in sociological and anthropological studies. She summarised Doxa as,

The way things are, so you buy into them and don’t see at the same time that they are forcing you down a particular route. You don’t see the impact it has on you.

Lather (1986) uses the term ‘false consciousness’ to describe the inability of the researcher to see their true self (or practitioner) and Richardson (1997) suggests that critical challenge reveals areas of self that may be hidden to the researcher such as values, motivations and actions. Additionally, whilst practitioners can reflect alone it is less likely to be sustained (Cox et al, 1991).

The role of the guide

Anam Cara, Gaelic for ‘soul friend’ resonated with the role of guide.

The *anam cara* brings epistemological integration and healing. You look and see and understand differently. Initially this can be disruptive and awkward, but it gradually refines our sensibility and transforms your way of being in the world ...for too long we have been blind to the cognitive riches of feeling and the affective depth of ideas. (O’Donohue, 1997:38)

Guidance enabled me to see through windows of opaqueness as I explored feelings arising from practice, augmenting a reflexive spiral in my journey of self inquiry towards my practice vision (Johns, 2009). The key tenets of the role of guide (Johns 2009:86) are:

- To enable the practitioner to take responsibility for their own performance in guided reflection and clinical practice
- To gain insights into self, one’s vision and one’s reality
- To hold the practitioner along this journey
- To remoralise the demoralized practitioner
- To gain insight into new ways of being and responding congruently
- To co-create meaning
- To infuse the practitioner with resolve to take actions as necessary

⁴⁸ Kathy Armour (2010) *Have you heard the one about? Narratives in reflective (professional) practice* - key note address Friday 26th June at the International Reflective Practice Conference University of Bedfordshire June 23-26 2010

I will now provide examples of guidance in four areas of practice which enabled me to see things differently:

- Shifting practice tension
- Challenging normal behaviour patterns
- Co-creation
- Resting and recuperative space

Shifting practice tension

Returning to creative tension, Senge (2006) describes it as the gap between our current reality with our vision; a source of energy to take action. Reflective guidance tuned into creative tension, shifting its nature towards achieving the practice vision (Fig 2.10).



Fig 2.10

For example, through guidance I became more aware of how I and others used 'voice' (Belenky et al, 1986) particularly regarding perceived 'authority' by others (E.g. Text:10). Empowered to respond differently through reflecting on my *use of voice*, creative tension was dissipated or harnessed as insights were gained or deepened (Johns, 2002). In this way guidance supported and remoralised me so that, "holding the intention of desirable practice" (Johns, 2009:10), I transcended self-distortion or limited ability to see beyond my normative self towards engaging others in new ways (E.g.Text:1,2,5,19).

Challenging normal behaviour patterns

Challenge was part of the dialogical process of guidance, perhaps about my use of particular words in the text or rhetorical questions, exposing me to new ways of seeing. For example, the question "Why have you chosen this experience?" revealed habitual patterns on reflections about people accessing my clinical services. Consequently, for example, I became more mindful of 'marginalized' people within homelessness itself, who didn't approach me in practice, nor I them. As I sought them out, subsequently, my insights about the lived experience of loneliness and loss for

people who had seriously offended, for example, were deepened.⁴⁹ Challenging normative behaviour through guidance transforms practitioners to new enlightened ways of being as we "see the way things are" (Johns, 2002:33).

Co-creation

To understand 'co-creation' I drew on Gadamer's (1975/2004) hermeneutic notion of the 'fusion of horizons'. He states,

The concept of horizon suggests itself because it expresses the superior breadth of vision that the person who is trying to understand must have. To acquire a "horizon" means that one learns to look beyond what is close at hand – not in order to look away from it but to see it better....the horizon of the present is continually in the process of being formed because we continually have to test all our prejudices. Hence the horizon of the present can-not be formed without the past. Rather understanding is always the fusion of these horizons supposedly existing by themselves (Gadamer, 1975/2004:304-305)

The process of co-creation was mutual as we journeyed together to dialogue about respective research studies.⁵⁰ When theatre lecturers joined the School of Reflective Practice in 2008, I was guided to reflect with story boards (Texts:18/20 *Spaghetti Junction/Can of Worms*), broadening my horizons through visual images that led to new metaphoric themes. They introduced empowerment theory around 'forum theatre' (Boal, 1979) which resonated with Freire's (1970) and Fay's (1987) empowerment theories and my work with oppressed people - but in a new way. Forum theatre enabled me to visualise empowerment through staged physical movement and team work. Thrilled, too, at the prospect of developing performance that linked to my work in homelessness education with a local drama company, the fusion of horizons was becoming a multi-faceted force in my practice.

Resting and recuperative space

Reflective guidance became the resting and recuperative space, highlighted by a number of theorists (Boyd & Fales, 1983; Johns, 2009) where I felt affirmed in writing transgressive reflections in my own endeavor towards desirable practice. Okri speaks about writing as in the spirit of play where playfulness 'lighten(s) all terrifying endeavors' (Okri, 1997:22). Playfulness nourished me against the back drop of suffering which I worked in and wrote about daily. Playfulness emerged through creativity: creative writing, art and photographic workshops. In one text, I was challenged to write a 'rap' around the abbreviations in it. It reduced my stress around authoritative powers that had the potential to oppress and constrain me, re-energising me towards my vision of practice (Johns, 2009:88).

⁴⁹ Text not included because of thesis word limit

⁵⁰ The PhD school of reflected guidance is an international multi disciplinary school of inquiry. From 2005-2008 health professionals were the core of the group but it now hosts education and performance as well

A Critique of Reflective Guidance

Margaret Wheatley (2002:34) states,

As we work together...we need to include a new and strange ally - our willingness to have our beliefs and ideas challenged by what others think...we have to be willing to let go of our certainty and expect ourselves to be confused... we won't be able to understand complexity unless we spend more time in not knowing.

Willingness to be challenged and *unknowing* as a process in learning development may also contribute to a health professional's vulnerability cited in reflective guidance literature. For example, vulnerability frequently relates to the student's disclosure of unsafe practice and the ensuing role of the 'supervisor' (Hargreaves, 1997:225). Viewed as a surveillance tactic, students may resist revealing their true self in reflective practice writing (Platzer et al, 2000, Cotton, 2001). Moon (2010)⁵¹ makes the point that when students decide not to disclose poor practice; students have already been through a process of reflection.

Reflective guidance has also been compared to a 'confessional' where the practitioner may be judged by another (Cotton, 2001; Gilbert, 2001). Acquainted with confessionals where I rarely felt judged, this metaphor seemed inappropriate. Fejes (2008) asserts that reflection in a confessional way to one's self reduces the risk imposed by authoritative power dynamics. Undoubtedly, reflective guidance can be an uncomfortable experience with a potential for abuse "from its collaborative intent" (Johns, 2009:93) when guides force their own agenda to determine what the insights are. Developing this critique, Sully et al (2008) and Freshwater (2002) both discuss transference and counter transference within group dynamics. Sully et al (2008:141) writes,

Our own supervision processes help us to reflect on our styles of working with student groups, as well as analyse our intervention strategies. We are helped to identify and explore the potential and/or actual processes that exist in our work, as well as how to face and deal with those which have occurred so we and the students are neither abused nor become mutually abusive. This process can be equated to the transference-counter transference relations (Malan 1979) between the student and us, and us and our supervisor.

Challenges were normally negotiated sensitively. But, I recognised that guides hold their own prejudices which limit their understanding and in the fusion of horizons each must, "continually have to test all our prejudices" (Gadamer 1975/2004:306).

Testing prejudices can be uncomfortable within the lens of transformation. When I found challenges too rapid - interrupting the flow of reading after one or two sentences - it was discussed in the group

⁵¹ Moon, J. (2010) In a key note address on reflective practice at the 16th International Reflective Conference 2010 held at Putteridgebury 23 – 25th June 2010

and ground rules were put in place.⁵² As I read Text 15, fiery challenges around faith archetypes, mothering and sexuality made me feel unsafe. Johns's view (reflective guidance session, Dec 2007) was that it was reasonable in reflective guidance to voice challenges which make the practitioner feel unsafe. I strongly disagreed. Dialogue brought this impasse to a satisfactory conclusion. I believed *all* the challenges were made in an authentic, caring relationship, marked by an affirming intention for transformation towards my practice vision in homelessness.

Fifth Dialogical Movement - Weave a Coherent and Reflexive Narrative Text that Adequately Plots the Unfolding Journey

In this movement I return to key concepts that weaved the narrative into a coherent whole to show my transformation in practice and effectively engage the reader in the sixth dialogical movement, where it will be opened up towards further dialogue. Key concepts in shaping the narrative were: narrative form, narrative plot, reflexivity and coherence.

Narrative Form

Returning to narrative form, the reflexive narrative is a substantive text consisting of twenty-one reflective texts which are interspersed with three analytical horizons. The term horizon is borrowed from Gadamer (1975:305) who pertains that the horizon or understanding of the present cannot be formed without the past. This seemed an ideal metaphor for naming the analyzing sub-narrative sections in the evolving reflexive narrative.

In the analytical horizons I gathered insights gained in earlier dialogical movements to summarise and signpost the reader about my evolving transformation in practice.⁵³ The insights are positioned in the reflexive frameworks: the Being Available Template (BAT) that illuminates my practice environment as *the net*, and to a lesser extent, *use of voice* mindful of Belenky et al's (1986) voice perspectives in my practice. Both are expanded on later in this section.

First, mindful of Johns (2009) who guides nurses to be imaginative and creative in reflective practice, I show how I gave richness and texture to the narrative.

⁵² This was altered to give individuals choice so that challenges could be during the reading of the text, at the end of the page or after the reading was completed.

⁵³ E.g. MSR (p.60) Framing Perspectives(p.68); reflective guidance (p.73)

Writing style

In addition to my transformation in practice, I gave considerable thought to how I should present suffering in the narrative so that it would be heard. In his illness narrative, Arthur W Frank notes,

One of our most difficult duties as human beings is to listen to the voices of those who suffer (Frank, 1995:25).

Narrative form was therefore aesthetically influenced by:

- Storytelling
- Metaphor
- Nature, spirituality and ancient wisdom
- Art, poetry and photography

These are now discussed:

- **Story writing and storytelling**

Homelessness felt like a secret world which storytelling would illuminate; my writing became transgressive,

Storytelling is always transgressive...without transgression there is no art, no risk... There is nothing more shocking or more dangerous or more upsetting to individuals and nations than truth. Giving truth direct narrative expression is to give it public explosion...transgression can simply reside in beautiful things...(or) take readers to where they wouldn't willingly go themselves (Okri, 1997:64)

Transgression is an act of service (Okri, 1997:43) and resonated with CSS theory and the moral endeavour towards creating a better world (Bohm, 1996). Why did this matter? In an intense and moving encounter with an alcohol dependent person a commissioner who was accompanying me said "I can't believe this; many practitioners could not do this kind of work".⁵⁴ Similarly, following the dissemination of the HNA (Appendix 1) a member of a senior management team commented, "I pass the day centre every day. I never realised this could be happening in England, never mind my own town." Such comments reinforced the impact of storytelling in health and homelessness against other forms of representation such as statistics. I opened metaphorical doors of perception for others to enter the world of homelessness. Practice stories were tools of enlightenment,⁵⁵ where Okri's (1997) guided me to:

- Capture suffering and joy (p.22)
- Write imaginatively (p.41)
- Be a witness who writes evocatively to reveal moods (p.26)

⁵⁴ Practice visit to clinic, spring 2008

⁵⁵ I used the stories, having honed them through reflection, to challenge perceptions of others

Aware that I inhabited a world where others don't care to look, (Okri, 1997:1), Okri's words became my mantle as I claimed agency in specialist practice and took a transgressive stance, in and through storytelling. Growing in practice knowledge and political awareness, storytelling widened perceptions of others towards transformation in local homelessness.

- **Metaphor**

I used metaphors extensively to herald new insights, often capturing phrases in a practice experience. Schwind (2010) describes the potential metaphors hold to shape transformation,

By purposefully exploring our metaphoric images, we are more fully engaged in life: with self and with other and so endeavor to construct meaningful wholes that will enlighten our path ... metaphors hold knowledge... (Schwind, 2010:17).

The opening paragraph of *The Spider's Web* (Text:19), a text based on gaps in mental health and homelessness, illustrates this,

Intricate, delicate, systematic - I feel like a sapient, Socratic spider drawing stray strands together, spun from experience. Spider silk, twice as strong as steel thread (Gore 2005); silk experiences as precious as gold dust, gathered from day to day nursing practice, drawing together a sagely web that unites some of the separate, steel trajectories on Spaghetti Junction.

Images emerged as I tapped into an innate creative well so that metaphor and playful alliteration liberated my writing style to reveal my role.

- **Nature, spirituality and ancient wisdom**

Wheatley (2002) affirms how connections arise through observing nature. In her reflection of sacred space, she states,

As I write this through the window I've noticed a mother bird flying back and forth, worms dangling from her beak. She's working diligently to provide for her babies. Watching her I remember my own mothering, and suddenly, I feel connected to all other beings who, as mothers try to keep life going. A brief moment of noticing one hard working bird and I feel...more connected (Wheatley, 2002:132)

In personal times of sacred space, I reflected on connections and learnt to cultivate silence. In turn, my therapeutic relationships were deepened. As therapeutic silence emerged in dialogue with my patients I held it, explored it, and waited to see what emerged from it (E.g. Text:8). Through silence I saw how people were connecting with themselves and with me, as if past, present and future were reforming in the present moment towards improving health. O'Donohue (1997:13) writes, "...behind your image, below your words, above your thoughts, the silence of another world awaits you." Physical, emotional and spiritual insights often emerged through silence.

I weaved nature into my practice stories, inspired by Wheatley (2002) and Johns (2004, 2006⁵⁶), so health professionals would connect to the reality of rough sleeping in all weather conditions or and to the domino effect arising when health service provision was, in some way, denied to homeless people through non-engagement by mainstream services which resulted in hostel evictions (Texts:9,13). My aim was to reveal the unique 'health' jig-saw piece in multi-agency homelessness practice.

I was influenced by Buddhist and Christian caring philosophies in considering the nature of my caring role (Johns, 2007; Christian-Buddhist retreat⁵⁷ 2007). Sensitive to narrative readers who may be agnostic, atheist or from other religions, I used the influence of religion practically. For example, I spoke earlier of the fear I experienced prior to my first visit to the night shelter. The Christian writer Nouwen⁵⁸ (2003) illuminated my path,

We are fearful people...the more I come to know people, the more I am overwhelmed by the negative power of fear. It often seems that fear has invaded every part of our being... The agenda of our world - the issues that fill our newspapers - is an agenda of fear and power... Fear engenders fear. Fear never gives birth to love (Nouwen, 2003:19).

Knowledge of others working in conditions of poverty and marginalization provided luminosity in practical and moral elements of my practice. For example, when I fearfully ascended a deserted staircase known to be a drug dealer haunt (Text:3) I drew on knowledge of Father Damien de Veuster living on the leprosy colony of Molokai from 1873 until his death in 1889. He was perceived as an angry individual by the Board of Health, outspoken against authority - an irritant leadership style used as a form of advocacy (MacNiven-Johnson, 2009). He could not remove leprosy but made huge improvements in the colony. This informed practice insights about my role and provided me with emotional support. I drew simple links - Damien's isolation, my isolation from other clinicians (QNI/HHI, 2008);⁵⁹ his use of voice, my use of voice (Belenky et al, 1987); I felt affirmed with the skills I needed to sustain my practice: courage, strong advocacy and a growing love for vulnerable people.

Generally, I used dialogue that valued beauty, spirituality and a love of others with an ethics of personal responsibility (Bochner, 2001) wherein, as the spiritual writer John Henry Newman writes, I

⁵⁶ See *The Heron and the Tree in Engaging Reflection in Practice* and also *Being Mindful, Easing Practice* (Johns 2004) where Johns, a Buddhist, also draws on the Christian spiritual academic and writer, Thomas Merton to his reflections

⁵⁷ Turvey Abbey, Bedfordshire: Christian-Buddhist retreat. April 2007

⁵⁸ Henri Nouwen was a Harvard academic, priest, psychologist and prolific author. Both *'The Inner Voice of Love'* (1996) and *'The Genesee Diary; report from a Trappist Monastery'* (1995) illuminate Nouwen's psychological and spiritual struggles that explore themes of love, belonging, acceptance etc (published by Longman and Todd).

⁵⁹ My isolation could not be compared to Damien's but I reflected on how he drew strength to sustain his mission.

recognized in my role that "I have a part in this great work; I am a link in a chain, a bond of connection between persons" (Newman, 1957:254). Such concepts were liberating, when homelessness had the potential to overwhelm me because of the vast health needs arising within it.

- **Art, poetry and photography**

My creative endeavours to form knowledge academically drew on Wilber's (1998) Four Quadrants Model of the Integral Vision (see p.71). Workshops hosted by the PhD school and in International Reflective Practice Conferences brought a creative endeavor to narrative.⁶⁰ For Ch 1 (p.20), I photographed my home to elicit deeper meaning, appreciating what 'home-less-ness' might mean to me. In Text 8 and elsewhere (Fordham, 2008) I illuminated how photography used in practice with a former rough sleeper, enabled me to grasp meaning about her search for personal peace. Gaydos (2005), a nurse-artist and nurse educator draws extensively on creative reflection as significant in nursing,

One definition of the art of nursing is an ability to grasp the meaning in patient encounters...grasping meaning is an intuitive act. The creative aesthetic process may be used in a variety of settings by nurses who do not identify themselves as artist but who are interested in using personal narratives as the bases ...to better understand their lives and their potential (Gaydos, 2005:257)

Drawing on art, poetry and photography, I used creative, aesthetic knowledge in the narrative. The Oxford dictionary (1970:13) defines aesthetics as 'appreciation of the beautiful'. Art illuminated the practice terrain and increased my practice knowledge.

Narrative Plot

Returning to plot, the concept of emplotment in narrative is a movement from the beginning through the narrative towards an end (Aristotle, 1934; Polkinghorne, 1998). 'Falling through the net', (Fig 2.11) lightly illuminated my role as 'net-weaver' to improve homelessness health care. It positioned me centrally in 'the web of relationship' which Ricoeur (in Kearney, 2004:157) alludes to, wherein the narrative 'who' is fulfilled, as agents and the circumstances of action are disclosed.

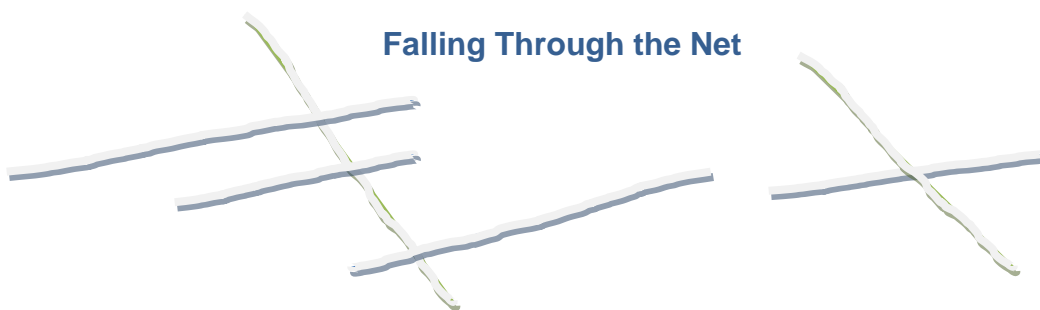


Fig 2.11

⁶⁰ Zahourek (2005) International Reflective Conference, Intentionality and Healing using collage; Kay Goodrich (2006) PhD Winter School, University of Bedfordshire; Lea Gados (2007) Art as Personal Narratives: University of Bedfordshire and International Reflective Practice Conference Aalborg, Denmark

Co-created during reflective guidance, the metaphor represented those people who found themselves unable to access appropriate health and housing services, or when they were accessed, engagement was not sustained. 'Falling through the net' also had the capacity of linking events in narrative time. For example, in Text:8, the dramatic events I was involved in with Heidi showed how her past experiences linked into her current situation of homelessness, revealing how she persistently fell through the 'net of services' from childhood. In this way, narrative "provides a moral perspective on past events" (Mattingly, 1998:29) so that gaps in homelessness health prevention are illuminated earlier for strategic consideration. *The net* captured the complex practice environment and the diverse nature of my role, illuminating its multiagency, multi-disciplinary aspects. Following most texts, I aesthetically link the reader to the weft and weave of the net (Fig 2.11).

Feminist Influences

In the narrative, a 'neat' plot did not actually occur for when I weaved one part of the net together another fell away, upholding the critique that emplotment belongs to narrative not to life (Chatman, 1978).⁶¹ *Falling through the net* provided the illusion of a narrative plot. I tentatively held it, aware that a masculine concept of plot sits in tension with feminist writers who value the textual body (Cixous, 1995) as noted earlier in this chapter. The openness of women's writing as non-linear and flexible above the patriarchal accord of order holds the potential to make it transformational and subversive (Cixous, 1996).

I drew on feminist theorists, through reflective guidance, to embrace 'writing as woman' and throw off masculine embodiment of former academic styles which I had previously been taught. Virginia Woolf (1945) discusses narrative dissonance between masculine values of 'mind/reasoning' with the mundane female 'emotional' body where "...the scene in a battlefield is more important than a scene in the shop" (Woolf, 1945:74). Like Helene Cixous, (1996) she challenges women to synthesize feminine and masculine in their writing so that the feminine can be equally known. In this way, mindful of feelings I brought them into the text to convey, for example, how my body responded to fear, sadness or peace, balancing these emotions with other forms of knowledge.

Feminist concepts are also embodied in the work of nurse theorists like Kralik et al (1997, 2001) influencing my awareness of how I worked *with* homeless people rather than *doing to* them to enable them in their onward health journeys. Kralik and Koch's research exposed the daily routine of practice so that nurses could look beyond their 'tunnel vision' to better understand patients' experiences (Kralik et al 1997:400). Similarly, they researched the daily experience of living with

⁶¹ Having engaged specialist mental health service support for homelessness at one stage in the narrative, another shows how quickly that service was taken away.

chronic conditions so that nurses can better understand and empower people with their self care (Kralik and Koch, 2001).

Framing Reflexivity

Here, I elaborate on how I used the BAT (Johns, 2002:52) and perspectives of voice (Belenky et al, 1986) to illuminate learning and transformation in the narrative.

Being Available Template [BAT] (Johns, 2002)

BAT was used as a reflexive interpretative framework to draw together insights from practice which eventually led to a SPHN Homeless Health Care Model (Chapter 4). Rather than an inflexible framework, I held BAT mindfully and lightly (Johns, 2002). Related to its six themes, the questions I pose below may guide the reader in my narrative:

- *Holding and intending to realise a vision* – Did my vision light my practice field? As new insights emerged my vision became a moving feast that was developed in sequential analytical horizons, culminating in working politically and educationally for health service inclusion.
- *The extent to which the practitioner knows other/services* – Did I connect health need to homelessness? Did I challenge non-engagement by others? Did I empathetically inquire, tuning into and flowing with the unfolding patterns of experience which were often complex and deep?
- *The extent to which the practitioner is concerned for the other* – Did I show my concern and compassion as caring energy? Did I ease suffering; work effectively in partnership with multiagency and multi-disciplinary others through effective use of voice?
- *The extent to which the practitioner can grasp and interpret the clinical moment and responds with appropriate skillful action* – Did I meet the health needs of homeless people in the most effective and moral way? How useful was my background *Forehaving* in Chapter 1 in illuminating why I acted the way I did?
- *The extent to which the practitioner knows and manages self within relationships* – Did I meet the ethical demand? How well did I look after my own emotional well-being to work effectively?
- *The extent to which the practitioner can create and sustain an environment where being available is possible* – Was I assertive and collaborative working towards a shared vision with colleagues? Did I politically maximize available resources for caring as I voiced the needs in homelessness health care?

A key element in each cue was my use of voice. I reflected on the process using Belenky et al's (1986) framework as empowerment theory, linking to CSS and feminist theories. Despite using my

voice effectively at the beginning of the research (Text:2), there was a process of emergence as I listened to the voice of homeless people in my clinics, in focus groups and from the voluntary sector regarding health issues. I used this model less extensively than BAT and outline its principles below.

Women's ways of knowing - development of self, voice and mind (Belenky et al, 1986)

Belenky et al (1986) identified five epistemological perspectives of Women's Ways of Knowing (Figure 2.12). The perspectives were a fluid categorisation of the way the women perceived the world, identifying transforming concepts of self in relationships with others (Belenky et al 1987:15/134).

Women's Ways of Knowing: The Development of Self, Voice and

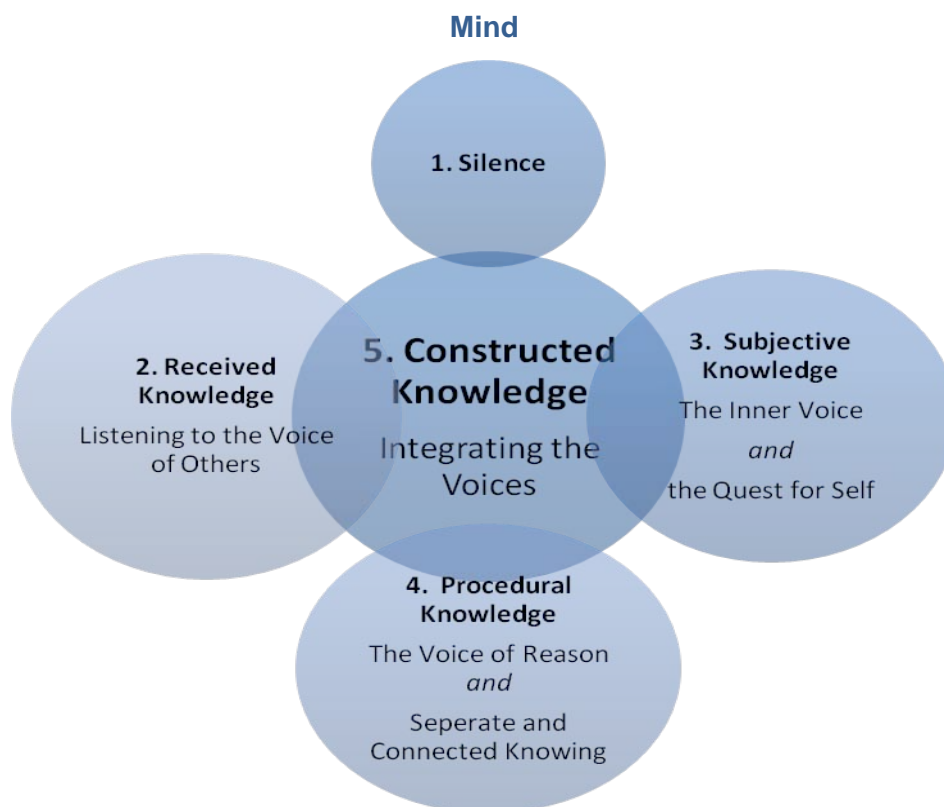


Fig 2.12

These perspectives merged with BAT themes as shown below:

- o *Silence: a position from which the women perceived themselves as mindless and voiceless, subject to the whims of external authority. Reflection tuned into insights to confront limits which were a threat to my voice and my 'vision' - not always to overcome them but to understand them, recognising why things are as they are (Johns, 2002) in order to direct and empowered my future practice. In Text:8 for example, I felt I was colluding*

with an unjust eviction through silence. In this creative tension insights about my role in evictions developed and could be framed with the BAT cue 'the extent to which the practitioner can create and sustain an environment where being available is possible'. The cue alerted me to the effects an eviction would have on access to health services where I and other services would be less able to sustain an environment of 'being available'.

- *Received Knowledge: women received or reproduced knowledge from external authorities but were not capable of creating knowledge on their own.* In homelessness this linked to the BAT cue 'the extent to which the practitioner can grasp and interpret the clinical moment and respond with appropriate skilful action'. For example, effective multi-agency practice meant acclimatising to new jargon. Initially I acted on received knowledge about housing decisions rather than questioning their rationale which I challenge later in practice.
- *Subjective Knowledge - The inner voice; the quest for self: In this perspective there was a turning away from external authority towards a private sense of authority but the women were without public voice or public authority. Women were often described as emerging from male oppression, sexual harassment or abuse.* In this perspective, I positioned some entrenched professional opinions that lacked substance about homeless people. It also gave meaning to my experiences with homeless people who were beginning their search for healing. This links to the BAT cue 'the extent to which the practitioner knows the other'.
- *Procedural Knowledge - The voice of reason; separated and connected knowing: In separate knowing, knowers 'weed-out' self; knowledge was based on impersonal procedures to establish justice, where, like tough-minded gatekeepers, they critically examined any possible loophole, often resulting in the loss of the voice of others. Connected knowing was developed through understanding and an empathic connection to the other's experience - truth emerged as care.* The cue 'the extent to which the practitioner can grasp and interpret the clinical moment and responds with appropriate skilful action' features here where voice was most significant and developed in connected knowing about homelessness through clinic and focus group dialogue. I became aware of strategic others, using a voice of separate knowing and acting as gatekeepers in health services. I was also a separate knower, critical of services as I tried to improve access to services.
- *Constructed Knowledge - Integrating the voices: These women had generally gone through a period of intense self reflection and had integrated connected and separate knowing.* Connected knowers made the transition to constructed knowledge more easily than separate knowers. Women experienced themselves as creators of knowledge, valuing

subjective and objective strategies for knowing. They integrated feeling and care into their speech, knowing that their ideas and values must be nurtured in environments which make them grow. They transcended moral commitment as action in their local community, contributing to the empowerment and improvement of the lives of others. Through constructive knowing, the cue 'realisation of the vision of practice' is realised. Undoubtedly, my voice as a constructive knower grew in homelessness as my unique practice knowledge developed, weaving personal and professional knowledge through systematic reflection.

It was helpful to link *use of voice* within the developing BAT - although not in a rigid manner.

Coherence

Positioned in the constructivist research paradigm, narrative seeks to understand meaning rather than provide a scientific explanation. It recognises multiple realities and that meaning is co-created to socially construct the nature of reality. In this way it differs from empirical positivist data which presumes an unchanging reality through rigorous, systematic and objective methodology to obtain reliable and valid knowledge (Denzin and Lincoln 2005:3). A criticism of the positive and post-positive quantitative research paradigm is that it produces one type of science which "silences too many voices" (Denzin and Lincoln, 2005:12). Denzin and Lincoln (2005) argue that all research is interpretative and based on the researchers "beliefs which guides the questions to ask" (p.12).

The controversial use of criteria to judge reflexive narrative is illuminated by nurse theorists such as Freshwater et al (2010) and Koch & Harrington (1998) who stress the importance of reflexive qualitative accounts that describe what is going on to make the research product believable and plausible. To this end, Johns (2010) champions the Six Dialogical Movements as a coherent whole endorsing Reason and Rowan (1981) who suggest that coherence is more appropriate than 'validity' because it more accurately reflects human inquiry. How coherence is weaved into the dialogical movements is shown in Fig 2.13.

COHEREHNCCE IN THE SIX DIALOGICAL MOVEMENTS (Adapted from Johns, 2010:266)	Text Coherence
1st Movement: Dialogue with self [Self-inquiry and hermeneutic theory] Authenticity (Wilber, 1989) Face validity (Lather, 1986)	<i>Journaling</i> Authenticity Face validity
2nd Movement: Dialogue with the story [Reflective theory to gain insights] Systematic process of reflection [MSR] (Johns, 2002)	<i>Reflective text</i> Systematic reflection (MSR)
3rd Movement: Dialogue with wider literature [position tentative insights with hermeneutic theory and other literature sources] Construct validity (Lather, 1986)	<i>Informed text</i> Construct Validity
4th Movement: Dialogue with guides to deepen insights. [Using hermeneutic theory, co-creating meaning (Gadamer, 1975)]	<i>Co-created Text</i> Face Validity
5th Movement: Dialogue with the emerging text weave the Narrative into a coherent whole [Narrative theory, reflexivity and ethics] Construct validity (Lather, 1986) Congruent reflexivity Rhizomatic validity (Lather, 1993)	<i>Narrative Rhizomatic,</i> Reflective validity
6th Movement: Dialogue to inform a wider audience [Narrative theory, hermeneutics, performance ethnography] Consensus reader validity (Lather, 1986)	<i>Evolving Text</i> Engagement <i>Performance Text</i>

Fig 2.13

The Oxford Dictionary of English (2005:335) defines cohere as "form a unified whole, *systemized into one consistent body of knowledge*". Coherence is set out in the following section as:

- Authenticity
- Face Validity
- Construct Validity
- Rhizomatic Validity
- Engagement and Performance Validity

Additionally, I have already discussed how I used systematic reflection with the MSR in the second dialogical movement (p.60).

Authenticity

In the first dialogical movement, Johns draws on Wilber's (1998) concept of authenticity as a criterion for truth in the upper left quadrant whereby interior truth can be reached through dialogue and interpretation,

...we are dealing not so much with exterior and observable behaviour but with interior states, and the only way you and I can get at each other's interiors is by dialogue and interpretation ...the validity claim here is not so much whether my statements match exterior facts, but whether I can truthfully report my own inner status (Wilber, 1998:15).

What do I feel about truthfulness? I carry a poem attributed to St Thomas Aquinas in my work diary.

The first stanza reads:

Give me the gifts that I need in my labour
A mind that is eager to seek for the truth
Keen to perceive it and strong to embrace it
A will that is eager and valiant to do

The truth I sought in my journey of self-inquiry was revealing self, nursing and homelessness in my ontological journey from being to becoming. Johns (2009:320) states "If I espouse to be caring, compassionate and collaborative ...speaking my truth is being responsible for myself and my actions...if I do not speak my truth I may cause suffering". I deeply desired to represent my homeless experiences truthfully. Yet, how would the reader know if I was falsifying my interior or exterior account of practice? Ellis (1995) guides readers towards a "feeling that the experience described was authentic, that it is believable and possible" (pp.318-319) yet when I first embarked in homelessness, what I was seeing seemed unbelievable. To make my research believable, the notion of the critical hermeneutic circle in the Six Dialogical Movements (see p.53) upholds Koch & Harrington's (1998) ideals of reflexivity in shaping narrative's tapestry by interpreting each reflective turn aware of social, political and critical insight. In my search for truthfulness, emerging insights were framed using Johns's (2010) framing perspectives as discussed on p.68.

To best represent my narrative experiences to reveal my transformation, I considered the mimetic question which Mattingly, (1998) notes as:

- Mimetic: The realist stance where narrative simply imitates experience
- Antimimetic: Narrative powerfully distorts life as lived to become meaningful

As a reflective practitioner, the mimetic stance was the only one where I could effectively negotiate the process of self-inquiry, carefully maintaining anonymity by changing character details.

Validity

Koch & Harrington (1998) note that Lather (1993) has retained the word validity unlike Reason and Rowan (1981), reconceptualising it within practices of theoretical representation. Lather defines three types of validity towards the growth of "illuminating and change enhancing social theory" (Lather, 1993:67): face validity, construct validity and catalytic validity. The emergence of rhizomatic validity (Lather, 1993) has latterly subsumed catalytic validity. They are discussed below:

- **Face validity**

Qualitative research has been criticized for lacking scientific rigour; its criteria challenged for being anecdotal, impressionistic and strongly subjective (Koch & Harrington, 1998). Whilst the process of

narrative construction is subjective, coherence is enhanced through co-creating meaning in a process of engagement and dialogue (Johns, 2009). The first and fourth dialogical movements brought transparency and face validity to narrative construction. Practice experiences and reflective guidance dialogue was written in the evening in the peace of my home so that I remembered to effectively represent and utilize other voices, using their language in the narrative. Writing a story around practice insights was an authentic (Wilber, 1998) process that emerged through reflexivity and in dialogue to co-construct meaning leading to my transformation in practice.

- **Construct validity**

The Six Dialogical Movements are an organizing framework that maintains construct validity. Lather identifies construct validity as theoretical framing. Theory informed my emerging insights within a wider community of knowledge. Wilber's (1998) subjective 'I' quadrant of knowing 'through experience' was substantiated by the 'it' theoretical sources - in the objective/collective quadrant. Theoretical framing is met through this paradigm but Johns (2002) warns, that 'truth' is not simply "...out there as an objective reality through which the personal notion of truth must be judged against to qualify as truth" (p.64).

In guidance, I was prompted to seek wider sources of knowing rather than merely rely on health and homeless literature or other extant knowledge that provided a partial view of experiences. So, for example, when theatre lecturers joined the PhD group, I lightly used novels by Charles Dickens and John Steinbeck (Text:18) to construct moods that I had experienced in practice. Knowing revealed through reflection and extant theory unfolded within the reflexive spiral of being and becoming as meaning was co-created in this way.

- **Rhizomatic validity**

The rhizome is used as a metaphor by Lather (1993) to re-inscribe rigour. She writes,

As a metaphor, rhizomes work against the constraints of authority, regularity and commonsense and open thought up to creative constructions which mark the ability to transform, to break down present practices in favour of future ones (p.680)

Homelessness is a complex multi-agency field of health practice. The rhizome metaphor opened up my thoughts to represent my lived experience and journey of self-inquiry as creative constructions - through story writing and storytelling - often working against the constraints of authority, tapping underground and unsettling from within (Lather, 1993) to represent practice insights. My journey of self-inquiry was a journey into the "intersections, nodes and regionalization of complexity" (Lather, 1993:680) in a chaotic, contradictory, and fragmented field of practice, yet like the narrative plot, it held within it a natural wholeness (Johns, 2009). Through attention to feminine texts that grasped complexity, challenging the masculine, positivist idea of orderly representation, my writing style

changed from my previous ways of academic writing to represent this whilst lightly holding the plot within it. I heeded Jarrett's (2009) advice about breaching the rules of rhizomatic validity which she encountered as she tried to separate her insights from the practice stories. She found that insights alone did not display the interdependency that practice issues hold.

Engagement and performance validity

Johns's sixth dialogical movement requires engagement and performance validity. Richardson & St Pierre (2005:964) provide criteria for aesthetic merit regarding reader/audience engagement called CAP (Creative Analytical Practices). It has holds five criterion, three of which are addressed below. *Reflexivity* and *emotional/intellectual impact* are addressed elsewhere.

- *Does the narrative make a substantive contribution to an understanding of social life? Does it seem real and true?* My narrative 'shows' a real homelessness practice terrain which is normally invisible to other health professionals and to society itself. Answering Bochner's (2001) call for more research with abuse, addiction, living with shame - I add here childhood trauma - I "...confirm and humanize tragic experience by bearing witness" (Bochner, 2001:271) through narrative. To be a witness is not enough in research (Clough, 2000). Johns's research genre shows how transformation leads towards social action.
- *Does CAP open up the text to invite interpretive responses?* I wrote text to show not tell (Ellis, 2000). I felt no obligation to neatly 'close' texts. They are left open for audiences to interpret (Denzin, 2003). For example, I wrote deep descriptions of homelessness practice to draw the reader in; I wrote short sentences in single lines, creating space in the silence between the words (Johns, 2009) for reader interpretation. I wrote to entice a wide audience, beyond nursing and academia for others in society to reflect towards a personal sense of social action around homelessness.
- *Is the text artistically shaped, satisfying, complex and not boring?* Armed with "...paintbrushes, camera, bodies and voices" (Finley, 2005:689), I sought to shine a light to *expand consciousness* about the darker areas of knowledge in health and homelessness artistically. In this way I felt that our 'community of inquiry' was joining an army of new researchers shaping narrative inquiry. Arts based workshops were interwoven into the Community of Inquiry.⁶²

⁶² - Performance workshop (with Amanda Price, April Nunes, Antje Diedrich 2008, 2009)
- Storytelling (key speaker, Ben Okri @ International Reflective Practice Conference 2010)
- Creative writing (Churchill College, Cambridge, 2006)
- Art workshops (with Rothlyn Zahorurek, 2006; Lea Gados, 2007)
- Photographic workshops (with Kay Goodridge, 2006)

Johns weaves issues of social justice into the sixth dialogical movement as the final movement of coherence. To bring about transformation of society, CAP offers an effective framework for engagement and performance/narrative criteria for validity. I am mindful, however, that it does not specifically consider how narrative writing moves the reader from the personal to the political (Denzin, 2003), nor offer utopian thoughts about how things can be different, nor unsettles taken-for-granted meanings (Spry, 2001) which are relevant and displayed in my narrative.

Ethics

Reflective practice academics (Johns 2010; Bulman & Schultz, 2009; Jasper, 2009) acknowledge that ethics in reflective practice is a contentious area with implications for the reflective practitioner, the population with whom they practice and the organisation for which they work (Bolton, 2005). Bolton notes that reflective practitioners are likely to deal with emotive issues which require expert supervisors, ideally with therapeutic skills. Hargreaves (1997) focuses on the deontological⁶³ perspective of questioning the morality of using patients other than for "direct recovery" (p.225) but also asserts that reflective practice involves personal interpretation and judgment which may be controversial and cross a moral boundary. Coherence, in the Six Dialogical Movements addresses these issues - to be coherent, the narrative must be ethical (Johns, 2009).

Johns (2006:59) develops the concept of intentionality; the reflexive narrative is written to 'realise caring in practice' for self *and* others. However, he cautions authors to carefully write when critical of others "without sanitizing" (Johns, 2002:63) to make stories appear acceptable. Tensions between the practitioners' perspective and the medical ethical perspective (Johns, 2010:280) are shown in Fig 2.14.

⁶³Hargreaves refers to Kant's (trns by Paton, 1964) maxim of deontology in the context that one should treat persons as ends in themselves and never as means to an end.


Ethical Tension Within a Narrative of Self-Inquiry (Johns: 2010:280)		
Practitioners Perspective	Tension	Medical ethics perspective
<ol style="list-style-type: none"> 1. Self-inquiry as an authentic process 2. Claim for autonomy in a servant mentality within a bureaucratic organisation 3. No formal contract to involve others in the inquiry 4. Duty of care to mask identity of name and place to protect others mentioned in reflections (do no harm/confidentiality) 5. Strong emphasis on beneficence - that self-inquiry leads to positive outcomes for practitioners and others 6. Emphasis on utilitarianism - some risk can be tolerated in terms of the greater good 	<p>Ethical Principles</p>  <p><i>Beneficence</i> <i>Malevolence</i> <i>Autonomy</i> <i>Utilitarianism</i> <i>Value/Duty of care</i></p>	<ol style="list-style-type: none"> 1. Imposes its own rules of injunctions on subjective approaches to research with bias towards a scientific approach to research and ethics 2. Essentially bureaucratic that seeks to minimize risk of complaint (primacy to smooth-running) 3. Parental perspective to protect patient from harm - seeks to protect patient's rights, mindful of beneficence and malevolence as underlying principle 4. People involved in research must give consent

Fig 2.14

As I wrestled with the tension of challenging the primacy of the smooth-running organisation against developing new knowledge in homelessness health practice, my ethical dilemma was eased by the concept of utilitarianism where some risk can be tolerated in terms of the greater good. Embracing such tensions between organisational and professional expectations, where resource implications may affect desirable practice, is an ethical act. I drew on the concept of self-inquiry as an ethical principle for professional development. Johns (2002) writes,

Research and developing self in the context of self's own practice demands no ethical approval from others. Indeed, it is a mark of responsibility to take self seriously and develop self's potential to realise desirable practice (Johns, 2002:58).

Carson (1994) sustains this, noting that it is a positive ethical approach to study one's practice story with other literature.

Jarrett (2009) in her reflective practice study about her transformation in her role with physically disabled adults has written extensively on consent incorporating the patients, their family and

colleagues perspectives. Jarrett's study almost exclusively relates to patients. Here, I particularly drew on her stance towards colleagues. She writes,

I could potentially cause harm to a colleague if I include an incident in the narrative, they recognise themselves and do not like how they are portrayed. To minimise or prevent this is changing (details) ...enough? ...Should I obtain their consent? Potentially they could then want some control on the way they are portrayed which could change my perspective and how I learnt from the story.....or worse I could now cause them harm by asking them to recall an event from four or five years ago that I classed as conflict which they may not have done. (Jarrett, 2009:95)

In my narrative, I have not written about personal conflict with colleagues but there is considerable description of meetings and challenges to staff in my narrative. As my awareness of poor health contributing to homelessness grew, it became the nature of my role. Jarrett cites Lathlean's (1996) action research study where representations of findings about colleagues were watered down to maintain confidentiality and anonymity. In hindsight, Lathlean and her colleagues would have preferred not to be anonymous as the study lost the essence of meaning. I wanted to avoid that.

Whilst I obtained oral consent from homeless people, I never attempted to do so with colleagues. I did make it known in the PCT that I was doing a PhD reflective practice narrative study and managers had partly contributed to funding it. I read narrative extracts in meetings and performed at the International Reflective Practice Conferences which I wrote about in a PCT newsletter. In 2010, after disseminating the Health Needs Assessment report, I performed *Balancing the Clay* at the PCT's Health and Homelessness Conference (2010) believed to be the first PCT led homelessness conference in the UK. I, like Jarrett, have laid the trail, set the seeds for my colleagues to grasp the depth and extent of my narrative in homelessness. I believed there was an onus on them to approach me if they had concerns but no-one has!

My Ethical Approval Journey

I sought guidance on whether ethical approval was required for the study (COREC 2001) from my NHS employers and from the local ethics committee in 2005 and again in 2006/7. The chairperson of the Local Research Ethics committee and the PCT research and clinical effectiveness/development lead were of the same opinion (personal conversations in 2005/6 and emails: 7/11/2006; 8/1/2007; 22/01/07) that it was unnecessary for me to submit a research proposal to the PCT research governance committee nor to seek consent from people with the proviso that identifying details were attended to in the study, e.g. use of pseudonym (Morse, 2002). Indeed, the chairperson had considered this with other students and reflective practice nursing narratives were already widely published (Johns, 2000; Johns, 2002; Johns, 2004 and Johns, 2006). The rationale used was the same as Johns's (2002) and Carson's (1994) that reflective practice research is a study of developing self in professional practice for which ethical approval is not required. However, so that the depth and nature of my reflective practice involving patients was

fully appreciated, I sent a reflective text (*Still Life*, 11/9/06 - not used in the final narrative) to the chairman on the 27th November, 2006. His reply (Appendix 2) raised two ethical issues about narrative construction research: possible identification of people and possibly generating my own mental illness through self-analysis.

The Chair's guidance juxtaposed with the paper I was required to submit to the same PCT's research governance committee about my proposed focus groups with homeless people which did require patient information (Appendix 4) and consent forms. Focus group interviews whilst often profound, were less intimate than the stories emerging from practice for the narrative. My ensuing ethical discomfort lay in the latter dialogical movements where practice stories would emerge in the public arena either by publication or performance. Reflecting on consent, I now see that over the three years of study I could not anticipate what would unfold each day within practice that would develop through the dialogical movements to plot my narrative. This made the research process vibrant, fluid and grounded in the unexpected reality of my practice world. Had I been required by the ethics committee to obtain consent it would have been difficult to accomplish – particularly if consent was required from patients and staff. I, like Johns (2002:57), believe that the process of obtaining consent would have considerably changed the interactions within a "...contentious practice environment regarding access to health services" (ODPM 2004:13). Considering this further, I believe that the research narrative becomes a story of liberation in my struggle for in homelessness health development where loyalty to my colleagues is respected, but I place greater value on revealing conditions which impede the development of homeless health care, for as Fay (1987:29) states in regard to critical social science research,

A main tenet ... is to stimulate people to reflect on their circumstances and change those practices and policies that cannot be justified.

I remain mindful that I need to balance the good which comes from the study whilst considering the potential harm or distress to self/others (Ellis, 2004).

Gaining Patient Consent

In practice I did obtain oral consent from the majority of patients whom, without exception, wholeheartedly agreed that I should write their personal stories into the narrative. Indeed, it seemed to form part of their own empowerment against negative forces that had colluded around them in homelessness. As such it became a joint study with those whose lives had been affected by homelessness at this time and place in history as they vociferously and warmly encouraged me on.

In one reflective text I did not request consent from the patient and did not see that person in clinic again, revealing the transient nature of homelessness which health care practitioners have to accommodate in practice. To omit this text would be missing an important part of the narrative plot

and to this end I concur with my academic mentors who feel that consent is not required from anyone in the development of self in practice.

With no other outstanding ethical considerations, I concurred with the ethical guidance of the chair of the ethics committee and PCT Research and development lead. Pseudonyms have been used and other identifying details have been changed to protect identities as much as possible without changing the nature of the experience (Morse, 2002).

Since then, in 2009 and 2010, having listened to *Spaghetti Junction* and *Balancing the Clay* performed at the International Reflective Practice Conference, Professor Jean Watson (University of Colorado) raised the issue of patient consent. She cited a research study where a patient initially agreed to have their story published but then withdrew their consent once they saw it written down. I am reminded that even when personal details are changed and performance imagination developed almost as fiction, it is not easy for nurses to hear stories from practice 'performed' – are we in sacrilege of a great taboo? Like Jarrett (2009), consent is an issue for me to keep revisiting as I write and rewrite, change identity details and sometimes combine different practice experiences whilst remaining true to the essence of the story.

Sixth Dialogical Movement - Dialogue with new experiences and with others to facilitate social action

To open a dialogical space,
with the intention of creating a better world for homeless people
(Inspired by Bohm, 1996)

As a reflection of social action, the narrative is presented as means for further action and in this final movement I show how narrative reaches outwards, towards greater social justice.

Social Action

Okri (1997) elucidates the relationship between writer and reader,

Reading is ...a co-production between writer and reader...whole worlds, eras, characters, continents, people you wouldn't care to sit next to...all come to life in the mind (Okri, 1997:41)

Through the narrative, I open a dialogical space with the intention towards creating better world for homeless people. The reader (or listener) is not passive but brings their own experience to the text to co-produce meaning (Okri, 1997). The narrative is written and performed so that readers and

listeners can self reflect from their own horizon (Gadamer, 1975/2004) in a deepening hermeneutic circle towards a fusion of horizons (Gadamer, 1975/2004).

Performance (auto)ethnography

I have shown how I use CAP criteria (Richardson & St Pierre, 2005) for performance engagement. Here, I illuminate the sixth dialogical movement as action towards my practice vision.

- **Audience Reactions**

When I perform stories that have been shaped by performance thinking (Denzin and Lincoln, 2005) I choose what to perform for particular audiences to be socially active (Chase, 2005). Like children in a story circle, SCPHN nurse students sit entranced, drawn into the cumulative complexities of Texts:3,4,15. Vibrant discussions follow - students become introspective about their childhood; others are dismayed about the social issues involved. They want to visit nightshelters and day centres. They have become co-producers through the meaning they bring to and construct from, performance (Ross et al, 2002). Alexander (2005) states that,

Performance ethnography most often entails an embodied experience of the other...allowing the participants in and audience of the performance to come to know culture differently (Alexander, 2005:413)

Strategically, I performed *Balancing the Clay* (Text:15) at the Health and Homeless Conference (2010) to evoke compassion and accountability, connecting children's health commissioners and mental health commissioners to the issues of youth homelessness. I showed the contributing health issues that had preceded homelessness illuminating my insights from practice and applying them to the new DH guidance document *New Horizons* (DH 2009). In this way performance ethnography was a moral act (Conquergood, 1985; Geertz, 1968). Conquergood (1985) working with Hmong and Lao refugees in Chicago states,

When working with minority peoples and disenfranchised subcultures, such as refugees one is frequently propelled into the role of advocate...a theoretical argument I want to make about the epistemological potential of performance as a way of sensing the other (Conquergood, 1985:2).

Sensing the transgressive nature of the performance some health commissioners directed audience hostility (Conquergood, 1985) to me verbally and non-verbally. I experienced resistance (Conquergood, 1985) and political violence (Spry, 2001:725) through performing my narrative. Others in health, housing and voluntary sector congratulated me. Like Conquergood (1985) who sees performance ethnography as embedded in moral matters because performance makes ethnic and intercultural texts transparent, I had made homelessness and health cultures transparent as a moral matter which had a destabilizing effect within the organisation - a positive CAP outcome (Richardson & St Pierre, 2005).

- **International Audiences**

In Iceland, at my first international conference presentation (Fordham, 2005), I heard a collective audience gasp during my presentation of a practice story about a homeless Kosovan family and my therapeutic role within it. This audience response amongst others (Fordham 2007, 2009, 2010) developed my appreciation of the power of performance ethnography and the humanitarian responsibility held within our global nursing family. Watson's (2000) words fuelled my passion towards developing performance ethnography further. She states,

Through internal and external existential dialogue and story ... we journey into the spiritual, the aesthetic, the ethical, the arts, that touch and celebrate the non-quantifiable that once again reunite the profession and the practitioner alike, with the compassion and passion of nursing's life and work. (Watson, 2004:x)

Stories from homelessness practice are too valuable to remain dormant in health care. I write with the intention that well-crafted stories in my PhD thesis will reach far beyond my own practice towards our global nursing village, contributing to the grand narrative of understanding human caring and human being.

Formalizing the Performance Turn

During the third year of data collection in 2008, the 'School of Reflective Practice' became the 'Community of Inquiry' and formally evolved from a 'narrative turn' towards a performance 'turn' (Johns 2009). Prior to that, Professor Christopher Johns had developed performance from his own narratives as a therapist in which I and other nurses had participated.⁶⁴ From 2006 - 2008 I worked with Woodenhill in my practice, a local performance company, towards developing homelessness awareness in local schools.^{65/66} This was a desired outcome of homeless people in my focus groups. It was with excited anticipation that I met with Professor Alexis Weedon, alongside Professor Chris Johns as the student 'voice' to show our enthusiasm for formalising links between reflective practice narrative research and Performing Arts within the University. Subsequently, three performing arts lecturers became doctoral co-supervisors. These were key moments in the changing nature of reflective practice and reflective guidance research as it turned from narrative, into performance. Johns (2010) elucidates,

Performance shifts narrative into a new domain, from representation of self to presentation of self... through engaging the audience in a lived experience of their own within an agenda to use the performance as social action towards change, however slight.(Johns, 2010:29)

⁶⁴ RAW was written by Christopher Johns and performed by Chris at his professorial inaugural lecture in December 2007 with Bella Madden, Lou Jarret and myself. It was also performed at the International Reflective Practice Conference, Aalborg, 2007.

⁶⁵I refer to this work in the narrative and hope to construct a post-doctorate performance based on it. Woodenhill performed *Rough Choices* written by John Handscombe from his work in local homelessness which he began with me. The performance was presented at the International Reflective Practice Conference in 2010.

⁶⁶ I funded performance training sessions for homeless people in two hostels with Woodenhill.

The turn towards performance was not timely enough for me to develop further in this study. However, Dr Amanda Price invited me to story-tell practice experiences to 1st year BA Contemporary Theatre Practice students, who then produced and performed *No Place* to nurses and other multi agency staff in my locality on six occasions and also in the Health and Homeless Conference. It was an exciting joint endeavor at a time which is now referred to as 'the glory days' in local homelessness development.

Generalisability or resonance?

The insights, gained through reflective practice and reflective guidance, are not generalisable, but they do strongly resonate with others, as my examples illuminate in the sixth dialogical movement. van Manen (1997) defines resonance as "...the sudden perception or intuitive grasps of the life meaning of something" (p.364). Likewise Jarrett's study (2009) and other papers (Graham, 2010; Foster, 2010) provide resonance with others. Resonance, then, is the hallmark towards deeper meanings and understanding in health and homelessness practice.

Summary

In this extensive chapter, I have illuminated how I constructed the narrative using the Six Dialogical Movements drawing on heuristic philosophical influences. I have shown how coherence and reflexivity are developed throughout the narrative so that it is presented as a scholarly and rigorous area of research. I have extensively reviewed ethical tensions in homeless practice. Drawing on Okri's (1987) consensus to develop a better world through dialogue (Bohm 2006), I now ask that you let the best of yourself meet the best of myself as I narrate my role in homelessness and health in Chapter 3.

3 Falling Through the Net: My Narrative Journey of Self-Inquiry and Transformation

Indra's Net

There is an endless net of threads throughout the universe...
At every crossing of the thread there is an individual
And every individual is a crystal bead
And every crystal bead reflects
Not only the light from every other crystal in the net
But also from every other reflection
Throughout the universe

From the Rig Veda as described by Ann Adams
(Wheatley, 2002)

The narrative begins.....

Text One: IN THIS SPACE

The Day Centre Clinic

9th January 2006

On this damp January morning the day centre looks austere! I feel the despondency within its walls
- will I ever really get used to this place and what it stands for? As I cross the busy town centre

road, carrying a large box of health leaflets, a dishevelled, dark-haired man around 30 years of age shouting inarticulately rushes towards me, causing adrenaline to pirouette through my body. As he asks for the "ccccentre ffff for ffff food," a prick of sadness pierces my soul; food, such a basic requirement and this vulnerable man is in desperate need of it in my home town.

The centre struggles financially. Partly funded by our NHS Trust, its survival, like many voluntary services remains insecure. Its outer austerity contrasts with the inner warmth and Val, the centre manager, cheerily greets me beyond the window-grill. Large iron gates are a permanent sign of separation *and* security, underlining undertones of marginalisation and criminality but also of belonging. I wonder how people who use the centre first perceive it, and recall from practice how some homeless people avoid it, fearing its perceived underground culture of drugs and alcohol whilst others make it their day time home - a local 'space of care' (Hodgett et al, 2007).

The security TV, tells me that this post-Christmas clinic will be busy; seasonal aspects of homelessness unfolding as I enter my second year of practice.⁶⁷ The ritual of catching-up with centre news is a special time, marking how "something important is happening" (Mattingly, 1998:162) as we analyse the current health and homelessness world. It sets the equilibrium for my clinical journey, forming a strong bond between health and homeless services. There is always vitality in this encounter and staff eagerly state that my engagement with homeless people is more effective than the medical model previously used here, causing me to quickly muse on the advantages of each model (Fig 3.1).

Outreach Clinic Health Models

Specialist Public Health Nurse model --- --- --- - --- --- --- Day Centre

Strengths:

- Strong multi-agency links
- Holistic, partnership model: referrals, advocacy, anchorage between health and multi-agency systems
- Leadership in health and homelessness development
- Combined strategic /clinical role

Medical model --- --- --- --- Day Centre

⁶⁷ Year 1 summary: 1) Base line meetings with multi-agency partners associated with homelessness - Housing, homelessness voluntary services, drug and alcohol services, mental health managers, hospital managers, primary care services, attending forums and strategic multi-agency meetings. 2) Public Health research on homelessness including focus groups 3) Clinical interventions - referrals from hostels and 3 clinics (Bail hostel, Day centre, Eva Centre)

Strengths:

Greater medical knowledge
Authoritative voice in health services
GP registration required for access to most secondary health care

**Fig 3.1**

Val's description of Pamela, my first client is intriguing - my prejudices of who could be affected by homelessness are challenged because she is a health professional! Pamela has just been discharged from an acute mental health setting. I am mindful that severe mental illness can lead to homelessness (Wright, 2002) and being homeless can trigger mental health problems (Bines, 1994); I momentarily ponder on which has occurred first in Pamela's case. Val tells me that following a food allergy Pamela stopped work, deciding to leave her illness to 'God', rather than seek treatment. She lost her home, her job and ended up rough-sleeping. In her disbelief, she was detained following a mental health assessment. Val exclaims,

"She is so articulate. You wouldn't think she has a mental health problem... but they wouldn't section⁶⁸ her just because of her religious beliefs, would they? She is a psychologist, so she has some insight!"

Perhaps it is this cold winter day that makes Pamela's homelessness story seem particularly extreme! I shudder at the mixture of tensions I am negotiating. Despite being detained under The Mental Health Act (1983), it seems that psychiatrists have not diagnosed an illness and Pamela herself does not believe she is ill. Furthermore, she feels she has been severely mistreated by mental health services. Val is also in a dilemma. As the centre's welfare benefits expert she is concerned that if there is a mental illness disability, extra income would enable Pamela to fund and sustain accommodation.⁶⁹ The link between poor health, benefits and daily living in homelessness entwine.

What is my role? I sense a quadruple challenge. How can I guide Val to apply for Invalidity Benefit in regard to Pamela's mental health when I won't necessarily know if Pamela has a mental illness or not?⁷⁰ If she hasn't, how can she understand what has happened to her, and how will she recover? What, as a health professional, is Pamela's perception of mistreatment? Does Pamela want to meet me anyway? I need more information about her admission from hospital staff but there is no homelessness hospital discharge protocol to alert me to her presence, as guidance recommends (DH, 2003, DH/DCLG 2006). As the gaps in services accumulate, the tension between striving to address strategic and clinical priorities is revealed.

⁶⁸ Under the Mental Health Act (1983)

⁶⁹ Should she guide Pamela towards Incapacity Benefit (IB) (paid at a higher rate) or Job Seekers Allowance (JSA)?

⁷⁰ I have already alerted CMHT managers to the mental health needs at this day centre. The possibility of providing a weekly clinic by the team is being discussed.

Suddenly, other negative perceptions about homelessness and mental health services flood my mind:

- The collective voice of angry homeless service providers at last year's Homeless Forum AGM regarding crisis intervention
- The health visitor concerned about an attempted hospital discharge of a young mother to a night shelter until I challenged it, calling an urgent case-conference. Psychiatrists displayed their anger when their authority was challenged;⁷¹ authority is a limit noted by Fay (1987) as discussed in Chapter 2 (p.48).
- All homeless services had requested more support from mental health services to maintain residents in homelessness accommodation

...*Mental health services* - a wobbly core strand in homelessness health care!



Yet, Pamela was involved with mental health services - it was she who was distancing herself from them. I wonder 'how do psychiatrists view Pamela?' Her extreme behaviour in the 'name of God' had affected her life to the point of vagrancy. Does her articulate presence make her a 'good' or 'bad' patient (Kelly and May, 1982) conforming or not conforming to paternalistic modes of care?⁷² Did Pamela's intelligence and knowledge threaten their control?

I phone the Ward. No-one is available to discuss Pamela. Aware of my limited psychiatric knowledge, I feel hesitant about engaging with a homeless health professional and recognise the dichotomy around which health model is most effective in homelessness. I reflect in-the-moment on a core insight: my role differs from a mental health /medical model - I am using a public health model, assessing her ongoing health needs to sustain her recovery and journey out of homelessness and part of that involves assisting homeless services to deal with anxieties about health needs that arise.

⁷¹ The psychiatrist was keen to identify the ward nurse who had 'colluded' with the health visitor and myself about the imminent night shelter discharge of the young mother. Following the conference, the woman was discharged to her extended family's home.

⁷² Kelly and May (1982), in a nursing study, suggest that patients can be regarded as good or bad as a consequence of the interaction between staff and patients, not because of their behaviour. They argue that the nature of the professional role must also be considered in regard to the moral judgments made as the conflicts and tensions within nursing practice arise.

Pamela cautiously enters the clinic room. Her eloquent speech and professional manner are immediately visible. Her pale, middle-aged face is softly framed by red, wavy curls announcing a liberal but wounded spirit. Framed by her recent traumatic hospital experience, vulnerability silently manifests itself as a question of trust about me. From the corner of her eye, her judgment sweeps across me. Aware of it, I overcome a fleeting feeling of shame about health services and gently begin to care for her at her pace. Softly, cautiously she yields, telling me her story. Offering space to be present to suffering seems in itself to be sufficient in my role - my concern that I am not psychiatrically trained fades away. Her strength shines uneasily out from a profound sadness. Quite soon, the cold clinical surroundings become insignificant. I am fully engaged in her presence (Senge et al, 2005).⁷³

As trust develops, I feel like a bridge, connecting Pamela to herself in this clinical space.⁷⁴ Through her loud sobs, Pamela vents an eloquent fury over mental health services. To her, the hospital experience feels like a travesty of human rights, a complete disempowerment of *human* being, preventing her feeling like a partner in her health journey. I hold the therapeutic space, affirming the way she empowered herself.⁷⁵ But Pamela's rage lingers, mostly about male psychiatrists whom, she feels, "*...may not even have a relationship with God*". She clarifies, "*I didn't say I hear voices, just that God talks to me in prayer*".⁷⁶

The spiritual nature of my practice is emerging. Spirituality in nursing remains a contentious area in UK (RCN, 2011), despite newly-qualified graduate nurses being expected to include it in their holistic framework.⁷⁷ Recognising some of her spiritual experiences from my own prayer life, I relax as she expresses her relationship with God. I recall a Conference workshop I attended, where one nurse spoke of her role in Reykjavik Hospital as a prayer nurse; another from Florida spoke of a prayer-chair situated within the nurses' station.⁷⁸ Having never experienced spirituality overtly in UK nursing practice like this, I was amazed - now I ponder on its use. In guided reflection, I am advised to be mindful of my background influences - careful of the spiritual traps which Borglam (1997)

⁷³ "The core capacity needed to access the field of the future is presence.... presence (first) as being fully conscious and aware in the present moment....then as deep listening, of being open beyond one's preconceptions.... of letting go of identities and the need to control...ultimately leading to a state of letting come... when this happens the forces shaping a situation can move from recreating the past to manifesting or realizing an emerging future". (Senge et al, 2005, p.13)

⁷⁴ Bridge is the metaphor I used in my early practice experiences.

⁷⁵ Challenging the culture of the unit - the secrecy of information flow on ward rounds, prescribing medication without discussing it with her, the adverse reaction to that medication, demanding a diagnosis from psychiatrists which, she says, was never given to her.

⁷⁶ Hearing voices: one sign indicating a potential psychosis or paranoid state of being.

⁷⁷ In partnership with the person, their carers and their families, makes a holistic, person centred and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and together, develops a comprehensive personalised plan of nursing care (RCN, 2011:2).

⁷⁸ Values in Healthcare: a spiritual approach - International Reflective Practice Conference, 31st May, 2005.

identified. Later, as I read about palliative nursing and spiritual inflation as one of eight traps, I replace 'dying' with 'homelessness'⁷⁹

We have the impression that we are especially sensitive, open, positive, and spiritual, so automatically we must have a gift for working with the *dying*. Then as care gives we can feel we are so intimate with the *dying* we become even more inflated...we may be lost in what we think we know (Borglam, 1997:68) (my italics)

Perhaps I am spiritually inflated, comparing my spiritual insights in Pamela's care more favourably to the psychiatrists who want to pathologise her religious experience, "not recognising it as a vital part of the person's identity and recovery" (Gilbert et al, 2010, p.29). But rather than inflation it feels more like spiritual awareness. I ponder on Pamela's experiences and wonder whether spiritual mentors would be more appropriately placed to help her, or assist health professionals who may, or may not, be spiritually unaware (Gilbert, 2008). Yet, Health has no links into pastoral care in homelessness. In the same vein as clinical supervision, spiritual direction would challenge and support Pamela, providing insights and exploration for spiritual discernment.

I remain cautious that my own religion does not flow inappropriately into the encounter with Pamela as I ask,

"Have you had spiritual counselling Pamela?"

"No I don't need too. I don't need a mediator between me and God."

Her abrupt response jolts my rhythm. What prompts such a categorical refusal from her? Why does she need to test her God so aggressively? Pamela's rationale for treatment refusal for a food allergy because her God will 'look after' her, has opened her to a poorer state of physical health particularly in winter weather conditions.

Having partially *let go of my (nurse) identity* as Senge et al (2005) suggests, I have connected more strongly with my spiritual formation and used it practically to understand the spiritual and psychiatric tensions raised as Pamela's story unfolds.⁸⁰ What are my options for ongoing clinical situations like this when mental health service intervention, and pastoral care is resisted and I have limited psychiatric experience?⁸¹ I explore the possibility of journaling her experiences as a therapeutic endeavour to self healing and testimony (Lorde, 1980; Frank, 1991).⁸² I am delighted to find she is already doing so! We link into the merits of journaling and decide to meet again in a week.

⁷⁹ Borglam writes about the shadow work of nursing in palliative care, citing traps which make the nurse feel good rather than the patient. The other seven traps are: sentimentality, voyeurism, idiot compassion, unresolved grief, expectation of a good death, laying a spiritual trip and fear of drowning.

⁸⁰ Spiritual exercises of St Ignatius undertaken in my religious formation as DHS lay associate (See Chapter 1)

⁸¹ Referral pathways for spiritual counseling are not prominent in healthcare

⁸² Lorde and Frank, in their respective journals of illness experiences, explore the events of illness: what it means to be human in the transformation from person to patient.

As she leaves, Pamela exclaims her relief at being able to talk about what happened to her. In this space I heard her wounded cry and provided some balance to the perceived brutality of her psychiatric admission, offering a safe place for her to tell her 'health' story. It has been an intense health encounter at a time when she had disengaged from mental health services.

Afterwards, Pamela and Val meet to discuss the benefits option.

The charge nurse returns my phone call. Pamela does not have a psychiatric diagnosis, so a Care Programme Approach (CPA) offering ongoing mental health services was not offered. I ponder on how few CPAs seem to be in place for homeless people. National guidance surrounding the tension between mental health illness versus mental health and wellbeing in homelessness is missing - a liminal space in health care that causes frustration in homeless services around supporting residents developing mental health problems. Would a mental health nurse in a homelessness team offer cohesion? Would an effective hospital admission and discharge policy with me as a bridge between health and homeless services be enough?

At home, my empathy deepens. I write a poem on the clinical space as a listening space where my being available to *know the person/services* (Johns, 2009) unfolds as therapeutic presence.⁸³

IN THIS SPACE

In this space I hear the cry of stolen liberty
As male medics, defrocked of white coats
Open wide a prison door
Born from psychiatric notes

Jolted by disbelief you walked
Through another door left slightly ajar,
Shaft of light beckoning freedom
But police escorted you, handcuffed, from afar

I touch, still, salty sinews of unparalleled fear
As *caring* nurses pinned you down
Injecting a rigid, naked, rear
Trapped by your golden prayer

I hear how you slipped into a zombied state
Before they halted medication
Freezing you and your golden prayer in a finite space
Until, empowered by your profession, you demand an explanation

Your articulate knowledge of the Mental Health Act
Sent shivered fear around a sullen ward

⁸³ Using Johns (2000:81) model of empathy applied from MSR cues and Being Available Template discussed in Chapter 2

Demanding your human rights
Another golden prayer was answered by your Lord

Now in this humble healing space
I catch your free flowing tears
As all becomes insignificant, save your suffering
And the way to restorative peace in future years

Post-amble

I meet Pamela again at my night shelter focus group. She is an articulate advocate for residents around insufficient housing stock and limited access to counselling. Much later, a tumour is diagnosed - perhaps the very health trigger into a homelessness journey.

Reflexively, I view my experience through the role and vision (philosophical) framing perspective (Fig 3.2). I am mindful of the creative tension in practice between the two. It is the reality perspective which informs my actions.

DEVELOPMENTAL FRAMING 1

REALITY PERSPECTIVE

VISION

ROLE

Clinical:

- Be available to hear suffering
- There is a spiritual nature to my work - I am mindful of my background

Create space to hear the voice of homeless

Who is the Homeless Person?

- Female
- Articulate health professional
- Middle-aged
- With family
- Traumatized
- Ill - **mental health, survival health needs**
- Refuses to re-engage with mental health services

Empower services involved with homeless

Limits to effective engagement: Health knowledge/ connection with health services

Which services require health/homeless linkage?

- Day Centre
- Night shelter
- Housing Team
- Benefits Agency

Engage health services

Who is already involved?

- GP
- Acute mental health service team

Limits to engagement

- Invisibility of homelessness/ staff's limited knowledge of homelessness services
- Pamela's perceived 'trauma' by mental health services results in non-engagement

Influence local and national homeless development /policy

MY ACTIONS:

1) Evidence for HNA

- Multi Disciplinary Team?
- Specialist mental health nurse/mental health pathways
- Fast track psychotherapy
- Counseling/spiritual counseling
- Training/learning development of clinical staff

2) Evidence for Homeless hospital discharge policy (mental health)

- influence service managers towards effective policy development

Bridge Building Fig 3.2

Text Two: **WINTER CRISIS**

Weaving: Multiagency and Clinical Aspects

Tuesday 7th February 2006

I am in shock - waves ripple through my body! I swizzle around on my office chair to face the Deputy Director of Public Health (DDPH)

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

"I can't believe it is happening in this day and age in the UK! A homeless man has been picked up from the embankment with hypothermia, frostbite; three necrotic toes may require amputation. He's had two heart attacks in A&E! Homeless people - dying in our town - because they have nowhere to go!"

She sits on the desk opposite me: concerned, energised, proactive. Until my appointment just a year ago these issues were invisible; the Primary Care Trust largely disconnected from the reality of street homelessness. She guides me with her response advising me to send a case-study to the Local Authority's Community Strategy and Diversity Officer who sits on the Local Partnership Board.⁸⁴ My clinical concerns integrating at a higher partnership level than a Housing Manager whom I had phoned yesterday.

Shock waves recede... my excess energy rounded up as if a wild, white horse has been tamed. Challenged by the extent of UK poverty, the DDPH is guiding me locally in partnership working – the burden is jointly owned. The Diversity Officer responds. Winter rough-sleeping is placed on the agenda for the Social Inclusion/Anti-poverty working group as a matter of urgency.

Earlier:

The wind blows a piercing chill across the snow covered street. I am aware of the icy feeling around my fingers, infiltrating my thermal gloves. Today, no-one stands outside the daycentre. I enter into its warmth and see that it is filled with vulnerable people. A middle-aged man at the reception grill has holes in his gloves. His face frozen; his eyes on fire...it seems like fear or *winter panic*. Across my observations Val, the centre manager's voice, breaks in with urgency.

"Maria, do you know the position with bed spaces tonight? We have six men here who slept-rough last night. I don't know how they survived."

Bed spaces? The 18-bedded night-shelter is full. They are giving out blankets and I've already used the 25 sleeping bags I bought in December. How many rough sleepers were out last year? What was the response from agencies then? This is all too late!

⁸⁴ Prior to Joint Strategic Needs Assessments (JSNA): The Partnership Board's Social Inclusion/Anti-Poverty Strategy is a key commitment of the Community Plan for our Borough and is the outcome of a highly engaged, participatory and evidence-based process. It aims to continue our commitment to develop sustainable communities – both existing and new – through collaboration with local people. The strategy embeds the Community Plan's message of *'Working Together To Improve Health and Well-Being'* by continuing to ensure residents in the Borough have equality of access to services, information and facilities. Last but not least, it recognizes that addressing poverty and exclusion involves not merely economics – but also society, culture and politics (taken from the Borough's web site).

Mingled with this, I remain shocked about Jack's near-death from hypothermia! Since phoning him yesterday, the housing manager has hastily arranged this afternoon's multi-agency meeting.⁸⁵ The day centre manager and I plan a co-ordinated confrontation about winter humanitarian resources from our Local Authority.

Late PM

We⁸⁶ sit around the long, oak table in the old part of the Town Hall; 20 painted eyes of ex-mayors watch the town's current 'cold' crisis. This meeting is the inaugural Rough Sleepers Task Force, chaired by a Housing manager. He tells us that the Office of the Deputy Prime Minister (ODPM) recommended action on rough-sleeping in cold weather and provided examples of good practice in the UK. My heart sinks. Despite contacting 'local agencies' at the beginning of December, there was no connection with me... or the day centre staff And no outcome since! "*The beginning of December! This is a life and death issue*" I authoritatively assert, for I still naively believe that this can not possibly be happening in the UK in this day and age. All agencies instantly quieten to listen to my story of Jack. It sets an urgent tone for today's meeting...

Monday 30th January

Who is Jack?

I meet him on a busy hospital ward. The cluttered store-room offers privacy. Stacked with Zimmer frames, I sit on the only available place, a wheelchair. I put aside his medical notes as the nurse manoeuvres Jack in. We sit side-by-side in wheelchairs. Touching his hand I say, "*Hello Jack I'm Maria. The nurses on the ward have asked me to see you because they think you might be homeless.*"

Like a little mouse he squeaks his existence on the earth; each word slowly pronounced and falteringly whispered. I hunch my body over to hear, to begin to get a glimmer of what he is trying to tell me: he is not homeless!⁸⁷

"For ...nine years I've lllived on my own. I have a bbbed, chair, eelectric fire, my rrradio. I llisten in every evening..... In the morning Ill walk to gget ggroceries in town (seven miles)... I don't see anyone other than that. I was homeless once.... lost money in a building contract, then my girlfriend left. I stayed in a hostel GGill"

He pauses - thinking of Gill whom he still misses.

⁸⁵ Homeless Forum members: statutory and voluntary organisations who work in single and family homelessness.

⁸⁶ Homelessness agencies, the local authority and myself

⁸⁷ I don't inform the inaugural meeting of this just yet!

Perhaps his long hair and unkempt appearance fitted a stereotypical image of a vagrant so that nurses assumed Jack was homeless. I recognise that humanity may be hidden by suffering and degradation, an insight confirmed by Zerwekh (1995) in palliative care who noted its recognition as a turning point for nurses to celebrate but has anyone listened to Jack's story since he regained consciousness two days ago? Jack's humanity ripples from his deeper being, brought to life through patience, allowing him time to use his faltering voice. In reflective guidance my criticism is challenged: why would I expect ward nurses to know he wasn't homeless? My role provides dedicated time to engage with complex homelessness needs, which ward staff do not have.

Worried that he may not be able to get back into his house, Jack agrees for me to liaise with Keith, a Housing Officer. Advocacy is pivotal in my role for Jack, connecting serious ill-health to housing issues. He thanks me and I am touched by his humility. The nurses are surprised when I say he has a discharge address.

Wednesday 1st February

Following investigations, Keith articulates that Jack's housing problem is a homelessness issue. If it were not for this hospital admission Jack would have been evicted from his home. DH (2003:74) guidance suggests,

The hospitalisation of a homeless person may present an opportunity to deal with underlying medical, social and mental health problems in a structured manner.

Jack was given a routine appointment by Department of Work and Pension (DWP) to review his Income Support (IS) but was not in when they called. His benefits were stopped without consultation with health or housing agencies. When Jack's arrears accumulated, he faced eviction. Providentially, his court appearance coincided with the hospital admission. This ill man was being evicted from a property which he had lived in for nine years without apparent disturbance to others because of an *inability* to engage with DWP; unable, it would seem, to cope with formalities because of his mental health and social isolation. The mental health team later reveal that support to Jack stopped years earlier because he was not in when they called. No follow-up attempts were made since. I note the invisibility of vulnerably housed, isolated people beneath the surface of society, which may lead to homelessness.

After a joint visit to the Ward, Keith and I return to his office. We feel Jack's eviction is unjustified. He contacts the social housing provider and DWP to begin an appeal against the eviction, and successfully secures Jack's future tenancy. Jack has a safe place to return to on hospital discharge.

Could the DWP have engaged with health services to prevent this crisis? Wheatley (2006:139) writes, "A system is composed of parts, but we cannot understand a system by looking at its parts. We need to work with the whole of the system...as we work with individual parts." Lazell (2010) also notes that partnership work between agencies requires a shift to connective thinking within a wider complex cyclical system of knowing. The constellation of systems in local homelessness is just unfolding for me.

Friday 3rd Feb

Return hospital visit

Jack is on a medical ward. His toes have responded to treatment and do not need to be amputated.

In blue, tea-stained pyjamas
He lies sleeping
I nudge him softly,
His eyes open
Does he remember me?
I smile
Telling him about the housing situation.
Wrinkles,
Telling of a long
Hard journey
Of a soul
Through this life,
Deepen
Into a heart-warming smile
Relieved, he sighs.

From his hospital window
I look out across the roof-tops
He has been through so much
An isolated life
Hanging by a thread
Tears sweep the surface
Of my eyes
This ward, his safe-haven
To recuperate
But how will he cope out there
In the world again?

Jack's discharge plan has CPN and DN input.⁸⁸ I recognise the limits of my role... but I leave him my contact details, to *be available*, in case!

⁸⁸ Community Psychiatric Nurse and District Nurse

As I reflect on the growing effectiveness of multi-agency working an insight emerges; preventing evictions/homelessness from health related issues sets a benchmark for my role in future health practice. I explore the research literature: Crane & Warnes (2004) has identified multi-agency collaboration in preventing evictions in a few Local Authority areas. Earlier research (Crane & Warnes, 2000) identified that mental health and finance problems contributed to evictions occurring in older homeless people. Neither cites DWP contacting health services prior to sending out eviction notices as a preventative strategy.

The Town Hall meeting continues.....

Mindful of Kieffer (1984) who notes of citizen empowerment that it is "nurtured by the effects of collective effort" (p.28), I choose my words to bring rough sleepers in from the cold and prevent death – through a local collective consciousness,

"A near death from hypothermia in our town – it could be any of the rough sleepers out last night or tonight"

The vibrancy in this room is palpable - demanding the re-instatement of a statutory rough-sleeper count to tackle the now visible and tangible risks of rough-sleeping.⁸⁹ The voluntary sector reports 35 people who they believe slept out last night; a number challenged by the Housing manager.

I draw on my Health Visitor/midwife experience to view rough-sleepers' life journey from birth - not from a recent downward spiral that led them to homelessness. How does the Local Authority view them? Inconsistent, difficult to reach temporary accommodation (TA) from 6.00pm-8.00am has been recently offered when temperatures are freezing for three or more nights.⁹⁰ Keys have to be returned and collected daily. It seems like a punitive, disconnected solution, disregarding health needs. Energised, I continue the challenge from Health's perspective,

*"They can't access the soup-run. They need **hot** food to prevent hypothermia."*

Empowered by clinical practice, I recall the focus group respondents; their challenge to society, to Government. I voice their words to the Housing manager:

"Surely empty houses could be used for accommodation".

⁸⁹*Evaluating the Extent of Rough Sleeping*, Department of Communities and Local Government 2006, www.communities.gov.uk Official counts can be discontinued if there are thought to be 3 or less rough sleepers in a town. Counts occur for one hour on one night of the year. Those bedded down are included but not rough sleepers who may be sitting talking to friends. Following the rise in numbers in the official count, DCLG officers visit the town. Funds are secured for further rough sleeping prevention.

⁹⁰Government guidance suggests TA should be offered when freezing temperatures are likely to be seen for three nights or more. (See DCLG (2007) Severe Weather Condition for Rough Sleepers, Letter to Local Authorities November 2007 accessed 27 May 2011 via <http://handbooks.homeless.org.uk/streetoutreach/deliveringquality/engagement/coldweather>)

“There is a big factory which has been empty for years. Couldn’t they give us that?”
“There is a shortfall in social housing.”

I publicly weave a thread of humanitarian possibilities into their consciousness, pushing parameters. I introduce the idea of tents - believing that if this was a third world country we would be sending humanitarian resources. But I am mindful that I need to work collaboratively with multi-agency partners and acknowledge limitations – but do I really understand them?

A Housing manager sympathetically responds, informing the meeting about sleeping-pods for next year describing them as a shell with toilet and bed - fear that anything more would be seen as rewarding them.⁹¹

Still dissatisfied, I drive for more, knowing others want more, knowing from my background that Churches may want to do more. I seek to make homelessness visible, extending the web of care.

“Church halls could be used that would be nearer... perhaps offering warm food?”

Yes...they are energised. Churches are named.

The possibilities become endless. But for the remaining winter, TA and sleeping-bags are the only options available.

Post amble

A statutory count (DCLG) reveals 10 rough sleepers, one of the UK’s highest numbers outside London (DCLG, 2007a). Government officials visit our town (DCLG) leading to the formation of a Multi Agency Panel (Text:20) recognised in 2009 as a national champion.

Later in 2006, a Housing manager, day centre Chief Executive and I meet the local Salvation Army Major to discuss a winter night-cafe for the following winter. A humanitarian web is forming. In the summer, a larger multi-agency group visits the Dawn Centre, Leicester - a national flag-ship homelessness and health provision. High level décor puts pods and the criminal lens in shade as our guide states, *“When people are treated well, there is no reason to damage or disrespect the accommodation we provide.”*

DEVELOPMENTAL FRAMING 2

REALITY PERSPECTIVE

⁹¹ Used in Brighton

VISION

Create space to hear the voice of homeless people

Who is this person?

- 59 year -old man
- Unable to respond to bureaucracy Silent, stuttering voice: Isolated, frightened
- Survival health needs: Hypothermia, frostbite, mental health

Empower Homeless Services

- Energize partners towards cold weather provision
- Voice homeless peoples comments to influence change
- Prevent evictions from health need

Engage Health Services

- Provide more homeless knowledge
- Promote effective referrals for Mental Health Assessments for homeless people

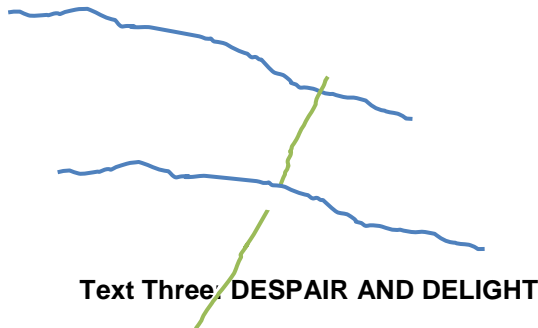
Limits to engagement

Ward staff: Time, knowledge, collaborative partnership working, protocols

Influence local/national development and policy

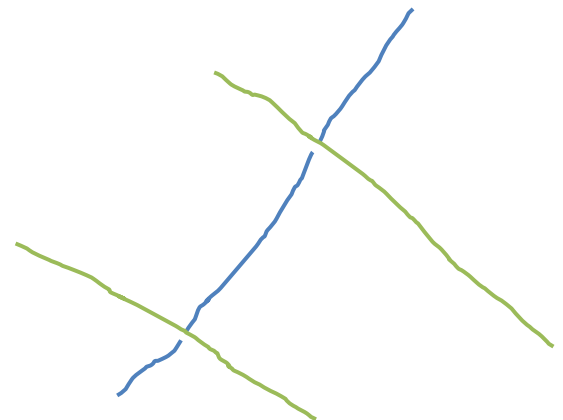
ACTION:

- I develop homeless health leaflet to connect health and homelessness (Appendix 3)
- I write the HNA to make homeless numbers strategically visible. Official Rough sleepers count ineffective - health cannot appropriately commission services
- I use a strong leadership voice in multi-agency partnerships to encourage political social action in the partnership net
- I begin to engage mental health managers in discharge protocols



Bridge Building

Fig 3.3



ROLE

CREATIVE TENSION

Clinical

- Hear suffering /life story which lead to Homelessness
- Advocacy role

Partnership

Political/Social action

- Connect near-death to lack of cold weather provision
- Challenge numbers of rough sleepers
- Challenge provision
- Work in partnership with housing in hospital discharges
- Recognise contribution of benefits disruptions to homelessness

Health service

- I guide/support ward staff. Complex homeless issues require time and specialist skills
- I enable nurses look beyond degradation to see the homeless person's humanity

It's freezing again. Val is impatient for me to meet a vulnerable, young rough-sleeping couple, two of the six rough sleepers on my clinic list. Twelve other rough-sleepers are using the centre today along with 70 more vulnerable people. I feel tension in the centre. A substance misuse worker identifies it as *despair!*

Despair - complete loss or absence of hope, a voice full of self-hatred and *despair*, in *despair* I hit the bottle. (Oxford Dictionary of English, 2006).

'*I hit the bottle*' rekindles in the despairing quote used by Will, a night shelter respondent in my focus groups earlier this week:

*"Where do you go?
What do you?
You have to take whisky to keep warm,
To forget where you are."*

Inside the iron gates, another respondent with hooded, drug-fuelled eyes smiles at me. I am shocked at his transformation.⁹² He spoke engagingly at Monday's focus group but now looks homeless and dispossessed: words slur; a roll-up sits between nicotine-clad fingers. I take the opportunity to engage with him. He used the expression *losing his child* in the group. He explains it as a result of partnership breakdown due to ineffective mental health service access despite a suicide attempt. I question why he feels this would be. "Dual diagnosis" he whispers; unwillingness by health services to accept clients with combined mental illness and substance misuse issue, a health access phenomena recognised in homelessness literature (Bines, 1992; Pleace et al, 1999; Crane and Warnes, 2001; DH, 2002).^{93/94} The Fabian Society (2010:5) identified how "services compete to avoid responsibility" for homeless people particularly for those without main need. The DH (2002:8) states,

Substance misuse is already part of mainstream mental health services and this is the right place for skills and services to be. Mental health services must also work closely with specialist substance misuse services to ensure that care is well co-ordinated.

⁹² Pete sported a clean, white T-shirt and handsome bright-eyed face on Monday speaking passionately about the need for mental health services support, the lack of which he associated with losing access to his child.

⁹³ In homelessness 'dual diagnosis' is may be referred to as 'tri-morbidity' : physical and mental ill health as well as substance misuse. Pete access difficulties were difficulty in GP access and subsequent referral to community mental health teams despite his apparent suicide attempt. He does access drug agency clinic.

⁹⁴ *Homeless people* – studies have identified high levels of concurrent substance misuse and mental health problems among groups of homeless people and rough sleepers." Homelessness almost trebles a young person's chance of developing a mental health problem. Assertive outreach to these groups and in-reach to hostels are necessary" (DH 2002, p.18). Crane and Warnes (2001) describe how homeless people had not seen a GP for 5 years despite physical health problems. Many were not registered. Bines (1994, p.15) notes, "Less than a third of single homeless people with mental health problems were receiving treatment."

Dual diagnosis and mental health support for parents require service development,⁹⁵ but I become aware when talking to Pete that loss of fatherhood and lack of social housing following relationship breakdown are areas of homelessness I had given little thought as a Health Visitor. I am beginning to see how inequalities permeate the most disadvantaged communities who experience *despair* about their lives and their health.

I recognise my understanding of substance misuse is limited. In midwifery and health visiting children were my main focus.⁹⁶ Wiklund (2008), however, confirms my previous perception that adult substance misuse *is* used as a way to handle suffering arising from life. She elucidates the tension of living with addiction,

The use of drugs helps the person to deal with life; on the other hand...abuse does not relieve feelings of chaos, loneliness, guilt and shame and being cut off from life (Wiklund, 2008:2432)

Homeless people are *cut off* - I seek to include them in health care.⁹⁷ To do that, I need to deepen my ontological understanding of 'being homeless' by *being available*, appreciating the nature of suffering, joy, and health need within it. In this evolving awareness, I rename the despair felt in this centre today as suffering.

Mary and Cain shyly enter the clinic. Both look underweight, pale and cold. Concerned at their plight, I ease their discomfort, moving chairs into place to welcome them in an unrushed manner, seeking engagement. They have arrived in this area because Cain's grandparents live nearby.⁹⁸ Unable to provide the couple with accommodation, they have continued their rough-sleeping lifestyle whilst applying for social housing in this area. Last night was their first night in TA, the unpopular cold weather provision for the rough-sleepers.

Mary speaks slowly through stray strands of strawberry-blonde hair. Shyly, she reveals a learning disability,

"I had tests – I'm below 70⁹⁹ and that's about the level of a 13 year old. I'm entitled to extra support which I had where I lived before but I don't think I need it now because of Cain. He helps me – we are a good team, aren't we Cain?"

Cain agrees! Her list of medical problems grows, edging my concern towards despair:

⁹⁵ 'Improving Pathways to Dual diagnosis' is presented by mental health services at the Housing Forum AGM. As service access is being reviewed I focus on other gaps in services.

⁹⁶ Substance misuse and Foetal Alcohol Syndrome; substance misuse and safeguarding.

⁹⁷ Focus group themes show that local drug services are well regarded by homeless people bar dual diagnosis

⁹⁸ Reconnection Policy for rough sleepers and other homeless people to be reconnected to local authority where they have a local connection (family member or lived in the area for six months)

⁹⁹ IQ of 70 and below warrants extra support for daily living from Learning Disability services – I refer Mary to the team.

- Raised by a mother with a heroin addiction
- Mother imprisoned for stabbing her father
- Childhood sexual abuse
- Learning disability
- A heroin user - unknown hepatitis status
- Asthmatic - no inhalers
- Epileptic¹⁰⁰ - no medications
- Psychotic history

Everything disclosed so easily. As they look at each other I ponder on their relationship. A few minutes later Cain proudly raises his sleeve to show me bruises and a slash mark on his arm,

“We were tussling - she used a knife on me.”

I watch Mary. Embarrassed by the disclosure, she laughs.

I elucidate,

“It must have been a volatile scuffle. Do you often fight?”

They do - domestic violence added to my list! Whilst domestic violence is recognised as a leading cause of UK homelessness (Buck, 2002; Quilgars & Pleace, 2010) and male victims of domestic violence is gaining recognition,¹⁰¹ strategies for coping with domestic violence in rough-sleeping couples are undeveloped.

I wonder whether they carry a knife for 'protection' but Cain says it was a cutlery knife. Alarm bells toll when I recognise Mary's parenting role-model pattern re-emerge in her relationship with Cain. How much of Mary's story is contributable to learning disability, child abuse or the violence I have occasionally witnessed and treated in street homelessness? Just when my professional anxieties are at their highest Mary slowly discloses that she had a young baby taken into care last year and she thinks she is pregnant again.

“No-one would take my child away”, Cain mumbles. I note the protective warmth in his naïve reply.

“How would you feel about being pregnant again?” I ask, praying she isn't.

¹⁰⁰ Approximately a third of people with learning disabilities have epilepsy (at least twenty times higher than the general population) and more have epilepsy that is hard to control (Branford, 1998:18).

¹⁰¹ British Crime Survey of 2008/09 reports that nearly 20 per cent of male victims had been subjected to violence more than 50 times (Irish Times 9th June 2011) The Next Steps Housing Association has created 100 places across Northamptonshire for husbands and partners in abusive relationships . Accessed 25 May 2011: <http://www.dailymail.co.uk/femail/article-1146783/First-refuges-battered-husbands-offer-support-male-victims.html#ixzz1NTUie46t>

“Oh great” she replies “really great.”

We watch the pregnancy test indicator. Slowly, silently the + sign appears. The room becomes filled with their delight.

Delight – great pleasure for young and old – from *light* (Oxford dictionary).

The air feels *light* – suffering disappears. New life brings new hope. For awhile they remain totally unaware of the effects of the issues revealed to me on future child-rearing. I muse on the very few pleasures that greet homeless people and engage within-the-moment in their delight. It has a huge pleasurable impact on their present life circumstances.

Mary begins to reminisce about Ruby, her daughter who was taken into Social Services care at six-months. From her navy track-suit she takes out a creased photograph to reveal a bonny-faced baby. The trauma of sudden removal, Mary's most significant bereavement, is acutely evident. She yearns for Ruby, who is in long term foster-care pending adoption. Talking animatedly to me, she expresses her grief for the first time to a health professional, causing me to reflect on the aftermath on parents when children are suddenly removed and the subsequent health support offered to mothers. I muse; does Health Visitor education extend adequately into parental health needs post-removal of children? Does it consider learning disabled mothers and homelessness as core elements in vulnerable communities? Or are these areas excluded - considered remote - marginalisation carried into education, feeding exclusion of vulnerable groups.

Significantly, allowing Mary to express her bereavement and her delight in her pregnancy secures effective engagement. There is an enormous amount of actions I have to promptly initiate.

..... I am the hub of the wheel (Fig 3.4) networking towards their ongoing care.....

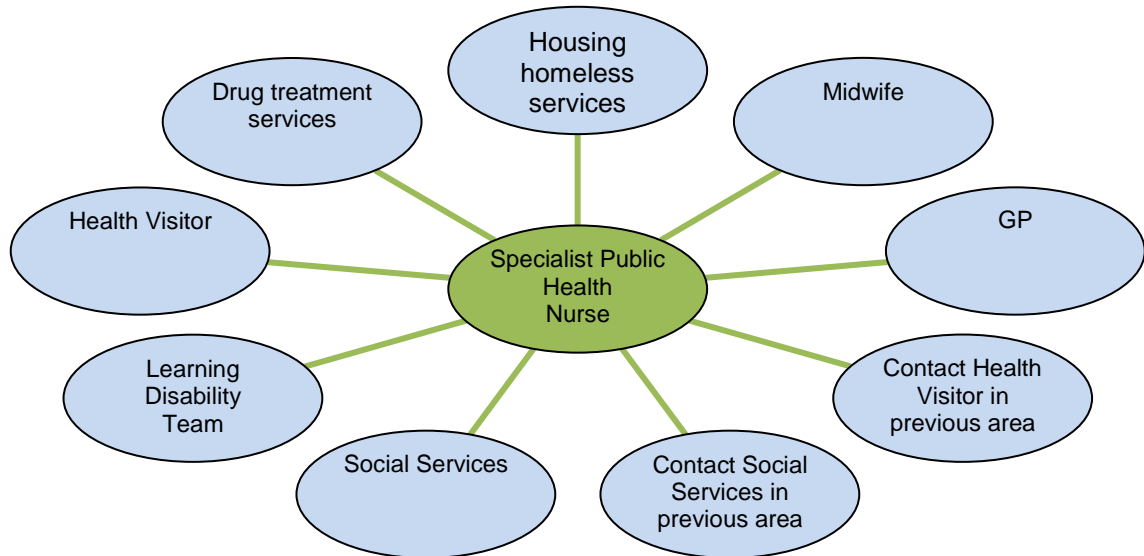


Fig 3.4

Supporting this young couple to engage with services underpins my advocacy role. Prompted in reflective guidance I consider 'advocate'. Gadow (1980) identifies existential advocacy as unique to nursing. Rather than consumerism advocacy, "a trouble-shooter willing to intervene when systems violate an individual's rights" (p.84), she argues that existential advocacy is,

The concept of professional involvement as a unifying and directing of one's entire self in relation to another's need ... in order that patient and nurse can participate as unified selves in the patient's process of self-determination (Gadow, 1980:90-99)

Beyond my previous assumption of consumerism advocacy, for I do feel like a trouble-shooter, Gadow's holistic definition resonates with my background and the biblical notion of Holy Spirit as: advocate, counsellor, friend, comforter, peacemaker, guide, "Spirit of truth" (Holy Bible, John ch15v26).¹⁰² To me, such ways of being address social justice for vulnerable people towards a concept of enablement in self-determination.

Research on learning disability and homelessness is limited (Markos & Stawser, 2004; Hebblethwaite et al, 2007), but I ponder on Hebblethwaite et al's (2007) point that learning disability makes survival in homeless environments difficult. Reduced capability results in fear, anxiety and despair, at a time when, despite increased physical and mental health needs, access to health services is difficult. Michael (2008) also describes how,

¹⁰² In Jesus' farewell discourse to his disciples (John 15:26) he promised to send the Holy Spirit as an advocate or paraklete

People with learning disabilities can find it more difficult to identify and describe symptoms of illness, and much harder to navigate the health system to obtain treatment. These problems also make it more difficult for NHS professionals to deliver treatment effectively (p.16)

Mindful of this, I negotiate the balance between acting as a trouble-shooter on their behalf and working in partnership towards self-determination,

The ideal which existential advocacy expresses is this: that individuals be *assisted* by nursing to *authentically* exercise their freedom of self-determination. By authentic is meant a way of reaching decisions which are truly one's own...it is the effort to help person's become clear about what they want... (Gadow, 1980:85)

Drawn from Mary's past experience, their values towards self-determination are clear; they want to engage services to be able to parent effectively.

I spend two hours trying to engage services – a three hour time commitment with this couple today, confirming under-resourcing and illuminating limits in *being available* to strategically develop homeless services. Limits (Fay, 1987), discussed in Chapter 2, challenge my practice vision. Service access issues shock me:

- Social Services refuse to see Mary until 28 weeks of pregnancy. It seems that homeless people with learning disabilities have little visibility or value in the provision of their services. I challenge them about addressing parenting issues early in the ante-natal period, perhaps through residential schemes, but funding for an assessment is unavailable.
- Housing teams stress that despite the pregnancy and subsequent *priority need* category she will only be offered time-limited TA. If assessed¹⁰³ as *intentionally homeless*, she will not be eligible for social housing. My previous Health Visitor belief held within our health visiting teams is significantly incorrect - pregnancy and parenting does not confer social housing rights. For Mary, the risk of rough sleeping still remains following this reprieve during the enquiry period.
- The learning disability team will not accept her because she is not registered with a GP.¹⁰⁴ I have to wait for the consultant to contact me later.
- It takes four attempts to find a GP who will see her today, despite not having any medications for asthma or epilepsy and her pregnancy.¹⁰⁵ Even then she will only be offered temporary registration, denied preventative interventions such as the asthma clinic

¹⁰³ Mary was categorised as 'intentionally homeless'

¹⁰⁴ Mary's IQ test which I attended was 71. The criteria for Learning Disability service inclusion is 70 - Mary was not offered services. Arguably complex disabilities and homelessness makes people more vulnerable and I feel borderline criteria should be assessed holistically with criteria lowered in complex need.

¹⁰⁵ Neither the drug treatment GP nor the designated GP is available when I phone. Public Health want mainstream services to become more involved in homelessness. I contact local GPs services on an 'urgent and necessary basis'. Three provide administrative reasons for not seeing them today - my role raises political tensions at a Practice Manager meeting, later. Additionally, only temporary GP registration is available for homeless people locally. I capture this issue in the Health Needs Assessment.

which she requires. Mary is seen through a particular lens which conspires against equity of health care provision.¹⁰⁶ Yet life expectancy is reduced in people with learning difficulties (Hollins, et al 1998) and the average age of death is 40-44 years for those who are rough sleepers (Crisis,2003; DH, 2010).

The very care which I regard as my role to coordinate is limited. So what happens to Mary? Multiple factors combine to impede access to effective treatment. How will that make her feel, when I feel despair about services? Systems for vulnerable communities organise themselves in silos (The Fabian Society, 2010), unaware of the exclusion they are causing to 'invisible', voiceless communities who are unable to fit into mainstream care - increasing their suffering. My knowledge on the way rules impede services and my practice vision is growing.

The complexities in homelessness are dawning! I must move politically and practically at a strategic level to change perceptions and policy towards inclusion. But where shall I begin when I can hardly disentangle myself from the provision of ongoing complex clinical care which takes up so much time?

Public authorities should never be allowed to treat their duties towards adults with learning disabilities under the Human Rights Act 1998 and the Disability Discrimination Act as optional (including their positive duties under the Disability Equality Duty.

(A Life Like Any Other, Committee on Human Rights [HL/HC 2008:95]).

In reflective guidance we dialogue about my role evolving from bridge to 'net-weaver' - an insight in the creative process of this genre of narrative research. It provides a wider concept of practice; an image that grasps and highlights the missing strands.

I am asked to consider how

I am a.....

¹⁰⁶ Hollins et al. (1998, p14) suggest that people with learning disabilities are 58 times more likely to die before the age of 50 than the general population

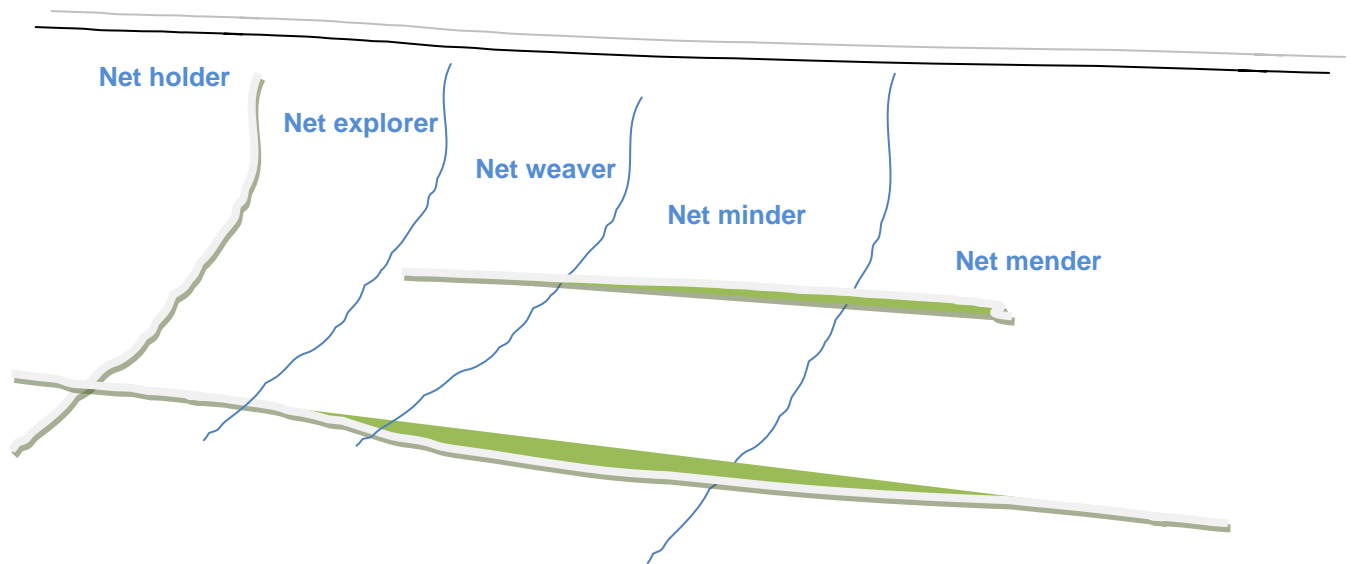


Fig 3.5 Images of my role in the net

Further experiences with Mary and Cain

- Leading first professional strategy meeting
- Visiting Mary and Cain in TA with the Learning Disability team
- Visiting them with a Housing Support worker
- Leading second strategy meeting
- Leading third strategy meeting - attended for the first time by Social Services

I next meet Mary and Cain in Registered Social Landlord accommodation....

Fears for homeless pregnant women forced to sleep rough

Pregnant women are sleeping-rough and being denied access to housing in some parts of the country, according to community nurses. **NURSING STANDARD** November 28: Vol 22:12

"*Horrible sexual abuse; the worst case I have ever known*", proclaimed the social worker at last week's child protection meeting conveying elements of Mary's childhood.¹⁰⁷ Born to a drug abusing mother, she and her siblings underwent systematic abuse by consecutive step-fathers. Mary's suffering will continue over the forthcoming months as captive circles clasp around her, to safeguard her unborn child. If this young couple are informed of parallel planning about the removal of their baby at birth, the risk of absconding will increase – a crisis return to fugitive rough-sleeping. So, for the paramount safety of their baby, they remain unaware. I carry the ethical tension¹⁰⁸ (Fig 3.5) of positive and negative collusion between agencies in my heart, as I care for them and their unborn infant today. Latchford (2002) negotiated a similar ethical tension around 'collusion' with social services. She notes of health visiting that,

Within child protection work, there seems to be a weakness of professional identity and attitude that has resulted in a collusion with the perceived values of social services ... (Health visitors) have become blinded by this oppression (Latchford, 2002:157/158)

Unlike Latchford who had initially remained silent by the oppression, I have used my voice to link care pathways and to advocate for this young vulnerable couple and their unborn baby in social services meetings.

The Registered Social Landlord (RSL) flat is the solution to their *intentionally homelessness*^{109/110} - a far cry from winter rough-sleeping. Our meeting was arranged so that I could engage Mary with her Health Visitor but the Health Visitor has cancelled due to illness. When mainstream services

¹⁰⁷ Third strategic meeting which I had facilitated - and the first which the social worker attended prior to the Child in Need of Protection Meetings subsequently arranged at 28 weeks. I had requested social service intervention much earlier.

¹⁰⁸ Using Ethical Mapping - see p.65

¹⁰⁹ Local Authorities have been encouraged to reduce homelessness for those considered intentionally homeless (in there is no duty to house them) by the use of RSL properties. Maryanne is not entitled to Local Authority housing and it is up to the landlords to decide whether to offer the property to them or not. The landlords will be supported by the LA in any issues which occur in the tenancy agreement.

¹¹⁰ Although Maryanne is *in priority need*, she was evicted from her last tenancy because drug dealers were using her property. Her argument that she was frightened off them held no weight, neither did her learning disability even though it may have contributed to her vulnerability and the way the drug dealers used her home. This was the only RSL property available. She would have been rough sleeping again despite being pregnant because the local authority have no legal duty to house her or her unborn child.

are fickle, *being available* for Mary and other homeless people is vital and key to my practice vision (see Chapter 2).¹¹¹

The four-storied accommodation block is known to be dangerous, a drug-dealer haunt, raided by police last week. I climb the stairs alone, prayerfully invoking Damien de Vestuer,¹¹² aware that a multi-disciplinary homeless team would improve safer working practice. Whilst it is nationally recognised that many homeless nurses work in isolation (HHI, 2007), how nurses manage the risks of lone working in homelessness is not researched. Jan, a Public Health administrator is my answer to lone-working. She is on the end of the phone....

"I'm going up now,"
"Be careful" she whispers
As if approaching
The crescendo
Of a detective story
I speedily ascend
The concrete staircase
My footsteps infiltrate
An eerie silence
No-one passes
So many closed doors
No noise!

At the top
Breathless by the ascent
I push a heavy fire-door
Leading into Mary's dark,
Windowless corridor
A timer-light is broken
My heart-rate quickens
I find myself involuntarily saying
"...Jesus, this is scary
- it's pitch black."

Frantically feeling
For a wall and door
I call out "Mary"
I never knew I could feel so *scared*
Conscious that this place is volatile
I turn to go back
On Jan's advice

¹¹¹ The Being Available Template - set out in Ch 2 p.84 and developed in the analytical horizons

¹¹² See Ch 2, p.81

"Is that you Maria?"
I jump!
Mary opens a door
A beam of light trickles
Then floods the corridor
She is smiling
Like a sunbeam!
Regaining my composure
I reciprocate as best I can
Relieved to see her radiant face

Still breathless
Shifting from fright to lucidity,
I follow Mary
To another room
Cain sits on a black sofa
Smiling an expectant greeting
I dwell
In the misplaced trust
Bestowed on me

Next to him
Two caged royal-blue budgerigars
Play and chatter
Unaware
Like their owners
That their
Freedom is curtailed

Orange ill-fitting curtains
Thwart a tidy flat
I reflect on a difficult journey
This couple has made
From rough-sleeping
To making this a comfortable
But basic home

Mindful of Gadwo (1980) I negotiate my therapeutic relationship with the need to safeguard their infant. Booth & Booth (1998) note that parents with a learning disability require advocacy to help them understand what is happening and have their voice heard in child protection (CP) judicial proceedings. Whilst I have been a patient's rights advocate for them in CP meetings, it is an element they are unaware of, which I am juggling in my therapeutic role today.

As a consequence, I am hesitant about opening deep dialogue.

They sit opposite; coyly excited in my presence. Through Mary's cerise T-shirt, the pregnancy is visible. Indifferent to the apologies I make on the Health Visitor's behalf, they share their good news with me,

"I had a scan on Thursday - I'm having a boy".

I delight with them in the excitement of the present moment and negotiate my tension by observing their responses. They romantically look at each other, then back to me. I tread a thin line of honesty,

"You will always be a father now Cain."

I could be alluding to him simply becoming a father but my thoughts consider the future when their son will be removed.... natural fatherhood can never be taken and I want him to value that – a seed for the future, where perhaps he will frequently look inward, outward, backwards; wondering about his child and the child eventually becoming the man....

I become significantly aware I am holding this couple in relationship to secure engagement.

They are going to call him Tom. Mary caresses her tummy as if she is fondling Tom's hair.

"We talk to him all the time. Last night in bed he was moving all over the place, wasn't he Cain?"

Cain laughs; two young parents proudly recalling intimate experiences of pregnancy, touching me with the warmth they afford their son. She wants to breastfeed him, like Ruby.

"... I got on alright for a month but the Health Visitor said I wasn't holding her properly..."

I look at her hand - it turns, limply, inwards indicating a degree of cerebral-palsy. Did this cause positioning problems in holding Ruby?

In the intimacy of our interaction, it is as if I had known Ruby; a comfortable dialogue created with Mary in the months I have dwelt with her in her maternal grief. My clinic provided space to voice her jagged bereavement when this pregnancy forced her to relive the frozen trajectory of motherhood.

A stab of reality stirs in me - I will not be helping her breastfeed Tom but will become part of her betrayal narrative, arising from the domino effect of her life patterns and disability. I remain

frustrated about social service late engagement, preventing funding for parenting assessment in a residential unit prior to Tom's removal.

Caught by the tender feelings of love which bond them to Tom, I guiltily go through the motions of breastfeeding advice, imagining that a timeless miracle will occur to halt the almost inevitable separation at birth. Cain is adamant that he will be able to support breastfeeding. The conversation initiates dialogue about the relationship with her ex-partner,

"David never helped me with Ruby"

I seize the opening, aware of the serious issues surrounding Ruby's removal from her care since last week's professional meeting. I allow Mary to choose what to disclose in front of Cain. Embarking into this deeper dialogue, concerns about her parenting role unfold.

"He was nasty. He sat with his friends like, well, shooting heroine.... he wouldn't move out. It was my flat but I was scared of him. He dropped the syringe in Ruby's cot but blamed me. The social worker found the needle sticking in her arm ...I said I would leave him...but they didn't listen I would have gone to my mum's for awhile ... he would have come after me anyway..."

Shudders vibrate through my body! I catch Cain's introspective pose, hands raised like a spire against his lips and nose; Cain, the rescuer but a rescue which ended in rough sleeping in UK towns. He provides reflective space for the conversation to continue. I ask,

"A needle.....how did that happen?"

"He was leaning over the cot and the syringe dropped in. She rolled onto it."

Unimaginable, unbelievable?

"Where were you?"

"I was there but I didn't notice, she didn't cry or anything. The social worker was visiting later and when she picked her up out of the cot...she saw it."

Heaviness hangs in the air!

I reflect on the timely visit by the social worker and ponder on Mary - oblivious to her protective, parental role in the scenario. How much had her learning disability contributed to it? Would Cain help her parent more effectively? Perhaps she will always be easy prey for those who wish to exploit the weakness of the vulnerable.

I confront her gently, inviting her to reflect on her own allegiance to heroin and weed.

“Have you taken heroin recently, Mary?”

“No. I stopped when you said I was pregnant. I took a bit of weed .. last week ... only once ... didn’t I Cain.... but that’s all.”

I nearly believe them, finding a small degree of contentment in the knowledge that illegal drug use does not necessarily lead to unacceptable standards of parenting (Street et al, 2004). But with Mary there are multiple issues: disability, poverty, safeguarding, domestic violence. They were seen street-begging last week, and whilst the midwife is strongly suspicious of continued heroin use, her clinical gaze does not include the holistic perspective of homelessness; she does not recognise that a change of address caused Mary’s Incapacity Benefit and Housing Benefit to stop temporarily. The immense hardship of benefit disruption for homeless people cuts across survival needs - perhaps into criminality? Locally, it is a hidden phenomenon; the DWP¹¹³ are still not involved in homelessness forums – an issue I have raised with a Housing manager since meeting Jack (Text:2). Mary’s street-begging was arguably necessary; she had nothing to live on except the evening soup-run, and two emergency food parcels that I had arranged to meet the nutritional needs of her and Tom, voicelessly developing in her womb.¹¹⁴

Child safeguarding concerns have also overshadowed the midwife’s routine ante-natal education. Tom is due to be born in eight weeks. No-one has told either of them about pain relief, signs of labour or modes of delivery. Tom may be born prematurely and have restricted intra-uterine growth with Mary’s history of rough-sleeping, poor nutrition and possible heroine use, (Little et al, 2005). So, I fall naturally into my midwifery background, continuing to guide them. Conscious that this is Cain’s first child, I probe his level of responsibility. He has yet to consider how he will get Mary to hospital.

I challenge them about a recent episode of domestic violence. They tell me their story – fighting in the corridor over who should go out – and a neighbour phoning 999. They are like children...

“Domestic violence is serious. Social Services have the power to remove a baby or child from a home — how will you control your feelings of anger?”

I hold the balance - aware that they may abscond if suspicious that Tom will be taken into care at birth, whilst offering insight for them to gauge parenting responsibility.

“No-one will take my baby.” Cain reflects in a non-aggressive tone.

¹¹³ Department of Work and Pensions

¹¹⁴ Arranged through St Vincent De Paul Society in a local church

I don't believe that removal at birth is on their radar – though absconding afterwards could be. They have little idea of the power of social services to make decisions which affect their lives so dramatically. Their voice is lost. My advocacy role in safeguarding meetings includes their voice and the voice of other learning disabled mothers who, internationally, form the greatest proportion of mothers who have their children taken into care (Booth, et al, 2005).¹¹⁵

I feel I am finalising my care pathway as I prepare them for the social worker's first visit. I have provided information on generic programmes¹¹⁶ to help them with their behaviour, but remain concerned that the learning disability team refused to engage when IQ assessment score was just one above borderline criteria.

I am left to consider the brokenness of their lives.

In reflective guidance I am challenged, 'Why did you write about this experience?' I draw on Welty who states....

My continuing passion is to part a curtain, that invisible shadow that falls between people, the veil of indifference to each other's presence, each other's wonder, each other's human plight (Eudora Welty in Wheatley, 2006:V)

Epilogue:

- First Child Protection Conference - I attend
- Second Child Protection Conference - I attend
- Tom's birth and removal from parental care - not involved
- Mary's becomes psychotic - admitted to mental health unit
- Accommodation is lost - they disappear into the world of rough-sleeping

¹¹⁵ Much later, I learn of 'legal advocates' for Learning Disabled parents undergoing child care proceedings. See Talerton B. (2007) Specialist advocacy services for parents with learning disabilities involved in child protection proceedings *British Journal of Learning Disabilities* 36 134-139

¹¹⁶ Relate counselling services, Freedom programme for Domestic Abuse

DEVELOPMENTAL FRAMING 3

REALITY PERSPECTIVE

VISION: 'The net'

Knowing the person

Who is this homeless person?

- Young pregnant woman/homeless couple/ unborn infant
- Volatile relationship
- Complex health needs
- Mourning multiple loss
- Uses illegal substances
- Traumatic childhood
- Becomes psychotic following infant's removal at birth
- Voiceless

Empower services involved with homeless

Limits to engagement:

- Pregnant Mary, deemed intentionally homeless, does not have social housing rights
- Social Services disconnect from homelessness until safeguarding action is required @ 28 weeks

Engage health services

Limits to engagement:

- Mainstream health services do not contextualize Mary's health needs within a homelessness frame
- Underfunding causing my clinical and strategic tensions

Influence local and national policies/development

ACTIONS: response to constraints

- HNA report: Recommend midwife/health visitor in multidisciplinary team (MDT)
- Training: Health Visitors/midwives
- I raise LD access with LD senior manager
- I raise GP access issues with Public Health managers/practice managers and provide guidance (RCGP, 2002)¹¹⁷
- I use this experience to influence senior managers in Public health, commissioning and HV services, and later in strategic meetings including the PCT Health and Homeless conference (2010)

Holes in the Net: Services do not want to engage in Mary's care - how shall I change the culture?

Fig 3.6
Falling Through the Net

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

ROLE

The therapeutic net

- Being available: complex trauma disclosed
- Fill gaps left by midwife/Health visitor
- Trust is compromised for safeguarding
- Poise: Emotional Intelligence; I overcome fear with courage.
- Tension between my clinical and strategic roles

The partnership net

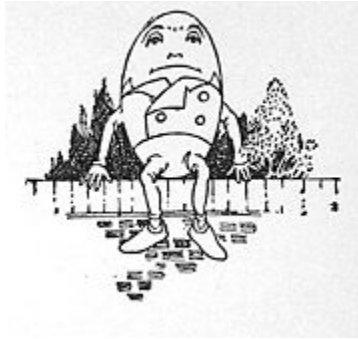
- I challenge non-service engagement
- I challenge Housing's: 'intentionally homeless' category
- I co-ordinate complex health care to supports services

The health services net

- I become the hub of the wheel
- I support health to engage: joint visits with LD team and HV. I co-ordinate multi-agency professional meetings prior to 28 weeks

¹¹⁷ See Royal College of General Practitioner (2002) Statement on Homelessness and Primary Care "All people have a right to equity of access to primary care services and to receive services which will enhance their dignity and independence" (accessed on line www.rcgp.2226 8 Jan 2012)

Text Five: ALL THE KING'S HORSES AND ALL THE KING'S MEN



Hostel - Hugh (RIP)

March, 2006

To support homeless services, I have facilitated health training sessions. This session, infection control training, is the fourth to date.¹¹⁸ As I finish, two anxious hostel workers hover, waiting to speak to me about Hugh. Hugh has severe paranoia but refuses ongoing mental health service intervention. A mental health assessment concluded that he was not a risk to himself or others.¹¹⁹ Yet, hostel staff are frightened; without health support they feel unskilled in coping with the real and unreal world which Hugh inhabits. I arrange a visit to support them and Hugh.

Nicola, the manager, 'bends the rules' to prevent evictions which lead to 'intentionally homeless' criteria.¹²⁰ Despite health needs which places Hugh in 'priority need', eviction would make him ineligible for social housing as he would be classed as intentionally homeless. Her compassion sits in tension with pressure to evict him because he won't engage with mental health services. Nicola feels she is a lone-voice; most staff refuse to work with him, frightened of his delusional state, forthrightness and physical strength. He believes there is a conspiracy theory involving the King and State. I feel momentarily helpless as I hear how Hugh constantly relives the nightmare of being restrained and injected by psychiatric nurses; his trust in services now broken. Unless he agrees, mental health services will not see Hugh except in crisis.

Hugh also refuses to see me. How can I break through his resistance, supporting him and hostel staff, to prevent rough sleeping?

I negotiate the tension creatively, drawing on my focus group experience suggesting two things:

¹¹⁸ Training provided by PCT nurses: TB (TB specialist nurse); Health and Homelessness (me), Diabetes in the 21st Century (Diabetic specialist nurse)

¹¹⁹ Mental Health Act 1983

¹²⁰ Nicola had offered a small amount of alcohol to a resident to prevent him falling due to his sudden alcohol withdrawal - even though alcohol is not permitted in the hostel and she feared the consequence to herself and the resident, if it were known. This indicates a training need on health issues to hostel managing executives.

- Invite residents to a meeting to identify needs for hostel outreach clinic
- Dialogue with the mental health service manager to re-engage their support for Hugh, and for hostel staff

As I leave, Nicola is thankful for my support and action.

13TH April 2006

Securing Mental Health Support....

Having intensely renegotiated and referred Hugh back into mental health services I have subsequently secured a CPN (Linda), in homelessness for one half day per month.¹²¹ I am delighted – a small, significant mental health thread in *the net* which I hope will grow and which strategically enables me to develop the HNA report.¹²²

Linda and I collaborate in our 'battle-plan' to engage Hugh. The basement meeting is filled with young residents. Hugh, at 54 years, is instantly identifiable. Perhaps because they are summoned to attend, none of the residents make room for us to sit - so, like humpty on the wall *we perch* on a coffee-table. I negotiate the resistance, seeking views on health service access. In my information letter (Appendix 4) I have told residents about our respective roles.

Hugh fires an opening shot directly at Linda.

“You should be ashamed of yourself, working in psychiatric services in the UK. How could you?”

The moment is tense. Others look on. Linda apologises - I wish she hadn't! Momentarily we are in retreat but Linda comes back stronger, more positive about her role and the way mental health is embracing the Recovery programme.¹²³ Hugh continues his bitter attack on psychiatrists whom, he declares, should be imprisoned or shot for what they do. How, I wonder, can we draw him into a therapeutic space?

I am getting anxious about the young guys in the room who may not engage with mental health services because of what they hear. I invade the space, balancing the conversation by acknowledging his experience and views.

¹²¹ The CMHT manager accompanied me to my Bail Hostel clinic following crisis health incidents. Her comment was, “Why haven't we been here before”. Resources were immediately released time for homeless development but only for one half day per month. I arrange an induction day for the CPN to shadow me in my clinical work. The CPN takes over my Bail Clinic.

¹²² Strategic role: Public Health, Health Needs Assessment on Health and Homelessness (Appendix 1)

¹²³ See: DH (2001) *The Journey to Recovery – The Government's vision for mental health*. London: DH

“Hugh, other people are helped by mental health services. What you have experienced sounds horrendous and you need to do something with those feelings. Other people have felt like you too... I sense your injustice. Write about your experience ...If you allow me to, I can use them in a study... to make a political and academic difference”

He likes this and instantly agrees. By validated his experience intellectually, he begins to engage. I tell him more about this research. I include others in dialogue. In this space, I draw them into a caring network about local progress in health and homelessness, shifting tension to create flow for dialogue. The group becomes vocal about health issues!

Hugh is calmer. He begins to talk about himself - like Pamela (Text:1) he is another health professional who has not practiced since his illness. His knowledge of health, like Pamela's, shines out. When the group session concludes, Hugh stays with us – it feels like an engagement success. But his illness is apparent,

“Influential people have caused my downfall....people in government offices... all over the world.”

The *king's men* - plotting against him in his everyday world.

He is wrought with suffering, disclosing that he was brutally assaulted and raped. I challenge myself on dealing with post-rape experiences. Robinson (2003) points out how trauma plays a significant role in the loss of housing and perpetuation of homelessness; healing hurt is core in the therapeutic relationship. I want to ease his suffering but how? It is so deep and he is so angry. I surf his resistance and anger to find his wavelength. Johns (2009:111) illuminates,

When people experience crisis...their wave patterns are likely to become chaotic; descents to ever greater depths as suffering and despair take hold.....understanding experience helps...(but) this can be difficult when the person is resistant, angry, uncooperative

Like a dance, Hugh takes a step or two with me, and then seems to remember that he can't trust us because we are the *king's army* of health workers who has been “abusive” to him. Progress is tentative. He walks with us as we are leaving. Linda suggests they have tea next week, and he agrees. I am hopeful that with her psychiatric experience, a healing space can develop. I leave Linda to contact me feeling relief that the homelessness burden is shared and I can progress with the homelessness HNA and strategy.

31st May 2006

Couldn't put Tony together again...

The fragile net tears.

Linda phones. Hugh died over the week-end.

Suicide, I ask. The post-mortem is being performed as we speak. Her shock is evident. I feel shocked! My gut wrenches further,

"He refused to do chores. Staff and other residents were getting upset by him. I took the hard line... I advised Nicola to evict him..... I discussed it with my manager first."

The hard line - eviction.

... Wrenched too, because ...

... *I discussed it with my manager...*

No return to me. Where am I positioned clinically?

Too busy in my Public Health strategic role to pick up the telephone and check progress, trusting that I would be contacted if problems arose. In reflective guidance I am challenged for blaming myself. This is vulnerable work where nothing is predictable. But I also recognise that a clinical team *around me* would make homelessness less disparate. The relationship between me and the CPN requires nourishment; she has her support in the mental health team but they are only tentatively linked into homelessness trajectories.

Wheatley (2006:145) in her seminal work on systems knowledge notes, "To make a system stronger we need to create stronger relationships...if a system is suffering it lacks sufficient access to itself....it might be ignoring those who have valuable insights." Amalgamating mainstream mental health services in homelessness is insufficient if services do not have time to develop a deeper understanding of homelessness and a whole-systems approach within it, where relationships are strengthened.

I confront Linda,

"I didn't know you were having problems."

Perhaps I wouldn't have been able to do anything but I am key part of the system and recall the tentative engagement at our first meeting with Hugh... breaking through his strong resistance.

Linda says,

"After that initial meeting he wouldn't look at me... he kept watching TV instead."

I reflect further on the *hard line* - if nurses block out suffering, distancing themselves from the bad patient (Kelly and May, 1982) how can they recognise their role in preventing evictions? Has the hostel ethos created the same ethos, particularly around 'chores'? In the light of Gadwo (1980) I note how paternalism rather than existential advocacy was used by the mental health team to "provide a good that is not desired by the one whom it is intended to benefit" (p.82). I feel at odds with paternalistic models in health cultures incorporating 'rules' without full knowledge of their effect, particularly in homelessness - another reason for a Multi-disciplinary Team (MTD). Yet, I seek to reassure her. Death in mental health practice, as in health visiting practice, brings legal considerations which cause practitioners to reflect on their actions. All of the mental health team, she says, are holding their breath...

Post mortem results

The next day, I visit the hostel to *be available* to offer bereavement support. I learn that Hugh died from natural causes - a heart attack. Everyone is relieved.

3rd September 2006

Picking up the health pieces...

Knowing Services/knowning the person

Hugh's brown walking boots 'stand-to-attention' in the corner of Nicola's office. They have become her lucky mascot. She illuminates,

"Hugh rapidly deteriorated before we had chance to evict him. He asked to go to hospital. In A&E they would only admit him to where his notes were - twenty miles away. But that's where he had bad experiences, so he refused to go. A community team offered support and his condition was controlled. His charisma came flooding back. When his medication ran out his symptoms returned. I called the team; honestly, a two minute assessment ensued. The nurse left without providing medication saying he needed to talk with the team first. "

"Maybe he did..." I challenge

“Yes, but we were left with Hugh in that state not knowing how he - or we - would cope. It took two days for them to return.”

Strategically, I gather this knowledge for A&E and mental health development in homelessness (Text:19). She continues,

“I was about to attend my grand-daughters baptism but made a detour to tell Hugh the team would be calling...I found him dead. I was so shocked. I called the police. I held his forehead and hand and cried.... Maria, the room was filled with peace.”

Nicola sniffles into her tissue - still trying to make sense of it – an emotional burden carried on her own. As she describes the loveliness of Hugh's family who to bring his body home, I recognise the impact of homelessness and sudden death on the family.

“They said how hard he worked in homoeopathy. Schizophrenia set in at 46. Until then he had no mental illness - there was no family history either.... The peace in his room was palpable”

... a healing moment in the chaos of a brother's unexpected premature death.

We are attempting to make sense of the life of someone who was homeless, and the suffering their families go through. Deepening our understanding of homelessness we,

Sit together, to listen, to worry and dream together ...Thinking together in the holiness of real listening (Wheatley 2002:5/91)

It takes time, but feels so right.

Davis et al, (2011) recognises the impact of death on hostel staff, other residents and families. They require bereavement support. The study also found like Hugh, "Residents can be unwilling to access healthcare delivered in environments in which they do not feel comfortable" (Davis et al, 2011:Slide 12).

My therapeutic relationship as an existential advocate (Gadow, 1980) extends to hostel staff, at a time when they feel vulnerable and alone in dealing with severe illness. My role is unique because of the homelessness knowledge I hold supporting deeper issues which cause turmoil, and peace in homelessness. I shape the net towards inclusion within a whole-systems approach embracing training and support to prevent evictions.

In reflective guidance I am asked to consider that I probably do more in my role than a CPN, who may have more difficulty seeing beyond the label of a mental illness diagnosis.

DEVELOPMENTAL FRAMING 4

REALITY PERSPECTIVE

VISION

Who is this homeless person?

- Middle-aged, health professional
- Traumatized
- H/o Paranoia
- Does not conform to hostel chores
- Facing eviction onto the streets

Limits to Engagement:

Refusal to re-engage with mental health services

Empower homeless services

- I secure a mental health nurse to support them - sharing the burden. Was it enough?
- I become an existential advocate - I provide emotional support, health training

Limits to Engagement:

Homeless staff are frightened/unskilled around severe mental illness.

Engage health services

Hostel felt unsupported by mental health services in crisis

- Making the invisible, visible I effectively dialogue with MH manager and a Specialist CPN is secured

Limits to Engagement:

Hostel's role in health/homelessness is not recognised by Health professionals; they do not see the bigger picture - the net

Influence Policy and development

Actions:

- HNA report: affirms CPN in homelessness multi disciplinary team
- How can I empower mental health services to prevent evictions through thinking in a whole-systems approach?
- Training: mental health services

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

ROLE

The therapeutic net

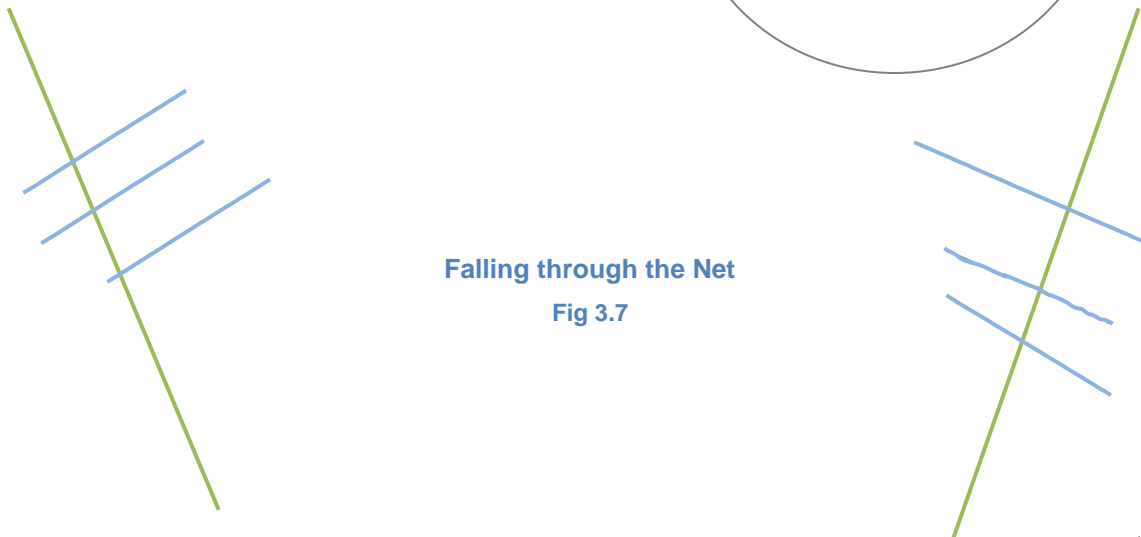
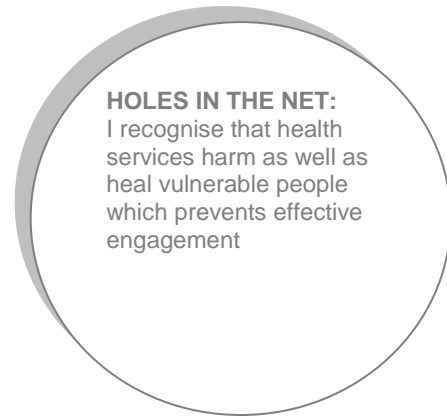
- Creative methods were used to engage Hugh
- Hugh values his story being academically told
- Poise: negotiating clinical and strategic tension

The partnership net

- I recognise mental health and bereavement as areas where hostel staff require high support

The health services net

- I challenge mental health to re-engage
- Half a day per month CPN secured; a welcomed but minimal resource
- Shadow days arranged



Falling through the Net

Fig 3.7

Text Six: CONNECTING AND REFLECTING

Homeless Forum AGM:

April 27th, 2006

There is a buzz in the atmosphere! The Town Hall meeting room is filled with 45 multi-agency partners. Having suggested the key speaker to the Chair, I am delighted he is here.¹²⁴ The Communities and Local Government consultant (CLG) is co-author of the forthcoming Hospital Admission and Discharge Guidance (DH/CLG, 2006) for homeless people. Mindful that this is an opportunity to spread the net of hospital health into homelessness, I have invited Rita, a senior hospital manager based in A&E, who is working with me on the local policy. Her nursing presence and general enthusiasm about homelessness is a strong thread in the health net, making me feel less clinically isolated. Amidst the welcoming camaraderie of multi-agency partners, I manoeuvre myself to sit next to the key note speaker (Paul). He is chatting to another speaker who will be presenting a research paper on the housing needs of local offenders (Broadbent, et al 2006).

It feels different from last year's AGM. Then, I experienced hostility about mental health service provision. Today, the PCT is mentioned more than any other agency in homelessness achievements in the past year:

- 10 focus groups with homeless people across the County
- The development of the HNA report
- The development of hospital admission and discharge policies (acute unit and mental health)
- An inaugural Health and Homeless Fair hosted by the Foyer
- Three regular nurse clinics: Day Centre, Eva Centre and Bail Hostel
- Health support to staff/ residents in hostels with improved access to mainstream services
- Training to homeless services: Diabetes, TB, Infection Control, Health and homelessness

I glow – feel the powerful yet humble. Warm smiles acknowledge Health's work. It marks my empowerment journey with multi-agency partners in the first 18 months in homelessness in my Specialist role. I muse on how I have *been available* to achieve quite so much despite part-time hours; my energy overflows. I draw on Kieffer (1984) in citizen empowerment theory, marking my advancement with homeless services,

Engagement in an organisation helps to recast both consciousness and capacity in social and political, rather than simply personal and emotional terms...gradually they become aware of the interconnections of social, political and economic relations. (Kieffer, 1984:21)

¹²⁴ The chair is an NHS drug treatment service manager

I have embedded myself with multi-agency partners to unite local homelessness issues politically, socially and economically - providing improved health access, and healthcare in partnership with them.

Paul begins his presentation by acknowledging Health's presence, stating that nationally, Health is usually invisible in such forums. I had assumed this PCT was less developed than other parts of the UK. The invisibility of Health nationally then, maybe a disconnection which keeps the true extent of UK homelessness from being revealed; it is only since Jack's near death (Text:2) that the rough sleeping count was reinitiated and further services developed.

Paul's presentation illuminates how hospital admission is a key time for assessing a homeless person's health issues (DH, 2003; ODPM, 2004, 2005). Rita is proactive in developing our policy; conversely, I have experienced resistance from mental health managers to engage with the policy.¹²⁵

Despite Rita's engagement Bob *slipped through the net* in the hospital discharge policy,

He sits
In poor health
A little lost gnome
In a hospital gown
'It's so hard
At 52
To live on the streets
or night shelter
I can't do it
I'll reoffend
Again'

His gastric bleed diagnosed and treated -
The RSL¹²⁶ flat ready for Monday
How effective partnership working is!
I glow
Unlikely now to collapse again
On a nameless street
In the winter freeze

¹²⁵ An introductory meeting with a senior manager on Admission and Discharge policy in the mental health units seemed satisfactory but three follow up multi agency meetings were cancelled often at short notice. When a new manager was appointed I chaired the multi agency meetings using the hospital protocol which I had developed with Rita. But that mental health manager suddenly left. It took three strongly worded emails to other senior mental health managers over the following year to advance the policy further. This was only done effectively following the Mental Health Task group meetings in 2008 (Text:19)

¹²⁶ Registered Social Landlord

I tell him so
Before I go on leave
Tears well in his eyes
'Thank you, thank you
You don't know what this means to me'

'It goes to pot
The day centre manager confirms
When you're not here'
'He was sent out
Onto the
Streets!'

Shocked, I phone housing
Keith says...
'A new ward sister
Refused
To hold the bed
Declaring
'Hospitals are not week-end hotels!'
Then,
She changed her mind
Didn't tell anyone
Until it was too late
The flat given
To someone else
In need'

And now?
'Re-offended
Within 24 hours'
Knocked on a prison door
Asking to come in
From the cold¹²⁷

The link between homeless and offending is well established (SEU, 1998, 2002; Smith et al 2004) but it seems that even one disconnected health professional can harmfully influence

¹²⁷ The local newspaper reported how he knocked on the prison door asking to be readmitted rather than live on the streets. He committed another crime (abusive in public place breaching a former ASBO) and was sentenced to 9 months; the judge stating that jail seemed to be the only option for him. When I met this man in hospital he was gentle, alone and requesting help. The housing officer had made significant efforts to obtain accommodation despite an arson offence which could have excluded him from most accommodation options. The hospital staff did not link this vital information with their role. In hospital he had begged for the flat he was going to be given – knowing that it was the last chance he would have of getting his own accommodation. The ward staff were stunned at how events evolved, and became much more aware of their own role in preventing reoffending and homelessness.

accommodation in offender pathways, despite our joint discharge working as guidance suggests (DH, 2003; ODPM, 2004, 2005).

My role is an effective link. Bob's experience illuminates again the need to educate mainstream health services to act holistically in awareness of local *the net*.

Empowered by Paul's knowledge of health scrutiny committees, homeless service providers raise the issue of late night-shelter arrivals from hospital by taxi. Having to leave the premises by 09.00 the following day, they cannot recuperate. Rita defends the hospital's position. I mindfully map the ethical dilemma (Johns, 2002). Whilst discharges to the night-shelter seem unsatisfactory there is no other accommodation available for rough sleepers. What can Health do? Discharge to the night-shelter fulfils the hospital's responsibility of safe discharge when no other accommodation is available – so long as their ongoing health care needs are addressed (DH, 2003;ODPM 2005). From this multiagency dialogue and my experience, I conclude that rehabilitation accommodation like Lambeth PCT (Lane, 2005) should be a recommendation in the HNA report.¹²⁸

Uncannily, the second speaker presents her report entitled 'Housing Needs of Offenders' discharged from prison. Her research recommends 'protected' hostel bed-spaces for offenders. I challenge it, connecting mindfully to the vulnerability of rough-sleeping women attending my clinic who are unable to secure shelter (Text:1,3). 'Protected beds' would also affect hospital discharges when no other accommodation is available. Does the researcher understand the competing multiple needs of our rough-sleeping community? I ask,

"What outcome measures would demonstrate the effectiveness of your recommendation in the rough-sleeping community? Health could request the same: protected bed-spaces for hospital discharges, and for vulnerable, frightened women at my clinic.¹²⁹ Blocking beds for offenders would negatively affect these groups."

"Good point", Paul encourages, and Rita agrees. The researcher hasn't an answer. She asks if I have one. I weave my growing knowledge of housing terminology and health experiences of homelessness into my response,

¹²⁸ See Lane 2005 - Lambeth PCT pilot of step up-step down accommodation for homeless people going into hospital

¹²⁹ Two other women from my health clinic come to mind – one who is sleeping on the steps of the housing department unaware of the night shelter; another - recently bereaved and lost - too frightened to go to a night shelter. Neither of these women had mental health or substance misuse problems.

“There isn’t enough housing stock. it’s more complex than that. Yesterday a man came to clinic angry about his discharge from a mental health hospital. He was sent to this town because we have a night-shelter - but it was full when he arrived. He had been a patient for several weeks following a suicide attempt yet there was no referral into our community mental health teams nor a CPA.¹³⁰ I am taking this case up with their chief executive and referring him into our teams locally.”

Mindful of my voice and alert to Belenky et al's (1986) framework my subjective and objective knowledge unite in the political unfolding of my practice.¹³¹ I feel it; they feel it. That UK hospital is accountable to me, to this forum and the patient. Injustices revealed in my clinic.¹³² There is so much which UK health services should be considering in preventing homelessness. Perhaps I am disloyal to Health in this multi-agency forum yet, as an existential advocate (Gadow, 1980), it is a moral issue. My integrity diffuses the nature of my responsibility, linking me and multi-agency partners more intensely into health and homelessness need, towards a therapeutic community.

Rita is fired up – she wants me to work in A&E, *“You could hold your own clinic for homeless people. Staff can come to your clinic and vice versa.”* Inspired, we arrange a date for me to present homelessness at the A&E Sisters meeting.¹³³

Paul and I exchange contact details - he has offered guidance on our draft discharge policy. Later our developing policy is cited as national good practice.¹³⁴

I reflect on my role - connections are growing; experiences link 'like links in a chain' (Dewey, 1963 [1938]). I am weaving the elusive net. Strongly emerging within the homeless fraternity, I grow more mindful of my voice where I want to share what I know,

....speech that simultaneously taps and touches our inner and outer worlds within a community of others...domination is absent, reciprocity and cooperation are prominent. (Belenky et al, 1987:146)

¹³⁰ He broke a beer glass and smashed it into his neck whilst in a train toilet. He presented at my clinic with a history of auditory hallucinations in which he described people from another world goading him into death. These have ceased since hospital admission but he requires more medications. What is my role? To co-ordinate medical and mental health care and provide information on hostel pathways! I also tell him about a rowing club option for night shelter users which I am trying to arrange. His whole face lights up at the possibility of engaging in sports. I write to the Chief Executive of the hospital he has been discharged from following a phone call to the ward discharge nurse and social worker but get no reply.

¹³¹ Belenky et al's framework is discussed in Chapter 2 (p.85)

¹³² I phoned the hospital and spoke to the social worker who had arranged the discharge, connecting him to the outcome of the discharge placing the patient in an unfamiliar area without securing appropriate accommodation and support services within it.

¹³³ The Sisters were not a receptive audience to homelessness; in fact they were hostile, particularly irritable about alcoholism and its effect on their work. Rita apologises for their resistance.

¹³⁴ See Shelter (2007) Good Practice guide

DEVELOPMENTAL FRAMING 5 REALITY PERSPECTIVE

VISION
'Being Available'
Holds my vision

Who is the homeless person?

- 'Old' 53 year old
- Hospitalised following collapse on street with gastric bleed
- "Too old to live on the streets anymore"
- Offends to be accommodated in prison

Empower homeless services

- Link national development to local homelessness - national speaker
- Celebratory atmosphere. about Health's achievements
- Communicate directly with the hospital manager via forum

Limits to Engagement:

Accommodation gap for complex need/ direct access short-stay hostel.

Engage health services

- Senior hospital manager engages in forum; possibility of integrated working with A&E

Limits to Engagement:

- Ward nurse does not act holistically. Should there be nurse homeless champions on each ward?
- Later, A&E nurses are hostile about homeless people in my meeting with them

Policy and Development

ACTION:

- HNA recommendation: Explore step up-step down hospital discharge accommodation
- The acute hospital discharge protocol development is cited in Shelter's good practice guide (2007)
- Ward packs and training (including A&E)

ROLE
Realising the vision

The therapeutic net

- Being available to Bob: 'Presence' creates space for offending to be voiced, and concerns over health needs and lack of accommodation
- Advocacy to secure accommodation

The partnership net

- Emerging as a leader with a strong voice
- Collaborative working with Housing secured post-discharge accommodation for those with h/o offending

The health service net

- Link hospital manager and others to forum - extending the net
- Ward nurses need to be engaged in local net

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

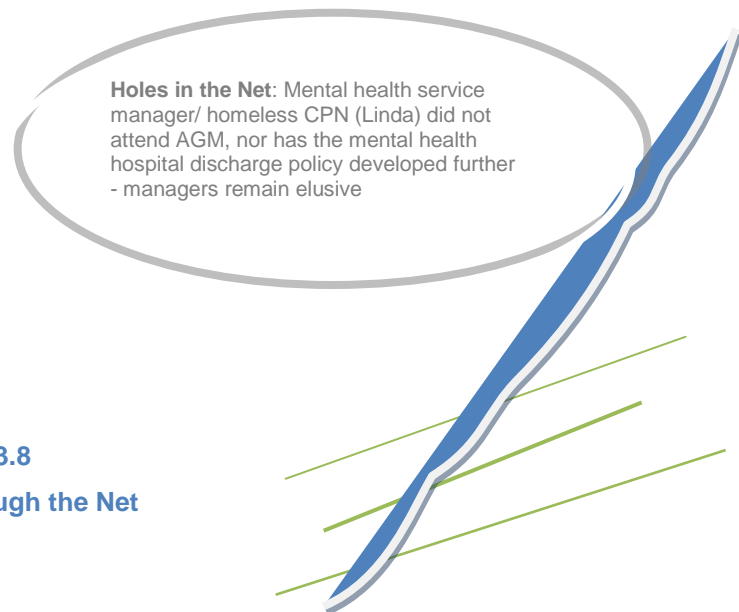


Fig 3.8
Falling Through the Net

Text Seven: BREAKING AN OFFENDING CYCLE

Robert: Hostel and Home Visits

June - December 2006

He was *the* success story - strategically used by me as an example of Health's effectiveness in homelessness with 'ex-offenders', preventing evictions by providing a therapeutic net. Imprisoned 9 times by the age of 23, my four hostel visits at a time when he refused to see a GP for anxiety, guided him at a crucial crossroads: to live independently or return to the perceived safety of prison. He had a strong yearning for prison. In those four visits, each lasting between 1 and 2 hours, he cautiously expressed himself. Through periods of silence in our dialogue, something deep unfolded.

Real communication can only take place where there is silence. But there is something more in this silence that goes beyond opening the heart and 'seeing from the inside'. (Senge et al, 2005:79)

Senge et al, links silence to mindfulness where one develops a penetrative awareness that sees connections that may not have been visible previously. In this therapeutic space, Robert disclosed for the first time, his violence towards his twin teenage sister, dying from leukaemia. Having therapeutically addressed his disclosure drawing on my background health visiting experience, Robert moved towards an exit route out of offending and homelessness.

Reflectively, I question myself: Would I, as a Health Visitor have recognised a sibling's grief as trigger to adult homelessness? His main teenage coping strategy was a journey with substances.

Robert moved from the hostel into accommodation supported for a short while by hostel staff. Government Guidance suggests that, 'Two of the most commonly reported factors in tenancy breakdown are debt and isolation' ODPM (2003:6) Whilst time constraints *limited* my post homelessness intervention to two visits, I referred him to Supporting People aware of his Housing Benefit interruptions and college attendance issues which had the capacity to deepen isolation.

2nd May 2008

Meeting Robert at his home again....

It is 18 months since I saw him; the phone call is unexpected,
*"I'd like to see you....no, I **need** to see you Maria...I'm not doing so well."*

I hardly recognise the face staring out at me from his door – loss of weight, a faraway look indicating perhaps a mental illness. Where is the healthy looking guy who sat on the hostel wall,

waiting for my arrival? Then, he had given up cigarettes and cannabis, and lost his craving to return to jail. Proof perhaps that, "Simply putting a roof over someone's head does not always solve his or her homelessness" (ODPM, 2003:4).

Back at the familiar crossroads Robert is contemplating prison ... I think of Bob (Text 6) who reoffended because he could not live on the streets....

"I like prison. No drugs, a gym, education, a cell of my own...just like this. "

Robert's arms spread out displaying his home.

It *is* homely now. That early sparseness was full of possibility, hope, dreams – a blank canvas waiting to be filled with new life. His body fitter, his eyes brighter...

I challenge him to consider the suffering a pathway into prison would cause others.

"Ok! I'll only seek revenge on those who bullied me at school."

Emotional wounds linger. Lemos (2000) deepens my insight about post-homelessness support,

The inability to make new friends with people of similar backgrounds or shared experiences and the breakdown of a primary relationship or newly formed partnership were all reasons given for abandoning a new home. Many also wanted to cut off from old contacts that were bad influences - old drinking partners, drug dealers or other partners in crime (p.9)

Fearing drug-dealers restricts his return to his hometown; his father visits him here instead, but Robert seeks youthful company. He continues,

"My mind is ..."

I fill the space...

"Too full?"

Intuitiveness reconnects him.

"Yeah ... no room in it! I stumble over my words; my thoughts have become abusive...racist."

His decline is profound. My stomach sinks as he continues,

"An Iraqi guy lives upstairs. I knock on the ceiling with a broom every day, shouting at him. I know I shouldn't! It happens when I'm passing black people in the street, I can't help myself. I whisper under my breath 'black bastard', then I shout it out. I don't want too; it just comes out from me."

Adrenaline in my body clashes like waves on the seashore.

His emotional strain is echoed in T.S. Elliot's poem,¹³⁵

Words strain
Crack and sometimes, break under the burden,
Under the tension, slip, slide, perish
Decay with imprecision will not stay in place
Will not stay still
Shrieking voices
Scolding, mocking or merely chattering
Always assail them.

I muse: is Robert developing a psychosis? I recognise I must refer Robert his GP, but I am keen to analyse my fear. My adrenaline surges are triggered by fear of attack, working alone in homelessness. I have prepared well for such risk today: situated nearer the door, work colleagues and my husband aware of where I am, mobile phone in pocket - so I ride fear's wave; reproach it, so that I can *be available* (Johns, 2009). He says,

"I've been to the GP - she's prescribed Citalopram.¹³⁶ I don't like it. She doesn't know I don't always take it"

I reflect on his partial concordance and reasons for it.¹³⁷

"When I began taking it, I needed to buy weed. The Citalopram put me on a high. Then I need to relax...I get jittery otherwise."

Cannabis and antidepressants – what does the literature say?^{138/139} These are not my areas of expertise so the medical information fails to roll off my tongue. Concerned about illegal drug use, I

¹³⁵ In Humphrey, P. (2009, P.xi) *Hope's Daughters: Faith and Culture*. Milton Keynes: Authorhouse

¹³⁶ 10mgs daily

¹³⁷ Barber et al (2004) studied patients who had been prescribed new medication for one of a range of chronic conditions that have been identified as priorities for the NHS. They found that 43 out of 171 patients (25 per cent) were non-concordant four weeks after being prescribed their medication. Of these, 17 (40 per cent) had stopped taking their medication altogether. Just under half (45 per cent) of the non-concordant patients were intentionally so and, of these, 89 per cent had completely stopped taking their medication.

¹³⁸ Cannabis can trigger underlying mental health problems in some people (HIT, Liverpool Drug Awareness Cards)

¹³⁹ Roeloffs et al (2002) reports that more than a quarter of primary care patients with either depressive symptoms or depressive disorders reported 12% illicit drug use and 11% cannabis use (Marijuana). NHS Direct provides guidance that Selective Serotonin Reuptake Inhibitors (SSRIs) including Citalopram, suggest that there is little evidence that people who use cannabis should normally not take SSRIs, despite the reported onset of mania in a person taking Fluoxetine with cannabis – although this could have been the result of Fluoxetine itself (www.nhsdirect.nhs.uk/articles/article.aspx?ArticleId=865). Bovasso (2003) found that cannabis abuse was linked to depression at a rate of 4 times that of those who did not abuse cannabis at follow up assessment, even when a mental health problem was not apparent at initial assessment. Substance misuse is common among individuals with depression seen in primary care settings. In our study group, one-third of patients with a probable depressive disorder also had co-morbid substance misuse. Under usual care conditions, depressed patients with substance misuse had an increased probability of ongoing depression at

refrain from criticising his cannabis use - I still need to understand more from his perspective. I inquire,

"Is it easy to get weed here?"

"No, I go into town... I haven't done it for a long time - just recently".

As Robert talks freely with me, I judge which care pathways are available that he will comply with. I provide Tier 1-2 drug prevention approach, but need to identify whether treatment services are necessary.¹⁴⁰

"I've even taken Crack"¹⁴¹

He looks shy.

"I had a relationship - she was a user. It lasted about three weeks... She was 42. That's not right, is it?"

Recognising the struggle with loneliness and isolation in his resettlement (Lemos, 2000) - a reason for poor tenancy sustainment (ODPM, 2003), I don't criticize the relationship, simply ask,

"How did she make you feel?"

His eyes brighten. He smiles broadly,

"Good...but I don't want to go down the drugs path again. I finished the relationship. She was old enough to be my mum...that's not what I want."

He dismisses *the drug path*... and the relationship because of it, affirming there is no requirement for Tier 3-4 treatment services!

"I want to be a dad...a young dad."

both the 6 and 12 month follow-up evaluations, despite higher rates of treatment relative to individuals without substance misuse. This extends previous findings that co-occurring substance use disorders are associated with depression and with poorer depression treatment outcomes and is consistent with the general beliefs that 1) substance use may induce and prolong depressive disorders, 2) the two disorders share common risk factors, and 3) depression may promote substance misuse (Watkins et al, 2006, accessed 8 May, 2008) .

¹⁴⁰ Drug treatment and prevention programmes are Tiered from 1-4 ranging from universal generic intervention to very specialised services

¹⁴¹ Crack Cocaine is cocaine hydrochloride that has been chemically altered to form crystal that can be smoked. (HIT Liverpool Drug Awareness Cards)

I fan the waves of hope - a better option than prison. Threads of dialogue entwine with conversations I've had with Farrah, a 22 year-old hostel resident. She also wants a relationship with someone who is decent "*but how do you find them?*" she asked.

Uncannily, my phone rings - it's Farrah! In awe at the coincidence, I just hear her words through this shock interruption.¹⁴² He sits on the sofa, unaware of the connection. If I were a matchmaker I would put them together - but it would be of dangerous uncertainty. I still tingle at the coincidence and ponder on its significance. Limited by an embodied fear of over-reaching professional boundaries, I leave the significance untested. So, we resume conventionally when Farrah's phone call ends; he agrees to a mental health referral and my liaison with the GP. Aware of his eagerness to return to prison to use a gym, I explore the use of a Leisure Service card to attend the gym.

That evening, recognizing the unyielding power of woundedness in people's lives I splurge my anxieties in my journal:

"Oh God, I feel so helpless.... He needs to belong. He needs a community of people to be at home with, a healthy community...But where are they, who are they? He doesn't seem to fit into anything...he has little money...wants to work but feels lethargic. He has to think of a 'decent' crime to commit so that he can go to prison to find community and use the gym. He is lonely; his mind and soul have become ill at ease...diseased. Why did that coincidence happen with Farrah? They have such similar personalities. Their separate vision is for a good life but they don't know how to achieve it. They are both young people overflowing with good qualities. It's just that their life experiences have made their dreams difficult to achieve.

Afterwards, I scan the literature on homelessness and loneliness (Lemos, 2000:1),

The continuing absence of social networks is a barrier to escaping homelessness.

In this light, Robert's return to jail as an answer to loneliness is significant.

*A few weeks later...*Robert did not engage mental health services. Mindful of Pamela (Text:1) and Hugh (Text:5), I am more alert to fear surrounding them. His phone call re-energizes me,

"I'm so much better again. I don't need the mental health team, Maria. Getting the gym card sorted out was the best thing that could have happened. Thanks for that. I'll be in touch again"

Robert has resisted a 10th prison term.

¹⁴² Her GP wants to discuss a letter to the hostel to say she is fit enough to live independently... the GP's need to confirm this with me.

DEVELOPMENTAL FRAMING 6

REALITY PERSPECTIVE

Vision 'Being Available'

Who is this person?

- 24 year old male
- Childhood trauma
- 9 prison terms -likes 'community' in prison
- Wants a 'good' family life
- H/o substance misuse

Limits to engagement:

My time: post-homelessness engagement is so far unrecognized in my role

Empower Homeless/Support Services towards sustaining housing

- I engage Supporting People

Limits to engagement:

Minimal support offered post housing; tension between him and hostel staff affects sustained engagement.

Engage Health Services

- Stop smoking services
- Awareness of drug treatment services

Limits to engagement:

GP - unaware about his non-concordance nor has she referred him to 'talking therapies'

Policy and Local /National Development

ACTIONS:

- Experience used strategically to illuminate successful links between health, homelessness and offending
- HNA recommendation: MDT post-homelessness support

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

Role

The therapeutic net

- I negotiated his tension between offending/ non-offending contextualised within his life journey
- Resettlement needs may last up to 2 years
- I value silence in the therapeutic space
- I fan desires of love and belonging as social/emotional health needs
- I hear his loneliness - I value sports for homeless people
- I am gaining knowledge of substance misuse but recognise I do not need to be a clinical expert
- Poise: I analyse my fear of attack

The partnership net

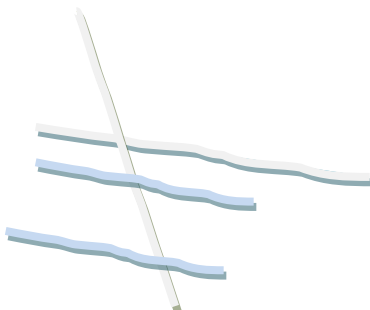
- I prevented his hostel eviction:
- I acquire sports pass from LA

The health service net

- I connect Robert to GP whom he refused to engage with prior to my hostel intervention



Fig 3.9
Weaving the Net



Text Eight: TORTURE

The Eva Centre

24 November 2006

Today, as I go to the Eva Centre, I look at the autumnal leaves bedded down along pavements and road sides. It is the cusp of a changing season marked by gold. I pass an abbey and feel connected to the spirit of the Abbott who brought the Centre to this part of the UK. Connecting to him feels like a blessing in the wind. I picture the little meditation chapel inside the stone walls and ask the Holy Spirit to be with me. I challenge myself what do I mean - to bring healing, to be wise, to be inspired?

I referred Heidi here almost eighteen-months ago from my clinic at a time when she had been rough-sleeping on the streets, newly released from prison. Diagnosed with Personality Disorder, she has issues with authority and alcoholism. She tells me her story about climbing onto the edge of a multi-storey car-park until a police mediator talked her down, bottle of whiskey in hand. I am aware that she has recovered enough to tell her story as an amusing anecdote; she laughs to hide the reality of what led her there.

As she places coffee on the table I am reminded that her whole life history is filled with pain and suffering; unimaginable physical abuse by her partner preceded by child abuse, including child prostitution. Today she discloses how her husband systematically electrocuted her and beat the soles of her feet until they were blue. She points to them, and says her past is continually in her head. If she has a pain in her foot she relates it back to the beatings. Later, as I write the word electrocution in my journal, I cry. I am reminded of Henderson's (2001) paper on the social construct of self and implications for working with abused women. In regard to the emotional labour of nursing and whether nurses are educationally prepared, she says. 'Nurses clearly do not think that their education prepares them for the impact of their work' (p.137).

As I talk to Heidi my former experience as a family Health Visitor emerges. It provides a strong connection almost as if I had known her for many years. Within it, I sense the aftermath of child protection cases and family breakdown laying in tattered pieces unable to re-connect to their own life story. Intuitively, I rename Heidi's suffering as torture, not abuse nor domestic violence. It is a cathartic moment. Heidi looks into a bottomless coffee-cup, caught back in time. Stilled, with glassy eyes she is overwhelmed by sadness. Silence folds its arms around us. I sit in it with her to let the enormity of what she is reliving form and settle. In the stillness, a tangible sense of deep healing is weaving itself in, between and around us.

Heidi later accepts a referral to a psychologist even though she has been sectioned under the Mental Health Act twice before and feels a deep resistance to mental health service intervention. I will also investigate within the PCT, the possibility of fast track-counselling for homeless people¹⁴³ - but feel that trauma like this requires more expertise.

A further critical issue emerges. Todd, her friend, was recently evicted from the centre for bringing alcohol onto the premises. Within days he was murdered while rough-sleeping. Heidi's anger about Todd's eviction is palpable. Preventing evictions is re-emerging in my role. Heidi has already reminded me that she lives with her own pain through addictions; hiding cans of beer in the adjoining fields. She is unwilling to attend treatment services. Heidi wants to leave the Centre but there are no onward housing options in place so she will sleep-rough. From my own clinical experience, I feel petrified for her as images of the distraught woman at yesterday's clinic needing suturing following a brutal anal rape are still on my mind. I tell Heidi how dangerous it is on the streets and for now, she says she will stay.

Minutes later I meet Katherine, the Centre manager in the office. I am stunned to hear that she is on the brink of evicting Heidi. Katherine says Heidi is stirring up other residents, making them vocal about Todd's eviction and ensuing murder; "She is disturbing the status-quo of the community." *Status-quo*, a subtle phrase meaning, 'Position of affairs...how it has been and is' (Pocket Oxford dictionary).

A fine balance is being trod here and I feel its tension. My goal is to work with Katherine to prevent Heidi's eviction or worse still her death or injury. In this moment I am mindful of phronesis. Aristotle firmly links phronesis to reflection, which he terms 'deliberation' to attain a good goal (Nichomachean Ethics 1142 20; 163). I need to move Katherine forward and sense my practice vision "singing from my soul". My hands tingle with energy. I explore the issues surrounding Todd's bereavement and the complex effect it is having within the community. I identify how Katherine can use Heidi's voice constructively rather than punitively and the idea that perhaps she could become a mentor to other homeless people emerges. Katherine likes this and asks if she can suggest it before I return. I offer to contact the Housing team before my return next week to see whether Eva residents can be placed at the top of the housing list following a successful residency - knowing that this process operates in other homeless accommodation sites.

¹⁴³ Through personal networking I secure fast track counselling service for homeless people until changes in PCT structures occur later in the year

'Eviction Notice' - 30th November 2006

Heidi and I sit underneath the cool, calm painting by Todd - her friend who was murdered. Following an altercation with a staff member at the week-end in which Heidi felt threatened and reacted aggressively (I explore the possibility of abuse towards her) she too has now received a warning letter stating she will be evicted if another incident arises. There is no right of appeal - her voice disempowered by the process. Caught in the fear that any intervention could lead more quickly to the fore-warned eviction Heidi resists advocacy on her behalf. I am momentarily trapped with her by the power of the eviction process. Perhaps I am colluding with its power. I am drawn to consider whether this silence is the oppression which Belenky (1986) describes, 'Where language and naming are power, silence is oppression, is violence' (p.23).

But my vision of practice re-emerges like a phoenix and Heidi is inspired by my planned strategic intervention: place eviction processes on the agenda of the multiagency forum, to discuss it with the housing manager and Supporting People commissioners and to network nationally.¹⁴⁴

Heidi still wants to leave and not wait to be evicted. Rough-sleeping beckons. I become anxious and remind her again about the reality of the violence on the streets. She says,

"I'm used to sleeping in the streets, even when I was married I sometimes stayed out all night, to be safe".

A pattern of escape is emerging. Heidi becomes still. She holds her body together with crossed arms in case those nights ripple out again from the core of her being. I feel all the years of her pain entwined within her current dilemma. A mighty roar lurks near the surface of her being, contained by a fragile silence. I am mindful of Blackwolf and Gina Jones (1996:28) who says, 'What dark caves must you walk through...? Learn to walk through your fear...you will not break.'

But the mosaic table which hold our coffee cups is a reminder that this is a broken woman trying to reclaim her life. I touch her arm gently and after a little while ask,

"Are you alright, Heidi?"

¹⁴⁴ I network with Shelter before putting this on the Housing Forum agenda. They inform me of Hostels Capital Improvement Programme CLG Policy Brief Page 4 summary point 7 – sets out the department's priority to reduce evictions. DCLG (2005) Hostels Review Toolkit which he describes as a self assessment to help staff deal with reducing evictions St Mungo's "Star" Outcome tool which looks towards softer more qualitative improvements that service users may achieve. Nottingham SP team document setting out procedures to look at reducing evictions from Short Term services (for up to 2 years). The Housing manager and Supporting People commissioner review evictions and alert me informally to a discrepancy in their numbers.

Almost in a whisper she says, *"I want peace, here in my heart."*...and after a pause she adds, *"without having to get out of my head with booze or drugs"*.

My peace-making role re-emerges. I am so eager to help her find peace, elusive peace. I watch as she traces her finger around the grouting holding together each piece of mosaic tile on the coffee table. Blue, green, yellow pieces of tiles, all different shapes and sizes, reset into the surface of a rectangular coffee table, beautiful and useful; broken pieces forming a new function, even stronger than their original function.



A picture of hope begins to emerge. Heidi points to her forehead and heart and says that God lives there. Picking up on what she is saying and mindful of Borglam's (1997) spiritual traps (Text:1) I say, 'Perhaps your God is looking after you, Heidi'. I want to connect her to a source of love for her, for who she is, and for what she has experienced. She smiles contentedly and I am reminded of my drive past the abbey last week.

Later I move Katherine the manager into my caring dance (Blackwolf & Gina Jones, 1996) for Heidi, and pause so that she can pick up my beat. I want to help her to grow and spend more time with her connecting her to the complexities we are dealing with amongst the competing tensions of the commercial world in which the Eva Centre sits.

Peace Flame Candle - 19th December, 2006

It is a Christmas card morning, a scene of winter delight. A large colourful crib stands outside the abbey connecting me to advent, a time of waiting, in which I feel invited to wait for a positive outcome in Heidi's story.

The image of the mosaic table has been on my mind and I take my camera to photograph it. Baudrillard (1997) suggests that objects want to be photographed in an endless circularity between

subject and object. I sense the circularity emerge within my own reflections about Heidi and the table. Nussbaum (1986:4) states, "By burrowing down in the depths of particular instances, finding images and connections allow one to see their significance." The significance of the mosaic table is that it has become an image for Heidi's brokenness and her search for peace. Capturing this desire I've brought with me a World Peace Flame candle from last year's Reflective Practice Conference in Cambridge. My gesture is a simple one, so that her vision for peace is not lost. Smiling broadly, she says "cool".

I ask Heidi's permission to photograph the table. In similar whispers of reflective practice, photography is like a mirror that looks at ourselves looking (Baudrillard, 1997). Butler (2005) notes how Baudrillard calls it a "coming together in which each part contains the whole" (p.9).

The wrapped candle sits on the mosaic coffee table. When I study the photograph later, I am intrigued by the connection of peace sitting on broken pieces.



The process of photography brings an amazing facet to our meeting in which its therapeutic process becomes evident (Aldridge, 2007). Heidi brings Todd's painting down from the wall. Transfixed by the camera she balances it on the mosaic table, her eyes gleaming with pride. It is as if she is holding Todd, to tell his story. This becomes part of Heidi's tribute to him and part of her healing process.

Saying Goodbye to Heidi - 11th January 2007

I look at the barren trees on my way to the centre and see new shoots pushing through the dark bark. On my journey I am reminded that "winter" is a powerful season for future growth and think of Peter Seigger's song 'There is a season turn, turn, turn...' My hope for Heidi is that her dark winter

is turning into spring. Yesterday, I learnt from Katherine that Heidi is moving to a new Eva Centre. There is a celebratory atmosphere - her return to rough-sleeping has been avoided.

I envisage that this may be a shorter visit than usual. But, oblivious to the coffee room sounds and rain beating down on the window, I listen again as Heidi relives her past, expressing the deep pain which Kearney (1997), in palliative care work, describes as soul pain. He states,

Soul pain...is the experience of an individual who has become disconnected and alienated from the deepest and most fundamental aspects of himself or herself.
(p63)

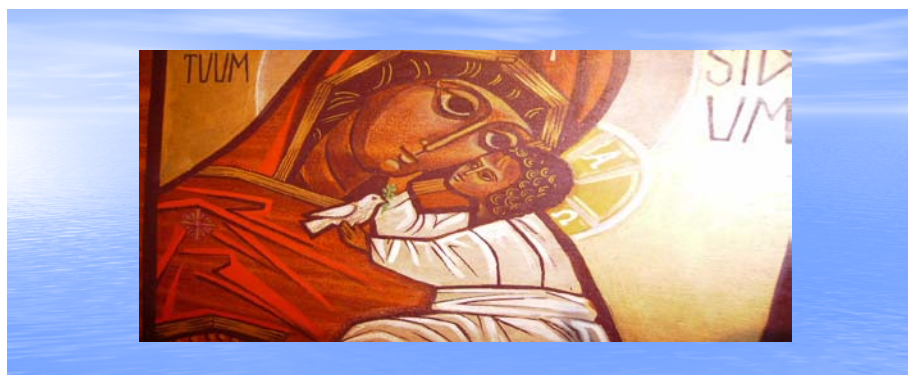
I begin to see myself and Heidi as pot-holers, connected to each other by an invisible rope in a joint expedition to the crevices of her deeper-world. I journey with her without any opposing tension on the rope, keeping her steady and safe. It feels as if she is showing me balm exuded on dark, brittle places during our previous expeditions and is ready to contemplate some of the surface brightness. Clearly excited by her move, she describes how the new centre will cater for her love of fishing and carpentry. I celebrate with her and tell her it is "Heidi time". As a farewell gesture I bow to honour what we have achieved together and what she has taught me about homelessness. Heidi bows more deeply. She waves until my car disappears down the country lane.

On my way back, feeling its poignancy, I stop off at the Abbey to reflect on my encounters with Heidi. I am caught unexpectedly by its name - The Priory of Our Lady of Peace. I am reminded of the words written in my journal regarding Heidi's search for "*peace, elusive peace.*" In silence and in this sacred place I honour the work that has been achieved in the name of nursing. There is a strong smell of incense in the meditation chapel; it is so quiet. I hear the heartbeat of the earth. An icon of the Trinity by Rublev seated around a low table which holds the Eucharist, connects me to the mosaic table and a recognition that perhaps Heidi's "broken pieces" lie, at last, within the grasp of peace.



(Courtesy of the Olivetan Benedictine Sisters, UK)

A painting, inspired by the icon 'Mother of God of Tenderness and Compassion' is inscribed with the text "*Sub tuum praesidium*" taken from the beginning of a prayer to Our Lady generally known as, "*We fly to you for refuge, Holy Mother of God.*" I recognise that I too have now sought refuge to recover. Quite soon and from deep within my own soul, a flow of silent, peaceful tears, ripple onto my cheeks. My work with Heidi has been a bridge in so many dimensions.



Painting by Sister Regina, copyright Olivetan Benedictine Sisters, UK

Later I reflect on the four sessions with Heidi in a photographic workshop. Each session had lasted over 90 minutes. The photograph's double exposure captures our exchange of energy: Heidi's emergence from a tightly cocooned self to a high flying butterfly; my diminished energy from intense therapeutic practice - yet its rewards cause me to smile.



Photographic workshop Kay Goodridge, University of Bedfordshire, 2007

Rather than role and vision, I reflect on my nursing intervention as phronesis, written for a paper presented at the International Reflective Practice Conference, Aalborg, 2007

The flow of phronesis (or practical wisdom) can be seen as a movement within the universal wisdom of sophia. In Heidi's story its development can be marked through the emergence and transformation of her behaviour, as a consequence of my nursing intervention. Carper (1978:17) notes,

The art of nursing involves the active transformation of the patient's behaviour into a perception of what is significant in it – that is what need is being expressed by the behaviour.

What is *most* significant within the text is that my meetings with Heidi occurred at a critical moment in her homelessness journey; a point where she could have headed back to the streets with a shortened life expectancy (Crisis, 2003) or continue her journey out of homelessness into a settled life style. My desired outcome was that she would find alternative accommodation where she could experience 'home' and that was achieved; at least for awhile.

Phronesis was established by aesthetics - "grasping and interpreting the clinical moment" (Johns, 2006); 'tuning into' Heidi during the initial unplanned visit. It opened the doorway of engagement. I held the space, explored the interface and helped Heidi make wise choices. *Being available* in Heidi's crisis was enhanced by my previous background experience: health visiting practice and also personal reflections on home which instilled a deeper empathy about the totality of Heidi's loss, in all the homes she had lived in through her life journey.

I also held Katherine's tensions, enabling centre staff to work through the effects of Todd's unplanned death becoming my practice vision as a net-weaver. Knowledge of Belenky et al's (1986) perspectives of voice fuelled my negotiating power in relieving tensions between the Eva Centre and Heidi more effectively.¹⁴⁵ Initially, when eviction proceedings seemed inevitable, I recognised my own 'silence' fearing for Heidi's sake - until my practice vision guided me to become political to achieve changes in eviction processes. Ethical mapping¹⁴⁶ enabled me to integrate voices as a 'constructive' knower. I raised Heidi's awareness of her passionate, aggressive voice - a quest for herself - as 'subjective knowledge'. Yet to be truly empowered she needed to learn the skills to be less aggressive in her responses. I suggested ways she could do this as well as help her to understand the detrimental effects her aggressive responses were having. The Eva Centre felt justified with their procedures about the eviction process when the moral perspective of care would have been better, i.e. to yield with rules and prevent an unnecessary eviction. Here, I draw

¹⁴⁵ Voice perspectives are discussed in chapter 2, p.85

¹⁴⁶ See p.65

on Gilligan's (1982/1993) notion of women's voices transforming a patriarchal world through care, rather than rules. As my concerns about evictions grew, this practice experience influenced training needs and 'Dealing with Aggression' was initiated through the housing forum by the Local Authority.¹⁴⁷ I also considered for the first time how vulnerable adults may require protection from abuse in service settings.

I have illuminated the tightly woven complexities within health and homelessness. Reflective practice offered me a still point to consider phronesis in effective nursing practice for people marginalised by society.

The individual who possesses the virtue of phronesis exudes that gift
as the rose exudes her scent
(Dante, *in* Delmar & Johns, 2008:6)

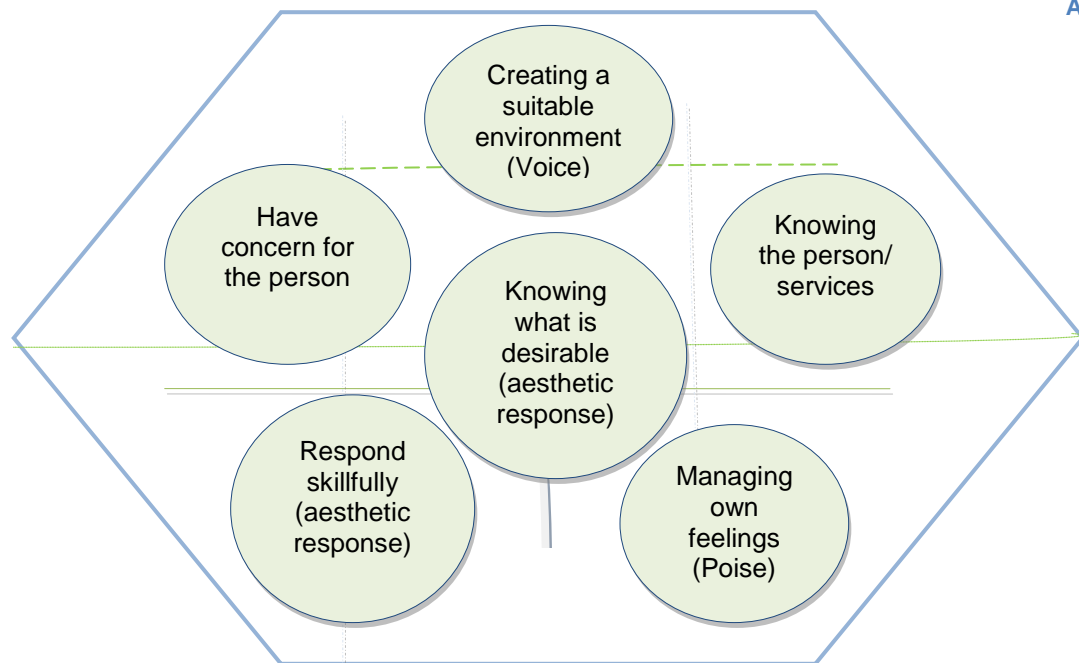
¹⁴⁷ The training achieved national good practice recognition (CLG, 2009) - the training was funded and organised by the Borough Council following my concerns about evictions which I brought on several occasions to the Homelessness forum and to the Housing manager and a Supporting People commissioner

FIRST ANALYTICAL HORIZON - 2006

In this analytical horizon (AH), I deepen key insights that were developmentally framed around role and vision as I used the Being Available Template - the metaphoric net for homeless health development where my role seeks to understand and prevent people *falling through the net* of care.

The Being Available Template (BAT) as 'The Net'

My vision of practice is to *be available* to homeless people and multi-agency services in order to develop health care services for homeless people as responsive and inclusive. In narrative texts, I used BAT not as an abstract concept but always as "being available towards enabling the other" (Johns, 2009:107). It is *the* metaphoric net which brings people in from the margins towards sustained health care engagement using six themes (AH1.1). Clinically and strategically, *creating an environment* where being available to homeless people with inclusion at its heart is particularly significant. It is in *environment* where practice constraints are captured - to show people *falling through the net*. My empowerment against those constraints especially *use of voice*, illuminates my development to *create a suitable environment*.



In BAT, the core therapeutic of holistic practice is irreducible; unfolding insights contribute to the whole of my practice.

Notably, in the first year of research, my growth in knowledge about *the net* as an inclusive or exclusive environment focused largely on the ontological aspects of being homeless from which I would better appreciate health needs in relation to the BAT themes. To *know the person* and make appropriate 'joined-up' response in a multiagency environment, I adapted the Burford Model of Reflection (Johns, 2009) (AH1.2) which triggered a vital paradigm shift where I viewed all illness experiences through a homelessness lens.

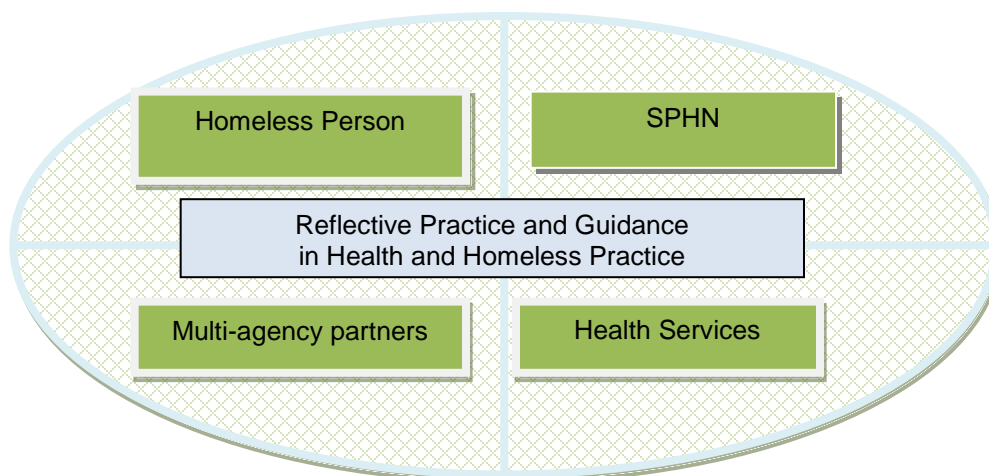
Who is this Homeless Person - adapted from Burford Model of Reflection (Johns, 2009)

- Who is this person?
- How is this person feeling?
- How do I feel about them?
- How has (poor) health contributed to homelessness?
- How has homelessness affected their health?
- How has homelessness affected their usual life pattern and roles?
- What support does this person have?
- How does this person view the future for themselves and others?
- *How have I used my voice in practice? (my addition)*

AH1.2

Developing Practice

Drawn from BAT themes, developing insights are positioned in four quadrants of practice towards my vision of inclusion in health care for homeless people (AH1.3).



Developing the Net of Homelessness Health Care

AH1.3

Key insights are developed in each quadrant aligned within the text to BAT themes.

The Homeless Person

Having concern for the person required me to *create a suitable environment* where I:

- Constructed an effective therapeutic relationship
- Recognised suffering and responded with compassion

Towards constructing an effective therapeutic relationship

To *have concern for persons* meant that I *must be mindful of presence* in practice. Johns's (2004) seminal work on mindfulness strongly attracted me to his narrative style. He states,

Mindful practice is the conscious dwelling of self with patients ... with the intention to ease suffering and nurture their growth through the illness experience towards realising a more harmonious sense of well-being... a clearing where I can tune my compassion and pause so as to respond wisely to what is unfolding (p.19)

In mindfulness, I considered my aesthetic *use of voice* with patients so that it was without judgement or interference, "...a mirror that clearly reflects what comes before it" (Goldstein [2002] *in* Johns, 2004:19). How easy was that to achieve in homelessness: degradation was present (Texts:1,2,3,5,8), distrust of services existed (Texts:1,5,7,8), my prejudices caused me to be fearful of potential violence in a community where mental health problems and offending co-exists and in which I was inexperienced (E.g. Text:5,7).

To be present meant I had to learn to attentively listen to their voice as evidenced in the narrative. As I did this the ontology of homelessness moved me beyond any previous awareness of what homelessness could be like, locally or in the UK and became a profound element in my evolving transformation. Senge et al (2005) suggest it is the transformation of the human heart that makes the difference as "we begin to see" (p.26). Presence, through listening, was a communion unfolding as trust developed where surface interventions - perhaps a dressing (Text: 8) or multi-agency health intervention (Text:1) - gave way to deeper issues where time seemed suspended and a homelessness trauma or life story unfolded (Texts:1,2,4,5,7,8). Nursing presence becomes communion, and is defined by Rankin and DeLashmutt (2006:286) as "a deep connection that forms when there is a willingness to *be open and available* to others" (*my italics*). Nursing expertise evolves from bedside presence into healing presence. My nursing expertise and *being available* to homeless people created a healing presence which allowed them to tell their stories (Texts:1,2,3,4,8). Attention to details such as arrangement of chairs and an open, unrushed and friendly greeting were prerequisite allowing me in the chaos of homelessness experiences to reach the still point and wise response (Johns, 2004). In presence, I used a voice of 'connected knowing' (Belenky et al, 1986) where harmony is established when one enters the other's frame (p.101) and "truth emerges through care" (p.102). In all my clinical texts, presence is illuminated and achieved through mindfulness in practice.

Recognising suffering and responding with compassion

Presence illuminated suffering in homelessness (Texts:1,2,3,4,5,7,8). Effective practice required me to therapeutically engage with people who were suffering. Wright (2007) prompts nurses to reconsider the word suffering, following her family's experience of her mother's illness with Multiple Sclerosis,

What happened to the word *suffering* in our nursing care? Why do we not routinely speak or inquire about suffering experiences in our patients and families? What happened that suffering is not a routine part of our professional language? (p.396)

From surviving cold weather to grieving parenthood or abused childhood, I witnessed suffering strongly residing within homelessness; its nature was physical, mental, emotional and spiritual often with a combination of all.

My compassionate response required a voice that saw the homeless person as a fellow human being, allowing my heart to be touched and to "act on what is seen" (Arman et al, 2007:383). This often meant sharing a therapeutic silence as the person reconnected to their deeper self to tell their life story. Therapeutic silence was not the silent voice which Belenky et al (1986) alludes to where "silent women were worried that they would be punished just for using words - any words" (p.24) but a silence that prompted inner connection and healing, re-energising and guiding people to make better decisions (Texts:1,2,3,7,8). Silence enabled me to feel,

... fullness and softness in listening....silence seems to hold the stories as we hear them - as we receive each other (Pickard, 2004:172)

To open the therapeutic space to suffering and be compassionate, I drew strongly on my background Health Visiting experience where suffering had presented itself as child abuse, post-natal depression, infant death, disability and family breakdown. I also drew on Catholicism, inspired by the Passion where Mary *stood* at the foot of the cross as she watched her Son being crucified (John:Ch:19 v 26). Suffering had to be lived through - but not necessarily alone; immersed in but as I was reminded in reflective guidance not absorbed by.¹⁴⁸ In mindfulness on suffering, Johns (2004) draws on love in practice. He imagined God working through him, where he felt a "great compassion sweep through my consciousness" (p.100) as he provided complementary therapy to a dying patient.

Reflective guidance supported me to write texts for seminars and conferences so that my voice became social action in an effort to further reduce suffering in homelessness (Appendix 5). Texts reflected this: storytelling required powerful images, such as pot holes in Heidi's story (Text 8) to draw audiences into suffering uniting them with my voice and the voice of the homeless person.

¹⁴⁸ I return to the use of reflective practice and guidance in this context of nurses as witnesses of suffering in chapter 5

Specialist Public Health Nurse

Insights arose about my own vulnerability in the therapeutic relationship which challenged me to consider how I managed my own feelings to *be available* in the therapeutic relationship. Johns calls this *poise*. I became more mindful in practice about:

- Spirituality
- Fear

Responding effectively to the spiritual needs of homeless people

Feeling my way around the net parameters in Year 1, I became increasingly aware of spiritual needs in homelessness (Text:1,7,8). In their study of nursing presence and spirituality, Rankin and DeLashmutt (2006), located student nurses in a homeless day centre where they could observe nursing care to the poor. They were transformed by a new understanding of holistic care that confirmed,

... through the soul-to-soul/spirit-to-spirit communion of the nurse-client relationship, the mind, body, and spirit needs of clients are met. (p.286)

Managing Pamela's overt spirituality in her illness (Text:1), my aesthetic response was to enable her to access spiritual counselling but where were these counsellors and psychologists in homeless health care? I cautiously entered into spiritual conversations in a creative tension between my nursing and church roles.¹⁴⁹ Drawing on Lather's (1986) notion of false consciousness, Johns challenged me in reflective guidance to be aware of spiritual traps (Borglam, 1997).¹⁵⁰ Spiritual traps would mean false rather than true presence - deluding self. Guidance heightened spiritual mindfulness: perhaps I was spiritually inflated because of its importance in my own life? Familiar with Borglam and Lather, I felt more comfortable discussing and writing about Heidi's search for God (Text:8) - a search for peace. Responding aesthetically, I was then able to bring her a 'peace candle' as an authentic part of my nursing role in her healing journey.

Discerning my fear

In clinical practice I had to mindfully negotiate fear to be fully present to form a therapeutic relationship (Texts:1,4,7). This is important because fear is likely to be felt by mainstream health professionals working with homeless people and has the potential to marginalise homeless people further. Fear nourishes non-engagement yet significantly there appears to be no nursing research to indicate this in homelessness health care. Recognising my fear, I drew on Nouwen (see p.82) and Damien de Veuster (Text:3). Rutledge (2005) offers another concept - two voices of fear,

¹⁴⁹ See personal Fore-having, Chapter 1, p.22

¹⁵⁰ See Text 1, Chapter 3, p.106

Healthy fear stands guard responsibly, informing us immediately of real danger and tells us. Neurotic fear works around the clock exaggerating and even inventing potential dangers..... Healthy fear tells us what can be done in the present. Neurotic fear speaks to us endlessly of everything possibly that could go wrong. Healthy fear is about protection and guidance. Neurotic fear is about the need to be in control (p.6)

In future clinical practice I would be *poised* to mindfully separate the healthy voice of fear from the unhealthy one in order to *be available*.

Health Services

In this section I deepen insights on attitudes, health service engagement and evidence for a multi-disciplinary team.

Attitudes

As I explored parameters and holes in *the net* in relation to mainstream health services and engagement with homeless people, the fragile nature of the net became apparent. To *create an environment where being available* to homeless people was possible meant *knowing services* in order to recognise negative attitudes and respond effectively. Løgstrup (1997:18) notes,

By our very attitude to the other person, we help to shape one another's world. By our attitude to the other person we help to determine the scope and hue of his world; we make it large or small, bright or drab, rich or dull, threatening or secure.

Attitude affects the therapeutic nature of presence. Rankin and DeLashmutt (2006) note that presence involves risk where *being available* is a chosen engagement in relationship of "investment of self in another" (p.286). Personal power makes the compassionate response a chosen one. I witnessed very few nursing interactions resulting in presence with homeless people; instead key health interventions stayed as surface interactions (Texts:1,2,3,4,5,6) either because of prejudices (Texts:5), time (Texts:2,5), fear (personal conversations) or complexities of homelessness which they had little knowledge of (Texts:4,5,6). My texts illuminated how homeless people easily fall into the undeserving category of the bad patient (Kelly et al, 1982:148) due to perceived deviant or rule breaking behaviour. Shaw (2007) in his 'dirty work' research with GPs describes how "problem patients have moral judgements made about them" (p.1039) and quotes O'Dowd's (1992) label of 'heartsink' patients, so named because of the demoralising effect on the practitioner. The ideal patient is,

...someone who is polite, who takes good care of him-or-herself, has an easily diagnosable condition, is strongly motivated to recover, complies with medication, and recovers quickly after treatment. The further patients are removed from this ideal, the more they are likely to be perceived as problematic (Shaw, 2007:1039)

In this light, homeless patients are likely to be perceived as problematic.

- **Preventing poor outcomes when services do not engage with homeless people**

Negative attitudes revealed hanging threads in the net. My role in *creating an environment to be available* was to challenge rigid rules in health and multi-agency services and develop an assertive voice where I could negotiate resistance by mainstream health professionals that was making the net precarious. As Rankin and DeLashmutt (2006:285) illuminate in their study on presence as a healing concept with 180 student nurses, "Without a relationship, there can be neither the manifestation of spirituality nor presence." In my narrative, I witnessed how the consequences of not engaging were vast, leading to re-offending (Text:6) potential rough-sleeping (Text:5,8) and mental health crisis (Texts:5). Similarly, when GPs refused registration (Text:3) the potential consequences were considerable - a denial of their gateway role for homeless people to access secondary care services despite complex and urgent need. When other services (E.g. Social Worker/Housing) did not engage or limited their engagement, the combined effects from all services were profound (Text:3). There was a moral basis for action given the potential consequences; I had to extend net weaving so that I could challenge and support health professionals to work effectively towards inclusion.

Gaining evidence for a multi-disciplinary team in homeless health care

In reflective guidance, the frequent rhetorical question posed to me was "What would have happened had you not been there?" What would have happened? In my specialist role I used my voice as a witness, leader, co-ordinator, persuader and negotiator around homeless health need. I hoped to secure additional services beyond mainstream,¹⁵¹ but this proposal was resisted by senior PCT managers who believed increasing specialist services encouraged marginalisation rather than inclusion. Yet, as I got to *know services*, my insight was: improving access to health services depended on individual responses made by mainstream professionals - some health managers were open to development; others were elusive.¹⁵² I was becoming more aware that services not homeless people were hard-to-reach. In future practice I would gain further evidence to support whether or not a Multi Disciplinary Team should be a recommendation in my HNA report (Appendix 1).

Homeless services

To *create and sustain an environment to be available* required collaborative working. To do this effectively required me to *know services* and manage contradiction in practice as discussed below.

¹⁵¹ E.g. fast-track PCT counselling (Text:8), a CPN (Text:5) for one half day per month, admission and discharge hospital protocol (Text:6).

¹⁵² E.g. Those involved in developing the Mental Health Homeless Discharge Policy

Appreciating the key role of homeless services

I increasingly valued the skills of voluntary services as integral to homeless health pathways. I was moved by the passion and solidarity I witnessed by staff in day centres, night shelters and hostels.

bell hooks (2000:49) states,

Solidarity with the poor is the only path that can lead our nation back to a vision of community.... It invites us to embrace an ethics of compassion and sharing that will renew a spirit of loving kindness and communion that can sustain and renew us to love in harmony with the whole world.

In homeless forums and in their places of work I felt a community working together for homeless people as multi-agency partners. As part of my solidarity with the poor supporting services around health issues that helped them sustain their work, was key to my effectiveness.

As I listened to homeless service staff, I heard outrage about mental health services (Texts:1,5,6); I witnessed their emotional labour equivalent to that of nurses (Text:1,5,8); I constantly saw their submergence in health issues, requesting my support. I sought to advocate for them (Texts: all clinical) and enable them, e.g. designing and producing 'Health and Homelessness' leaflets (Appendix 3). To extend the health *net* to support them, I linked health professionals into homelessness forums (Text:6) and strongly voiced health issues in multi-agency forums (Text 2,6). I carefully chose words that strengthened *the net* in a collective effort; for example, working towards adequate cold-weather provision to reduce the risk of death from hypothermia for rough sleepers (Text:2). Equipped by my background, particularly in Health Visiting where I was used to collaborative working with multi-agency services, I was able to support homeless services with homeless health needs as summarised in AH1.4:

SPHN Role With Homeless Services

Health training
Health dialogue
Health guidance
Health advocacy
Health enablement
Health assessments
Health consultations
Health fairs
Health and Homelessness leaflet
Health literature
Health focus groups with their clients

AH1.4

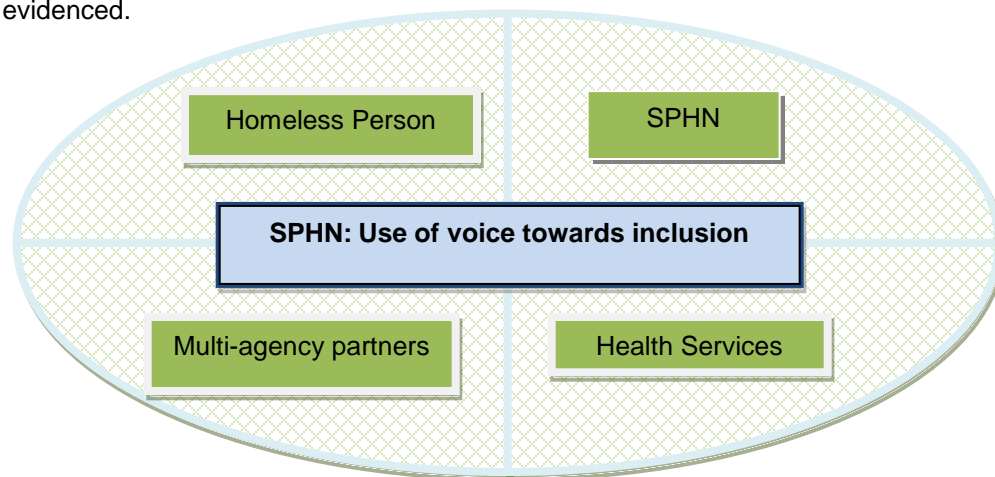
Managing contradictions in practice

I had a growing concern about evictions from homeless accommodation which were emerging as a health issue (Texts:3,5,7,8). Residents told me they felt they were walking on 'egg-shells' in fear of breaking hostel rules (Text:7,8). Evictions moved health need to survival need where *being available* (Johns, 2009) would be less easy for me and other health services to achieve. These

people were *falling through the net*, evictions triggered by health need would remain invisible to health services without my specialist role. Texts:2,7 show how benefit disruption contributed to evictions. In year 2, preventing evictions would develop as part of my net weaving with multi-agency services.

Appreciating Precarious Engagement - Being Mindful about the Net's Fragility

As I reviewed the core developmental BAT themes for net weaving, the concept of *precarious engagement* arose in which *use of voice* was fundamental for practice development. Holes in the net - limits and constraints in practice that prevented engagement - had emerged in each quadrant (AH1.5) as evidenced.



Appreciating Precarious Engagement in the Net of Homelessness Health Care

AH1.5

Appreciating 'precarious engagement' became significant as insights about engagement and non-engagement arose within *the net* and my role to create a suitable environment for addressing the health needs. Jarrett (2009) conceptualised her deepening nursing insights of living with spasticity as 'precarious harmony'. She, too, used Johns's narrative construction methodology (2002). She illuminates,

I use 'precarious harmony' to describe a matrix of highly refined strategies, unique to each person with a complex disability and their family which allows them to effectively function as a family unit...such a framework is fragile, not secured and often jeopardised by the smallest of variation (p.170)

Johns and I dialogued about using the same concept to form new knowledge for my study but I felt that the partnership aspects and joint clinical and strategic elements required a broader theoretical concept. 'Engagement' was *the* key issue in homelessness - the term 'precarious engagement' was co-constructed. *Precarious* defined in Jarrett's study as "...not securely held, dependent on chance or uncertainty" (p.170) was most significant in relation to my plot of 'falling through the net'. Its

juxtaposition with *engagement*, defined in the Concise Oxford Dictionary, (1951:394) as "...hold fast, pledge, bind oneself", illuminated the concept of precarious engagement as 'holding when not securely held', a notion which embraced *being available* to those historically regarded as chaotic or having chaotic pathways leading to homelessness (Quilgars et al, 2008). It would ably draw insights on my role development and draw other health professionals into a new paradigm beyond that of homeless people being 'hard to reach'. BAT would illuminate net tensions, developing a homeless-health matrix to frame new knowledge around 'precarious engagement'.

I weaved precarious engagement into my evolving vision as summarised below.

Precarious engagement is a concept that illuminates my role in helping homeless people access and sustain health engagement by creating an environment of *being available*. Effective health care emerges through strong multi-agency partnerships that combine to hold a homeless person securely in a net of services, particularly health services. The health net is multi-layered, frequently fragile, filled with holes and often invisible. It is "not secured, and jeopardised by the smallest variation" (Jarrett, 2009:90). Appreciating precarious engagement strengthens the net as I, and others, grasp the unique contribution we have in net-weaving: fixing, shaping and expanding the whole net in health care for homeless people, whilst working in partnership with others. Appreciating *precious engagement* requires me to be mindful of how I *use my voice* in practice, fundamental for securing the net.

Use of Voice

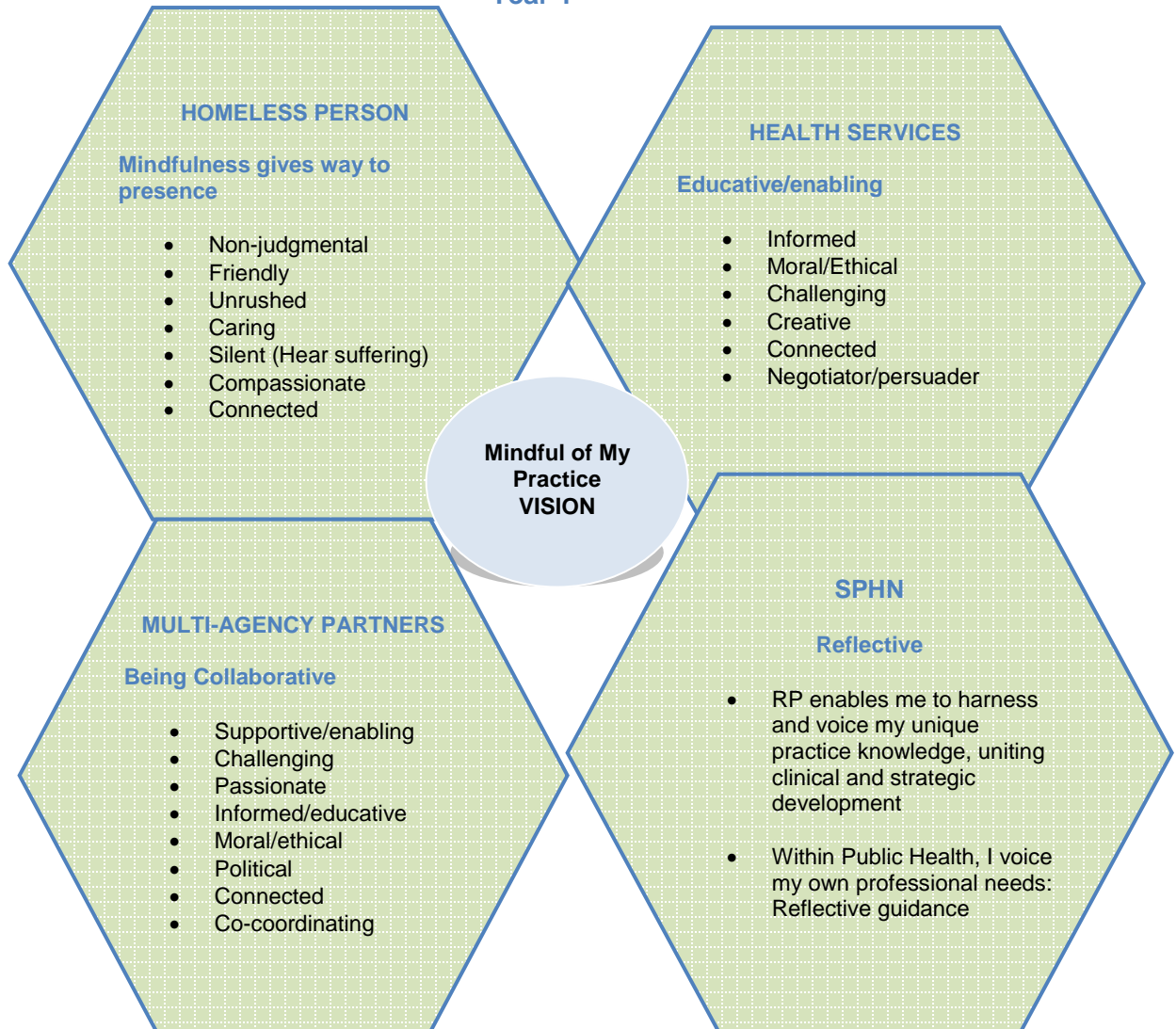
Key to my learning development *to create an environment where being available is possible* was *use of voice* - particularly in the light of *precarious engagement*. Realising homelessness health care as a lived reality required my voice to be: political, informed, passionate, moral and assertive. In Year 1, the net was weaved more securely where my voice was strongest - with homeless people and partnership agencies and least developed with health services.

Increasingly mindful of Belenky et al's (1986) framework in practice, I developed my own matrix of voice in the four quadrants of precarious engagement (AH1.6). It evolves in sequential analytical horizons.

Appreciating Precarious Engagement

Use of Voice to Weave the Net

Year 1



AH1.6

Year 2 - 2007

To weave the net more securely, my practice reflections shift in emphasis towards a deeper awareness of mainstream health service engagement with homeless people and how that connects with homeless services. In latter texts, I focus on childhood triggers which lead to adult homelessness to illuminate preventative strategies for health visiting/school nursing practice.

Text 9 - DANCING WITH DEAN

Hostel Visit
2nd March, 2007

Energised by a multi-agency visit from our town to the UK's flag-ship Dawn Centre in Leicester yesterday, I feel affirmed that a greater CPN presence in homelessness as well as better GP access are the two things I must prioritise as recommendations in the HNA report. Seeing health services functioning as a multi-disciplinary homelessness team (MDT) highlighted my clinical isolation - picking up health problems that *fall through the net*, as well as the strategy required for service development.¹⁵³

Today, my feelings plummet from vision to reality framing (Johns, 2009). There is an urgent message about Dean on my answer-phone. On the streets from the age of 14, he previously refused contact with health services, triggered by his dislike of child psychiatric services. Having opened the therapeutic space with him, he remarked, 'I can't believe I'm here talking to you like this'. His health issues related to substance misuse, aggression, nutrition, BMI and strong body odour. Today, Christine his key worker sounds anxious,

"He's hearing voices. He told me he had schizophrenia when he was 12..... Two days ago he talked about his plan to murder John, followed by his own suicide. He'll talk to you. I don't think we should use a sledgehammer to crack a nut! "

Adrenaline pirouettes through me - *murder and suicide - two days ago!* I distinguish my healthy fear from unhealthy fear (Rutledge, 2005), I acknowledge the professional training required for mental health assessments of people experiencing auditory hallucinations, and I am aware of the resource tension within my clinical and strategic role. Ethical mapping (Johns, 2009) inwardly charted, I feel that hostel staff must enable Dean to access crisis intervention, empowering themselves to use mainstream services. I can't do it all. I must prevent 'burn-out' in this multi-faceted role.

I overhear Christine,

"No, Dean, she won't section you. It's just that she has more knowledge than us."

Fear of section - familiar scenarios in homelessness with people who have experienced mental health services (Texts:1,5). Fear making engagement precarious. A CPN as a regular feature at hostels would address this.

¹⁵³ E.g. Public Health HNA report, the homeless section in the annual Public Health report (2007), Admission and Discharge of Homeless people policy, homelessness strategic meetings, family homelessness notifications, homeless professional pack, health and homeless leaflets

“Christine, I'm not an emergency service. Your responsibility is to phone mental health services or the police. I'll visit when crisis issues are dealt with.”

Whilst I seek to enable Christine in health service access, she illuminates her worry: high level mental health needs means eviction for Dean; this hostel is low to medium support without 24-hour cover. There is no automatic transfer into a higher support hostel,

“There isn't a bed available – we won't keep him here because he could be a danger to other residents.”

This is more than a health crisis - it is a homelessness crisis. Increased mental health needs triggering rough sleeping!¹⁵⁴ In this awareness, I contact the mental health team manager to engage them with me in a joint visit. Her procedural voice is evident; he must go to A&E or contact the mental health crisis team if he gets worse! I reflect, is this the best response? What other choices are there? The ethical nature of homelessness practice is apparent. Aware of my developing 'moral' voice to connect her to homelessness, I draw on the Leicester model where a CPN is part of the homelessness team, and assert,

“But he refuses to go to A&E - he is frightened. Fear is an issue that causes people to fall through the net. A familiar CPN clinic in the day centre would help people engage with services.”

I seek to inspire her, to open-up local rigid health systems in homelessness, reaching across silo rules through joint multiagency working. It requires a strong voice as I chip away to uncover practice, push parameters, and become political. I negotiate the tensions, recognising that if services do not engage my ultimate power lies in HNA recommendations, and in lecturing and writing academic research to transform health cultures in homelessness.

She pauses. Instead of a joint visit, she offers phone support to hostel staff. I am still relieved. At intervals, I map how the crisis is progressing. Staff say, *“We are walking on egg shells, waiting for the police to arrive. We are trying to get him to register with a GP.”*

In his pride of 'needing no-one', Dean had resisted GP registration.

As the working day ends, I phone the hostel again. The hostel worker says, *“You have been wonderful, Maria”*. I am surprised. I negotiated guilt about fearing the unknown in an area of practice I am inexperienced in which resulted in my own rigid rules on the SPHN role in crisis

¹⁵⁴ Later, the Government's intention to end rough sleeping by 2012 (CLG, 2008) and concern about evictions (CLG, 2008) were published.

intervention. My effectiveness, however, came from tentatively engaging mental health services, and more importantly, making hostel staff feel they were not battling alone.

Post amble

I meet Dean the following week. I write in my journal,

Mid-afternoon in a hushed hostel reception
Both changed
Recognising limits
At crisis points
That affects my caring dance
Does he feel let down?
A wallflower left at the side?
I feel culpable.

He declares, 'Prison isn't bad'
Familiar echoes in homelessness -
As he contemplates the crime
He didn't commit
I remind him of his dreams
A family of his own

Negotiating the distance between us
I invite him to my sofa
We choose a GP
From the Health and Homelessness leaflet
Resistance fades
Through paternalistic advocacy
Not because he is a child
But because he is proud and scared!

Yet, is it more?

She resists engagement
"I'll speak to the practice manager"
My homelessness title
Gives away homelessness
Such incomprehensible difficulty
Securing appointments
With mainstream GPs!

When services are finally engaged
He smiles in grateful relief!

Later, I reflect on health service response: How can I transform cultures towards inclusion? Through Fay (1987), I recognise that homelessness does not transcend health's cultural ability to respond differently. Drawing on Freire, he states,

These people are submerged in a situation in which they do not possess the capacities for critical awareness and response...they do not perceive that they have the potential power to intervene in the social world and transform it (Fay, 1987:106).

Through reflection and advocacy, I seek to shift and open cultures through an effective voice that secures engagement. Linda, the half day per month CPN, (Text:5) is a fragile link in the net and on her next assigned day, she agrees to:

- Develop a mental health service flow chart for hostels
- Offer support when people do not engage with mental health services.

DEVELOPMENTAL FRAMING 7

REALITY PERSPECTIVE

VISION To be available

Who is this person?

- 19 year-old, living on streets aged 14
- Health issues: nutrition/underweight, body odour, aggression, substance misuse.
- On the brink of offending

Precarious Engagement:

Fear of mental health services (psychiatrists)
Persistent refusal to register with GP

Empower Services

- I negotiate the tension between advocacy and enablement in supporting hostel staff

Precarious Engagement:

Eviction onto the streets will happen without health service support.

Engage Health

- Better mental health access required

Precarious Engagement:

Unable to secure CMHT services because he does not have a GP - can attend A&E services.

Policy and Development

ACTION

- HNA report: recommend MDT/ CPN affirmed
- Mental Health: Flow chart with contact intervention points developed by CPN; CPN will provide a limited service to homeless people without GP
- Anger resolution classes for all homeless service staff through the homelessness forum (via Housing manager)

ROLE

The therapeutic net

- Dean therapeutically engaged with me having previously refused all health professional intervention.
- I provide post-crisis intervention/ and secure GP registration
- Effective health engagement prevents offending.

Precarious Engagement: My role should not be a replacement to mainstream crisis interventions

The partnership net

- I act as existential advocate and enabler supporting staff to prevent eviction

The health service net

- I negotiate CMHT resistance/'rules'
- Secured services: CMHT, GP - Homeless Health Leaflet, Specialist CPN

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

Hole in the Net: No route into higher support needs accommodation

Dean's fear of mental health services links to Texts:1, 5

Fig 3.10
Falling through the Net

Text 10: A&E - ZERO TOLERANCE!

Sunday 17 March 2007

The local news story is harsh; a rough sleeper is removed from A&E without treatment. Shock ripples through me. A friend of the man says, "*Staff misinterpreted his distress as aggression.*"¹⁵⁵ The hospital response is slick, 'zero tolerance rules OK'!

I am reminded of sterile tones of polished resistance, bordering on hostility, which I experienced in an A&E Sisters meeting during a presentation on my role, despite working effectively with their manager (Text:6). I am reminded, in guidance how transactional organisations want a smooth running organisation (Johns, 2004). Sisters had labelled all inebriated patients attending A&E as 'homeless'; a collective inability to view homelessness through an untarnished lens. It concerned me. Labelling is fodder for the 'dark side of nursing' (Jameton, 1992, cited in Johns, 2004) to root - the dark side of the hill is a colder side where the practitioner "wraps herself up in herself to keep warm. Her focus is inwards, not outwards warming others" (Johns, 2004:152). Yet hospital admission provides an opportunity to improve the health of homeless people (DH/CLG, 2006; Crisis, 2004)

3 days later

Clinic: Dora

As I walk into the centre, Rex who has dysphasia, strips off his sock to show me a large sore on the sole of his foot - a spontaneous gesture recognising me as "the nurse". Others taunt him. I quieten them, mindful from reflective guidance that I sometimes slip into 'maternal thinking' which Ruddick (1980) sees as a way of protecting the vulnerable child. Dora is shyly watching. I haven't met her before. Large carrier-bags capture the image of street homelessness and synchronise with the bags under her eyes. She hobbles towards me.

" Will you look at my ankle?"

"Of course"

My smile is not reciprocated. I sense her fear, and her pain. I must be gentle.

Startled at shades of navy, yellow and red bruises on an oedematous ankle and foot, I can hardly believe she has been living on the streets like this, barely able to walk since slipping on mud, four weeks ago. Dora attended A&E but left without treatment.

¹⁵⁵ The Oxford Dictionary defines aggression as "Unprovoked attack" whilst distress is defined as "mental pain, severe pressure of want or danger or fatigue"

"Why did you leave Dora?"

"I don't like hospitals. I panic... had some good friends die there.... ."

Her previous hospital experiences of death concern her more than the pain and immobility which affects her very survival on the streets.

"Have you rested your ankle Dora?"

"No, I can't on the streets... sometimes I go to the nightshelter."

Dora at 35 looks 55. Like many homeless people I meet, she has aged prematurely. Rather than a learning disability or mental health illness, her childlike fear emerges as a social disability.¹⁵⁶

"I should have gone back but I don't want to go there."

I leave the space open for us to dwell.

In the space, Dora mentions the death of a child, and two normal pregnancies. Is it this death that causes her dislike of hospitals?

"I don't know where my children are now; they were taken into care."

Perhaps this could be Mary (Text:3/4) in ten years time - a bag-lady like Dora! Beyond her image, Dora has been a child, been loved, been sexual, parented, grieved and *has* children. She has been in health and social care systems: midwifery, health visiting, and social services. What help did she have when her children were removed, and died? Maybe distrust of these systems underlies her fear of hospital engagement. I consider asking her about the child who died but she is in pain so I hold the information for another time.

Faced with Dora's experience of living on the streets in chronic pain and fear of hospital I negotiate a tension between enablement and advocacy. Guided by empathic connection, I seek to smooth her pathway into A&E and offer to phone them. Dora is grateful.

Increasingly aware of how many health professionals react to homelessness, I am under-surprised when I introduce myself and the staff-nurse fails to acknowledge me. It reminds me of another A&E

¹⁵⁶ 'Social disability' is a term I use to describe my understanding of the net's fabric. Social disability enabled me to recognise, in my transformation, the extra needs homeless people have in accessing mainstream health services in systems which are largely inflexible.

nurse, resisting homelessness crisis intervention who asked "Are you a **real** nurse or employed by the daycentre?" Homelessness health need seems beyond their awareness.¹⁵⁷ Significantly, today, it makes me feel isolated and marginalised. How does it make Dora and other people feel when society disempowers them?

The staff nurse's continuing words are hostile - not efficient,

"There is no way she will be seen any quicker than normal. We triage children and psychiatric patients - but she will have to be seen in the order she arrives."

I want to dismantle the tall wall of oppression, to make her aware of Dora's humanity.

"I agree they are important groups to triage as priority. But Dora is living on the streets where it is dangerous; she is barely able to walk. I'm not saying she should be seen before anyone else - I am conveying her emotional and physical needs to help you and to prevent her leaving A&E again - otherwise she will go untreated."

Have I enticed her into compassionate engagement?

"She should go to her GP - she needs an X-ray."

Unlike some rough sleepers Dora has a GP. I respond,

"Her GP and the walk-in centre are on the other side of town. She'd have to walk there and then back to the hospital for X-rays. She hasn't any money for a taxi."

Her dissuading tactics develop,

"Was it an accident? Is it actually trauma?"

Mindful of *use of voice* to secure my practice vision, I change tactics in this power game. Having already explained Dora's injury, I lead assertively, mindful of Sunday's newspaper report,

"Dora needs her injury assessed and treated. This phone call is to make that process easier for A&E staff and Dora. I'm sure A&E wants good outcomes for homeless people as well as housed people."

¹⁵⁷ Nurses working with homeless people have expressed how they believe they are stigmatised by other nurses as if they are homeless themselves (Personal conversations with nurses at HHI study days London NVC Headquarters, 2009 and 2011). HHI (2007) note in their publication the isolation that nurses working in homelessness may feel.

"We do".

I ask her name, provoking her to accept some health care responsibility and inform her that I am working collaboratively with A&E matron.¹⁵⁸ The nurse becomes meeker - the invisible wall dismantling. Am I naive to believe that caring responses should arise intuitively from a compassionate nature within nursing itself? My spirit pines for the heart of nursing to embrace homeless people in flexible systems of care, but how can nurses engage in homelessness and understand their role within it when their tall walls seek to keep it invisible? What kind of distant leader am I to nurses? I want to lead by a transformational style, rather than resorting to authoritative transactional styles like this (Cope, 2001).¹⁵⁹

Dora smiles as I advocate for her! Her bright eyes hold my gaze at last, as if a huge weight has been removed from her troubled mind - and ankle. I feel renewed! Securing engagement with this nurse had de-energised me. Dora's confidence to re-engage has revived me - she is going to A&E.

As I reflect on the net, I ponder on the oppression I have just negotiated. Freire, (1970/1993) notes

To surmount the situation of oppression, people must first critically analyse its causes, so that through transforming action they can create a new situation, one that makes possible the pursuit of a fuller humanity (p.29).

My actions have begun to shift prevailing cultures that impede equity of care. Homeless people overuse A&E because of difficulty in accessing GPs (Crisis, 2003). They have been perceived as inappropriate A&E attendees (Griffiths, 2002; ODPM, 2002) whose medical problems were negatively categorised by some hospital staff as self-inflicted (Pleace et al, 1999). Poor perceptions by staff taint the caring lens, as my text demonstrates. Yet, A&E nurses are subject to high levels of abuse. Jansen et al (2005) cites two studies of nurses dealing with aggression. In one American study 82% of Emergency Ward nurses had experienced physical assault in their career and in another study 11% experienced more than 15 assaults during their career.

An understanding of Rutledge's (2005) fear theory may help nurses see homeless people as individuals. Wright (2002), in his Leeds GP practice with homeless people reports that in five years there was not one single act of physical aggression from the homeless population he served, despite seeing over 5,000 patients in 55,000 consultations. He suggests that these figures are evidence that behaviour triggers violence and that if the triggers are avoided it is highly unlikely that a violent act will occur. He suggests that the core ethos is encouraging consultations where the

¹⁵⁸ The A&E Matron and I continue to work to create better communications around homelessness: List of my clinic times sent to A&E, successful liaison in other phone calls, set up a link sister in homelessness – possibility of A&E nurses coming to my day centre clinic, protocol on admissions/discharges, presentation at the Sisters meeting. Still needed: protocols, training, Homelessness pack

¹⁵⁹ See Cope (2001) Who is Steering Your Boat? Lead Yourself. Leadership is explored further in AH 3 (p.276)

homeless patient is seen as an equal to the doctor and not subordinates. This ethos lies at the heart of the Being Available Template (Johns, 2009) and I too, have never yet experienced an act of aggression towards me in homelessness practice.

In reflective guidance we dialogue about the complexity of my role as a net-weaver. I am placed like a hand coming down on health services (Fig 3.10),



Fig 3.10.1

'The hand' weaves laboriously but my title holds limited power in local homeless health clinical leadership. We name storm a more powerful title such as Community Matron¹⁶⁰ or Consultant Nurse¹⁶¹. Cope (2001:19) notes, "grand titles ...are used as a substitute for the personal strength that comes from knowing who you are." However, my 'grand title' would set out the expertise required for working across health silos and with partner agencies at clinical and strategic level. Most of all, as a leverage of power, it would provide instant clinical impact when most required.

¹⁶⁰ Warrington PCT

¹⁶¹ Leicester model

DEVELOPMENTAL FRAMING 8 REALITY PERSPECTIVE

VISION Being Available

Who is this homeless person?

- Prematurely aged rough-sleeper 'Bag-lady'
- A&E wait too long
- Mother - children in care; 1 death
- Health need: Pain- ankle sprain/fracture?

Precarious Engagement:

Fear and distrust of health services/hospital-advocacy required

Engage Health Services

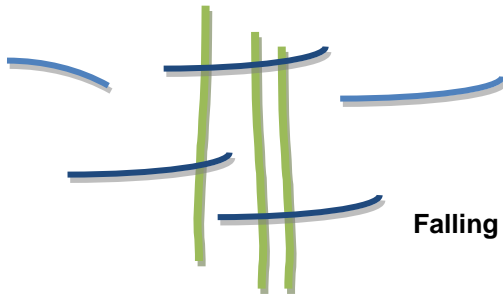
- I raising Dora's humanity and the effects of street living to secure engagement
- The nurse responds to traditional authoritarian leadership

Precarious Engagement: Prejudice: A&E sisters are frustrated by 'homeless people whom they categorized as "alcoholics" taking up their time. 'Flagging-up' homeless patients in A&E has not progressed Text 6 (Time/resource limit)

Service Development

ACTIONS:

- Health and Homelessness leaflets already in A&E to connect services
- HNA Recommendation: Homeless packs. A&E pathways (e.g. 'Flag-up' homeless patients in A&E/data collection)
- Training : A&E staff



C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

ROLE

The therapeutic net

- Being Available: What would she have done had I not been there?
- Tension between advocacy and enablement is evident in my role with homeless people (Box 1)

The health service net

- I draw A&E into engagement
- I experience walls of resistance

Precarious Engagement: My title does not hold power leverage with health services. What kind of leader am I? There is tension in this leadership model; I feel marginalized.

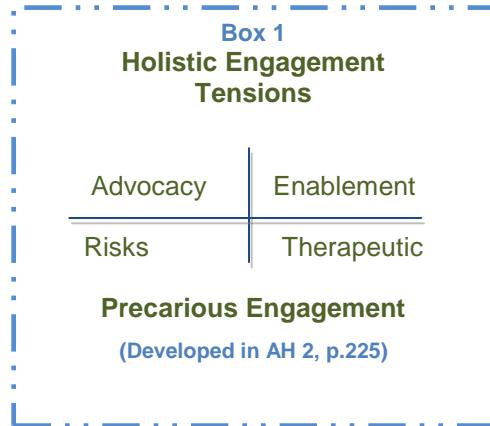


Fig 3.11
Falling through the Net

Text 11: INVISIBLE HEALTH

Regional Government Offices
Homeless Planning Day

15TH March 2007

I muse at how far removed this magnificent building is from the day centre clinic. It is the fourth meeting I have attended - my role stretching to board rooms, tying regional strands in the homeless health net. In preceding meetings, a colleague from a neighbouring PCT (soon to merge with ours¹⁶²) and myself were the only health representatives. Apart from us, the health link is invisible. The room is packed with a large Local Authority Housing contingent, regional government officers, representative from Shelter and another homeless charity.

The morning presentation highlights the current government thinking on homelessness around:

- o Reduction of Temporary Accommodation by 50% by 2010¹⁶³
- o Challenging the effectiveness of hostels (CLG, 2006)

The homelessness data is alarming. Our area has the highest regional homelessness statistics yet some PCTs have homeless multi-disciplinary teams in place - myself and my colleague are doing Public Health strategy and clinical! Today we judge that we can most powerfully be heard by presenting a joint voice on health issues. We plan to raise two issues for this political body to consider:

- o More health representation on this group
- o Homeless prevention in schools which is not remaining in the regional action plan for 2007/8. Focus group respondents voiced this as a key area of development and I am working with a local drama company to take homeless 'stories' into schools.^{164/165}

When discussions start, I set the health scene early,

¹⁶² Commissioning/Provider NHS reorganisation

¹⁶³ Temporary Accommodation (TA) is used largely for households/families whose homelessness status is being investigated prior to a decision on whether the LA has a duty to house them. Some families stay in TA for up to a year or even longer (Data taken from my health visiting practice).

¹⁶⁴ I financed three drama consultations with homeless people from the focus groups to look at training for schools and the production of a DVD to go out to all schools in our area about experiences of homelessness (Woodenhill Drama Company).

¹⁶⁵ See St Basil's (2006) STaMP project - Schools Training and Mentoring Brochure. Gold winners in tackling homelessness 2006 St Basil's (St Basil's, 2006) also completed research on the value of school prevention work

“We’ve heard much about housing and homelessness this morning but not so much about health and homelessness and the complexities that link them. Working together regionally in health and homelessness is as important as it is locally. Have other PCTs been invited to attend?”

The health link is acknowledged but supported by others, the chair, resists,

“Health is represented in other regional forums. It doesn’t need to be in this homelessness group.”

My knowledge gap around other regional forums is a broken link which frustrates me. Poor health is not recognised here to be a pathway into homelessness (Texts:1,2,5) of regional concern. Nor do they appear to recognise childhood trajectories, entwining health needs that lead to homelessness (Texts:3/4,7,8,9,10). I persist using my voice constructively, stressing the need to have more discussion on health and homelessness in *this* group. A housing manager interrupts,

“Health should remain at sub-regional level.”

“But this is a regional action plan for homelessness. Health needs should be included - linking across the region to be politically effective.”

My colleague, Phil, supports me,

“In each PCT there must be people like me and Maria who are points of contact for housing departments and hostels. Those people should be here too.”

Two voices refuse to be silenced (Belenky et al, 1986) - and reluctantly they add *“more health representation”*.

What a battle!! Overcoming the resistance emerging at regional level, Phil and I smile at each other,

“What is it? What is their perspective? What are we missing here?”

“I don’t know”, she replies, “it’s interesting, isn’t it.”

I muse on the struggle to be heard as we voice homelessness health issues. We nurses have the power of *presence* in homelessness: to voice stories, health needs, multi-agency working, preventing repeat cycles of homelessness so why do regional government officers position health as sub-regional players? A revolutionary thought goes through my mind - the Homelessness Regional Action Plan should be *Health* rather than *Housing* led! But, the reality perspective is that I am stretched from street to board rooms and to be truly effective, I have to ensure I do not burn-out.

Later that evening, I reflect on the national voice of homeless nurses: where are the other homelessness nurses? Why are we such a quiet bunch? What can we do to make homeless health more visible?

**One year later
April 2008
The Homeless Health Initiative¹⁶⁶**

I respond to a questionnaire sent out by the HHI for its first birthday. My response is later used on the background powerpoint displays at the first national HHI Homeless Health conference (2009),

"I feel as if I have been part of the narrative of liberation of UK homeless health professionals over the past year - a huge sway, almost gathering arms, to network and connect, so that our communities are also liberated and empowered in individual health journeys. Well done!"

Shortly afterwards, an email arrives inviting me to lead a HHI discussion group in Birmingham July 2008.¹⁶⁷ As health begins to co-ordinate its approach to homelessness through nursing, my frustrations with last year's regional housing forum disappears. Specialist nurses nationally are uniting as a strong voice to tackle homelessness.

¹⁶⁶ Homeless Health Initiative (HHI) started in June 2007, under the umbrella of the Queens Nursing Institute with the appointment of the HHI Co-coordinator. An Administrator was appointed in October 2007. It is a three year lottery funded project to support homeless health specialists across the UK.

¹⁶⁷ **HHI facilitators sheet**

a) Sharing of good practice examples around homeless health care - Each person to provide examples of good practice that they have heard of or used themselves around homeless health care e.g.

- What are you proud of in your current service?
- What do you think you/your team does well?
- What could others learn from you?
- How do you manage the challenges you face in your work?
- Have you heard of any other examples of good practice in homeless health care?

b) How HHI could best support our members in developing and improving practice

- i) Would members prefer this support through specially developed guidelines (in which case please could they suggest any important items for inclusion?)
- ii) Offering professional development through groups like this, formal speakers or workshops?
- iii) Are there other means of developing and improving good practice which would work well?

c) Content of Small Group discussion

a) sharing of your practice currently around health promotion Each person to introduce themselves and mention how they work with health promotion issues currently. People may need to be reassured that it is fine if they do not have many opportunities to do this. If people are stuck, you could prompt them by asking the following questions:

- How do you encourage people to take better care of themselves?
- Do you do any harm reduction work?
- What are the opportunities for you around health promotion with homeless people?
 - What are the challenges for you around health promotion with homeless people?
 - Could homeless people themselves contribute towards health promotion?
 - What about the new 'health trainers'?

b) In the context of this discussion, please consider how HHI could best help members with health promotion. Possible examples include: Resource pack with examples of presentations, training session

Text 12: FAMILY HOMELESSNESS NETWORKING

Health Visitors Meeting Disseminating Focus Group Findings

16 May 2007

My insights about the precarious nature of engagement with health services was confirmed in the following focus group quote,

The GP wouldn't register me because I was living in TA.¹⁶⁸ I said I had a baby. The practice manager phoned the next daysaid it was OK. When the Health Visitor came, she was in a hurry. I didn't know where the clinic was ...I went back to have Jack weighed by my 'old' Health Visitor (17 miles away)... We were evicted from our last home because of rent arrears - our finances are dire. We've been fighting and drinking more since coming here.... The wardens told us not to speak with the neighbours because problems kick off.... I feel so alone and depressed.

(Mother of a three-month old infant - focus group respondent, 2006)¹⁶⁹

My intention when I address the Health Visitors (HVs) professional meeting today, is to strive towards improving health experience for homeless families, providing them with equity of care. The mother who voiced the above views was one of two mothers. The other had entered TA via the domestic violence route and felt supported by services. Louise, on the other hand, did not. Her response raised concerns about access to local health services *and* assessment techniques of vulnerable families.

My recent visit to regional offices, alerted me to our area having the highest statutory homelessness statistics in the region (CLG, 2007) - mainly families.¹⁷⁰ Prior to a meeting with their senior operational manager (Children's Services) tomorrow to review service development for homeless families, I seek to clarify Health Visitors' perceptions about their service access for homeless families. I have already met some health visitors, identifying jacquard specialist support in refuges and the Life Hostel, as well as TA.

As I enter the meeting, a major service review of the 0-19 team is being discussed; the atmosphere is tense! This is a defensive group responding to another NHS change.

¹⁶⁸ TA Temporary Accommodation

¹⁶⁹ Focus groups held for the Health Needs Assessment Report (Appendix 1)

¹⁷⁰ Our local authority area hosts numerous temporary accommodation sites which Health Visiting teams are responsible for in their geographical area. Core services are offered. Families with school aged children are not offered specialist intervention. Not all TA is in Sure Start catchment areas (now Children's Centres).

In this atmosphere, I seek to open a space to promote pathways of inclusion for homeless families. I want to use the opening quote in this Text, to illuminate health need and health assessments but recognise that it is controversial. I also intend to guide the Health Visitors towards national guidance which suggests the implementation of a Notification System between housing and health services for homeless families (CPHVA, 2004).

I begin my dialogue with them using family homelessness research.¹⁷¹ Rather than tell them, I want them to identify gaps in their services. I ask,

“How are you currently informed of families moving into TA?”

As I watch them engage, I anticipate their response: GP notification, child health department, other agency referrals, self referrals.

Mindful of a housing officer's recent comments,¹⁷² I use the experience of a 7 year-old, absent from school for seven weeks after arriving in TA, who wasn't picked up by services. I ask,

“Do you feel you are currently reaching most families moving into TA?”

Yes, they believe they reach all families with children under 5 but there is no provision for over 5s. I clarify pathways into their services and potential gaps become evident:

- When a family remain registered with their existing GP and the practice is informed of their change of address into TA, the HV will do a health assessment. I take the opportunity to prioritise this assessment knowing in this scenario it does not always occur despite being recommended as good practice (CPHVA, 2004).
- If a family, placed in TA, does not notify their GP or other agency of a change of address, the Health Visitor will not be aware that the family is there. Silence - the gap is revealed!
- If a family move in from another area and the HV in the previous area is unaware, the family may become disconnected from services – particularly when they do not register with a GP. They agree. Like Louise, in the opening quote, they may experience difficulty registering with a GP.
- School aged children won't be offered a health assessment by HVs or school nurses. They agree.

¹⁷¹ See: Vostanis(1999); Tishcler et al, (2002); CPHVA/DH (2004); Vickers (1991); Walters (1997).

¹⁷² At the Health and Homelessness Fair: As part of health development with hostels, I work with the Foyer to facilitate an annual Health and Homelessness Fair. Information about service development is built informally at these events and gives services an opportunity to get to know each other and share their knowledge on homelessness health needs

They chatter between themselves - a notification system (CPHVA, 2004) would be beneficial,

"Often we visit and they've moved on – it's a waste of our time.... There's always problems with late 'imms'¹⁷³, when we don't know they are there"

The netting is being placed for a notification system; I feel I can address the focus group comments - positive and negative. When I read Louise's angry comment they are shocked. This is a confident, proud group of professionals who do their best for families in our area. They don't dispute the quote but sit in considered silence. I suggest it is evidence towards recommending a Specialist Health Visitor for homeless families in a multi-disciplinary team (MDT).¹⁷⁴ They agree; some express interest in it. Networking continues:

- An invitation to the clinical group reviewing initial assessment forms¹⁷⁵
- Phyllis seeks a shadow day at my clinic
- A family homelessness group is suggested

Having 'opened the space' towards new ways of working I have sensitively confronted them about poor practice, mindful of previous research which stated,

Some professionals lacked any understanding or awareness of the nature of homelessness or its impact on people's lives: *You feel like you'd like to take some professionals to the places where the homeless people are and show them their situation* [Health Visitor] (Hall et al, 2000:25)

Next Day

Meeting with Senior Manager

Homeless children, young people and their families are very vulnerable, and likely to experience complex needs – which creates major issues in assessing their needs and in safeguarding children (and vulnerable adults) from harm. Homelessness creates new risks for families whilst frequently exacerbating the issues they already have.
(QNI, 2009)

She sits in a small office, fluttering her eye lashes. I wonder if the fluttering is friendliness or malice. She begins to talk personally about my manager - I feel uncomfortable. I take the lead, talking through my family homelessness report, illuminating how the recommended notification system would help Health Visitors identify and assess family homelessness. She protests,

"The Health Visitors are very pressured and can't take anymore work on. Your recommendation for a part-time health visitor in your homeless team is the way forward. We don't need a notification system."

¹⁷³ Immunisations

¹⁷⁴ In the Health Needs Assessment Report

¹⁷⁵ The initial assessment form does not incorporate financial and substance misuse issues. I later also meet with the BDAT commissioners to identify targeting family homelessness with substance misuse

We don't need a notification system! How has she made that assessment? I am mindful of Freire (1970) who states 'dialogue cannot exist without humility' (p.71). She is blocking my net weaving. My recommendation for a Health Visitor in a multi-disciplinary team will require a business case. A notification system could begin almost immediately. She remains unperturbed that this PCT could be missing vulnerable families.

I negotiate the tension with an assertive voice showing her good practice guidance (CPHVA, 2004). Does she hear me? She tries to silence me. With a wave of her hand she dismisses the document, as if it will magically disappear.

"That's out of date!"¹⁷⁶ We now have Multi Agency Allocation Group (MAAG) and Common Assessment Frameworks. (CAF)"

We do! She fails to acknowledge additional gaps where families need to be identified prior to CAF/MAAG. I persist illuminating how homeless families may still *fall through the net* evidenced from focus group quotes. As a net-weaver, I use my knowledge of research, guidance and practice to remain assertive.

"I've been on CAF training. Homeless support workers aren't trained in CAF, and it's up to individual families to accept CAF processes. Vulnerable families won't have health needs assessed by homeless support officers."

Her eye lashes flutter for a prolonged time; she smiles awkwardly. I continue,

"We have homeless people placed in B&B accommodation from another local authority area - the invisible ones. They don't appear in local homeless statistics. Our Housing department¹⁷⁷ have exceeded the government's target - we have no families in B&B."¹⁷⁸ I am recommending a health visitor in the HNA. It would be safer if a notification system was in place earlier."

Peering into my folder, she menacingly points her finger,

"It is a recordable offence to receive personal information through emails. In fact... the manager who records offences... like yours ... is just outside my office window....right there.... Can you see her...? Did you receive that information through an email? Shall I call her in?"

Her eyelashes flutter gleefully! I am taken aback. Freire (2007:82) notes,

¹⁷⁶ The CPHVA 2004 document was endorsed by CLG guidance (2006) on notifications to health services about families moving into TA

¹⁷⁷ Good practice recommends local authorities should notify the authorities when they place homeless people in their areas

¹⁷⁸ The Government set a target that by March 2004 no homeless family with children will be accommodated in Bed & Breakfast (B&B) hotels except in an emergency and even then for no longer than 6 weeks

Opressors, wreaking violence upon others, and forbidding them to be, are likewise unable to be...that is why the oppressed by achieving their liberation, can liberate the oppressors.

Can I liberate her? I have two notification documents - one from our local housing authority given to me by their housing manager, and another from a neighbouring authority with consent for names and addressed to be shared with agencies. Whilst information sharing is contentious between agencies, routine information from housing to our HVs would be securely co-ordinated. In an era before encryption when information sharing is guided but unclear¹⁷⁹ (HSC, 1999; HMG, 2006), I feel threatened and silenced - a political novice. She has no intention of moving towards a notification system ahead of the major service review. Next time, more politically empowered through reflection, I would state that in our dialogue! I am drawn to Edelsky (1981) who talks of two floors of conversation - the turn-taking floor and the collaborative floor. The former is a hierarchical floor which creates a 'win or lose' space where women, in particular, have learnt not to assert themselves. I had asserted myself, to weave dialogue around the review - to collaborate - and I am satisfied that my case was made on the lower floor. I decide not to waste energy in this politically violent interaction, but to use my own power to highlight family homelessness issues in HNA and in multi-agency forums. My net vision for family homelessness remains precariously engaged.

Uncannily, her boss, the Chief Operating Officer (COO) calls me as I leave her office, "*Maria, let me introduce you to Harry. He's my new assistant.*"

Hot on my heels, she hovers beside me looking tense. I judge whether to invite him to intervene...to interrupt his excitement about a shadow visit.¹⁸⁰

I lose courage!

Numbed from the violence I experienced, I am silenced (Belenky et al, 1986). I recognise my own emotional needs: there is only so much I can do at a time. I dialogue with him on the shadow day and my forthcoming paper to be presented at the International Reflective Practice Conference. I will shape *the net* with Health Visitors at the forthcoming Family Homelessness group.¹⁸¹

¹⁷⁹ See: Thomas and Walport (2008) *Data Sharing Review Report* which led to HM Government (2009) *Information Sharing: Guidance for practitioners and managers*. London: HMSO

¹⁸⁰ The COO moves to another PCT before the shadow visit with me.

¹⁸¹ July 2007 One Health Visitor attends; three others send apologies. Heavy workloads and NHS reorganisation impacts on sustainment of the group.

DEVELOPMENTAL FRAMING 9

REALITY PERSPECTIVE

VISION Being Available

Homeless people

- Public Health Focus Groups: I use young mothers voice: service development to identify gaps

Engage Health

- HVs more connected to local adult and family homelessness

Precarious Engagement:

Whilst the Health Visitors agree with a notification system, I experience political violence from their senior manager

Empower Partners

- Collaborative working toward a Notification System

Influence Local and National Service Development

ACTIONS:

- Disseminate HNA report to Senior Management Team, 2008
- I recommend a Specialist Health Visitor for homeless families
- At a launch event, following the HV review, homeless families are highlighted as a top vulnerable group for HVs to assess
- I collaborate with HVs on a generic assessment forms to include prevalent issues in homelessness
- I add Notifications Systems to the newly formed 16-19yr olds multiagency Family Homelessness action plan and devise a notification form
- I meet with a Drug and Alcohol Team commissioners/managers to highlight substance misuse issues and isolation of parents in temporary accommodation to make services more accessible
- In 2009, I review a national briefing paper on Family Homelessness (QNI, 2009)
- From 2009, Masters students Specialist Community Public Health Nurses (School Nurses and Health Visitors) are involved in homelessness placements with me in their core programme, I highlight homelessness throughout the life journey
- In 2010, I write a Family Homelessness Standard Operating Procedure for Health Visitor Teams.

C
R
E
T
I
V
E

T
E
N
S
I
O
N

ROLE

The therapeutic net

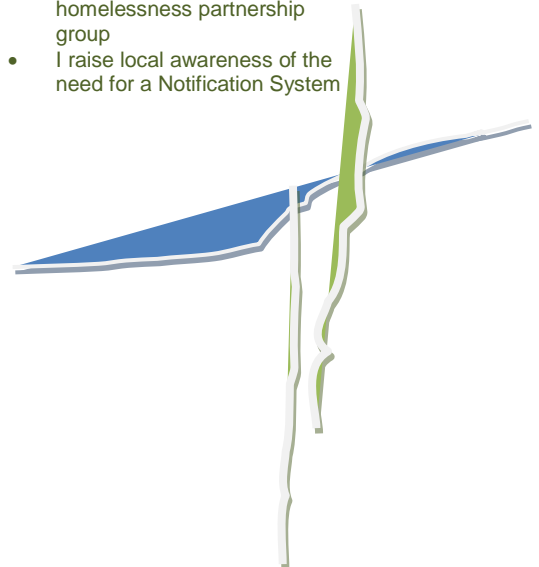
- Being available: I engage 0-19 teams to support them in their work with homeless families
- Focus group identified where families *fall through the net*

The health service net

- In a transactional world, I must become politically skilled in dealing with political violence

The partnership net

- With this experience, I seek to use a constructive 'voice' in the strategic family homelessness partnership group
- I raise local awareness of the need for a Notification System



Weaving the Net

Fig 3.12

Text 13 - TURBULENT WAVES

Clinic
12 June 07

Rudi sits heavily on the chair. A smart, long sleeved shirt hides the mass mutilation of self-harm on his arms.

"Hi Rudi, how are you?"

My casual tone seeks to calm the turbulence radiating deep within him. He doesn't know where to start, or what to say. His closing eyes are a retreat from the world.

"Have you heard from CMHT yet - it's a month since I made the referral?"

His response is curt.

"No and I'm never going near that psychiatrist as long as I live. I went to A&E as an emergency. Do you know the first thing he said? 'You should lose weight .. how many cigarettes do you smoke?' He didn't ask me about suicide or assess me for admission. He just said, 'don't do anything silly or I'll be the one who gets in trouble. I went in for serious self-harming!'"¹⁸²

Scarred physically, scarred emotionally; scarred by a self mutilating hand, scarred by a psychiatrist's sharp tongue. I had hoped CMHT engagement would prevent A&E admission. I want to scream *"Another unbelievable mental health story!"*

What is the psychiatrist's gaze on Rudi? I am more aware in practice of Foucault's (1973) narrow clinical 'gaze' used by psychiatrists, rather than a holistic perspective which remains unseen. Rudi's words link to other texts,¹⁸³ where having entered psychiatric care, further contact with services is resisted or refused. Rhythms of disengagement beat carelessly, awkwardly, arrogantly, powerfully - the sound is deafening.

Rudi serves another silent shot in the silent war, *"If it goes on like this I'll be dead in six months."* It may be true - people who self-harm are 18 times more likely than the general population to commit suicide (McAllister et al, 2002).

¹⁸² I read these words out as part of Rudi's story in the third Mental Health Task Group (multi agency) May 2008 in which senior mental health managers participate. The group evolved from HILG (which feeds into the LAA) and the dissemination of my Health Needs Assessment at HILG

¹⁸³ E.g. Texts 1,5,8,9

I bend low picking up the health pieces seemingly tossed aside - placing a small, invisible gauze over jagged, psychological wounds.

Mindful of Doyle's (1988) experience of surviving trauma of childhood abuse, I reflect on hidden moments of care like this,

It is important to state that interspersed with the trauma were moments of great love and affection. From the gentle kiss of a young nurse to the soft hand of a caring nun. It may well be the case that these were the moments which preserved my sanity and gave me something to live for (p.11).

I speak softly to Rudi, providing the therapeutic space he craves.

"It must be unbearable for you at times. Is there something I can do?"

As if responding to a lull-a-bye Rudi's eyes close, his mouth opens, answering sleep's call.

Maternally, I glimpse the examination couch behind his head and picture tucking him safely in for an hour or so. In sleep he is not in torment. I look at his long forehead; it seems at breaking point as if alone, it is carrying all the anxiety he has spoken off. My hands want to massage his pain away. For a second time in this morning's clinic I wonder about having complementary therapies within the clinic setting.....

When the evening is spread out against the sky
Like a patient etherized upon a table
Smoothed by long fingers
Asleep...tired

From The Love Song of J Alfred Prufrock (T S Elliot, 1888-1965)

My therapeutic role is to linger awhile with Rudi in turbulent waters.¹⁸⁴ I watch until he awakens undisturbed. He sits forward, engaged and rested, arms supporting his head. Is he truthful when he assures me he has not taken extra Meperidine for Charcot's Disease¹⁸⁵ - a condition, arising from diabetic neuropathy, causing severe pain when walking¹⁸⁶ hampering his return to employment as a decorator. He has been unable to sleep for most of the week because of his current anxiety.

¹⁸⁴ In reflective guidance Lei offers Elliott's poem as a reflection of this experience.

¹⁸⁵ Stress fracture developing from neuropathy

¹⁸⁶ Meperidine (oral pethidine) prescribed by GP

In this peacefulness, Rudi talks about Gail, his partner who died. Her suicide is the stem of loss in his own life story; *the* event which devastated his life.¹⁸⁷ Perhaps the blood that flows from his wounds is a metaphor for that loss. Would he risk suicide to be with her? Is he cutting out his deep pain to curb his soul loss? This therapeutic space allows him the time and space he needs to talk about her, and his soul pain...

Embarrassed, he says, "*I've tried reading the Bible to be near to her.*" In homelessness, "God" seems to be more present than in other parts of nursing I have worked in. Mindful of Borglam (1997), attuned to spiritual traps in spiritual conversations, I recognize the spiritual essence to my work (Texts:1,7,8). He is searching, trying to make sense of who he is in the great universe and to find a way of dealing with his pain. Rokach (2008) noted in his Canadian paper on homelessness that homeless people's coping strategy for loneliness had higher scores on religion and faith than the general population. They found inner peace and strength in their connection to a divine entity - searching for meaning and purpose in which to value themselves (p.222). As I gaze on Rudi I think of him in an invisible tomb which keeps him captive - perceiving perhaps that there he feels closer to Gail... he peers out but then retreats. A picture of Jesus saying "*Lazarus come out*" (Holy Bible John:Ch11v43) comes to mind. Unspoken images within me, alerting me to deeper psychological interventions needed in homelessness health care.

Rudi leans towards me, thanking me twice. He says,

"You are the only person I can talk to who doesn't look at their watch."

I have opened a therapeutic space for him - an anchor that steadies him when health service engagement is precarious.

Afterwards

I phone the mental health team. The manager says, "*His care plan says that each time he goes into A&E he should be assessed*"

"Why wasn't he?" I challenge.

She replies, "*He should have been. I'll speak with the team.*"

I write to the manager to confirm no action following my referral to them last month, illuminating Rudi's evolving and urgent health needs.

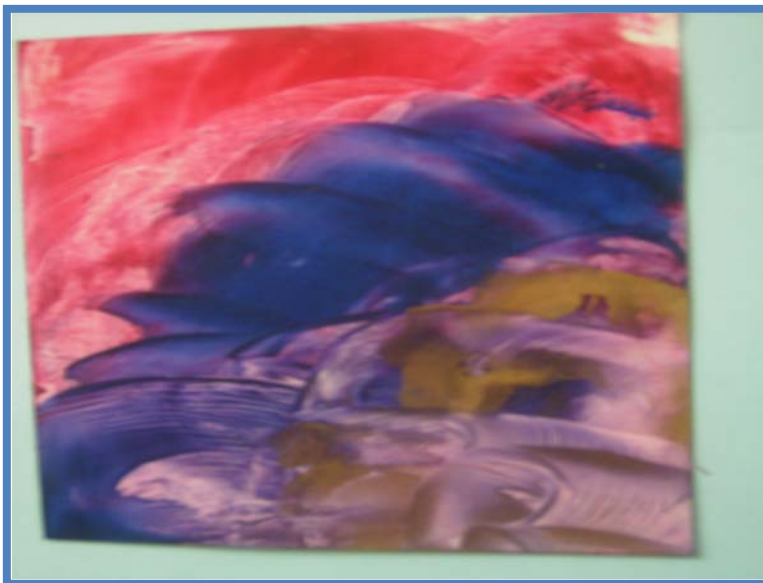
¹⁸⁷ Overdose and drowning

Reflective Guidance

I am reminded that 'chipping away' transforms health services and develops learning (Johns, 2002). In reflective guidance we consider touch. I am not a complementary therapist - should I be? I become more mindful of how I use touch in practice.

I am asked to consider my role in becoming a peace-maker. Quoting the beatitudes my guide suggests, "Blessed are the peace-makers for they shall be called the sons of God" (Holy Bible, Matthew 5v9). Such uncharted territories in nursing practice are very concrete areas of my being where justice and peace are aligned to personal Fore-having and DHS charism (p.27).

In an art workshop, University of Bedfordshire, 2008, I reflect on Rudi's self harm, shown below,



'Turbulent waves' emerged in reflective guidance as my paper reminded Lei of *The Love Song of J Alfred Prufrock* – T S Elliot (1888-1965).

The process of painting drew me into a deeper appreciation of people living with serious 'self-harm' and the crisis effects on hostel staff.

The story continues...

Painting by Maria Fordham

Two weeks later, 25 June 2007

I phone the hostel about another resident but quickly attune myself to anxiety around Rudi.

"We've had a terrible week-end. Rudi kept repeating 'I'm going to top myself'. We'd called the mental health crisis team... they wouldn't visit... he wouldn't go to the hospital. He said he was going to jump from the multi story. They told us to phone the police - the police brought him back here because he said he wasn't really going to do it. What were we supposed to do with him? He said he was leaving a note – everything suggested he was serious. We needed help from the mental health team but didn't get it - even afterwards."

I feel professionally numb; an injustice that I don't yet understand has occurred. I hold the hostel worker's tension: easing the pain, listening, investigating, encouraging, congratulating. Rudi's *turbulent waves* had taken them to the limit.

“What triggered Rudi’s crisis, Sally?”

“He applied for a crisis loan because his Incapacity Benefit was stopped. He didn’t get it. He’s had literally no money for two weeks”

The DWP remain absent (Texts:2,3) from local homelessness partnership meetings.¹⁸⁸ *Cutting* Rudi’s Incapacity Benefit occurred as a consequence of his attendance at A&E for the emergency serious self-harm treatment episode.¹⁸⁹ *Cutting* his benefit had the capacity to trigger a diabetic crisis because he was unable to buy food. Homeless people unable to pay rent are one step away from street homelessness as arrears accrue; a pathway to ‘intentional homelessness’.¹⁹⁰ Precarious engagement is visible - net holes are wide around mental health service and benefits. Concerned, I make two urgent phone calls to mental health teams.

As I mention Rudi’s name, the community team manager remarks too swiftly,

“He’s a Personality Disorder... ..not entitled to services ...”

...labelled and neatly packaged, put away on the ‘Personality Disorder’ shelf. These health professionals are policing access to health services. In a literature review of homelessness and complex trauma, Maguire et al (2010) state,

..in the entrenched homeless population very little research has been conducted on how the resulting personality disorders lead to entrenched or repeat homelessness....(p.4)

“Not entitled?” I challenge,¹⁹¹ *“Is that why there hasn’t been a response to my letters? Isn’t he owed a duty of care suggested in Self Harm Nice guidance?”*¹⁹²

“He’s only eligible for crisis intervention.”

¹⁸⁸ Department of Work and Pensions: An issue highlighted early by me in partnership groups without effect. Yet to be voiced by me at higher strategic groups e.g. HILG for influencing at Local Area Agreement (LAA).

¹⁸⁹ He was in A&E with the day centre manager being sutured following self harm and failed to attend the medical. Rudi was refused a Crisis loan after his Incapacity Benefit was stopped. Once again the stark reality that I had been oblivious to before coming into this role in 2004 hits me – benefits are often suddenly stopped and homeless people have absolutely no money to buy food

¹⁹⁰ Housing benefit is affected by changes in circumstances which may affect payments

¹⁹¹ I quote these words at the inaugural Mental health task group. The PCT mental health commissioner dismisses them to multi agency partners as if that response would never have been made. I captured it in writing – and the commissioner never came to subsequent MH group meetings.

¹⁹² ‘With the risk of death by suicide being considerably higher among people who have self-harmed, whatever the expressed intent, and with their high rates of mental health problems... it is no longer acceptable for healthcare professionals to ignore, or fail properly to address’ (NICE Guidance on Self Harm, 2004 p.28)

“But, the crisis team didn’t come out at the week-end when phoned by hostel staff! When he goes to the hospital he’s told to go away again¹⁹³ ...what is he supposed to do and how are hostel staff expected to cope?”

“But he doesn’t engage with us.”

“He engages with me... why wouldn’t he engage with you? My concern is that he will end up on the streets because his mental health needs are too high for hostel staff to cope with on their own. You know how serious his self-harm is. His health will deteriorate further if he and hostel staff are not supported by mental health services, costing health services even more money.”

After a pause, she finds his care-plan,

“The CPA¹⁹⁴ clearly states ‘for crisis intervention only’ Rudi is one of those people who uses services when he wants too – he’s had everything over the years - he’s even been into the Maudsley.¹⁹⁵”

The door is closed firmly by the community team. Access to health care for homeless people is impeded through rigid rules and lack of engagement in homelessness (Texts:9,10) as they use procedural voices. To be empowered, I need to address these issues at a higher commissioning level, when the HNA report is completed. Self-harm protocols and pathways are also required for hostel staff. The tension between strategic and clinical development is pulling heavily at me.

I phone the crisis manager. She confirms the team would not come out,

“When he chose not to come to A&E we advised the hostel to phone the police. The psychiatrist is here...”

I grasp the opportunity to dialogue with the psychiatrist, opening the clinical 'gaze' towards the partnership work we are doing locally to reduce rough sleeping.¹⁹⁶ It promotes a break-through - an immediate and helpful response, drawing mental health into the net. A psychology referral is instigated for Rudi. As Maguire et al (2010) states on homelessness,

There is a clear case for promoting models of intervention and clinical management which are designed to address problems (e.g. of attachment, emotional regulation, interpersonal skills, social problem solving) associated with complex trauma and PD (p.8)

Health care silos, limiting my practice vision, disappear as I connect local homelessness knowledge to key health professionals empowering them to engage in a network of care. St Mungo's and Crisis (2009) affirm the need for meaningful joined-up dialogue in homelessness mental health,

¹⁹³ Reference to Deep Cuts and the remarks made to Rudi by the psychiatrist.

¹⁹⁴ Care Programme Approach

¹⁹⁵ specialist treatment centre for self harm

¹⁹⁶ Rough sleepers initiative group – CLG concern about level of rough sleepers

Even when the appropriate services for housing, mental health and other support needs exist, it is often the case that a lack of dialogue between these services can prevent lasting solutions being achieved for homeless clients. A framework in which services could communicate easily and effectively would ensure *less people slip through the support net* (Crisis, 2009:3) (My italics)

...less people slip through the net through effective communication! I phone Sally at the hostel to let her know the outcome. She is relieved by the psychology referral! I offer to visit them knowing they may require support for, as Maguire et al (2010) notes it is,

... Important to consider the emotional and psychological needs of front-line homelessness staff, which should be recognized, quantified, and addressed (p.13)

An hour later, in a busy clinic, Rudi asks to see me. He is hungry and volatile, unaware yet of progress with the psychiatrist; survival needs outweighing health intervention. The reality is he has no money - his benefits have not been reinstated. Attention to Maslow's (1954) hierarchy of need is particularly essential in homelessness. I phone the DWP. His appeal is being heard. Am I too late? Knowledge of the power of my voice as an existential advocate enables me to authoritatively assert,

"How can benefits just be stopped as a result of an emergency admission to hospital? Please... tell the panel about the high level concern from health services. It has been extremely distressing and very dangerous for his health. He is diabetic and needs money to eat. It has also posed major mental health issues for him."

I hear the concern in her voice - responding to my concern. She agrees to deliver the message during the appeal. Rudi will hear the decision early this afternoon.

"If my money doesn't come through this afternoon I'll top myself!"

Conscious of the turbulent waves he sends out, I remain anchored. I offer to bring a sandwich later to the hostel. Just thirty minutes later, enmeshed in another health crisis, I receive a message about Rudi, *"Tell Maria I got my benefit through. I don't want her to worry about me."* I am humbled by his concern; turbulent waves are diminishing around him....

..We have lingered in the chambers of the sea
By sea – girls wreathed with seaweed red and brown
Until human voices wake us and we drown

from The Love Song of J Alfred Prufrock – T S Elliot (1888-1965)¹⁹⁷

¹⁹⁷ Lei Foster a fellow PhD student researcher, suggested Elliot's poem to frame this experience as the text strongly reminded him of it. Co-constructing illuminates the creative process of this research methodology. The ethereal nature of the poem connected me to Rudi sleeping in the clinical room and to the trauma of his girlfriend's suicide when he awakened.

DEVELOPMENTAL FRAMING 10

REALITY PERSPECTIVE

Vision

Being Available

Who is Rudi?

- Grieving young man
- Health Need: Charcot's Disease, self harm, diabetes, personality disorder
- Finds hostel chores/rules difficult
- Painter and decorator

Empower homeless services

- Hostel staff need support and training on mental health issues and collaborative relationships with services

Precarious Engagement:

Unsupported health crisis makes the net fragile

Engage health services

- I challenge services to engage with Personality Disorder

Precarious engagement:

Health professionals seem to police access to services

Service Development

Actions:

- HNA: more evidence for a CPN in a MDT
- Voice mental health services issues in strategic meetings
- Homelessness health: Strategic engagement required in local mental health/homeless service development

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

ROLE

The therapeutic net

Appreciating precarious engagement

- Peace-making - being an anchor amidst crisis
- Longer, deeper therapeutic interventions I consider touch/ complementary therapies
- I work to prevent eviction from health need

The health service net

Appreciating precarious engagement

- I raise issues of accountability assertively challenging mental health professionals
- I draw the psychiatrist into local homelessness and secure psychotherapy referral

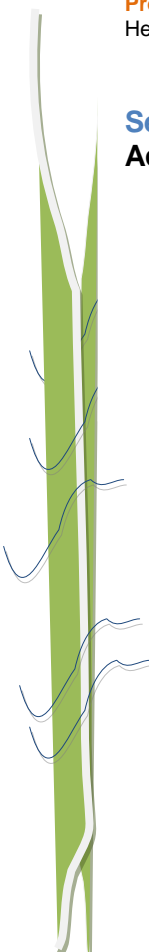
The partnership net

Appreciating precarious engagement

- I recognize hostel staff need to be supported in health crisis
- I advocate for them with health services
- I connect Benefits staff to survival and health needs

Falling through the Net

Fig 3.13



Text 14 - Department of Health National Award



Ask About Medicines DH Award, Portcullis House

6 June 2007

Squeezed into a taxi with the Chief Executive and two PCT pharmacists, I'm on my way to Westminster to receive a prestigious DH /Ask About Medicines award on pharmacy support to homeless hostels. It all began with an email, similar to this, about George ...

March 2006.

Dear Jackie

Could you please advise me on the medication of a gentleman attending my homelessness clinic? Following amputation of three toes he is experiencing severe pain which peaks at 03.00 hrs. Shelter staff do not allow free access to medicines and there is some discrepancy about when and what he is allowed. I tried contacting the consultant who saw him yesterday but have not had a reply. Packet instructions are:

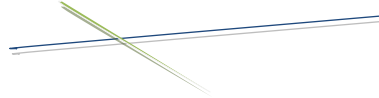
- *Zamadol 100mg 3 capsules BD*
- *Tramadol 100mgs 1 tab QDS*
- *Atenolol 50mg 1 tab each morning*
- *Clopidogal 75mgs 1 tab each morning*
- *Ibuprofen - packet instructions*
- *Panadol - packet instructions*

There is one slow-release tab which he should be given at night - the staff do not allow him to have it when he has taken analgesics during the day. I am unfamiliar with some of the medications. I suggested a written regime of times much like a medicine chart but am uncertain about interactions myself.

Within an hour Jackie replies,

Dear Maria - I am concerned that the first two are the same. Zamadol is the trade name for a drug called Tramadol - this means he has two lots of the same thing with different doses on. Zamadol is a slow release capsule. The maximum daily dose for the drug Tramadol is 400mg daily. If he is taking 3 caps Zamadol twice a day that is 600mg but if he is having Tramadol tablets as well four times a day then that is another 400mg!!!! Another huge problem - he is on clopidogrel which is an anticoagulant - he should not be taking ibuprofen with this at all!!

My joint working in homelessness with the PCT pharmacists had begun!



My concerns about prescribed medication initially arose in the Bail hostel, where residents had difficulty obtaining their usual medicines when newly registered with GPs. On one occasion, it led to a severe mental health crisis. George, however, did not have an offending history. Post-operative pain following amputations was severe. I met him walking snow-filled, icy streets, waiting for the shelter to open. Three areas of concern arose:

- Recuperative accommodation following hospital discharge for homeless people¹⁹⁸
- Safe prescribing¹⁹⁹
- The handling of medications in hostels

Having initially supported shelter staff with the new regime, outlined by the pharmacists, I placed 'Handling medications' on the next homelessness forum agenda. It was like a bomb exploding

"They can't keep the medicines themselves – they have to give them to us and we put them in a cupboard."

"We don't know what they are supposed to take so we give them what it says on the bottle – but we don't chase them - so if they don't come and find us they don't have them."

"No, we let them keep them...It's their responsibility"

"But our rules say they can't have drugs on the premises..."

Feeling hotter and hotter, I listened to unsafe hostel medicine practice; residents completely disempowered by the power and authority of hostel staff. Some staff adhered to rules as if **all** drugs were illegal. In disbelief, I described the discussions with the pharmacists, and training for hostel staff began.....

¹⁹⁸ I research accommodation on hospital discharge - Lambeth PCT are piloting step-up, step-down accommodation for homeless people.

¹⁹⁹ The pharmacists dealt with safer prescribing issues with GPs,

19th April, 2007

'Safe medicine' training was controversial and the pharmacists are anxious!

"If they are giving out medications, then they should be registered as Care Homes. But they can't afford it. They are charities - just financially surviving. It would cost £2,000 to register. We need an enhanced pharmacy practice so that each hostel could receive the services of a pharmacist..."

The NES pharmacy support to homeless hostels is born.

I phone a few hostels to hear how they received the training. Confusion reigns. They require further guidance on drug practices. I network with the pharmacists. Training and a hostel protocol on safe handling of medications unite safer practice.

I reflect on my role: utilizing skills of existing NHS staff provides expert guidance in homeless health care – I feel like a spider connecting gaping holes in the netting

The award raises awareness of homelessness and my PCT role - a productive time. Homelessness is becoming very, very visible!

DEVELOPMENTAL FRAMING 11

REALITY PERSPECTIVE

VISION

Being Available

Who is this person?

- George, middle-aged
- Recently discharged following amputation of 3rd toe (frostbite)
- He walks cold icy streets each day when night shelter and day centre are closed

Empower homeless services/ Engage health services

- Collaborative working: Safe prescribing practice are weaved within homelessness: PCT pharmacists provide: expertise, knowledge, protocols and training

Precarious Engagement:

The hospital discharge process remains precarious
Unsafe medication management in hostels

Policy and local/national development

ACTIONS:

HNA recommendations:

- Podiatry clinic in day centre
- Recuperative accommodation on hospital discharge with effective safe, pain relief
- I need more clinical support to allow me time to strategically tighten the discharge process

ROLE

The health / homeless service net

- Net weaving: I link health needs in safe prescribing connecting pharmacists, GP prescribing, homeless staff.

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

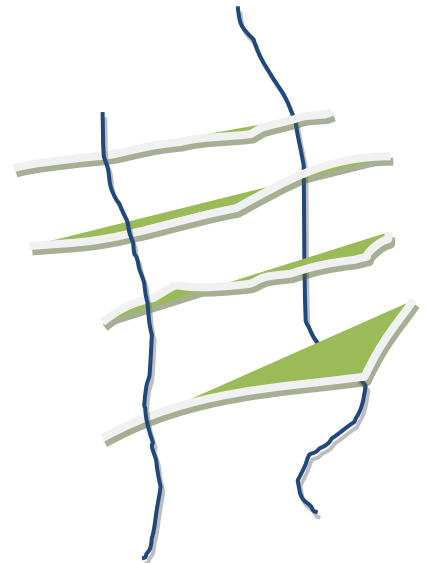


Fig 3.14

Weaving the Net

YOUNG HOMELESS WOMEN

The following 2 texts are examples of practice development as I build knowledge around the health needs of young homeless women. They build on knowledge of childhood trajectories which lead to adult homelessness (Text:3,4,7,8,9). The Fabian society (2010) reminds me that,

Around half of all prisoners ran away from home as a child, almost a third were in local authority care, half were excluded from school and two thirds have a numeracy level below that of an 11 year old child. Similarly, up to a third of rough sleepers were in care, 40 per cent of homeless young women were sexually abused as children and family conflict is the main immediate cause of homelessness for at least two thirds of homeless young people. We also know that substance abuse correlates strongly with the experience of family breakdown and dysfunction amongst young people (p.19)

Text 15: Balancing the Clay²⁰⁰

**7 October 2007
Hostel Visit**



This painting emerged as I reflected on feelings around self-harm in hostel settings. I later used it in self-harm training with homeless services workshop, June 2008.

Painting by Maria Fordham, Reflective art workshop - University of Bedfordshire April, 2008

A young hostel worker greets me with a troubled face.

"Her carpet was covered in blood stains. I was so shocked. I'm glad you're here Maria, it's too much for me to deal with on my own"

²⁰⁰ I developed this text as 'Balancing the Clay', performed at the PCTs First Homeless Health Conference, 2010, and at the International Reflective Practice Conference in Putteridgebury, June 2010. Students of drama and performance, University of Bedfordshire performed with me. The title was inspired by John O'Donohue's (2007) poem, Beannacht in Benedictus, Bantham Press:London

It is two days since 16 year-old Lucy's self-harm incident and Elizabeth's anxiety remains high.²⁰¹ She asked for an immediate visit on Monday morning but confident, through reflection, that my role is not a replacement to urgent health care (Texts:9,13) I delayed it until today.²⁰² I hold some service anxiety about self-harm, remembering that just a few weeks earlier, I referred Rudi (Text:13) into mental health services to prevent serious self-harm but was told, "He's a Personality Disorder! His CPA categorically states - **for Crisis intervention only**"! Subsequently, I have sought self-harm training for homeless service staff.²⁰³

I have learnt a lot about self-harm from Rudi. His urge to cut develops a few days before cutting with ritualistic practice runs, preparing towels and bowls, which in itself makes him feel better; keeping bandages and blades accessible in a lower drawer; planned actions of self-violence to control and release psychological suffering. Groom (2002), an A&E nurse, describes her journey with self-harm patients moving from 'anxiety and avoidance' to 'connection' through reflective guidance. She found that in A&E patients who self-harmed were stigmatised allowing the 'dark side of nursing' to root (Jameton, 1992). She quotes from Lynn's (1998) experience of rejection when attending A&E with self-harm,

Needing stitches is a nightmare. I felt embarrassed and shamed about being stitched up by a nurse whose comments or lack of comment made me want the ground to open up and swallow me (p.56)

I muse on avoidance or distancing used by health professionals in: homelessness, self-harm and personality disorder.

Lucy has been a resident for six weeks. Entitled to CAMH²⁰⁴ services until she is 18, she refuses intervention, reminding me of *precarious engagement* caused by homeless people following previous mental health service intervention (Texts:1,5,9). She has a social worker and GP but no other mental health support. Hostel staff are in crisis, without a clear vision of managing her pathway into independent living. Mindful that she did not attend A&E on Monday, I seek to engage her in holistic health care today.

Elizabeth and I are interrupted by a loud knock,

"Is she here? I have to go out in fifteen minutes"

²⁰¹ We discuss the stress on staff when residents self-harm.

²⁰² Advised to go to Accident and Emergency or GP, not only due to the serious nature of serious Self Harm incident but because I am unable to provide a crisis health service to hostels.

²⁰³ I presented and facilitated self-harm training with a mental health nurse/psychotherapist- 3 sessions in May 2008

²⁰⁴ Child and Adult Mental Health Services

We smile; having discussed self-harm in detail and providing her with literature, Elizabeth is less anxious about the amount of blood she saw on the carpet. Lucy's impatience heralds a message about engagement with me, as well as a frustration about our meeting.²⁰⁵

In the conservatory, Lucy sits with crossed arms and legs; her conversation restricted to one or two syllables, wearing closed body language (Miller, 2005) like a shield. Her sullen, teenage face appears a ghostly shade of pale, except for a shiny, silver nose ring, chaperoned by two nostril studs. I purposefully gauge my own lightness of speech, devoid of direct questions until she is relaxed. Lucy tentatively responds and within minutes, spontaneously recounts her family story.

"I thought it was normal to be beaten up every day. I was 10 when I realised it wasn't normal - I was shocked when it didn't happen to my friends! My younger brother had a learning disability. He used to copy my mother – really lay into me - she wouldn't stop him. It's as if that was what I was there for. Sometimes she would lock me in my room for hours. She was never able to look after us. When I realised it wasn't right, I told her mental health worker. Just because she had mental health problems didn't make it OK to do that - did it?"

"No, it didn't. Was your dad at home then Lucy?"

"Dad suffers from depression. He moved out when I was young... I see them both from time to time"

Family breakdown framed beyond housing statistics provides me with a clearer indication of health issues which lead to adult homelessness. The account of daily physical abuse from a mother and younger brother is shocking. It causes me to consider that Health Visitors, School Nurses and mental health teams should provide shared models of care for families where mental health illness is present. Like Robert (Text:7), Lucy's story highlights how children who have siblings with special needs have their own special needs - which may trigger homelessness. But Lucy was connected to Children's services, education services and mental health services....

"What help did you have Lucy?"

"That place – CAMH – they just stare at you, waiting for answers. I'm not going back there."

Transitional outreach models (DH, 2009) may help teenagers like Lucy.²⁰⁶

"What do you think would help you now? The staff are very worried about you – especially when they saw so much blood on the carpet on Monday morning."

²⁰⁵ I provide Elizabeth with "The Truth About Self harm" – a Mental Health Foundation Trust booklet

²⁰⁶ 2009: See New Horizons A Shared Vision for Mental Health (DH 2009)

“That worried me too. I couldn’t actually remember doing it. I was out with my friends having a good time and within minutes of coming back to my room I was using a razor.... I used to self-harm a lot more. It helps at the time. I don’t care whether I live or die - they hold the same value. I used to constantly walk along the railway tracks at night waiting for a train, deciding whether or not to jump in front of it. What’s the point of life?”

Lucy's lead into self-harm is frantic. With her previous dark thoughts of suicide emerging heavy and laboured, internal alarm-bells for re-involvement with mental health services ring.²⁰⁷ She challenges me about the point of life and I challenge myself about whether I would have recognised these family dynamics as a route into homelessness as a family Health Visitor. Would I have put effective preventative strategies and joint working in place?

Lucy is the same age as Sophie, my daughter - childhood journeys spanning the same 16 summers. Hues of my own motherhood emerge. Curiously, a sun dipped robinia leaf ‘dances’ in the corner of my eye. I catch its weightlessness and playfulness - challenging us. It is a point of stillness, timelessness and space becoming one, as if the whole universe is connected to Lucy’s recovery. Senge et al (2005) recounts how alertness to nature became his teacher, in which it caused ‘the boundary between nature and me to collapse,’ (p.60).

Lucy turns her face to the leaf and it too becomes ‘sun lit’, almost as if the sun dancing through the leaves thaws the ‘frozen stare’ of child abuse.²⁰⁸ It is *the* turning point of our meeting; a deeper connection where peace emerges, much as it did when I renamed Heidi’s abuse as torture (Text:8). Perhaps peace is fleeting but in the present moment, it opens Lucy to the possibility of re-dreaming her future.

To redream one’s place in the world – a beautiful act of imagination and a sustained act of self becoming... (Okri, 2002:55)

“My counsellor gave me the Celestine Prophecy to read. It’s just like that...sunshine and leaves...The joy of living in the moment. Have you read it?”

In this spiritual harmonisation it is easy for me to use nature and seasons, metaphorically connecting Lucy to seasons of life, leading perhaps from the painful past, into awareness of a growing independence as a young adult, and a future in which she has more control - filled with new people and new events.

Lucy’s face is peaceful.

²⁰⁷ When I contacted the Lucy’s social worker she said that Lucy frequently walked along the railway lines and night and previously self harmed four to five times per week. “She is a lot better than she used to be.”

²⁰⁸ Frozen stare is one sign to observe in Health Visitor practice regarding physical abuse in childhood.

Mindful of peace, my voice, is like a lullaby,

“Do you know any relaxation exercises Lucy?”

“No... I relax to music, or talk to my friends”

We become still, centring...Her proactive response contrasts with her first resistant greeting to me an hour ago. After a few minutes, she is so engaged that her jaw drops and her eyes close. I wonder why no-one has provided relaxation before.

*In a still side-stream
Cut-off from maternal rapids
I hear for the first time
The exclusive voice of the traumatised child
Drifting towards adulthood
A tear wells
As meditation awakens
Global innocence
Caught in a maternal lap
Of caustic pain*

In meditation I disconnect from Lucy's mother to hear Lucy's voice; *Caring motherhood* was intermittent; family violence normative. Welldon (1988) notes maternal indifference to a child's suffering,

We should not be surprised at the existence of the 'other side' of motherhood...why is it so difficult to see that for some women, motherhood intensifies their previous problems to the point where they are unable to cope. (p.66)

In reflective writing I reconnect to the maternal voice I know so well. Lucy's life story positions me back as a young midwife placing new-born babies into maternal hands. How I wondered had services failed this family? Had I failed as a Health Visitor for families like Lucy's?

Okri (2002, p.55) says that to recover from violence and regain authenticity as human beings,

The only hope is in the creation of alternative values, alternative realities.... (So) that in some way we breach and confound the accepted frontiers of things.

Who will teach Lucy about her own beauty and inner love? How can she re-dream herself, sing her own song? She lifts her hand to show me a diamond engagement ring. Romantic love is aspired to by homeless people (Lemos, 2000) (Texts:7,9) and is a route out of homelessness but sexual health needs and the possibility of teenage pregnancy become another health focus in my engagement with Lucy.

“His mum does everything for him – she dotes on him. I don’t ever want to have children. I wouldn’t want to bring them pain, like my mum brought me. I wouldn’t want to harm them with my mental health problems“

Her humble, protective words move me as she considers her future mothering skills. Would a parenting skills programme, designed for those who have suffered abuse be effective – or would it simply label them?

Lucy does not want to be re-referred to CAMH nor take the prescribed Prozac.²⁰⁹ I ask her to see her GP before our meeting next week, during which time I will discuss a referral with the adult mental health team and liaise with her social worker.

Later in my journal, I reflect on 'violence' in mothering... had I really considered its impact so deeply before? Empathically connected, I write the following poem,

Robinia Tree

Caustic mothering suffocates sweet infancy,
Comfortable childhood, inspired youth
And the Goth styled daughter sits in sunlight with me
As citrus leaves dance on the robinia tree,
Nebulous, numb, notes frame to disclose her nonchalance about life
Neither caring to live nor die,
Unrhythmically dancing with both, choosing neither
.....another homeless shadowland

Ethereal eyes engage less fleetingly
As trust begins to flow
Revealed by a porcelain dolls white hand, raising a black sleeve
Over a manic criss-cross mesh, tucked underneath the pirate hoodie;
Visible cuts that slash across her soul pain
Slit by a razor’s edge

I cringe inside, not one or two
But hundreds,
A now forgotten, frenzied, war like action
On youth’s flesh: her neck, stomach, thigh, arms
Child of sweet innocence self-harming
Cry, violent motherhood, on your bitter pain
Born in physical and emotional abuse

And the rustling leaves on the robinia tree sing
As she later laughs at the story of her first engagement ring



Poem and Photograph by Maria Fordham

²⁰⁹ Prozac has been prescribed but Lucy stopped taking it several months ago against medical advice

The following week

The social worker asks,

“Would you consider being the lead professional in the Core group²¹⁰ for Lucy?”

The possibilities in my clinical role made explicit with her question. The reality perspective is that without a homeless team around me resources prevent me holding a key safeguarding role as a replacement to current service activity (Texts:9,13). Compared to previous episodes of self-harm occurring three of four times a week, the social worker is optimistic that there is a general improvement in Lucy's well-being and will see her again later this week.

All last week's tension has disappeared at the hostel when I arrive. Lucy and Elizabeth are finishing a key worker session and Lucy is attending college again. Her physical scars have healed quickly; the emotional ones less raw. Today, she uses loving words about her mother, reminding me that love is the binding power of the umbilical cord. In dialogue, she is making sense of who her mother is within her mental illness. I am reminded that,

Healing ... is not in the goal but in the journey (Mattingly, 2007:81).

The following week, Lucy moves out of homelessness, into her boyfriend's home.

Post script

Following a conference performance based on this text,²¹¹ a Supporting People commissioner asks, 'Why are people with mental health issues like this placed in homeless hostels?' A mental health manager fails to reply effectively in her dialogue about care in the community.

I am reminded that my role to visualise health needs of homeless people and the issues which homeless staff face, has become a reality.

²¹⁰ Child protection meetings

²¹¹ Balancing the Clay Health and Homeless Conference, 29 Jan 2010

Text 16 - VOLCANIC ERUPTION

5 November, 2007
Hostel: Ariella

Bare branches replace a summer green canopy formed by the London planes in this Victorian avenue. I have come to see Danni, but following a domestic violence court case against her partner she has been successfully placed in social housing.²¹² Just as I prepare to leave, a mouse-sized voice emerges from a dark telephone booth in reception,

"Hello Maria. Can I see you instead? She has left you this. She's mad"

She hands me the piece of paper. On it, Danni poured out descriptive images in an exploration of who she is, accommodating self-knowledge and self-value from our dialogue last week. In her spider-gram, she has described herself as 'funny', 'promiscuous', 'artistic' 'angry', 'motherly'. Having sign-posted Danni to the Freedom Programme I already sense a strong inner movement of transition which she wants to continue with me in her new home.²¹³ Like Robert (Text:7), I recognise that homelessness nursing should extend into community recovery to be truly effective but without a homelessness team, time and resources limit my availability.

Ariella and I sit in the conservatory. I have to listen intently because her body is hunched over

"How has it been, living here, Ariella?"

"Awful - It's a brothel. I don't smoke, drink or do drugs, they do it all here. I need my own space."

Hostel culture encroaches on Ariella's space; I am mindful of others who have found hostel limited space.²¹⁴ van Manen (1990) illuminates,

Lived space (spatiality) is felt space...the experience of lived space is usually preverbal; we do not ordinarily reflect on it. And yet we know that the space in which we find ourselves affects the way we feel (p.102)

Differentiated by her morals, Ariella eagerly awaits independent living. Staff have told me they find her distanced and difficult to engage, unable to support or identify her emotional needs. Isolation hangs around her.

²¹² Domestic violence - Danni is now owed a duty of care by the local authority to be re-housed as she is in priority need and is not considered *intentionally homeless*.

²¹³ Freedom Programme is a 16 week domestic abuse training programme which provides skills for abused people to live independently

²¹⁴ "Walking on egg shells" is a metaphor used also by Robert (Text: 7) and Dean (Text: 9) about the lived experience of being in a hostel where people have to negotiate rules, evictions, hostel culture and fitting in.

I ask her homelessness *story*,

"My mum died....in a volcanic eruption on our island"

Her eyes fill; hot tears cascade like latent lava learning to escape, boiling from the core of her being. My arms and chest tighten, my tongue sticks to the roof of my mouth in sadness.

" I. was 10 ... at school. We hid under our desks...I... could see the lava and black cloud. The lava gets to 900°C. I knew she was dead - no-one had to tell me...."

I visualise her as a schoolgirl looking out from her classroom towards a blue sky filling with pluming ash from a groaning earth. Screams erupt - a moment that changes this schoolgirl's life forever.

"Have you received counselling Ariella?"

She shakes her head; tears continue their cascade.

"Has *anyone* helped you with this?"

"No-one."

I touch her hand. It is a tender moment.

She resists a counselling referral.

Just to confirm hostel space is limited space, a knock on the door heralds a move into the kitchen to make way for an electrician. At the kitchen table, it is as if Ariella's hunched body is protecting her schoolchild heart; the wet, shredded tissue is torn again. Aware of the positive effects of intentional touch (Frederickson, 1999) since Rudi's text (Text:13), and dialogue on touch in reflective guidance, my hand is intentionally placed around her shoulder. She tenderly leans into me, heavily sobbing - a child's impulse for a motherly embrace? As she cries, I hold her in the knowledge that UKCC (1999) guidelines on practitioner-client relationships are supportive. Physical contact is viewed as an integral part of healing.

I feel her shoulder muscle, like a tight coil, unfurl as if she is beginning to free-up that hurt school-girl heart. Knowing the effectiveness of relaxation techniques with Lucy (Text:15), I invite Ariella towards the same. Afterwards, she freely talks about her "*good, kind, loving, mother*". The therapeutic space has opened for her to dwell in healing moments. Its value is highlighted by Pennebaker et al (1997:864) who notes,

Especially when losses are traumatic, they may be difficult to discuss or even disclose to another. And yet the psychological and physical burden of harboring painful memories without the release of sharing can prove far more destructive in the long run.

In the after-silence of our work together, Ariella sits with me for some time. It is peaceful and she doesn't want to leave.

In my journal, that evening, Ariella's parental loss mingles with my own,

*Untimely parental death,
Leaves us orphaned,
Lost to the spinning winds,
Of formless years
Stretched between death and life
And Heaven and earth
Until we find ourselves
Contentedly earthed*

The following week, Ariella started to work in a fast food outlet prior to moving into her flat, beginning to tentatively and actively grasp her journey of social validation towards reconstructing herself. As Niemeyer (1999:65-68) poignantly notes:

Reconstructing a world of significance in the wake of bereavement is more than a cognitive or emotional exercise; it also requires survivors to recreate social validation for their changed identities.

I ponder on precarious engagement - her suffering had previously been debilitating to the point of affecting her tenancy because hostel staff could not engage with her. Ariella was unprepared to go for counselling. Recognising the precarious nature of the net my role becomes a psychological holding place towards recovery and reconnection at a time when people 'stall' on their healing journeys. It is a process of enablement which facilitates successful pathways out of homelessness.

Post amble

I feel enlightened, and whole. Listening to the voices of young people's traumatic stories of childhood reconnects me to generic family Health Visiting. I challenge myself to consider how, as a family health visitor, I would now practice differently:

- I would be more mindful of patterns emerging from loss as routes into homelessness - childhood bereavement, sibling illness or disability, paternal mental health, parental alcohol misuse
- I would be mindful of family transitions in step-parenting and raise awareness of children's needs within second relationships

- I would promote closer working relationships in primary care with mental health colleagues
- I would be more mindful from ante-natal onwards that parents may have been abused in childhood, appreciating their specific parenting needs

Reflective Guidance

I am forcefully challenged to consider that I have categorised mothering into Carl Jung's 'Madonna/Whore' archetypes. It shocks me. Had I? Whilst many young homeless women had categorised their mothering experiences as 'good' or 'bad' which had intrigued me, I had always sought in health visiting practice to equip women to mother 'well', particularly when higher needs were present: disability (child or parental), partners in prison, bereavement, safeguarding, isolation and depression, prostitution, travellers, homeless and war-torn refugees.²¹⁵ Additionally, my background illuminates my history of being from a 'one-parent' family - I was alert in practice to judgemental attitudes about single parents. The RG challenge assumes that all the preceding mothers (in this paragraph) are from 'lower social classes'. They were not. I find continued challenges offensive and conflict enters the reflective guidance group for the first time. It is resolved through dialogue. I reflect on this further in Chapter 5.

In the mothering discourse, I am directed to mothering research.²¹⁶ On mental health and mothering, Greaves et al (2002:8) in their Canadian study notes,

Prejudicial and inaccurate beliefs about mental illness are still widely circulated that create a social climate in which women with mental illnesses are viewed as dangerous and incapable of caring for children ...the result is that women who have been diagnosed with a serious mental health condition lose custody of their children.

In Greaves's discourse, two other areas of 'mothering under duress' are considered: substance misuse by mothers, and woman abused by partners. In the tension that exists between child protection and the rights of mothers, Greaves highlights the importance of supporting, preserving and maintaining the relationship between mother and child as a unit where the rights of the foetus/child and those of the woman/mother are not separated. I had practiced this way (Texts:4,8) despite the challenge by my reflective guides, and in meditation with Lucy I was able to listen solely to the voice of the child as an adult for the first time. I was already familiar with the maternal voice. Meditation provided a new perspective on mothering and childhood suffering in homelessness.²¹⁷

²¹⁵ I presented a paper at International Conference of RP, Iceland 2005 - Regaining a Voice in Professional Practice which identified my role with three homeless families including a Kosovan family where safeguarding concerns existed.

²¹⁶ See Arendell, T. (1999) *Hegemonic Motherhood Deviancy Discourses and Employed Mothers' Accounts of Out of School Time Issues*. Berkeley: University of Canada

²¹⁷ For example, Lucy wanted information on mental illness from me to offer her mother. She spoke about her love for her mother and continued tentative relationships with both parents in their mental illnesses. Farrah (not included because of the thesis word limit) became homeless following abuse from her step-father whom her mother 'chose' rather than Farrah.

van Manen's (1990) thoughts on lived space articulate what I was trying to grasp from the 'child's experience' in my homelessness role,

The space experienced in the home may turn out to be supportive or neglectful, open or smothering, liberating or oppressive for the child....the child experiences the adult's confidence and trust, without which it is difficult to make something of oneself (p.106)

DEVELOPMENTAL FRAMING 12

REALITY PERSPECTIVE

VISION Being Available

Who is this person?

- Young homeless women
- Traumatic childhoods

Precarious Engagement

- Lucy refuses to attend GP services
- Ariella had not accessed GP to discuss the hostel-living issues that were affecting her health

Empower homeless services

- Hostel staff are supported when person does not engage with other health services
- Reduce fear of self-harm
- Effectively engaged, health prevents evictions triggered by health needs

Engage health services

Precarious engagement:

- Lucy falls between CAMH and adult mental health services

Prevention:

- Better integration of mental health services with health visitor/school nurse practitioners
- In policy and education, family transitions which trigger homelessness should be highlighted as core practice e.g. step-parenting interventions
- Consider ante-natal education around parents needs who may have been abused in childhood

Local/National/ International Voice

ACTIONS:

- I facilitate self-harm training for multiagency staff including hostel staff
- Audiencing: I perform 'Balancing the Clay' (Text 15) to engage childrens services at the Homeless Health Conference. I also perform it at the International Reflective Practice Conference.
- I highlight this experience to mental health service commissioners (Later texts)

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

ROLE

The therapeutic net

Being available

- I effectively engage with those who have disengaged from health services
- Effective engagement allows traumatic childhood stories to be disclosed, often for the first time
- I recognise that hostel space is limited space. Being different in the hostel culture, further excludes.

The partnership net

- My peacemaking role extends to hostel staff, shocked and stressed by self-harm
- Effective engagement, working in partnership, prevents evictions

The health service net

- Without mindfulness, reflective guidance may cause undue suffering

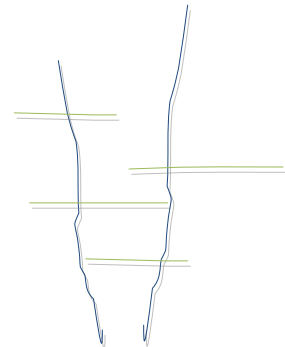


Fig 3.15
Net Weaving

Analytical Horizon: Year 2 - 2007

In this analytical horizon I review key insights from Year 2 where I sought to weave a tighter net. BAT themes were embedded within my daily work. The concept of precarious engagement continued to unfold through four quadrants of practice but I was particularly attentive to mainstream services. *Use of voice* marked my empowerment to prevent homeless people *falling through the net*. I begin by reminding readers that the Being Available Template represents *the net* and show its evolving themes in Year 1(AH2.1).

Being Available - Year 1 Review

- Vision
- Having concern for the person
- Knowing the services
- My aesthetic response
- Poise
- Creating an environment

I am mindful that health inclusion is the core essence of my practice vision. *Being available* requires me to have concern for the person in the therapeutic space where mindful practice allows presence to unfold so that I hear the voice of homeless people including their suffering. My effective aesthetic response demands that I *know services* and respond appropriately. *Precarious engagement* illuminates that services, not just the homeless person, are 'hard to reach'. Appreciating *precarious engagement* means that I am better able to hold the person in therapeutic engagement, when they are not held securely by other services. In this awareness, I *use my voice* effectively to build a strong net in four quadrants: homeless person, health services, multi-agency service, SPHN role.

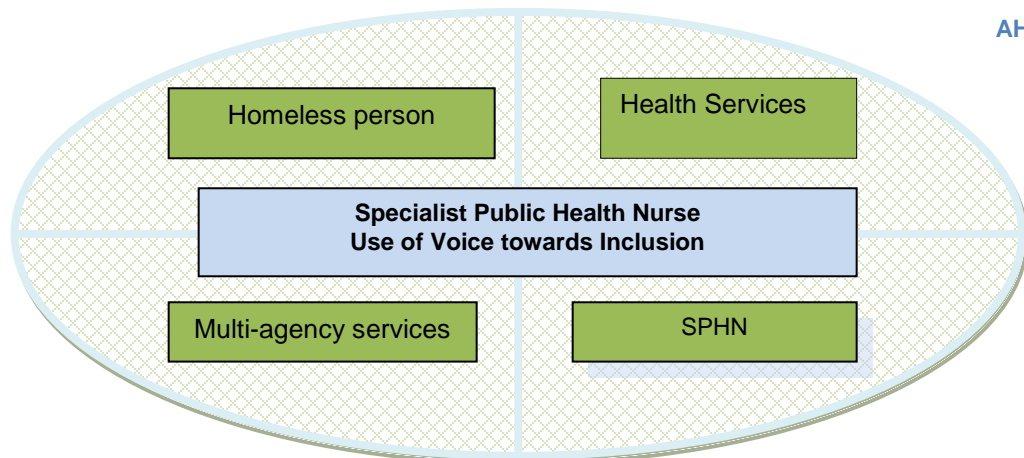
Through reflective practice and guidance I am mindful of poise: spiritual traps, fear and coping with the emotional demands in my role so that I can *be available* and work towards my practice vision.

AH2.1

Developing Practice in Year 2

The overarching concept of 'precarious engagement' continued to develop in four quadrants of homelessness practice (AH2.2). In each quadrant, key insights for practice development are positioned within BAT and developed further.

AH2.2



Appreciating Precarious Engagement in Homeless Health Care

Health Services:

This section is organised as:

- Attitudes in mainstream services
- Learning to recognise oppression
- Recommending a Multi-Disciplinary Team in the Health Needs Assessment report

Attitudes in mainstream services

In Year 2, I focused on developing further knowledge on health service response. Clinical texts illuminate some of the resistance I experienced from health professionals which became a focus of self-inquiry as I came to develop and *know services*. Reflective practice and guidance, guided my *aesthetic response* as shown in this section. Recognising and effectively responding to negative attitudes towards homeless people was the key insight to *create an environment where being available* is possible, weaving a tighter net.

Some key health professionals responded passionately to homeless health care development which resulted in national recognition with PCT pharmacists (Texts:14). However, compared with my children's services background,²¹⁸ *knowing services* illuminated *precarious engagement*. Resistance to engagement felt like 'walls' of resistance wherein I sought to shift social norms through *use of voice*: speaking-up against tradition, embodiment or authority (Fay, 1981) that prevented net-weaving. Wiman and Wikblad (2004) also refer to 'walls' in a study of caring and uncaring encounters of nursing in an emergency department. They draw on Halldorsdottir (1996) who uses the two metaphors of 'bridge' or 'wall' when describing the patient's experience of care. Bridges are the metaphor for connectedness, akin to my net theme; walls are not. They note,

Nurses build walls of different sizes and shapes which symbolise negative or no communication, detachment and lack of caring connection (Wiman and Wikblad, 2004:424)

In Year 2, walls were easily palpable (Texts:9,10,12,13). In Gadov's (1980) paper on existential advocacy she states,

Patient advocacy is seeing that the patient knows what to expect, and what is right... [and] the willingness and courage to see that our system does not prevent his getting it (p.84)

*prevent his getting it...*My effectiveness, particularly as an advocate, depended on being heard by health colleagues - dismantling the walls.²¹⁹ Understanding how system prevents his "getting it" became my focus of inquiry. Reflexively, I turned to Fay (1987) and Belenky et al (1986) to shed

²¹⁸ See chapter 1

²¹⁹ At this time I was also developing ward packs on homelessness to accompany the Hospital Discharge policy; distributing Health and homeless leaflets throughout health services including A&E services, and the discharge planning teams

light on the 'walls of resistance' which contributed to precarious engagement that impeded my net weaving vision as discussed below.

- **Learning to recognise oppression**

As I got to *know services*, I recognised that the power of oppression in health services was a significant 'wall of resistance'. The most menacing I experienced, was power as 'brute force' (Fay, 1987:119) which silenced me (Belenky et al, 1986) in family homelessness (Text:12). My vision for a notification system between housing and health was strongly opposed, hidden even, at a prudent time when it could have been incorporated into a children's service review.²²⁰ The manager asserted her authority over me with threats of sanction if I continued to voice my concerns. Used as "threat or harm" (Fay, 1987:121), power in this instance, brought about an unhealthy fear (Rutledge, 2005), arising from my embodied response towards the nurse's seniority as she commanded a bureaucratic-hierarchical communication style, traditionally used in nursing. The 'brute force' felt like violence, which I rename as 'political violence', akin to horizontal violence in nursing which arises from stress in the oppressor (Street, 1992). Acting as a tough-minded 'door-keeper,' the manager defended her position, rather than speak a common language of connection with myself, her Health Visitors and Government guidance (CVPHVA, 2004). Clearly, an insight for developing practice was that I had to manage political violence and develop my own strong political and moral voice in strategic development rather than be silenced.

I was becoming more aware of other forms of oppressive power evident in practice. I experienced power by coercion, "assertion of one group over another" (Fay, 1986:121) at regional level where homelessness, health and housing seemed disconnected until I used my voice strongly towards health inclusion (Text:11). In clinical practice examples of oppressive power included: receptionists blocking GP registration until sanctioned by practice managers - reflecting a traditional stance (e.gText:9); the A&E staff nurse (Text:10) who used 'power by manipulation' (Fay, 1986:123), attempting to dissuade me from sending Dora to A&E; coercive power used by the mental health team, where, collectively, it had been decided that Rudi's Personality Disorder (Text:13) entitled him to crisis intervention only - yet when accessed, he experienced treatment as inadequate. I name this as 'policing of health services' where health workers use "combative energy" (Belenky et al, 1986:116) to prevent health issues being effectively addressed in complex needs of homeless people.

Generally, I was skilful in dismantling the 'walls of resistance', knowing that separate knowers have a weak sense of identity, feeling secure only when they place themselves in a niche within a

²²⁰ The service review was later led by a senior project implementation manager and family homeless incorporated into the major redesign of children's services. Family notification systems were implemented in 2010

structure (Belenky et al 1986).²²¹ Appreciating *precarious engagement*, I was able to challenge disengagement through *use of voice* as a growing part of my transformation in homelessness (Texts:9,10,13). It demanded courage as Gadow (1980) suggests.

But, for homeless people with limited personal resources, negative attitudes by health professionals concerned me. Wright (2002), in his GP practice with homeless people, notes them to be a trigger to aggressive responses. I was beginning to understand how negative attitudes from health workers were perpetuating the very prejudices they held about homeless people - contributing to the concept of precarious engagement?²²² Wright pragmatically suggests,

The core ethos is encouraging (GP) consultations where the homeless person is seen as equal to the doctor and not a subordinate (p.36).

HNA Report: insights for a MDT in homeless health care

'Walls of resistance' by health services towards homeless people was leading me towards recommending a MDT in the HNA report because it felt as if the soul of caring or 'caritas' (Watson, 1997) was absent in mainstream services, impeding my vision of inclusion *to create an environment where being available is possible*.²²³ Using Watson's concept of caritas as caring, Cara (2003:9) notes it is,

... a special way of being-in-relation with one's self, with others, and the broader environment... the nurse has to be conscious and engaged to care in order to connect and establish a relationship with the cared-for to promote health/healing.

the nurse has to be engaged... in the broader environment. Without effective caring and knowledge of multi-agency services, the vicious circle of exclusion is perpetuated. Picard (1997:41-53) notes,

Without honoring the soulful experience of patienthood, the person is left in a disengaged, vulnerable, potentially, suffering place..... The focus is the soulfulness of engagement as communion at whatever level of care the person needs, be it a wound-dressing change ... or a dialogue about the loss of a child. With this orientation ... nurses can honor the reverence of each unique human life in a new way, opening up to the creative potential inherent in all activity. This is an essential aspect of compassion and care for embodied souls.

²²¹ See p. 85

²²² For example, a pregnant homeless woman having slept in her car for several nights, was refused GP registration without ID or an address causing her to swear at the receptionist. She was subsequently banned from the premises. Outcome: This was caught in the net - a PALS complaint resulted in GP commissioners visiting the practice. Another homeless person was concerned because a GP commented on his rights to owning a mobile phone.

²²³ My *being available* (Johns, 2009) to homeless people was not always possible in my part-time role. Homeless people experienced health services as uncaring, as expressed in this narrative, in focus groups and in clinical practice

From these theoretical insights, care for homeless people by many mainstream health professionals was largely deficient; a meeting point where care becomes careless and increases suffering by causing discouragement rather than empowerment (Halldorsdottir,1996). Homelessness was an elusive concept; its complexity largely unrecognised. In reflective guidance (Text:10), my Public Health role was described like a hand coming down into diverse clinical spaces to net weave yet it was not easily contextualised by clinicians or managers as it crossed so many health silos (Texts:10,9,13) and reached into strong multi-agency partnerships. As clinical and strategic tensions competed my insights for practice in Year 3 were strongly leading me towards recommending a homeless multi-disciplinary team along with mainstream service development to prevent people *falling through the net*.

The Homeless Person

To *create an environment and have concern for the person* requires constructing an effective therapeutic relationship. In this section key insights are organised as:

- My role in complex trauma and entrenched homelessness
- Developing knowledge of childhood trauma as triggers into adult homelessness
- The therapeutic net: recognising the creative tension between enablement and advocacy

Complex trauma and entrenched homelessness

Maguire et al (2010:3) notes,

The experience of sustained exposure to traumatic events has recently been termed *complex trauma* (Herman, 1992). This sustained exposure to toxic experience distinguishes complex trauma ... from post-traumatic stress disorder ... cognitive, emotional and behavioral reactions to a single event. Although circumstantially complex trauma makes clinical sense in terms of a high prevalence of childhood abuse and neglect in the entrenched homeless population, very little research has been conducted on how the resulting personality disorders lead to entrenched or repeat homelessness.

...*Very little research ... entrenched homelessness*. In texts:13,10,9,8,4 entrenched homelessness associated with complex trauma is illuminated. Creating *a suitable environment* required that I weave a therapeutic net where trauma, when it is revealed, is effectively managed by services. Maguire's statement affirms my appreciation of *precarious engagement*; in the complexity of homelessness it often felt to me as if patients were in a war-zone, a battle-field of survival needs, financial destitution, service disengagement, and evictions - all sitting alongside their health problems including complex trauma. In the midst of this, I described myself as the hub of the wheel - a war-zone nurse - engaging people by my *use of voice* in a fragile net of services where the interventions which Maguire et al illuminate had yet to penetrate local entrenched

homelessness.²²⁴ I was not surprised by repeat homelessness, which Maguire refers to, but I was concerned when health professionals did not do their part in alleviating it, perpetuating entrenchment! (Texts:9,10,13) Johns notes "...the realisation that practitioners can be uncaring and contribute to, rather than ease suffering, is profound." (Johns, 2009:78) His methodology enabled me to paint the whole picture of the battle-field as I was witnessing it, bringing new practice knowledge around precarious engagement with health and other services in the hope of affecting positive change in homelessness and complex trauma.

Developing knowledge of childhood trauma as triggers into adult homelessness

My health visiting experience with families resonated with homeless people - they often disclosed for the first time their experience of childhood trauma. The significance of a Health Visiting model in homelessness is not only its therapeutic intent, illuminated in clinical texts but its preventative aspect where trajectories into adult homelessness from childhood triggers are revealed, pertinent to services (AH2.3).

²²⁴ Maguire (2009:8) "These include family therapy, therapeutic communities, behavioral contingency programmes, cognitive-behaviour therapy, psychodynamic psychotherapy, 12-step programmes, and generic counseling in the context of supported housing. There is as yet no evidence to support the suggestion of a single treatment of choice."

	Childhood trigger	Adult homeless/ health experiences	Towards preventing adult homelessness
Robert 23 yrs (Yr 1 - Text 7)	Health and family focus is on twin sister, Emma, 15, receiving palliative care for leukaemia. Robert finds relief in 'street-drugs' with friends	<ul style="list-style-type: none"> • Chest pain • Anxiety • Survivor guilt; feelings of worthlessness • Heroine and cannabis misuse • Smoking • Paranoia • Nine episodes of offending - no family history of offending 	<ul style="list-style-type: none"> • Child in Need/CAF • Primary care: Macmillan team working <i>with</i> children's 0-19 team • Children's bereavement counselling/family counselling • Family drug intervention programmes
Heidi 49 yrs (Yr 1- Text 8)	Maternal mental ill-health and domestic violence culminates in mother's suicide. (Heidi finds mother with plastic bag over her head). Heidi introduced to child prostitution by her father	<ul style="list-style-type: none"> • Sprained ankle • Personality Disorder • Alcoholism • One episode of offending 	<ul style="list-style-type: none"> • Child in Need/Safeguarding • Primary Care: Mental health services working with 0-19 children's services in Primary care • Children's counselling services
Lucy 16 yrs (Yr 2 - Text 15)	Parental mental ill health/ sibling has learning disability. Lucy experienced 'daily beatings' - believing it was normal until she discussed it with school friends aged 10	<ul style="list-style-type: none"> • Extensive cutting (self harm) • Depression • Suicidal tendencies • Sexual health 	<ul style="list-style-type: none"> • Child in Need/Safeguarding • Primary care: Joint working between mental team, learning disability team and Children's 0-19 team • CAMH outreach/transition into adult services model
Ariella 19 yrs (Yr 2- Text 16)	Mother dies in volcanic eruption when Ariella was 9	<ul style="list-style-type: none"> • Loneliness/isolation • Anxiety, depression 	<ul style="list-style-type: none"> • Primary Care: GP new patient assessment/CAF • 0-19 Children's team • Bereavement counselling
Farrah 19 yrs ²²⁵ (Yr 2)	Father dies. Step-father is physically and emotionally abusive. Mother 'looks-on'.	<ul style="list-style-type: none"> • Self harm (cutting) • Anxiety, depression, • Agoraphobia 	<ul style="list-style-type: none"> • Child in Need/Safeguarding • Step-parenting programmes for family adjustment. • Freedom programmes for domestic violence
Ned 29 yrs (Yr 2)	Father dies. Sexually abused by one of five brothers. Becomes Looked After Child	<ul style="list-style-type: none"> • Depression • Offending history • Wants to be a 'good' father 	<ul style="list-style-type: none"> • Child in Need/Safeguarding • Information at school - "somewhere to go and someone to talk to" in family crisis

AH2.3

²²⁵ Ned and Farrah's texts were not included in the narrative due to word limit - to be developed in a post doctoral paper

In AH2.3 the childhood triggers noted may not have alerted me towards possible trajectories into adult homelessness when I was a family health visitor or school nurse. Neither would I have appreciated the preventative array of potential partnership working (end column)?²²⁶ These are significant points in my transformation. I considered my role development as a homelessness-health educator to make a stronger preventative net in future practice which would include homelessness outreach placements for health visitor/school nurse students.

But how should nurses deal with such deep psychological issues? Reflecting further on life journeys of homeless people and the key role nurses play in family intervention, a Scottish study on Health Visitors and School Nurses working with children with psychological and behavioural problems was illuminating. Wilson et al (2007) discuss how key community nurses deal with complex problems, often without the local support of qualified mental health professionals. The authors cite an inability to access swift specialist support as a key concern leaving the nurses ill-prepared and overwhelmed to deal with many psychological and behavioural problems. However, parents and children preferred nursing intervention, perceiving them as reliable, *available* and non-stigmatizing (O'Lunaigh, 2002; Baudier and Pallais-Baudier, 2005). This resonates with my homelessness practice on several levels: it confirms where children may *fall through the net of services* regarding psychological support and illuminates my *being available* as a nurse when key others are not available in homeless health care.²²⁷

In AH2.5, Ned's comment in the bottom/end column illuminates the therapeutic importance of the clinical space. Seeking to understand what may have prevented homelessness, I would often ask, "What would have helped you?" The reply, "This, simply this; it's perfect" reinforced nursing's therapeutic outcomes.²²⁸ But at times my role boundaries were challenged (Text:9) particularly when mainstream psychological pathways were difficult to access before 12 weeks (Text:8), psychology referrals by mental health services were not made (Text:13) or because of the person's resistance to referrals because of previous psychological interventions (Text:9;15). Like nurses in Wilson's et al's (2007) study, I identified my need for extra clinical training,²²⁹ structured access to fast-track psychological services, and supervision. Supervision reinforced the importance of reflective guidance in my practice.

²²⁶ Families are currently encouraged into Common Assessment Framework (CAF) when needs are identified, my insights from homelessness practice illuminate the significance of joint working in family crisis across health disciplines, as well as other services.

²²⁷ E.g. I had acquired fast-track PCT counsellor but as a non-commissioned service his time was limited. He met one person for six sessions only. Others (E.g. Robert Text 7 did not want a referral but preferring my services)

²²⁸ Text:7 Robert's quote (clinical consultation prior to written text),

²²⁹ Training requirements identified for nurses in Wilson et al's study included: self-harm, mental health problems in children and young people, violence, substance misuse, deliberate fire-setting. The QNI (HHI) offered national support and training to nurses from 2007 which I attended.

Developing the therapeutic net: the creative tension between enablement and advocacy

Both enablement and advocacy remained key aspects for inclusion in the therapeutic net. Howie et al (1997, 1999) defines enablement as the patient's therapeutic experience with a practitioner where the clinical encounter enables a patient to cope with and understand his or her illness. In the narrative, enablement contextualises illness within the ontology of being homeless and empowers the homeless person (E.g. Texts:16,15,8,7); it does not create dependence and this is evidenced by my maximum patient contacts in homelessness as 6 (Text:7). Advocacy is also therapeutic, acting both as 'trouble shooter' and 'professional friend' (Gadow, 1990) in the lived reality of *precarious engagement* by mainstream health services: in crisis intervention/referral resistance (Texts:13,10,9) and in surface engagement, not engagement which seeks to establish a caring relationship which makes nursing effective (Watson, 1997) (Texts:3,4,5,6). When complex constellations in homelessness conspired against effective engagement (Texts:3,8,9,10,13) I was alerted to safeguarding of vulnerable adults within systems - an area for further learning development in Year 3.

The tension between enablement and advocacy is summarised in AH2.4. I also show key SPHN therapeutic skills and creative tension of the SPHN role

Enablement and Advocacy in the Therapeutic Net

Enablement

Environment: Therapeutic empowerment

- Being heard
- Being re-energised
- Being empowered
- Having a good knowledge of services
- Feeling anchored between services

Advocacy

Environment: Therapeutic - weaving the health service net for those who

- Feel silenced
- Feel excluded
- Require specialist mainstream services
- Have lost trust in services
- Require safeguarding

SPHN Skills in advocacy and enablement for weaving the therapeutic net

- Clinical skills: open therapeutic space that grasps health impact of homelessness; ability to hear suffering; recognise trauma/childhood trauma; empower rather than create dependence.
- Appreciation of 'social disability' where people find it difficult to access or engage with services e.g. when they have lost trust or feel unheard.
- Public Health skills: high multiagency collaboration and clinical challenge
- Education: Reflective practice/guidance

SPHN Practitioner Risks

Current reality versus my practice vision

- Heavy and complex work-load in clinical and strategic role
- Lone working
- Emotional labour required in negotiating 'walls of resistance'
- Low psychological/psychiatric support for patient care
- Vicarious trauma/burn out (see p.226)
- Tension in leadership/health models:
HNA Recommendation: MDT required to support the clinical workload

SPHN: Appreciating Precarious Engagement

AH2.4

Specialist Public Health Nurse

To *be available* required me to be aware of *poise* in my role as a SPHN. Insights are organised as:

- Being courageous
- Preventing vicarious trauma and burn-out
- Supporting practice: art and spirituality

Being Courageous

The origin of the word courage is derived from the French word for heart, 'coeur' (Oxford Dictionary of English, p.397). I was becoming more aware of courage as a key requirement in homelessness practice to prevent fear becoming an obstacle to my net-weaving not just clinically (Texts:4,7,10,13) but strategically (Text:11,12). Mindful of my background spirituality,²³⁰ mantras such as '*Love more and you will fear less*'²³¹ (SSCC, 1804:199) inspired me to focus on each patient's humanity and develop my political voice. In nursing, Lindh et al (2010) cite two predisposing conditions required for moral courage:

- Recognition and experience of others' suffering
- Compassion

They also note,

... it is necessary for nurses to have the courage to recognize the potential for seeing what is, reaching a vantage point of insight on what could be, and having the courage to act according to what ought to be (p.561).

Courage leads to positive outcomes: self-affirmation, the ability to effect change, to face challenges, and motivate others (Lindh et al, 2010:564). In strategic practice 'to act on what ought to be' meant developing my *use of voice* politically as an effective *aesthetic response* against what I termed political violence as discussed earlier in this AH.

Preventing Vicarious Trauma and Burn-out

Vicarious trauma, where professionals experience acute distress when working with trauma survivors for 30 or more hours a week was noted by Killian (2008) who states,²³²

...bodily symptoms are diagnostic criteria for PTSD and are initial evidence that therapists who work with severely traumatized clients do run the risk of developing secondary traumatic stress (p.33)

²³⁰ See Chapter 1. DHS Lay Associate. Mission statement: "...we are sent forth *in boldness* to witness God's tender love for all, especially the least favored, so that all may have life and have it to the full" (my italics)

²³¹ In a letter to Sister Agnes (SS.CC.) from her superior in Cahors in 1804 (BM 1804-1805, pour la Soeur Agnès à Cahors, LEBM 199 www.sccpicpus.com - accessed 22nd August, 2011

²³² Killian describes traumatic events as: child sexual abuse, domestic violence, exposure to combat zones, and displacement.

To *be available* I had to manage the impact of stories of childhood suffering and other trauma to prevent vicarious trauma. Whilst I remained passionate and energetic in practice, unlike those who have vicarious trauma, I was alert to a growing risk of burn-out as my role snowballed. Through effective *use of voice* I managed any "sense of powerlessness and helplessness to affect processes in larger systems" (Killian, 2008:40) (Texts:9,10,11,13) through reflective practice and guidance, but I also recognised that the growing net required a MDT in homelessness - a recommendation for the HNA report in which the clinical and strategic tension in my role would be alleviated.²³³

Supporting Practice: Art and Spirituality

In Killian's study of vicarious trauma, one effective coping mechanism for therapists was to attend to their own spiritual needs. Whilst I attended to my spirituality through religious associations,²³⁴ the use of art developed in reflective guidance workshops also honoured my practice stories. Marek, in Farrelley-Hansen (2001), perceives art as a spiritual practice,

I could not put words to my experience ... I knew the broken world of Chicago contained a world that was sacred (p.53)

The power of art to connect with experiences through colour and shape deepened my appreciation of trauma in homelessness whilst being self-protective, meditative and sacred. Art (Text:13,15), photography (Text:8), and later performance enabled me to play, to be creative, to make sense of the health-homelessness world. This aspect of reflective guidance is developed further in Chapter 5.

Homeless Services

Practice insights regarding *creating a suitable environment* in the net with multiagency services are organised as:

- Being a peace-maker
- Collaborative working - instilling a health orientated network

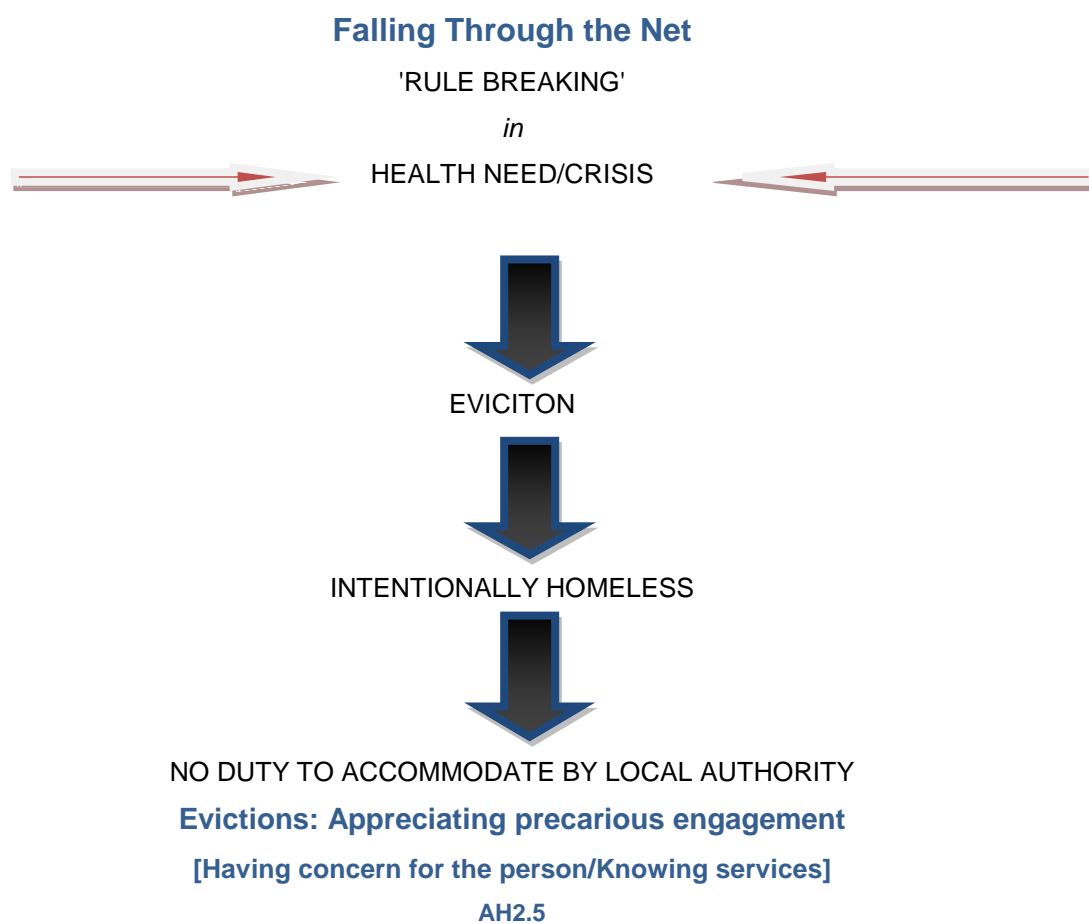
Being a peacemaker

In reflective guidance we noted how I was becoming a 'peacemaker' to homeless services particularly in pending evictions where health needs were evident (Texts:15,13,9,8,7,5,3). Evictions occurred through varying degrees of 'rule breaking' (Texts:9,3,15) often triggered by health crisis,

²³³ Killian's (2008, p.36) study of 20 therapists illuminates key risk factors in developing stress: High caseload demands and/or workaholism, personal history of trauma, irregular access to supervision lack of a supportive work environment, lack of supportive social network, social isolation, worldview (overabundance of optimism, or cynicism etc.), ability to recognize and meet one's own needs (i.e., self-awareness)

²³⁴ Background chapter personal fore-structure: DHS Lay Associates (p.27)

perpetuating the cycle of homelessness (AH2.5) even when their health categorized them as a *priority need* housing category.²³⁵



Evictions identified holes in the net. Peacemaking was net weaving. Elise Boulding, a feminist peace researcher and educator, grounded her work in her early experience of parenting and social activism. Morrison (2006), writing about Boulding's work, identifies how the philosophical values of love, compassion and reverence for all life create a better world and are empowering. Morrison notes of Boulding,

If her ideas may be summed up in one word, that word would be networking - sharing the knowledge gained in one sphere with colleagues, friends and acquaintances in other settings. Central to her ideas on connectedness...the skills needed to build a peaceful world include listening and dialogue... (Morrison, 2006:173)

Listening, dialogue, networking - resonance with my practice vision.... I networked with Shelter about local evictions and they forwarded Outcomes Star Guidance on deferring evictions. Further

²³⁵ E.g. Fear of mental health illness, fear of self harm, not being in own rooms by 10.00pm, zero tolerance for drug paraphernalia, or alcohol.

networking with the local housing manager, Supporting People commissioner and the homelessness forum made evictions visible. At the AGM, the Homelessness forum invited a speaker from Brighton's Inclusion protocol and training was arranged by the Housing Manager on anger diffusion.^{236/237}

Collaborative working

Central to the philosophy of peace was power in relationship, not power by hierarchy (Morrison, 2006) which is evident in medicine management (Text:14). Generally, I was immersed in integrating health services into hostels, day centres, night shelters.²³⁸ I used my voice with homeless services as a mentor, ally, instructor and friend to offering emotional support amidst daily frustration and conflict that homeless service staff experienced. Homeless services were becoming health enhancing communities through my collaborative *use of voice*.

Development of Voice

In Year 2, I became more aware of my voice particularly where I was or was not being heard by local health services. Silenced by a manager, it made me more aware of voice as a key tool of shaping my practice which required political courage which I sought to develop in Year 3. Generally, I learnt to challenge prejudices, be a witness, act on what I saw and be knowledgeable about homelessness and health.

In contrast to some local responses to my voice I presented and co-presented two papers at the International Reflective Practice Conference in Aalborg in the second year of research. Moved by my presentation (sixth dialogical movement) including the use of photography in my practice with Heidi (Text 8) and excited by Johns's narrative construction methodology Lea Gados, an art therapist nurse who has published widely on personal narrative and holistic nursing (Gados, 2005, 2004a, 2004b, 2001) dialogued about the narrative, emphasising that "The turning point was renaming Heidi's suffering as torture". This insight affirmed the value of my therapeutic role in the net. Who else was available to affirm Heidi's experiences - to validate her life story at such a deep level, enabling her to engage with her traumatised self at a crisis point in her homelessness narrative? My practice story was engaging an international audience on homelessness whilst Johns's methodology introduced another student to the PhD group.²³⁹

²³⁶ Outcomes Star Guidance was developed for St Mungo's, one of UK's largest homeless voluntary organisations

²³⁷ The LA was then cited in national good practice (CLG, 2009). In 2011, the new evictions (inclusion) protocol was evaluated by Supporting People with improved outcomes - evictions were significantly reduced

²³⁸ E.g. facilitating health training, pharmacy initiatives, challenging mental health teams who refused to engage.

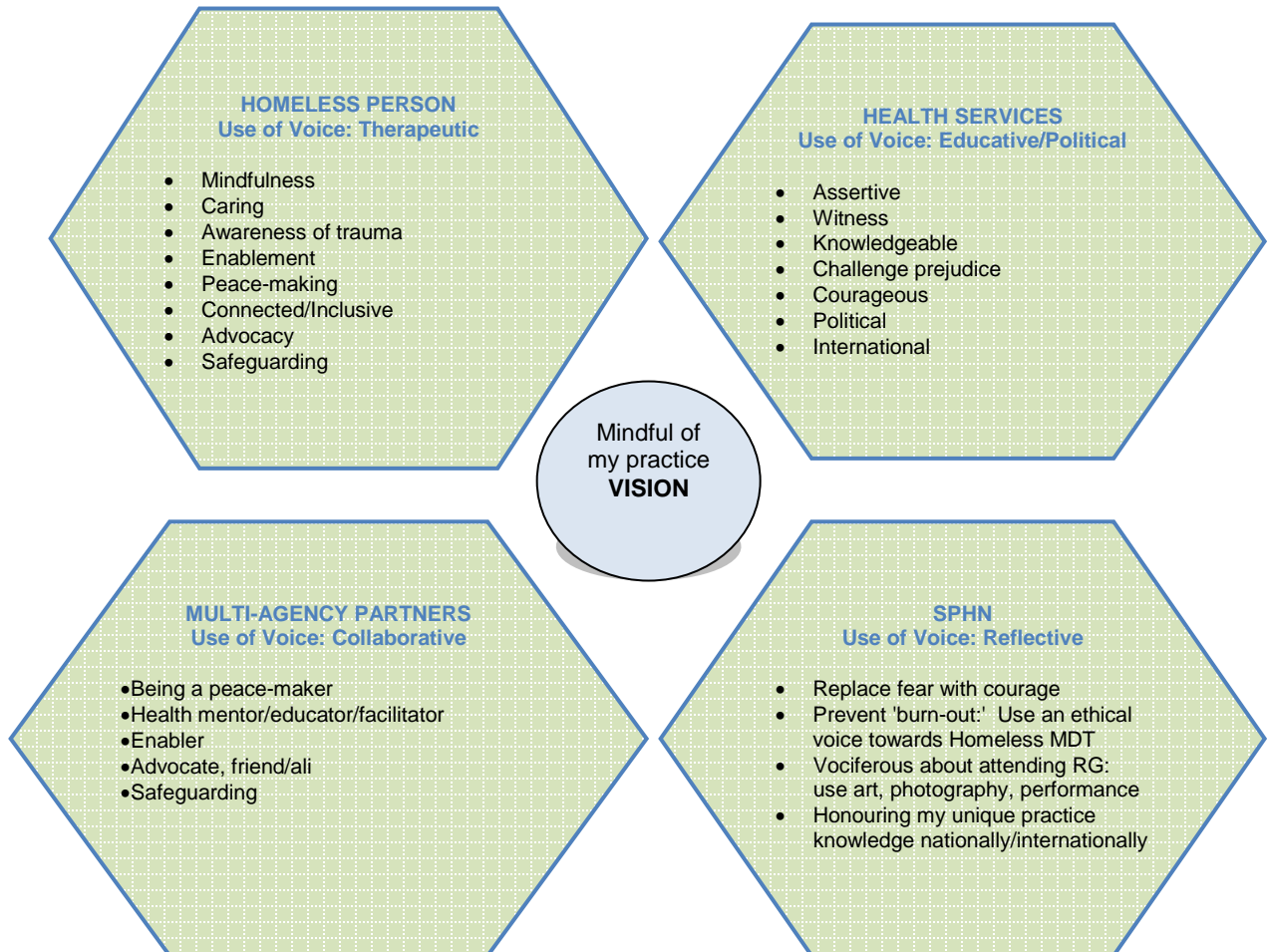
²³⁹ Margaret Graham, University of Limerick

Year 2:

Appreciating Precarious Engagement

Weaving the net

- My voice in practice



AH2.6

Year Three

Developments

My third year of reflecting on my practice is set against Improving Lives; Saving Lives (DH, 2006) and its regional variation: The NHS Commissioning Framework 2008/9 (East of England, 2007). Nine regional pledges were made to improve health services. Homelessness fell into Pledge 9,

We will ensure that access to preventative and healthcare services is as available to marginalised groups and looked after children as it is to the rest of the community (East of England, 2007:6)

The following texts were developed at a time when Theatre Studies lecturers became Reflective Guidance PhD mentors.

Text 17 - EMBRACING THE LEAP

Joint thematic partnership group:
HNA report dissemination²⁴⁰
3rd December, 2007

Make haste, my beloved, and be like a gazelle or a young stag upon the mountains.
(Song of Solomon, Holy Bible, Ch8:v14)

It is time to leap energetically from clinical into higher strategic groups to voice homeless health needs. Until now, I have been enmeshed in the suffering existence of homelessness where clinical needs always override strategic projects.²⁴¹ I reflect now on my political skills across the 'board' room table. This meeting is extremely influential and feeds into the LSP (Local Strategic Partnerships) which influence LAA (Local Area Agreement) – the Government's local agreement to the people in our area to improve health and reduce inequalities.²⁴²

Excitement overrides fear because I have practiced what to say - to 'become my vision'. It is the first opportunity, outside Health, to raise awareness of local multi-agency gaps in homeless health care. I am conscious that there is much criticism of health services voiced by homeless people in my report.²⁴³ Can I put the concerns across constructively? Can I challenge strategic complacency around homelessness where it exists?

The group is chaired by a lawyer involved in a local charity where funding opportunities lie. Other group members include senior officers from Public Health, NHS Commissioning, Mental Health, Education, Social Services and Supporting People commissioners. Apologies have been received from a Local Authority Chief Officer and a Housing manager. Aware of *the net* strengthening and expanding in local homelessness, I am unsurprised that the housing manager phoned me earlier about issues he planned to raise. He seems oblivious to any political sensitivity in asking me to take them forward on his agency's behalf. His concerns are my concerns - mirroring the same holes in the health care net:

- o CMHTs lack pathway precision in developing mental illness crisis (Texts:5,9,13) and referrals are bounced between teams. Homeless services perceive them to lack awareness of each other's roles and of homelessness.

²⁴⁰ A fore-runner of Health and Wellbeing Boards

²⁴¹ The journey of the HNA itself has been a long and arduous one, and in reality I am 18 months post the date I hoped to roll it out. I am also finalising the hospital discharge protocol, investigating Notification systems between Housing Departments and the PCT at a time of national NHS changes resulting locally in the dissolution of teams and administrative support.

²⁴² Improving Lives; Saving Lives (DH, 2006), East of England Commissioning Framework.

²⁴³ From focus groups and clinical interventions

- Mental health diagnoses are required early to categorise *'priority need'* and ascertain whether there is a duty to be accommodated. As homeless people present later in illness journeys (Wright, 2002), referrals need to be proactively and rapidly managed.
- For those with undiagnosed mental health needs who are vulnerably housed or homeless, a multi-agency protocol is required to support their needs.
- There is a gap when increased mental health needs do not meet MH services criteria and hostel accommodation cannot be sustained.

In his farewell remarks the housing manager reflects positively on how I am perceived by other agencies in the town,

"You must be cloned. At every meeting I go to I hear your name. How do you manage it all? Everyone talks about your work with them."

The dramatic impact of my specialist nursing role for homelessness services is visible. Crucially, his comment affirms the need for a MDT around me as recommendation in my HNA report. My focus at this meeting is to influence its development in order to accommodate the expanding net

The meeting begins. The directness and efficiency of the Chair is well-known - he doesn't introduce group members, heading straight to the first agenda item instead. I choose not to be an anonymous,

"Can I introduce myself"

As I do, another person speaks and another...three new people in the meeting. I have made an assertive start and observe the chair looking awkward in his faux pas.

It is clear that funding is a major part of the group's work and I try not to recoil. Successful communication, in part, requires that participants draw from a common vocabulary and experience (Hadlow et al, 1991). Various funding streams, and jargon like 'LAA' (Local Area Agreement) and the 'LPF' (Local Performance Frameworks) require me to acclimatise to the group's language.²⁴⁴ It reminds me of the first report I heard on labour ward; I thought I was listening to a mathematician - not a midwife reporting on the imminent birth of a baby.²⁴⁵ I soon became an expert, rapidly proficient in its use. Now, in a similar situation I do recognise the jargon but find it difficult to retain because I don't use it on a daily basis. I challenge myself: if I am to become strategically effective

²⁴⁴ See CLG (2007) *An Introduction to the Local Performance Framework – Delivering Better Outcomes for Local People*, HMSO, London

²⁴⁵ Dilation measurements of cervix, foetal skull measurements of presenting circumferences

for homeless people, I must learn it. Perhaps, I am a subjectivist women (Belenky et al, 1987:71) who, “*distrusts logic, analysis, abstraction and even language itself*” – because I do not understand it - or a woman silenced by funding-speak because my own health budget is so small.²⁴⁶ Reflective guidance reminds me of another perspective - perhaps I am simply a woman in a patriarchal society - join them or perish!

With mixed feelings of delight and sadness, I listen to reports from two head teachers about an early intervention project for children that are causing classroom disruption. It has received national attention. The project is exciting and challenging, inadvertently relating to homelessness prevention. Do they realise that? Later I ask them. But it highlights the decline and crisis in Health Visiting services where their projects replace a traditional Health Visitor role.²⁴⁷ The Director of Public Health, drawing on my Health Visitor experience, invites my comments,

“Any early intervention project like this is welcomed but the findings could be viewed as a national concern. Childhood disabilities that are becoming evident through this project may have been detected earlier by regular Health Visitor contacts - these have declined in recent years.”²⁴⁸

The chair attempts to rein me in but I have already made the political point about my profession.

“National government changes are not within the control of the group - although with the success of the project it could be expanded to a younger age group so that disabilities are detected earlier.”

I am intrigued by his skill to keep the discussion focused whilst also valuing what I have said. This style of strategic leadership-in-action develops awareness of how I could develop my political skills.

I link the project to the prevention of single adult homelessness, so that locally, they can appreciate life patterning where major themes and patterns within each person's story relate to his or her despair (Cowling, 2000).²⁴⁹ Robbins (2002), comments that weaving your message into your listeners concerns is a powerful form of communication. I challenge the presenters to consider how many of the children in the project are homeless. Two Heads' nod! “*We have children from the refuge and from TA.*” We smile in connection. The impact of my role in this group is made, and I have yet to disseminate the HNA report. I am conscious of my voice being “*responsive to situation and context*” (Belenky et al, 1986:138). Viewing connecting *nets*, I feel like a gazelle happily leaping to the top of the mountainside.

²⁴⁶ £2,000 per annum - leaflets, facilitating training, travel to HHI events, homelessness literature, developing ward packs

²⁴⁷ 18 month and 3 year developmental checks in the home

²⁴⁸ Home visits by Health Visitors are targeted following universal 'birth visit' health assessments.

²⁴⁹ Cowling explored despair in the context of 10 life situations: major depression, addiction, sexual abuse, child abuse, homelessness, loss of a loved one, terminal illness, spinal cord injury, infertility, and chronic illness.

The mental health manager begins **his** agenda item - 'Homelessness and mental health'.

“Well there isn’t much to report. I’m going to have a meeting with the Housing manager and he can use the protocol developed in the south of the county.”

His timid and impassionate response irritates me. How can he miss this opportunity to raise awareness of mental health issues in homelessness and inspire people? As I pitch my challenge, I find it difficult not to condemn. My list from the housing manager does condemn. How can it fail not too? I soften what I am saying, stating that the issues in homelessness are entangled with complexities which affect all health disciplines. We enter into constructive dialogue about interventions that would be effective and agree to a three-way meeting. I am now positioned strategically with him and the Local Authority for developing mental health services, combining the political power of three agencies to shape and influence policy (Hakesley-Brown, et al 2007).²⁵⁰

“Have you anything further on homelessness, Maria?”

Not swayed by the Chairs remark seemingly finalising the homelessness section on the agenda I intend to disseminate my HNA report and begin with a stark focus group quote from a rough-sleeper, who had lived on our streets from the age 14, *“Homelessness is like a fire....it eats you up - it eats everything”*. The local connection captures their attention instantly. I aim to change perceptions: *“They miss appointments because they often don’t have watches...They can’t cope with fast, efficient NHS systems - they may not have the capacity to deal with them”*. The Chair sits back, relaxed, in open body language. Confidence exudes from me because of Health Visiting and homelessness experience - I am flying. So much so, that he comments on the local charity he is involved with and suggests I consider a bid which he will look over prior to submission. Bingo!

The Chair articulates my networking role, *“This is about connecting health services - you are ideally placed to do that.”* As he looks the PCT Director, I experience a nudge to let go of clinical practice to coordinate clinical pathways strategically, particularly as the night shelter GP suddenly began weekly surgeries at the day centre. There is agreement that my priority for setting up training for all health care staff is vital and could include performance.²⁵¹

I am invited to become a permanent member of the group, keeping homelessness on the agenda. I feel empowered by my constructive voice (Belenky et al, 1986). The new social services

²⁵⁰ The following day I attend the Supporting People consultation strategy event (2008-2011) in which mental health support is explored for homeless service providers. It highlights the silos created even when agencies are working together. I invite them to become involved with our meeting.

²⁵¹ Homeless performances rolled out 2010 with UOB theatre students

representative comments after, "*I would never have guessed that was your first meeting. You were well into it.*" His feedback was affirming.

The young gazelle on the mountainside extends the proverbial *net* strategically in homeless health care. As I review this experience reflexively, it is Wheatley (2006:182) who offers the insight,

Over time a network is fuelled more by passion than by information...

Post-amble

A Mental Health Task Group is initiated, accountable to this group through me and the Housing manager (Text:19).

As strategic others begin to fix the netting with me around services, the net feels less ragged, more organised, and stronger,

But there are still holes

DEVELOPMENTAL FRAMING 13

REALITY PERSPECTIVE

VISION

Build specialist services towards a MDT including:

- Psychiatric nurse
- Practice Nurse
- Health Visitor
- Podiatrist
- Direct access to psychologist

Develop stronger strategic partnerships in homelessness

Develop Health and Homeless Knowledge:

- Training: for mainstream health services
- University Education: homelessness health

Precarious engagement:

- Poor strategic understanding about health and homelessness by health managers

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

ROLE

Strategic Multiagency Net

- Making homelessness visible: I disseminate the HNA and strategically voice the 'homeless voice'
- I challenge mental health services complacency
- I act politically for social justice
- I link Health visitor role and education services into homelessness prevention
- Mental health task group is formed
- Poise: I enjoy politically performing with a strong voice

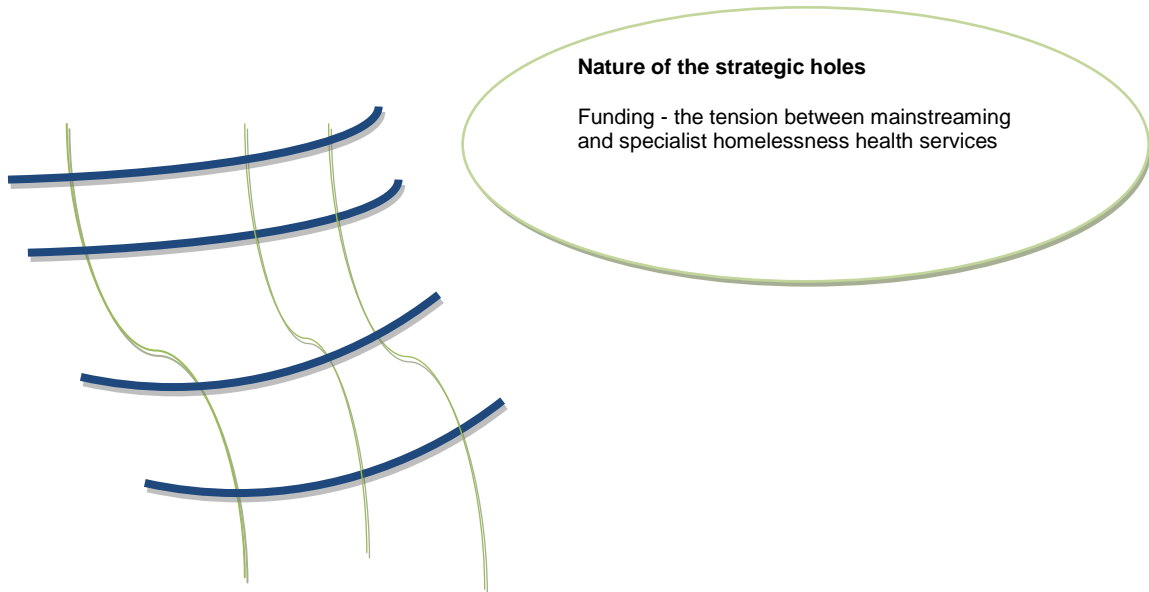


Fig 3.16
Net Weaving

Text 18 - SPAGHETTI JUNCTION²⁵²

Hospital admission and discharge

6th March 2008

I muse on how housing, health and social care systems simultaneously curve around each other like rigid steel trajectories, entwined yet disconnected, and ponder on the ability of vulnerable or homeless people to negotiate them, particularly when they are alone and ill. So, what happens when there is a break-down on Spaghetti Junction?

Edward and Tristan are upper-middle class, intelligent men who speak with English public school accents. Both live alone, both are in housing crisis. For nearly two months since, Tristan has been stuck on Edward's grotty, 'Miss Havisham' floor; doubly incontinent, deeply depressed, continually scratching, and unable to adequately converse - broken down - physically and mentally, much like his beloved silver Porsche, which lies abandoned outside Edward's Victorian home. Edward himself has become *the* ghostly Miss Havisham figure, paler by the day with long unkempt hair, billowing like the long cobwebs hanging like grand chandeliers from the high ceiling of his damp bed-sit. He too had become *stuck* in a caring role which had been thrust upon him.

On New Year's Day a crisis mental health team arrived at Edward's drab bed sit to assess Tristan's mental health. Unaware of his abandoned silver Porsche, they advised Edward that Tristan should return to his home town, two hours drive away, for ongoing care *"or else go to Accident and Emergency services if a further crisis emerged."* Tristan was unable to do either and continued instead, to access temporary registration with Edward's GP whom, it was reported, found Edward's caring role quite amusing. In frustration Edward had brought Tristan to my clinic at the day centre. Over the next month my jacquard intervention, sought to connect health and housing professionals to Tristan's crisis, to his aloneness and to his physical and mental inability to return to his home town. Edward had said,

"No-one has looked out for him...no one wants to care for him... This man will be dead in six months. He is dying of a broken heart and loneliness."

Steinbeck's (1937) words on loneliness crossed my mind,

A guy needs somebody....to be near him. A guy goes nuts if he ain't got nobody. Don't make no difference who the guy is, long's he's with you. I tell ya, I tell ya a guy gets too lonely an' he gets sick. (p.72-72)

²⁵² Spaghetti Junction is a large road network in Birmingham. Using 'story-boards' in reflection, an image of Spaghetti Junction inspired me to frame this text with a view to performance. Subsequently, I performed this at a Pre-Conference workshop at the University of Limerick in 2009.

Heartache and loneliness connected these two men as email companions. Perhaps, I mused, Edward is right – the spiralling effects of loneliness could cause one to die - or at least become very ill. In Tristan's case a brief but ill fated relationship with a married woman had crushed him. The broken romance had triggered depression, and shortly afterwards, a Bipolar disorder was diagnosed during an acute unit mental health stay in his home town. Discharged "too early", in Edward's opinion, Tristan had subsequently squandered his inheritance on fast cars.²⁵³

During the dark, winter days of his debilitation, the fine line between being vulnerably housed and homeless was unrecognised. I pushed more skilfully through *walls of resistance* erected by mental health teams because he did not live in this area and was not permanently registered with a local GP:

*walls of resistance that rise
Like prehistoric, serrated rocks
On a silent, turbulent sea
walls that exclude
Making the visible, invisible
walls that stop flow
Towards healing
walls -what are you?
I push you
With soft, pointed words
Sculpting your granite form
To shift and create onward flow*

Languishing in Lauer (2008) I pondered on the walls. Were they erected because of the mental health team's lack of compassion and understanding of the total situation or from lack of resources (Lauer, 2008)?²⁵⁴ What stopped them recognising timely intervention to avoid involuntary hospitalisations? Lauer describes this as a form of criminalisation.

As I sought to move the mental health team's perception beyond the "ordinary awareness of the world (which) serves as the basis of (our) responses and actions," (Polkinghorne 1983:10), I kept Tristan's needs visible, requesting a copy of the mental health assessment and negotiating and

²⁵³ Bipolar disorder is a brain disease, or group of diseases, associated with periods of depressed mood as well as periods of particularly elevated or irritable mood. Although generally episodic, it is nearly always recurrent and lifelong. Recent epidemiologic data confirm that bipolar disorder is both chronic and disabling. Bipolar disorder is associated with significant mortality; lifetime risk of death from suicide approaches 20 times that of the general population (Perlis, 2005)

²⁵⁴ Citing Camilli et al (2005) Lauer describes how patients presenting in mental health crisis at an Emergency Department were provided with adequate medical care to stabilise them but their care often lacked compassion from nursing staff.

persuading the team to support Tristan²⁵⁵. On the very day that they agreed to do another mental health assessment, Tristan was brought into Accident and Emergency and admitted urgently to a medical ward - not a mental health unit.

I approach Tristan on the six-bedded bay, wondering whether he has the cognitive ability to recognise me from those clinic meetings. Sky blue, hospital pyjamas cover his lean body. His head neatly clothed by white hair, rests uncomfortably on the metal head rest. *“Hello Tristan, how are you? I’m Maria – do you remember me from clinic?”* Eyes, previously lost in an unfocused gaze on a busy ward, light up as he sits forward. Mindful of intentional touch (Connor and Howett, 2009), I hold his hand in greeting.

“I’m not too good, Maria.”

“Are you feeling any better than when I saw you in clinic, Tristan?”

“I’m not sure.”

In his debilitating depression I had expected him to be on an acute psychiatric ward but here he is on a medical ward, ready to be discharged. Can he really have made such a remarkable recovery in so short a period of time? The ward Sister had phoned me asking for guidance on the discharge of a homeless person – but why had she pronounced him homeless?

Edward, had ceremoniously dumped all of Tristan’s belongings on the hospital ward, unwilling to provide him with ongoing care and uncompromisingly, declared Tristan ‘homeless’, perhaps in an attempt to get him the professional care he felt he needed. He has not been back to see him since²⁵⁶. Supporting the *homeless* theme, Tristan believes that the tenancy for his flat is jeopardised because he has not been there or paid his rent since Christmas, and believes the ‘dodgy’ landlord would not hold it open for him. Swirling loss and chilling words sweep around his social health crisis,

“I had my credit cards stolen... they threatened to break my legs. The landlord will have let it out now. I haven’t got money. I haven’t got keys.”

Downward spirals into *homelessness* continue in his trajectory of demise caused by ill health.

“Is your car still outside Edward’s house, Tristan?”

“I don’t know Maria.”

²⁵⁵ Normally patients must be permanently registered with a local GP for the team to offer care. (Yet research clearly indicates that homeless people have difficulty in accessing permanent GP registration.)

²⁵⁶ Abandonment in hospital has occurred three times this year rendering patients homeless on discharge which complicates the discharge process

In my mind's eye, accumulated parking tickets, stick unceremoniously to the windscreen whilst clamped wheels deny the Porsche its freedom on the road. Later, I phone the police to alert them to the redundant, silver Porsche.

“Do you think you will be able to look after yourself Tristan? Can you drive – cook meals and feed yourself - the doctor's believe you are well enough to be discharged? I am just wondering how you feel about that and where you would like to be discharged too.”

“I don't know Maria.... I haven't any clothes.”

I sense, Tristan's enormous hesitancy about going “home”. I am concerned, too, about his ability to cope alone, to negotiate traffic or transport to get “home” and, once “home”, to negotiate and advocate for his own health needs – even though medics feel he is fit enough to be discharged. Whilst my good practice²⁵⁷ acclaimed Admission and Discharge protocol of Homeless People (Shelter, 2007) lays dust laden in the filing cabinet, I am mindful of Government guidance on hospital discharge,

Safe discharge is the duty of the hospital trust. (DH/CLG, 2006:4)

And on homelessness the Government states,

It is vital all hospitals consider the housing situation of patients to ensure that people are not discharge to inappropriate places, homeless or become homeless as a result of their stay in hospital. (DH, 2003:74)

As he has nowhere to go *home* to, the hospital discharge could be at odds with Government guidance particularly if Tristan is discharged to the night shelter in this condition. The creative tension I felt with mental health team stirs within me as systems allow people again to *fall through the net*. What will I do to improve Tristan's care? What would you do?

As Tristan moves on the hospital bed, the odour of sweat, scented pyjamas remind me about his entry into destitution – the request for a warm second hand jacket on that cold, January morning, in the day centre. The jacket didn't seem to quite fit, much like Tristan's awkwardness in the homeless world that surrounded him. His inability to coordinate sentences provides me with the evidence to challenge his pending discharge. I probe the Ward Sister about the nurses' observations, putting the practicalities of discharging him into reality - changing perceptions, challenging discharge cultures.

²⁵⁷ Shelter (2007) cites the protocol developed from Homeless Link guidance on Admission and Discharge of Homeless people. My work load and the multi agency coordination it needs I can only work on it periodically.

“Do you think he can do a two hour drive ... and care for himself now? Can he discuss his needs with you...Does he speak with you in more than one or two sentences?”

Sister replies:

He doesn't say much at all. He showers and eat But we remind him. There is no way he could drive all that way. He is having a psychiatric assessment tomorrow prior to his discharge.... just in case....but otherwise medics say he is well enough to go home.”

'Home' that word again. She uses it as if she has forgotten the absence of a *home* for Tristan to be discharged to.

She adds: *“He is being investigated for Huntington's Chorea ... such a horrible disease. We have tried to tell him but we don't know whether he understands.”*

Huntington's Disease! So, that may be the answer to Tristan's mental and physical demise. If he is going to be homeless or vulnerably housed, it is a major health issue which triggers concerns. I reply,

“How sad, Huntington's Disease is progressive - yet he is only just coping in a safe hospital environment - what is it going to be like for him out there - especially if he is likely to become more debilitated. He will need coordinated support and secure housing. That takes time to arrange.”

She nods in agreement, although timidity and an outbreak of Norovirus²⁵⁸ seem to preoccupy her. *“Staff nurse,”* she cries, *“bed 3 is vomiting.”* Acknowledging the stresses the ward staff are under, I confront and encourage their voice to be heard in this discharge process,

“You convey your concerns to the medics and psychs' about his discharge. I'll phone the housing departments for advice in case he can't go back to his own property.”

Phone calls with housing: it takes an hour of sophisticated haggling for either the local housing team or the one in Tristan's home town, to own an investigatory responsibility into his housing or homelessness needs. In the event of him being homeless, neither will accept a homeless referral over the phone even with a homeless discharge policy in place. If our local housing team accepts Tristan for a homeless assessment, he will be placed in temporary accommodation pending further investigation, to establish *priority need* with a duty to accommodate. A Reconnections Policy will then link him back to his home town²⁵⁹....but the local housing officer wriggles,

²⁵⁸ Norovirus, an RNA virus of the Caliciviridae taxonomic family, causes approximately 90% of epidemic non-bacterial outbreaks of gastroenteritis.

²⁵⁹ Reconnections Policy - a national development is used by our Local Options Team for homeless applications for people from out of area

“You know what it’s like Maria...so many drug dealers around temporary accommodation flats....he will be very vulnerable. He should go back to his home town.”

The housing manager in Tristan’s home town informs me that his landlord may have re-let the property if his rent was unpaid. *“But what about his belongings?”* I ask, *“Can’t someone go and check?”* *“No, that’s not our role”* she rigidly replies.²⁶⁰ If he is discharged to his home town, Tristan will have to present as homeless on the day of discharge by making the two hour journey, not knowing whether he will have accommodation that night. Only then will he be assessed regarding a duty to house him as a vulnerable person, *“And that”*, the manager declares, *“is difficult to do without proof.”*

The housing walls of precarious engagement are palpable - a reluctance to accept someone from hospital for a homeless assessment from either authority! Is it because a homeless assessment takes too long to do? Is it too complex? I argue the point with our local housing officer, knowing I have worked well with her predecessor in joint ward visits previously (Text:2). But Housing is not yielding - they play a rigid game – a reminder of curving steel in Spaghetti Junction, running alongside but disconnected. So where will Tristan be discharged too?

I return to his bedside. He points to a grey, hospital carrier bag where he says all his known possessions sit - except his beloved silver Porsche. At 5.40pm, after telling Tristan and the nurses the housing options and pathways available, I leave the ward feeling anxious and concerned with housing *and* health: concerned about where he is being discharged to, and that he is actually being discharged without his mental health needs being addressed. But if I thought today’s break down on Spaghetti Junction was bad, then tomorrow is worse – in fact it becomes a convoluted pile up!

7th March

The next day the psychiatric assessment confirms Tristan *is* fit for discharge. In disbelief I confront the ward sister on whether she has voiced her concerns about his discharge. In her silence (Belenky et al, 1986) I am quickly passed to the Matron. Matron insists that the bed is freed in time for the week-end but I am equally insistent on a case-conference citing Safeguarding of Vulnerable Adults (SOVA), positioning Tristan’s care needs against superficial fiscal acumen. I agree to phone all agencies for attendance at the following day’s conference - my day off.²⁶¹ Where are the hospital social workers and the hospital discharge planning team? I encourage Matron to invite them to the conference. That evening, I receive a phone call at home from the county SOVA lead. She listens to Tristan’s discharge issue and promises to send someone to the conference.

²⁶⁰ Later, I consider Tristan’s legal rights: An eviction in these circumstances would be unlawful.

²⁶¹ There is no cover for the clinical aspect of my role when I am not there (I work part-time). I await the MDT homelessness team recommended in the Health Needs Assessment. I have previously approached the wider health visiting team to cover homeless clinics but no help was forthcoming.

8th March

Just before 1.30pm, I arrive on the ward. Tristan is pacing up and down. He is agitated. I had expected the ward office be filled with case-conference attendees and am surprised to see that that Matron is alone. Her voice is calmer; either more submissive or more compassionate than when she was looking for empty bed spaces yesterday. She has since engaged with Tristan to make her own assessment...

I inquire,

"Carol, he is very agitated. He can't speak to me today. How can he possibly be ready for discharge?"

"Don't worry Maria – he's not going. The psychs did the assessment but haven't written the notes up – and I want another one done. He is clearly unable to go."

A 'u' turn – and a third psychiatric assessment! Did my liaison with SOVA reveal an unsafe hospital discharge or had Matron's personal engagement with Tristan allowed his humanity and suffering to be revealed?

"I am relieved - but where is everyone? We still need discharge pathways in place."

Even though agencies are unaware that Tristan is not being discharged today, no-one except myself, Matron and the SOVA representative (a physical disability social worker) are here. Empty chairs awaiting:

- Local Authority housing team
- CMHT
- The psychiatrist
- The hospital social worker
- The hospital discharge coordinator
- The ward sister

Assertively, I phone Housing and the CMHT manager but no-one is available. Used to Child Protection case conferences where there is a statutory responsibility to attend, it causes me to reflect on the statutory obligations in regard to vulnerable adults. This vulnerable adult keeps *falling through the net* between gaps in assessments and gaps in services who do not engage. Even the SOVA representative states that his physical disability team will not be involved because Tristan does not have a physical disability. *"It will fall to mental health teams."* But mental health teams will not offer support without a mental health diagnosis - and the psychiatrists have, so far, said he is well enough to go home.

Like Tristan we are *stuck*. Spaghetti Junction's rigid steel trajectories clamp down on us. We invite Tristan in. He is lost and desolate. Even when he tries to speak, he is speechless. It frustrates him.

“Sorry...sorry, follows each attempt to answer our questions. Matron tells him not to worry, “You are not going to be discharged today.”

Sadness wells up inside me. As I leave the ward I sense Tristan following me. I speak softly with him and direct him back to his bed. In the car park I check that he has not followed me but there he is again, standing in his sky-blue pyjamas watching me like an abandoned child left on the pavement.

The following day, after the third mental health assessment, Tristan is finally admitted to the mental health unit. Three months later, Tristan was transferred to a similar unit in his home town.

Christmas 2008

Edward sends me a Christmas CD demonstrating his improving keyboard skills which is therapeutically preventing his homelessness. In an accompanying letter he says, *“Tristan has now recovered - but is back buying fast cars and ‘blowing’ money.”*

I surmise that a diagnosis of Huntingdon’s Disease was never made.

Reflective Guidance

The need to honour chaos stories is both moral and ethical. Until the chaos narrative is honoured, the world in all its possibilities is being denied (Frank, 1995:109)²⁶²

Mindful of Frank (1995), I read the story to the PhD group, in the knowledge that this is a rolling story of chaos and resistance involving community and hospital health teams as well as housing services. It opens a space for the group to dwell on homelessness and the way it is perceived. CJ reminds me that Okri (1997) views story tellers as transgressors, liberators, witnesses, explorer of hidden depths, resister, sufferer, poet and writers to gain insight (pp1- 41). Again, he rhetorically asks what would have happened if I had not been there. I am directed to Belenky et al’s (1986) stages of voice to gauge reflexivity within the story and my narrative journey. I note my own development as I gain skills to overcome resistance - as a passionate knower, I refused to be silenced. I integrated Constructive knowledge around the weaving of homelessness and health issues as I faced hospital managers, housing experts and mental health services who were disconnected from the net by their own procedural agendas. Belenky et al (1986:127) states,

Women who rely on procedural knowledge are systematic thinkers...they can criticise a system but only in terms of the system’s standards...they cannot be radicals.

²⁶² See Frank (1995) The Wounded Storyteller - His classic account of the chaos of the illness experience and finding voice within it as a storyteller

Ultimately, the power of using an effective voice, aware of safeguarding and homelessness, prevented Tristan's hospital discharge until his health needs were effectively addressed.

Precarious Engagement - Multiagency Services
<ul style="list-style-type: none">• Mental health services did not pick up on homelessness prior to admission• Medical discharge had not considered mental health needs in the context of homelessness• Housing departments were reluctant to do a Homelessness Assessment• Local Housing was reluctant to place him in Temporary Accommodation• Having to attend Housing departments for a Homeless Assessment failed to consider his health needs• Minimal engagement at case-conference by key professionals• Ward nurses were too busy to deal with complex issues - hospital discharge teams were not engaged• Funding between physical disability and mental health teams is in tension• Psychiatrists were disengaged from homelessness needs
REFLECTIVE GUIDANCE "What would have happened had you not been there?"

Fig 3.17

- **Performance**

In reflective guidance, Spaghetti Junction, challenges Dr Amanda Price's social perceptions that homeless people could be middle-class which causes me to reflect on the value of my nursing voice as social action. Spaghetti Junction is subsequently used as performance ethnography (Bochner and Ellis, 2002) to Amanda's performing arts students. In 2009, they develop 'No Home', inspired by three of my reflective texts. I accompany them as it is performed to mental health teams, housing teams, district nurses and homeless services to dialogue further on homelessness and health.

Text 19 - THE SPIDER'S WEB

Mental Health Task Group



Photograph by Maria Fordham

Dramatic backdrop

".....We dizzily spun webs of significance, moving from silence, to utterance, to transcendence - and performance." (Tillman – Healy 2002:12)

Dancers in spider suits, perform around a circle creating a silver web, weaving in and out of the circle... colourful streamers link people in the circle whilst stories/ideas are voiced. The structure of the newly formed web catches a homeless person, (previously seen at the side) and then another...preventing a fall between the gaps (of service) into a void – perhaps the very void leading to cardboard city below spaghetti junction!

Web Circle:

Senior member of mental health trust board, locality director of mental health services, lead specialist mental health nurse, Supporting People commissioner, Local authority housing manager, executive member of Supported Housing forum & nightshelter, Specialist nurse/HV homelessness.

Vacant chair: mental health service commissioner

18th April, 2008

Intricate, delicate, systematic - I feel like a sapient, socratic spider drawing stray strands together, spun from experience. Spider silk, twice as strong as steel thread (Gore, 2005); silk experiences as precious as gold dust, gathered from day to day nursing practice, drawing together a sagely web that unites some of the separate, steel trajectories on 'Spaghetti Junction'.

Seven people sit on the diameter of the web's circle, unaware of its presence, yet holding it taut like guy ropes on a tent. It is an important circle,²⁶³ accountable to HILG (Text 17), where strategic networks will be established to create care pathways which secure homeless peoples' access to mental health services (DH, 2007). All positioned - except at a vital point in the net - the absence of mental health commissioners.²⁶⁴

I circulate the government's guidance document on homeless people accessing mental health services (DH, 2007), keen to bring benchmarking initiatives to this meeting early. I recognise that

²⁶³ The professional gathering has arisen following the dissemination of the Health Needs Assessment (HNA) and the Thematic Partnership Group meetings²⁶³ (Texts: 17, 21) which showed a gap in service provision and the need for coordinated care for homeless people.

²⁶⁴ The commissioners hold the purse strings required if gaps in services cannot be met by current provision

although I am not in the 'chair' I am a key player, bridging health services and housing professionals, the latter of whom I work more closely with.²⁶⁵ Confident in my specialist role, I know from other meetings that senior health professionals need to be guided in a flexible application of health principles to the homelessness world. My local health and homelessness knowledge is imperative if a fuller vision towards integrated health and multi-agency service development is to be achieved.

The document pre-empted a relief filled sigh from the new director of mental health services, reprieved from a homelessness knowledge gap causing him to apologise on several occasions. In pointing out the models of good practice and aware of precarious engagement in four quadrants, I prime all agencies towards a MDT that includes a Community Psychiatric Nurse (CPN). It is a confrontational move in a forum with partner agencies because of its resource implication and because it draws homeless people outside of mainstream provision (DH, 2007). Senior PCT managers believe this creates a dependency rather than empowering culture. I aim to explore the costing of specialist services so that the consequences of not providing a MDT can be calculated against poorer health outcomes to inform my argument for future service plans.^{266 267}

I hope to politically draw these people further into the 'spider's web', ensuring senior managers are primed to support and promote the MDT model - although any improved mental health model of service provision would be beneficial.²⁶⁸ As the meeting gains ground, a ripple of awareness echoes inwardly, that I am in *the* group position I feel most relaxed in, most powerful in; one where another person holds the structure in place by chairing, and I extend the netting through relationship links, homelessness guidance and expert knowledge drawn from practice - offered as affirmation *and* challenge! There is camaraderie between myself and other health professionals, whom often look to me for confirmation when the housing 'chair' is speaking, akin to the

²⁶⁵ The housing manager (LA) chairs the meetings: Others include HF, MAP, Discharge from hospital, referring clients to their services

²⁶⁶ For example, the Social Exclusion Unit's (SEU, 2004:118) report - *Mental Health and Social Exclusion* - summarises the costs of various forms of mental health services:

- Cost per inpatient per day:
 - NHS psychiatric intensive care unit - £420;
 - Acute psychiatric ward - £165;
 - Long stay hospital £141.
- Cost per average stay in intensive care unit - around £5,169 and annual cost of care around £31,000.
- Community mental health team - around £59 per hour of patient contact.
- Specialist community psychiatric nurse - around £70 per hour patient contact.
- Cost of privately obtained talking therapy or counseling – around £732 per year.
- Basic cost of medication treatment for depression - around £170 per year

²⁶⁷ Planning implementation document (PID) – the current PID for 2008/9 does not include costing of specialist service provision against health outcomes.

²⁶⁸ A multi disciplinary social in/exclusion homeless team would lower my workload/stress/creating more availability to homeless/vulnerable groups. Benchmark numerous Homelessness teams in the UK

camaraderie I feel in multi-agency forums.²⁶⁹ In this atmosphere it feels like campfire stories unfurling – and I am fired up, focused, aware that individual’s stories set the scene to secure a local homelessness narrative where the net is woven tightly.

I declare that daily mental health challenges appear in homelessness. *“Just today”, I tell them, “a providential experience occurred....”*

.....it incensed me but I choose not use that phrase.

“.....An email informed me that the half-day per month CPN has suddenly been withdrawn following a management reshuffle”.²⁷⁰

Fragile net threads broken which I had worked hard to secure (Text:5). Having positively raised the CPN at last month's meeting they connect strongly to its impact. Shocked, voiceless stares confirm their concern. I continue,

“The (new) CMHT manager has not entered into discussions with me to coordinate the changes.”

Where had 'Queen B' placed me...disempowered me in my role by leaving it to the CPN to send me the email. Our organisations sit side-by-side; I am not a fellow mental health professional, but we share a health responsibility in a community where mental illness is greatly increased (Bines, 1994). CPN 'goodwill gestures' rather than commissioned services are tentative links that demonstrate 'precarious engagement' exposing tensions in my role – as I draw one part of the net together another hole emerges for homeless people to fall through.²⁷¹



“The CPN cited ‘increased demands on time from homeless hostels’ as a reason for discontinuing - her input disappears without root issues being addressed - where is mental health service accountability in this?”

²⁶⁹ Supported Housing Forum/Multi Agency Panel

²⁷⁰ The service was introduced following a very concerning episode where a bail hostel resident was placed in a secure mental health unit.

²⁷¹ For example, fast track counselling (see Text 8). In 2009, IAPTS was commissioned as a mainstream service. In 2011 the IAPTS manager informed me the team does not receive many referrals for homeless people.

Increased demands in hostels..... The irony - when these discussions seek to improve rather than reduce services. Humorously, I am holding an audience with senior mental health managers to constructively voice my concern.

Joining me, Housing and Supporting People commissioners confront the three mental health managers. Two acknowledge the disappointment; the third is silent, holding a finger to her lip... *as if letting go of the web with one hand....* Our eyes meet - she remains in sullen silence. I acknowledge her with a smile - a political smile, for I can sense that like clinical others (Texts:10,12,13) she does not know where to place me - *who is this homeless health specialist making the invisible visible in homelessness* - as I reveal the political power that my role brings where mental health managers must be accountable for their services to homeless people.

I continue,

"Mental health issues absorb my time when I could be creating pathways in family homelessness. I can't do it all. I am not a CPN. Another way you could precede would be to link mental health teams to hostels in each locality to promote relationships and provide training "

I can't do it all ... Belenky et al (1986:152) uses the same phrase for constructivist women; ordinary women who try to balance commitments and transform their moral convictions into the wider community,

These women cannot do it all...they learn to live with compromise...they set an example of idealism and realism...they feel a part of the effort to address with others the burning issues of the day

The raw reality is that I will drop out of homelessness health care unless health services engage. With key clinical services withdrawn so easily, I feel I am facing burn-out in this clinical and strategic role!

There is so much going on in this meeting with eyes: looks, tenderness, resource limitations and health need. What will *they* put in place? I probe parameters, pushing, examining the options... beyond mainstream services. Here now, the spider's web is connecting the ripped netting, *tying knots more securely in the mental health service web ... before I let go,.....but not just yet*

In the considered quietness, space is opened to illuminate the need for specialist services.²⁷² Excerpts of 'Spaghetti Junction' (Text:18) roll from my tongue - providing insight into disconnections between services. Gasps escape from senior mental health service managers – in response to homeless mental health stories told compassionately, not angrily ... *connecting silk web strands.*

²⁷² A former hostel resident, a teenager has had severe paranoid disturbances but is not accessing treatment. He was evicted and is now rough sleeping; An 18 year old former Looked after Child has persistent behavioural problems with suicidal tendencies, climbing onto the roof of the hostel saying she will jump off

Real issues revealed, my focused guidance is met with no walls of resistance - accountable others are listening.

'Housing' pronounce that they are "waiting to hear" whether Tristan has been discharged. It confirms my frustration about delays in some hospital discharges - housing blame late notifications from hospital. The housing manager's face reddens as I immediately confront him.

"Housing has known for several weeks that a homelessness assessment needs to be in place for Tristan, either here or in Camford. I have been monitoring it to inform our new admission and discharge policy."

Faux pas revealed, he retracts - *the spider's web silken trap* reveals a local contention in hospital discharge coordination! Even in my assertive but gentle approach seeking adult-to-adult interaction (Stewart and Joines, 1987), I feel like the arch-overseer with a whip by my side; practice knowledge giving power to my role. Mental health professionals are gauging my empowered relationship with the local authority and I am aware of it. The resistant mental health manager ponders cautiously. Am I a threat to her, to mental health services? These are the political sensitivities I have to tread in partnership working.

My role reveals the invisible, including mental health's resistance to engagement in the newly formed Multi Agency Panel (MAP) for rough sleepers which this manager is due to attend (Text:20).²⁷³ The housing manager discusses how complex referrals from MAP could provide evidence for a proposed Complex Needs unit for people with highest needs (Texts:13,9,8).

"We need to act on issues of mistrust in MAP".... I suggest, and another *silver strand* is linked! A core member of MAP expressed information sharing concerns because of police presence on the panel. The housing manager and I work well together in this arena. He smiles sadly; his compassion evident. He works extremely hard on the homeless agenda and affirms the agency has approached him. We devise a collaborative strategy to improve trust within MAP.

Finally, the impact on voluntary services when people are in mental health crisis is described by the chief executive of a homeless charity. Like the hero in Cronenberg's (2002) film, the character 'Spider' was brought to A&E in a psychotic state but unlike the film he had no means of containing his mental distress.²⁷⁴ The charity worker had to:

²⁷³ The MAP for rough sleepers developed from Text 2. It became a national CLG champion in 2009

²⁷⁴ Acted by Ralph Fiennes - a connection made when reading this text in reflective guidance.

- Get him to A&E - an achievement necessitating a quick health response
- Get urgent service cover to attend A&E with him
- Contain him in A&E for 6 hours awaiting a mental health assessment

Such tensions contribute to precarious engagement! I ponder:

- Were A&E/psychiatrists aware that leaving without an assessment would have excluded 'Spider' from the night shelter because of the difficulties in dealing with his illness?
- Were they aware of the government target to reduce rough sleeping (DH, 2008; CLG, 2006) by 2012?
- Were they simply too busy with other life threatening issues to see a homeless person in mental health crisis as a priority?
- Is the homeless world easily dismissed; and mental health illness in rough sleepers not recognised despite higher morbidity and mortality than a housed population (Bines 1994) with a average age of death between 40 - 44 years (DH, 2010)?

Failure to connect homelessness and mental health illness, and rough sleeping and government recommendations to reduce rough sleeping (CLG, 2006), leaves a hollow space for people to *fall through the net*.

Alarmed, the meeting considers that the same mental health team is being cited in several cases. I offer my insight,

"They are experts in their own field, but seem unable to make connections with homelessness. Health continues to work in silos - the effects are enormous but usually invisible to health! We need a strong net in place and joint training between mental health and homeless service to improve partnership care."

Success!! *Silver strands tentatively positioned* so that mental health managers can shape service design. Storytelling makes it easy - approval from everyone. They murmur noisily between themselves, planning what can be done for their staff to respond differently.²⁷⁵

I feel I can let go of mental health development in homelessness. I have fed into systems and cultural changes for some of the most vulnerable people in our town. My empowerment story lies in my unique practice experience, honouring the stories of those I meet and voicing them constructively within service knowledge (Belenky et al, 1986). The transformation within my role is marked by a growing confidence that my knowledge and experience is recognised by others, even

²⁷⁵ Joint training and shadowing days were initiated by the mental health manager the following year.

if, at times, that can appear threatening - *as the spider crawls steadily along collecting stories in a web of homeless health care.*

Spider's forge their webs in silence...where others don't care to look.

(Okri, 1997:1)

Text 20 - A CAN OF WORMS!

Multi Agency Panel for Rough Sleepers (MAP)
[National Champion D/CLG, 2009]

1 April 2008

The Conqueror Worm

Edgar Allan Poe (1843)

*Lo! 'tis a gala night
Within the lonesome latter years!
An angel throng, bewinged, bedight
In veils, and drowned in tears,
Sit in a theatre, to see
A play of hopes and fears,
While the orchestra breathes fitfully
The music of the spheres.*

Audience 'Angel throng': Police officer, Probation Officer, Salvation Army Major, Salvation Army Soldier/officer Housing Officer (Local Authority), Rough Sleeper Coordinator (Local Authority), night shelter manager, night shelter support worker, day centre support worker, housing floating support regional manager, two substance misuse workers, Mental Health Service Manager, Specialist Nurse.

Invisible 'Actor puppets': 15 rough sleepers - *at the bidding of formless things* like this audience of 'puppets' as described by Poe. Sarah is the most prominent today

Twisting uncomfortably around minutes after the meeting has finished, the mental health manager places her outstretched hand on the floor, preventing herself from toppling over. Almost pinned to the yellow linoleum, either by the suffering of Sarah, a rough sleeper with dual diagnosis who is without mental health service support, *or* by the weight of the protective armour worn in regard to mental health services to the homeless, she struggles to look up at me. I lower my body to meet a hesitant and troubled gaze, inviting her into a dialectic space. Keen to show her that I am not the one pinning her down, I softly say,



"This is what we were talking about at the mental health meeting... when homeless people try to engage with mental health services, the doctors and nurses in the team resist engagement ... simply because of homelessness "

Her armour silently drops,

*"I suppose" she reflects, watchful that others aren't listening, "They don't want to open a can of worms."*²⁷⁶

²⁷⁶ Sarah is known to alcohol and drug agencies but has not had a mental health assessment despite attending A&E having jumped from a roof following the death of her partner and a subsequent rape. She is currently in mental health and homelessness crisis

Having voiced a culturally held perception, she is wriggling like the proverbial worm, a twist of fate; much like the final caged scene in *Understated* (Southwark Theatre July 10, 2008) where tables are turned on the indifference of the asylum seekers public who become incarcerated by their own thoughts, behaviour and prejudices.²⁷⁷

I sense she is using the phrase in the hope that I will collude with mental health colleagues. Latchford (2002) found that because health visitors had a weaker identify than social workers they colluded in child protection work with the stronger, empowered service. Even as a lone homelessness nurse, I have no desire to collude. My role is to address suffering in street homelessness and inequalities in health care.²⁷⁸ I continue to use constructive dialogue, so that mental health services can be accountable for services that address mental ill health in homeless people.

The story begins...

An angel throng... in veils, and drowned in tears.

Life is a stage and the audience has congregated. The Multi Agency Panel (MAP) is seated in the Salvation Army Hall, an exalted venue apt for an '*angel*' *throng* and now central players in our winter night-cafe for rough-sleepers, (Text:2).²⁷⁹ Silence heralds the tragic tales of this month's caste of *puppet actors*, the invisible rough-sleepers waiting in the wings; lives inevitably and precariously balanced on the edge of death (Crisis 2003, CSIP 2005).²⁸⁰ It is the third *act* of this newly formed *theatre* group.

On my way to the *show*, almost dazed as I passed the scene, I quietly acknowledge the 21 year-old, murdered on Saturday evening. I have known his family from childhood. I hear the death broadcast on regional news, illuminating the local devastation of youth violence, currently taunting the UK (The Times Editorial 01/07/08). It is the second harrowing youth murder in this town within six months. Poignantly, I note that the premature and often preventable deaths of local rough-sleepers, remain consistently invisible, hardly ever making headline news.²⁸¹

In the *theatre*, I sit in the *front circle*, a short distance from the '*archangel's*' chair.²⁸² I await the appropriate moment to engage in an orchestrated plan to address issues of mistrust between some

²⁷⁷ Understated - The PhD group attended the performance

²⁷⁸ Providing information to commissioners and providers of services about gaps in health services for homeless people via the dissemination of HNA and constructing patient pathways in service development

²⁷⁹ Although I represent multi agency group as Poe's '*angel throng*' I do so tongue-in cheek demonstrating the heavy presence of caring, religious, and law enforcing agencies in the group – and an unholy alliance between some of those present

²⁸⁰ Suicides account for 1 in 4 deaths of homeless people (Mental Health Foundation, 1997)

²⁸¹ Three rough sleepers have died unexpectedly this year – one is Sarah's partner (Just weeks after originally writing this Sarah's new partner tragically drowned)

²⁸² The local authority rough sleeping coordinator Chairs the meeting

of the 'angel' audience, revealed following the last *Act* (Text:19).²⁸³ Lifting some of the *veils* covering authentic dialogue is necessary for working collaboratively to improve the health and well-being of rough sleepers (CLG, 2003) - the primary function of the group.²⁸⁴ Anxieties have largely focused on police presence and general issues of confidentiality in a multi-agency arena. Even with Caldicott guidance (HSC, 1999/012), information sharing remains a grey area in homelessness which I have addressed with PCT Information Governance Committee where the local Caldicott Guardian sits. I hope to equip the *archangel* to dismantle invisible walls (Texts:18,13.10) recognising the strong legal clarification required to propagate trust and growth – and competent leadership within the newly formed *throng*.

Unaware of the concern surrounding police presence, the police officer sits heavily, a radio-aerial protruding high above the bright, fluorescence jacket, perhaps consolidating the fears of those who cannot see beyond the dominant, authoritative figurehead of an enforcing *angel*. But, a fuller picture of each person's humanity shared on this *stage* should allow the *throng* to engage holistically with each 'actor puppet' so that the complexities of health and housing, addiction and criminality, where they exist, can be jointly tackled (CLG, 2003). From my experience of child protection case conferences and child care foster panels, I value police presence and hope today's meeting will provide clarity of its value to the *angel throng*.

The *show* begins. As planned, the *archangel* seeks clarity that the correct composition of the group has been achieved. The objecting *angel* fails to recognise it is a cue to raise her concern about police presence and, unanimously, agreement to their continuing presence is easily achieved. But, another drama unexpectedly unfolds. The mental health manager nervously declares,

"Well I don't think I need to be here! I mean ...I can't sit in a room like this for two hours not saying anything. I'm used to talking a lot in meetings. I haven't time. I'll give you my mobile and can contact me if there are mental health issues."

She wriggles like the proverbial worm, despite awareness of local gaps in mental health care which have been adequately displayed at the mental health meetings (Text:19). Having only attended one previous *show* and here for less than five minutes today, it is clear her judgement is grossly premature. Mental health crisis invariably arise in rough sleeping (Pleace, 2002), as experienced in the last *Act* (Text:18).

²⁸³ Both myself and the housing manager had been approached separately and reprimanded for including a police officer on the panel.

²⁸⁴ Some services have never worked in multi agency settings and are concerned about sharing confidential information despite and information sharing protocol.

A wave of nausea passes through me as she pulls the armour of indifference closely to her skin, wrapping a coating of professional arrogance which seeks to position multiagency meetings as low priority for mental health professionals. From their perspective, local mental health services have strong capacity issues but our mental health task group meetings have revealed the relentless mental health needs in homelessness. In the haze of slow motion which inevitably accompanies shock, I feel the mental health net being strongly, snatched away. I'm not going to let that happen, having fought hard to make services accountable. It is with disbelief - before I voice anything - that I hear the *archangel* say,

"Of course, I understand, not everyone can be here...."

These *angels* are passive in her power! The *archangel's* polite, naive response is totally disconnected to the cascading effect of losing a mental health presence at this vital juncture where care could be *care – fully* coordinated! I interject immediately in the knowledge that Constructivist women are caring women who do not avoid conflict (Belenky et al, 1986),

*"It is much too early to say you won't participate in the group. This multiagency panel needs a strong presence from mental health services, making pathways easier to access for homeless services and for those who suffer on the streetsAt the moment they can't or won't access services - or when they do, treatment is not adequately provided²⁸⁵.... this panel needs to be connected and mental health response need to be coordinated **and** informed..."*

"We just haven't got the resources for that..."

Resources....a powerful word; No resources, a trump health card cutting, through my passion!

Voiceless *angels* stare into a growing health chasm, their eyes fixed on me. In the pause of a heartbeat, and for the very first time, I cynically believe that perhaps mental health services find it more cost effective to let people die on the streets. I override my cynicism,

"Providing an effective mental health service to homeless people would be more cost effective than late diagnosis and illness crisis. It is much more expensive to have people seen in mental health crisis in A&E - £300 a visit²⁸⁶ compared to the cost of a mental health professional supporting homeless services and rough sleepers at this meeting....."

She shrugs dismissively; embarrassed by the figure quoted in my continuing challenge. Two nursing *angels* contesting in a multi agency arena...my challenge her response... little movement!

²⁸⁵ Provocative words - mindful of Texts: 5, 9, 18

²⁸⁶ Crisis (2003) *Crisis Fact sheet 7: Homelessness Statistics*. London: *Crisis London*

Walls of resistance so slowly dismantled. Why do local mental health services seemingly struggle to engage in homelessness at every level - entrenched in silos, shielding themselves from mental health need (Texts:18,13,9)?

And this *throng* remains disempowered in her presence!

Everyone awaits my response, as if I am the only one qualified to confront a fellow health professional.

"We have already lost the half-day per month CPN – it is vital that mental health services remain visible to hear the mental health crisis arising in street and hostels"

Prickly vibes arise from her inflexible body posture as she responds

*"Well, **we** are having meetings - we can feed back to this group."*

We...a hopeful word so I yield, knowing that there is a timeliness in which to further respond, knowing too that my power lies in the HILG group (Text:17) in which mental health services will be ultimately accountable to the local partnership board.

*Mimes, in the form of God on high,
Mutter and mumble low,
And hither and thither fly-
Mere puppets they, who come and go
At bidding of vast formless things
That shift the scenery to and fro,
Flapping from out their Condor wings
Invisible Woe!*

Vast formless things shift the scenery to and fro

This *angel throng* has settled into the *shifting scenery* revealed in the evolving political world of homeless health care. They await the arrival of Poe's invisible *puppet actors* from the wings, the cast of 15 rough-sleepers who will emerge onto the stage as powerful stories that are narrated by individual *angels*.

Sarah is introduced by the substance misuse *angel*. She is alcohol and heroine dependent, and in severe mental health crisis - a rapid deterioration following her partner's death and subsequent rape. Wanting to die, she jumped from a roof, received ankle injuries and was taken to A&E.

Sarah's story highlights A&E and mental health liaison, and mental health service accountability. Clearly unable to see this, the disempowerment of the substance misuse angel is evident; it consolidates my earlier observation of voluntary organisations oppressed relationships with health services.

Clarifying I ask her,

"Was she seen in A&E after she jumped from the roof?"

"Yes"

"Did they arrange a mental health assessment?"

"I don't know.....well, I think they just sent her out again"

The mental health manager stares straight ahead at the floor and is now silent despite earlier protesting that she liked to talk in meetings. Over the next few minutes she guards her whole body – arms crossed around her chest and abdomen, shoulders turned inward, head down. I observe her body posture (Navarro, 2008) noting that she sits like this for some time whilst the conversation continues around her.

Even the police do not want to challenge health professionals. Cutting into the myth of unease about police presence on the panel, the police officer provides valuable information about Sarah,

"It's plain she is in mental distress....when we got the medical doctor in, he said she was fine and discharged her. We can see she isn't - but what can we do? We can't question the doctor's judgement. She's in a terrible way."

Oh what huge health care gaps, and, non-health professionals silenced (Belenky, et al 1986) by health's professional power!

*That motley drama - oh, be sure
It shall not be forgot!
With its Phantom chased for evermore,
By a crowd that seize it not,
Through a circle that ever returneth in
To the self-same spot,
And much of Madness, and more of Sin,
And Horror the soul of the plot.*

A crowd that seize it not.....

Poe's phantom - resistance and disconnection! Nothing will progress if the *crowd* of health professionals and homeless service providers *seize it not*, sitting in circles like this, returning to the same spot. All agencies seem to be at a complete loss watching Sarah's horror unfold. I seek to stoke their powerlessness and invite them to politically grab the invisible monster of disempowerment that works against homeless people,

"These are huge gaps...there is so much valuable knowledge in this group that we can offer others. The police surgeon needs to know that MAP existsI will let him know about multi agency partnerships and the support Sarah is currently getting, so we can work together... One of the functions of this group should be to become more political about the hidden issues in homelessness."

Still aware that Sarah is lost within a *madness* of homelessness, alcohol addiction, suicidal tendencies, criminality²⁸⁷ and deep bereavement and that this *throng* is also lost about her care, I sew political seeds about the potential power of this group.

"What else can be done for her?" the substance misuse *angel* asks.

I state what they are all feeling

"She'll probably die if we can't engage her in health services or provide housing for her,"

Sarah could soon be one of the Government's statistics in the early deaths of rough sleepers, as her partner was, and to higher rates of suicide in homelessness (Crisis, 1996).²⁸⁸

Breaking her silence to gain clarity about dual diagnosis, I ask the mental health manager,

*"Why would Sarah not be kept in for stabilization? Why would she be allowed to leave (A&E) without a mental health assessment?"*²⁸⁹

"I don't know I wasn't there."

"No. But generally, if someone jumped from a roof because they didn't want to live anymore, they would have an assessment, wouldn't they?"

"Yes, but I don't know about these particular circumstances."

²⁸⁷ The police tell the meeting that she is due in court for stealing sanitary tampons – I hold a supply at my clinic for rough sleeping women.

²⁸⁸ Crisis (1996) – people who sleep rough are thirty five times more likely to commit suicide than the general population and the average life expectancy of a rough sleeper is 42 years of age when they have experience of sleeping on the streets from the age of 16years

²⁸⁹ See HHI(2008): DH recommendation that all dual diagnosis patients should have a mental health assessment

I seek to make mental health services transparent,

“Perhaps not, but there is a whole range of information here about Sarah from services who hold grave concerns about her mental health... having a mental health assessment should be routine practice when a rough sleeper presents in A&E with a history of jumping from a roof when we know there is a greater risk of suicide. The psychiatrist’s and these agencies in the community can work together to provide Sarah with ongoing support once she is stabilized. If they write to housing about her current vulnerability it could perhaps change her housing status....”

The housing officer clarifies,

“She has massive arrears - she is intentionally homeless.²⁹⁰ She won’t get social housing, even if she is vulnerable.”

Noise erupts, everyone is roused, talking now about the need for complex needs accommodation. The *archangel* reports two units are planned by the Local Authority. Meantime Sarah has to survive on the streets as hostels have failed to accommodate her successfully. I muse on whether more clinical availability in the homeless team integrating a CPN into homelessness health would contribute towards a successful tenancy.²⁹¹

Reflecting on the A&E scenario, the mental health manager looks at the police officer,

“Something could have been done under section 136.²⁹² Even now, the police have powers to pick her up and it doesn’t matter if she is drunk – they can wait ‘til she is sober before the assessment is started.”

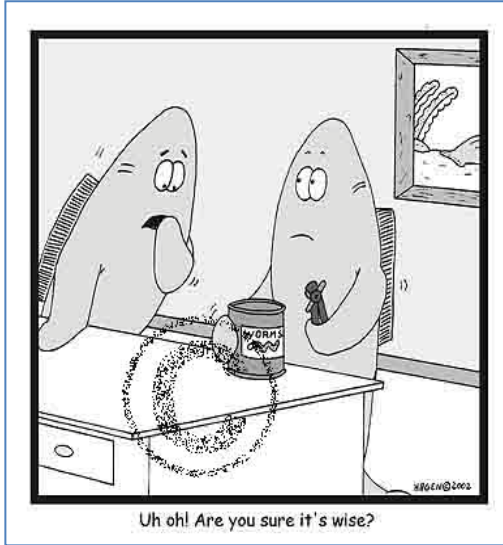
I sit back - affirmation of police and mental health service inclusion in MAP meetings!

Later, as the curtain begins to fall on the final *scene*, the mental health manager offers to evaluate Sarah’s care in A&E.

²⁹⁰ 'Intentionally homeless' relieves the Housing Authority’s duty to rehouse although they must provide advice.

²⁹¹ Birmingham Gold Award for complex needs accommodation and the tie in with professional mental health service support. Benchmark: Leicester PCT Mental health services for homeless people

²⁹² The Mental Health Act (1983) section 136 details removing a mentally ill person from a public place to a place of safety. It details police powers and the rights of someone in this position.



 The mental health manager's metaphor *fear of opening a can of worms* has left me breathless,

"If only they would open it...the team would then be aware of all these agencies. Everything needs linking up so we can coordinate care..."

Her collusive whispering continues,

"I think a case like Sarah's should be treated in the community not in the hospital....."

'Care in the Community'! Has she been listening! We cannot do it alone! I think of homeless people in the community who have neither their housing nor health needs adequately met.

"I agree - so should Sarah have been referred into CMHT services from A&E?"

"It doesn't happen routinely and they wouldn't be able to offer ongoing support anyway."²⁹³

Pinned by her argument, I help the mental health manager arise awkwardly from the floor!

*But see, amid the mimic rout
 A crawling shape intrude!
 A blood-red thing that writhes from out
 The scenic solitude!
 It writhes! - it writhes!- with mortal pangs
 The mimes become its food,
 And seraphs sob at vermin fangs
 In human gore imbued.*

As *lights go out* and the *angel throng*, disperse I am aware that their own story of empowerment has to be embraced with mental health services. The *actor puppets* - roam these hot summer streets, surviving illnesses without a place to rest which they can call home. As I emerge into the sunlight and pass the grey slabs, my thoughts again return to my friend's son the 'gentle giant' who lost his life here on Saturday evening,

²⁹³ The Healthcare Commission (2006) acknowledges that if Community Care is to work for the mentally ill, more access is needed to talking therapies and out-of-hours crisis care

*Out-out are the lights-out all!
And, over each quivering form,
The curtain, a funeral pall,
Comes down with the rush of a storm,
While the angels, all pallid and wan,
Uprising, unveiling, affirm
That the play is the tragedy, "Man,"
And its hero the Conqueror Worm.*

-THE END-

Poe declares *the end*; but the lights on the world stage are ever alight and even as my friend receives the body of her son into the church for his funeral, I see the Conquering Worm is never really the ultimate hero!

Reflective Guidance

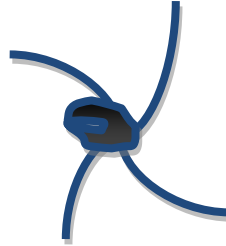
Dr Antje Diedrich grasps the insight of courage required in my practice. It is a key landmark for me, where courage is recognised in the health and homelessness terrain by others.

But I am sensitive to other criticism. Having risked visualising practice as performance, framed through Poe's poem, I am disappointed when it is described as "too forced...it doesn't work"! To me, the experience felt like a stage! Creative writing as a therapeutic endeavour to sustain me following a highly charged practice experience somehow seems lost.

Text 21 - TYING THE KNOT

Practice Based Commissioning Consortia: HNA report dissemination

3 December 2008



Homelessness - the delighted bride at the PCT's top table; next to me is the gypsies and travellers Specialist Health Visitor (Text:11). We are *the* guest couple, proposing HNA recommendations for service development for vulnerable communities. The bulging agenda matches a room filled with PCT and practice based commissioners.²⁹⁴ We have fifteen minutes to make our case, competing with current high-level Trust items scheduled over the next four hours. Will our voices synchronise pragmatically to engage them in our vision for vulnerable communities? Or will our dowry be rejected?²⁹⁵

There is businesslike vibrancy filling the space. I feel openness to development in line with regional development for Vulnerable Communities.²⁹⁶

²⁹⁴ "Practice-based commissioning (PBC) continues to play a vital role in health reform. It puts clinicians at the heart of PCT commissioning and allows groups of family doctors and community clinicians to develop better services for their local communities. Primary care trusts (PCTs) are the budget holders and have overall accountability for healthcare commissioning, however practice-based commissioning is crucial at all stages of the commissioning process. In particular, practice based commissioners, working closely with PCTs and secondary care clinicians, will lead the work on deciding clinical outcomes. They also play a key supporting role to PCTs by providing valuable feedback on provider performance. PBC is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions. Practice based commissioning will lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want." ([http://www.Departmentof Health/Commissioning/Practice Based Commissioning](http://www.DepartmentofHealth/Commissioning/PracticeBasedCommissioning) accessed July 10 2010)

²⁹⁵ Black Monday is not included here. In it the SMT Provider Services did not engage proactively with the recommendations in my report because of 'Turnaround' - the NHS term used for financial redress of overspend. Since the advent of World Class Commissioning today's consortia is ultimately more powerful.

²⁹⁶ Pledge 8: The NHS Commissioning Framework 2008/9 (East of England, 2007).

In preceding meetings, I had confronted commissioners about non-engagement by health services in homelessness.^{297/298} The proposal being placed on the table today marks their involvement towards a MDT.

A lead commissioner sits beside the Mental Health services commissioner whose deputy in homelessness has been elusive. Despite political games played around provision of care by mainstream services versus homelessness specialist services, he is inviting me into friendly interaction.²⁹⁹ Knowing these two are key players for funding in this consortium, I play along.

Across the table sits another key player - an executive nurse - whose support, I am told, will place political pressure on two remaining PBC executive nurses to engage with our recommendations today.³⁰⁰ A few hours earlier, he and his colleague had accompanied me to the day centre to begin discerning my recommendations in the HNA report. Having visited all vulnerable groups they described an earlier visit with me to the nightshelter as their most '*profound*'.³⁰¹ Today's visit had tested them too.....

Three hours earlier:

It's another cold winter morning - perhaps the day centre affects me more today because I haven't been here since summer.³⁰² I lead the commissioners into the sitting area...

*It is a pitiful sight
Eight men and one woman
Sit on the sofa and chairs
A few watch TV
Most are coiled-up sleeping.
Pale, bluish-cold skin
Fractures
The mass of dark, gloomy colours
From which lost eyes
Peer up at us;
Noses drip, finger nails encrusted,*

²⁹⁷ Pledges 8 and 9: Since the summer of 2008 the Vulnerable Communities and Inequalities in Health commissioning group have responsibility for commissioning homeless service development.

²⁹⁸ A mental health commissioner failed to attend 5 mental health task force meetings in *steel thread*, a text not included due to word limits. I described in the text, the courage needed to confront her.

²⁹⁹ I.e. Discussions on the removal of the CPN from the homelessness arena and reference also to the Mental Health Task Group where his deputy failed to attend. The commissioner leading on inequalities has not committed more funds to homelessness or mental health.

³⁰⁰ The IG chair has included us in the political landscape of this group.

³⁰¹ Gypsies and Travelers, Refugees, EU Migrants, BME groups, Looked After Children

³⁰² I discontinued the clinic at day to deal with the increasing strategic side of homelessness – inviting referrals only. Meantime district nurse managers tried to provide an alternative nursing presence which was not facilitated but the GP began a weekly clinic.

Bad smells emanate.
All still wearing hats, scarves heavy coats
One or two familiar stalwarts
Suspiciously catch my eye
Anxious about the guests,
Most faces are new.

I turn to the commissioners,
Previously at my shoulders
They have disappeared
Cowering,
Hiding behind me
Having taken a peak,
They momentarily recoil.
There is something about homelessness
That leaves one speechless;
Words inadequate to describe
What you see, when you dare to look.

Whilst I wait for the commissioners to acclimatise, I talk to those who are awake about our visit. One articulate man tells me about the health questionnaires they have completed. We have already discussed the emerging themes.³⁰³ Beyond themes, all our senses are required here in this room for data collection.

A young woman asks, "Are you a nurse?"

The commissioners listen as I quietly engage her about health needs on the streets.

"It's the violence – especially for women. I was attacked by 4 people last week. I have bruised ribs; one of them is cracked. I went to the hospital. I see the GP here too.... No we don't get smear tests – hey what's that? ... Can't remember the last time I had one".

Someone stirs from sleep - it is Will from my night shelter focus group! My heart sinks. His 50 year old body looks almost 75! He had made such a positive transformation from rough-sleeping that I'd asked him to consider telling his story of rough-sleeping to school children via the drama group.³⁰⁴ I

³⁰³ The Chief Executive of the day centre pre-empting our visit designed the questionnaire. Themes show that the majority of this group do not want immunizations for Blood Born Viruses but would like Stop smoking, Sexual health, nurse clinics, dentist, podiatrist, contraceptive advice. All of these health interventions have been offered here except dentistry, podiatry and immunizations.

³⁰⁴ I am working with a local drama company to engage homeless people in telling their stories which, it is proposed, will be dramatized to go into schools nationally.

have the poem he gave me, 'The Mask I Wear'. I last saw him a year ago in a hostel.³⁰⁵ I sit next to him on the sofa arm, engulfed by the odour of stale urine and faeces coming from his body and clothes.³⁰⁶

"Will, what happened? Aren't you living in the hostel anymore?"

"I lost it... started on the old bottle again. I've been sleeping behind the supermarket for 4 nights but I can't do it anymore. I feel like a dog - worse than a dog. This isn't a life, fit for a dog. It's my own fault, my own fault".

Is it?

"What would have made a difference Will?"

"Someone to talk to... to steer me in the right direction. No-one can tell you what it's like to be here but when it happens it happens so quickly. No-one wants to be here. I won't survive. I just can't kick the bottle completely. It's OK for a while.... but then it comes back."

It the bottle or It the sexual abuse that may have occurred when he was a child in care?

It is rhetorical.

He is using some of the words he used three years ago in the focus group. I am absorbed by his evocative, compassionate voice - a philosopher born from suffering, blown relentlessly adrift by the winds of childhood misfortune! In the dignity of his faltering words, I am lost in their strength and power.

Yet here he lies, like any terminally ill patient, waiting to die.

I ask Will's permission to call a commissioner over. Enmeshed in his odour, the commissioner listens compassionately to Will's story. I need to stand because the smell is too strong to take anymore.

He asks,

"Was it the loneliness Will that made you hit the bottle again?"

"Yes - that's it - loneliness."³⁰⁷

³⁰⁵ He stayed in the hostel for over a year. Treated by GP, hospital and DN intervention for Prostatectomy and hernia repair.

³⁰⁶ Facilities for showering and change of clothing are available at the day centre but with my movement away from clinical to get the strategy in place who has assessed Will's health needs? I ask the day centre manager to place him on this week's GP list.

³⁰⁷ Will's experience reminded me of a visit to the night shelter with commissioners when a resident refused to go to hospital despite having a TIA and losing feeling in the right side of his body. He said. *"This is my home - these are my friends - they understand me. I'm not going to hospital"* He refused to go in the ambulance.

He has engaged quickly and asked a profound question.

But I also consider Will's eviction process from the hostel. There has been no referral to health services, no right of appeal, and MAP have not highlighted him as a new rough-sleeper; another hidden evictee - alcohol heralding descent to the streets again.³⁰⁸ The process of evictions, despite local progress, frustrates me. I have no formal power and neither I, nor the archangel in MAP, is systematically connected to the process.³⁰⁹

The conundrum of improving health to the house-less is not easily remedied by health services left to pick up the fragile health pieces, shredded further by failed housing options. The issue of providing complex-needs accommodation for alcohol users is re-affirmed - another political area to raise, using Will's experience, at the higher level drug and alcohol treatment (DAT) commissioning group next month.

As the commissioners and I dialogue about my recommendations for a MDT, including a practice nurse and podiatry services, I feel I am leading a hand-over, *spreading the net*. Homelessness is coming in from the cold.

In the PBC meeting, I am again confident in my practice knowledge. Commissioners have already voiced their commitment to increased clinical resources and witnessed more than I could portray with words at the daycentre.

4th on the agenda, I choose my opening words with care. As the room quietens, I begin,

"Inequalities are killing people - on a grand scale – World Health Organisation, Geneva, August, 2008 – and - I would argue - nowhere more noticeably in our locality - than in the vulnerable communities we represent here today."

The room is stilled.

Nods and tutts of disbelief come later....

as I tell stories, reflecting suffering humanity

³⁰⁸ I followed this eviction up with the Rough Sleeping outreach worker. Will had been doing very well until one of his fellow street drinkers was housed in the hostel with him. This match was detrimental for Will.

³⁰⁹ Multi agency draft eviction protocol developed in 2010 with significant drop in evictions

I look up to catch a few eyes – sad eyes, tilted heads, listening...

I hear myself say,

“...amputated toes ... but podiatrists³¹⁰ refuse to see rough-sleepers without a health professional referral... accessing a GP and secondary care can be difficult.”

Knowing this is the seat of power for commissioning GP services I confront them with the words from focus groups respondents about access:

“You can’t get registered... I tried 5 GP’s before I got someone”

“They said they don’t take on people living in temporary accommodation but I said I had a baby who was ill. The next day the practice manager phoned me and said I could have an appointment.”

“When you need prescription drugs you can’t get through the first hurdle because you haven’t got an address.”

“We are looking for food and shelter ... trying to keep dry...I can’t think about health problems.”

Recalling *praise* I also move this audience into another zone about what works well locally:

- The specialist GP in the nightshelter and day centre
- “Brilliant” local drug services
- “I came through the domestic violence route and my GP, HV and SW were really great. The boys have settled much more since we have been here.”

I assert the need to engage mainstream services as well as a MDT and am greeted by a growing chorus of “Yes”. We are in union - they like the dowry! Working the crowd, I move their gaze towards the mental health commissioner. A wide-eyed stare indicates his concern at what is coming his way,

“Mental health services, along with GP access, are by far the biggest area of concern in homelessness. Engagement on the ground requires a CPN as part of a MDT in homelessness”

He nods to the group; accountability now made public!

³¹⁰ When I first came into post I offered to fund a podiatry chair for podiatry clinics to be held at the day centre. Despite it being cited as the reason why clinics were not provided, the offer was rejected. More recently the podiatrists have asked to be removed from the Health and Homelessness leaflet saying it would attract rough sleepers. I have refused to remove it and remain in dialogue with them about podiatry needs in homeless health care. In 2011, podiatry was finally commissioned for the day centre.

I endorse it with highlights from practice... Rudi and Dean (Text 13,9)...tutts and gasps!

"What do they do in other areas?" I'm asked.

Benchmarking, I draw on Leicester's Dawn Centre - the national flagship...

*"Or in the next county - a GP access centre – with a MDT: a CPN, podiatrist.... QOFs are unaffected by the large homeless client group."*³¹¹

The Inequalities commissioner suddenly shouts, *"And this is all we have in this area – this is it – they can't do it alone."*

Both hands are directed at us. I feel numbed: suddenly stunned by the realisation of how hard it has been in homelessness. Others join in as she offers profound thanks for the work we have done.

It has taken 3 years for the health care net to be grasped by senior health commissioners. At the top table a love knot is sealed in homeless health services.

The Net



A love knot:

Tying in the loose ends of homeless health care

That evening, it is Will who remains uppermost in my mind and prayers. Later, in another commissioning meeting, the executive nurse declares, *"That poor man - I nearly cried listening to him."*

When one dares to look and hear, humanity's suffering cannot fail to shout at us in its own quiet manner. But Okri (1997:13) cautions,

Poets may choose to align themselves with the wretched and the voiceless....but they must draw to themselves heaven's aid for their calling is absorbing and demanding...

It is through heavenly aid, integrating its energy into my life that I, in my homelessness nursing role, have found my strength from 'street' to 'board' room. My practice vision of *The net* is theoretically falling into place.

³¹¹ Quality and Outcome Frameworks - GPs numeration is assessed depending on health targets achieved.

Post amble

Feedback highlights the 'powerful' presentation - *“particularly the stories ...people were saying they couldn't believe this was happening locally.”*

Immediate funding for 2 full-time commissioners (Vulnerable Communities) - circ £90k - is secured.

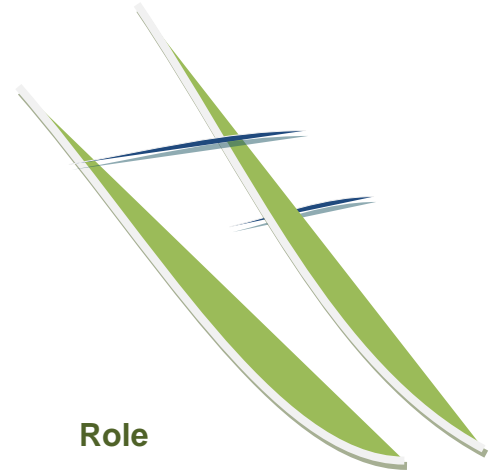
An action plan includes two MDTs (Vulnerable Communities) across the County:

- Practice Nurse
- CPN
- Health Visitor
- Pharmacy advisor
- Podiatrist
- Dental outreach

Halleluiah (Leonard Cohen)!

DEVELOPMENTAL FRAMING 14

REALITY PERSPECTIVE



Vision

Who are the homeless?

- Having grasped the ontology of homelessness, I use this knowledge strategically so that others view homelessness with a less tarnished lens

Engage health services

- The HNA recommendations and my research provides local evidence for strategic direction
- I engage other health professionals in MAP - it has the potential to become the ' hub of care' (as opposed to my role - Text 3) (Text 18:I invite discharge planning nurses join MAP in 2008)

Limits/precarious engagement

Tension exists in mental health strategic engagement and engagement on the ground (e.g. Text 20)

Empower homeless services

- Strategic inclusion in the health net - voice their perspective of health issues to senior health managers (E.g. Text:19)

Policy and Development

- To secure better mental health engagement, the HNA report recommendations include a CPN as part of the MDT.
- All my recommendation in the HNA report to be acted on by local commissioners

C
R
E
A
T
I
V
E

T
E
N
S
I
O
N

Role

Partnership Health Net

- I disseminate key HNA report at strategic meetings to build a stronger multi-agency net
- I guide health managers in service development through storytelling used as strategic tool - others join in with their stories
- I challenge health professionals who do not want to engage in multiagency forums
- I collaboratively underpin the development of the Multi-agency Panel (MAP) by using my knowledge of case-conferences and counteract mistrust by securing information sharing training

Poise

- Fearing burn-out in my clinical and strategic role, I let go of clinical outreach clinic as GP services are secured there (Text not included due to word limit).
- I feel I am passing over strategic leadership to a higher level - I am mindful of the bridge background chapter where my role disappears as services are secured

Net-Weaving

Fig 3.14

Analytical Horizon 3 2008

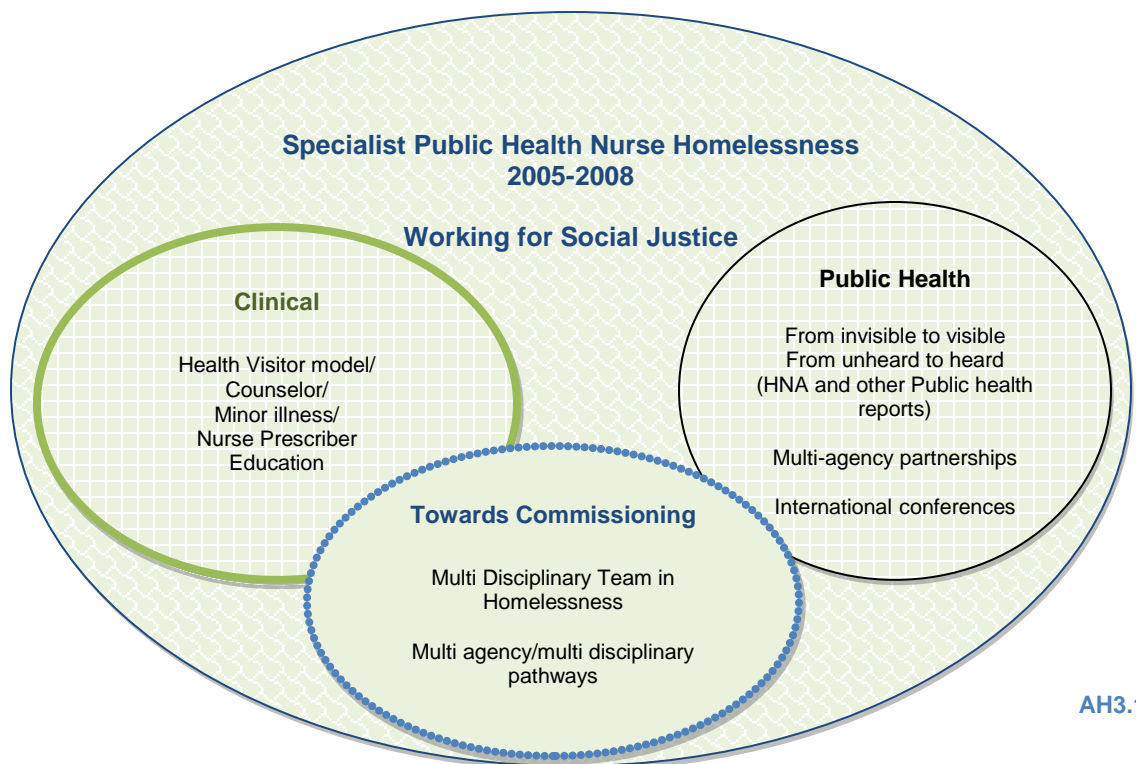
My research is completed. I ask myself, 'Am I more available? Are others more available?' I feel confident that I have woven a tighter net and feel more secure dwelling within *precarious engagement*, mindful that *the net* continues to expand.

In this brief analytical horizon, *the net* is discussed solely from my SPHN quadrant. This mirrors how in practice health and multiagency services were coming together to weave a tighter, less precarious net as I dialogued with them in meetings drawing on my clinical experience.

Developing Practice: SPHN - Weaving Strands in the Net

By the end of year 3 my role interweaved with health and multiagency services wherein the plot became an "intrinsic webbing of multiple figures" (Mattingly, 1998:84) culminating in a combined effort to "change or attempt to change...an effort at transformation" (p.94) of homeless health care locally. Weaving is a process of transformation. Weaving the strands clinically and strategically as shown in AH3.1 strengthened the net rope. My unique knowledge, crossing services and organisations as it did, empowered me in my moral endeavour to *create a environment* in health and multiagency care that was more inclusive for homeless people through three strands in my role: clinical, public health and towards commissioning strands.

Creating an Environment where Being Available is Possible Three net-rope strands in the SPHN role



Public Health and Towards Commissioning as shown in AH3.1 completed the three key strands of the net rope which made up my role in Year 3. I draw on these strands again in Chapter 4 but in this section I illuminate insights arising through dialogue which was *the* key feature used in developing the health care net towards my practice vision in Year 3. Insights that *create an environment to be available* are organised as:

- My political emergence
- Becoming a transformational leader

My Political Emergence

In a call for nursing activism that shapes the delivery of health, Warner (2003) makes clear that nursing is political. She notes,

Motivation for this political growth relates to our commitment to influence the determinants of health, advocate for clients, contribute substantively in the creation of our health care system, and position nursing for its optimal role in delivery of care (Warner, 2003:143).

In health services, strategically as well as clinically there was a lack of appreciation of health's unique role in homelessness and the effects this had on the homeless person - homelessness was still largely seen as a housing issue (E.g.Texts:18,20). In order to change, systems need to "learn more about itself from itself" (Wheatley, 2003:145). My unique specialist knowledge and skills contributed to this. For example, Warner (2003) defines a number of political skills of nurse activists: using expertise as a currency; creating opportunities through networking; using powerful persuasion; gaining commitment to collective strength; taking a strategic perspective, and persevering to bring about transformation of services.

These political skills resonated with my unique practice knowledge to *use my voice* as a constructivist woman aspiring to "the empowerment and improvement in the quality of life for others" (Belenky et al, 1986:152). I recognised the processes which had contributed to my political development as:

- Holding a unique position in health and homelessness with unique knowledge (All Texts)
- Recognising that senior managers and commissioners require guidance around tensions in the net in homeless health development. Confident and assertive I weaved knowledge and experience to guide them (Text:17,19,20,21)
- Shifting forces that constrain my realisation of desirable practice (Johns, 2009) to improve access and engagement especially in mental health services (Texts:17,19,20,21)
- Recognising that health assessments should be performed with a homelessness lens, making others accountable for their services and using SOVA intervention where necessary (Text:18,19,20)

Appreciating *precarious engagement*, I brought knowledge to others around multiagency networking that linked into a whole system approach (Wheatley, 2006) embracing the four quadrants of my practice: health services, homeless services, the homeless person, my role. I recognised that weaving *the net* depended on organisations as well as individuals being reflective, and in dialogue through storytelling, I began this process with them, challenging assertively as I thought necessary. My political emergence was an act of social justice (Bohm, 1996) and being effective in this way required inspiring and charismatic leadership which I explore below.

- **Becoming a Transformational Leader**

Ably recognising oppression which had the potential to limit my vision, I confidently replaced fear with courage and in so doing opened up the taken-for-granted, allowing transformation of the environment to occur through dialogue. Burns (1978) notes that transformational leadership occurs when, "...one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (p.19). This is clearly seen in texts as bulleted in the previous section. Creating an inclusive net through transformational leadership was not easy; homelessness remained elusive to some health professionals. Johns (2009:232) writes about transformational tension,

On one hand there is the dominant transactional world characterised by high anxiety transmitted through its bureaucratic hierarchy, resulting in command and control tactics to ensure its targets are met. In such a culture, people are means towards reaching targets. The humanness factor is lost in the machine...on the other hand there is the transformational world that seeks to create the best environment for patients and staff...where humanness is valued. It is as stark as that.

The humanness factor lost in the machine...

BAT themes embraced humanness, particularly *having concern for the person* and *knowing services*. Throughout practice, BAT themes provided me with unique knowledge about *the net*: its holes; its fragility. Strategically, through storytelling I was able to convey complex knowledge in health and homelessness; transforming for those who heard them (E.g.Texts:17,19,21,*Black Monday*) Such knowledge should be welcomed in a learning organisation which Senge (1990), describes as,

One where people continually expand their capacities ..., where collective aspiration is set free and where people are continually learning how to learn together (p.3).

...learning how to learn together... The strategic coming together of senior managers in health and multi-agency partners enabled me to make visible the invisible. My transformational leadership within a transactional organisation required political competence and political boldness - a strong, assertive, reflective voice that weaved practice knowledge with development of services.

Clinically, initiatives like the Multi-agency panel (Text:20) became a route into meeting the precarious tensions arising in Text 18 and replaced my hub role (Text:4). As I continued to weave the net by engaging others, discharge planning nurses were invited to be a part of the core MAP group along with other health professionals.³¹²

Development of Voice

My strong political voice in action developed from my unique practice knowledge and learning development. I continue to net weave in homelessness health care locally, nationally and internationally through effective *use of voice* developed through reflective guidance.

Embracing the 'performance turn' (Johns, 2010) my story writing style changed. I performed 'Spaghetti Junction' (Text:18) at the University of Limerick in a pre-conference workshop to the International Reflective Practice Conference, aware that my *voice* was embracing my vision in homeless health as a key political and humanitarian nursing instrument.

Year 3: Summary of *use of voice* in precarious engagement: Net Weaving



AH3.2

³¹²E.g. An A&E consultant regularly attends MAP meetings

Indra's net opened the narrative. My role in making a stronger local *net* in homeless health care developed from insights through self-inquiry and transformation using the Being Available Template, mindful of *appreciating precarious engagement*...

Appreciating precarious engagement

The net of inclusion

Shaped

From presence

With homeless people,

Transform cultures of exclusion

Making visible the invisible

To bring people in from the margins

Towards equality

Appreciating precarious engagement

Recognizes limits

In ourselves, our health systems,

In our multiagency partners,

In the homeless person

Using our voice

We choose

To effectively engage

For the voiceless

Poised

With courage

To grasp the other

Strengthening the whole net

To ease human suffering

As we listen and act

In a joint journey of compassion



4 Weaving New Knowledge in Homeless Health Care

Introduction

Setting the stage for this chapter, I draw on a quote by Dr Jim O'Connell, a highly regarded physician who developed the Boston model of homeless health care.³¹³

The economic argument has to be made, we do have to look at the outcomes viciously, but it is the stories of the people you take care of that really draw you in. How I wish we could convey those stories in a way that would really grab you! Homeless people live lives of absolute courage outside in the elements, and it is breathtaking to watch. (CIVITAS, 2009:16)

O'Connell's quote relates to the power stories have to reveal (Okri, 1997). My whole approach to the narrative has been story where revelation is shaped through weaving an inclusive net, given theoretical form by the Being Available Template (BAT). It is my hope that the narrative was written in such a way that conveys with breathtaking insight the complex plight of homeless people and my developing role in health services. I have not presented the economic argument in the thesis which O'Connell cites but the stories of practice implicitly contribute to it by illuminating the impact of *holes in the net* and the related poor outcomes of these holes as evidenced in the narrative.

In this chapter, key insights are deepened in dialogue with an informing literature about my narrative journey as a SPHN (Homelessness) aligning it where possible with recent health and homelessness research. I will not simply repeat knowledge presented in the analytical horizons which the reader has already examined. Instead, I shall illuminate my transformation as my learning developed, concluding with an account of the updated *net* at the time of writing this chapter in 2011.

I begin by summarizing the concept of the development of *the net* that illuminated my practice field wherein I saw myself as a net-weaver, ultimately using three core strands of practice to make up the net-rope (Fig. 4.1)

The Net

Arguably, homelessness is perceived as a murky world due to its association with criminality, substance-misuse and violence. Using *the net* metaphor, I sought to draw the reader into the homelessness terrain; a world, not generally open to society or where it is lip-service is paid rather

³¹³ The Boston Healthcare for the Homeless Program: A Public Health Framework *in* Standards for commissioners and providers of services (COM/Pathway, 2011)

than an authentic movement towards social justice. What I experienced in that world, I wrote about, reflecting systematically to gain insights and develop knowledge in homeless health care as a means of further dialogue towards social justice (Bohm, 1996). *The net* gave shape to my practice in the research process as the environment I tried to create and influence. As I developed my understanding of BAT themes, the nature of *the net* grew through the narrative. Focusing on the ontology of homelessness as a basis to view health issues I defined how I used BAT in AH 1 (p.160) as *being available* to bring people in from the margins towards sustained health care engagement. In sequential analytical horizons, I showed how as a net-weaver, my role shone a light across a multiagency and multidisciplinary landscape on missing connections, towards strengthening and expanding the net into a tighter hold.³¹⁴ *Appreciating precarious engagement* became a key organizing concept developed in the analytical horizons, illuminating the net's fragility in four quadrants of my practice: health services, homeless services, the homeless person and my role as a SPHN (See p.168). I found a precarious net, shaped by forces of power, embodiment and tradition that had the potential to constrain and limit my practice vision. To *create an environment* that overcame limits my *use of voice* was crucial in developing health care services as evidenced. Towards the end of the narrative, my clinical and strategic part-time nursing role raised an important insight: as I fixed one hole in the net another appeared; I had to let go of some clinical work to develop strategy. My unique nursing position, facilitating 'street to boardroom' practice insights as presented in this study, are relevant to health services and beyond: to homeless services, police, probation and academics to name but a few.

Core strands in the net

Framed through Framing Perspectives which I used following most reflective texts, key insights about the net rope evolved in three core strands as shown in the final analytical horizon (AH3.1).

They are:

- The Public Health strand
- The clinical strand
- 'Towards commissioning'

Prior to my PhD transfer assessment, I co-created Fig 4.1 with my PhD colleague, Lou Jarrett and refined it in reflective guidance. I have not used it as an organizing scheme for this chapter but its

³¹⁴ In their Crisis report: 'A review of single homelessness in the UK from 2007 to 2010' Pleace and Quilgars (2010) summarise research that debates societal and interpersonal factors which heighten the risk of homelessness. The more someone exhibits individual risk factors and/or is exposed to structural risks, the greater the risk that they will become homeless. They quote Fitzpatrick (2005) who argues that economic and housing 'structures', interact with 'patriarchal and interpersonal structures' (child neglect or abuse, domestic violence, weak social supports) and 'individual attributes' (including support needs, self confidence and lack of self esteem) in causing homelessness (p.27).

key themes summarise the importance of the net-rope. These themes ripple through the narrative; most are developed further in *precarious engagement* later in this chapter.

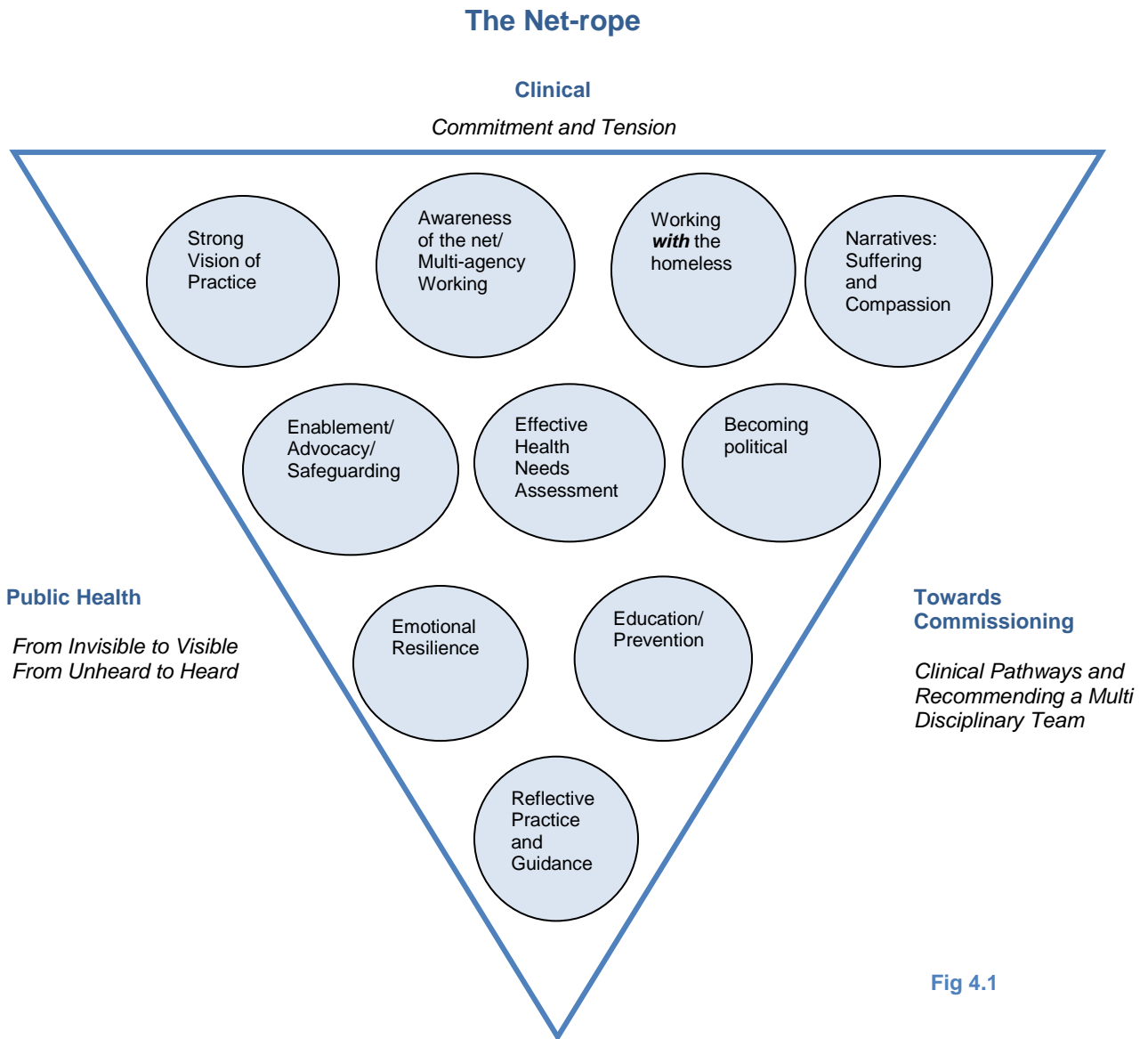


Fig 4.1

Underpinned with appropriate funding, the core strands and themes held within them strengthen the net's fabric. But the net is elusive; it cannot be effectively weaved without *appreciating precarious engagement*, summarised in this chapter. One could say that homeless health practice will always be held in this precarious tension and that becoming the practitioner I desired to be is achieved only by working creatively within its appreciation, as evidenced in the narrative. As I recognised this in practice, my transformation from being to becoming the practitioner I desired to be unfolded as summarised below.

My Transformation

At the International Reflective Practice Conference in 2005 I presented a paper using the Golden Gate Bridge as a metaphor for my role in achieving my practice vision through connecting homeless people to health services. It was a fog covered bridge across an unknown landscape with little to guide me - the image of the net had yet to emerge. Step-by-step with homeless people, academics, homeless services and health services as my guides, I reached a clearer horizon. I write from that horizon to illuminate three concepts that marked my transformation through learning development. They are:

- The Being Available Template is '*The Net*'
- Precarious Engagement
- Use of Voice (my empowerment)

The Being Available Template is '*The Net*'

As I used the six themes in BAT it gradually illuminated the homeless practice landscape beyond the 'bridge' metaphor to become *the net*. Unlike Indra's shining net (p.100), I found that the homeless health net had muddied connections and missing or hanging threads. Viewing myself as a net-weaver in practice with others, *the net* eventually sparkled with a number of national recognitions.³¹⁵ Whilst the nature of homelessness and health means *the net* is unlikely to be 'hole free', BAT shaped effective practice as illuminated in the analytical horizons. It culminates in the development of a theoretical model for SPHN homeless health practice, summarised in Fig 4.2.

³¹⁵ Shelter 2007 Good Practice Guide: Hospital Admission and Discharge; DH/Ask Medicines Award (2007) Pharmacy support to homeless hostels; Training to hostel staff (Borough Council award) DCLG (2009) Multi Agency Panel - National Champions DCLG (2009); Specialist Interventions (Health) (DCLG, 2009), Strategy and Partnerships (DCLG, 2009); First Health and Homelessness PCT Health Champion, 2010

**Vision of
Practice -
A SPHN
Homeless
Health Care
Model**

THE NET

SPHN: Being Available in Homeless Health Care Model

The SPHN *vision* of practice is inclusion of homeless peoples in health care through a role of enablement and advocacy. The *aesthetic response* requires that I mindfully engage with the homeless person, anticipating and responding to their needs. Weaving *the net* securely requires my strong *appreciation of precarious engagement* where I effectively *use my voice* in four quadrants of practice: health services, homeless person, housing/homeless services and as a specialist nurse.

Through mindful practice with the homeless person, I take nothing for granted but am open to their uniqueness. I work *with* them towards holistic engagement even when they are not held securely by other services. Being available means I effectively respond to their physical, mental, spiritual and emotional health needs where they often express traumatic life experiences including childhood trauma for the first time. In the therapeutic space trust is created and peace unfolds, even if peace is time limited. *Being available* in this way, I judge whether to act as an enabler and/or advocate as necessary.

Mindful that homeless people are marginalized by a society where all services sit, I *create an environment to be available* in health care through weaving a collaborative multiagency net. *Knowing how services respond* in a multiagency and health service net requires me to *use a voice* that is assertive, moral and political, shifting 'walls of resistance' - the attitudes and prejudices that create and prolong further suffering. In awareness of the net, I challenge and guide health and other key professionals to *grasp the net* and be accountable for their service inclusion and development. In this way multiagency collaboration is seen as mutually beneficial to health services, the homeless person and multiagency partners. When the health needs of homeless people threaten to overwhelm homeless accommodation providers I act as a peace-maker, and in this way prevent evictions and reduce rough sleeping.

Strategically, I illuminate how people *fall through the net* so that local health services are commissioned appropriately and homelessness health care recognised as a highly specialized and complex area of health practice.

Creating an environment to be available requires weaving the net extensively in university education. I provide unique knowledge to Health Visitors, School Nurses and others about childhood trauma that illuminates pathways into adult homelessness towards its prevention.

To be available requires me to be mindful of poise: the origins of my fear, the emotional demands in my role, burn-out or vicarious trauma. Reflective practice and guidance remains fundamental to professional development and to the emotional support required as I work towards securing the engagement of a multi-disciplinary team.

Fig 4.2

Being Available in Homeless Healthcare Model gives meaning to the SPHN role in a complex practice environment. It recognises the precariousness of the net, shaped as it is by forces of power, embodiment and tradition which have the potential to constrain and limit my vision. *Use of voice* to overcome these limits to secure a stronger net to *be available* is vital. To illuminate BAT themes in the model, I now summarise key knowledge arising from insights beginning with *Vision*. It provides philosophical meaning to my practice. The remaining BAT themes and knowledge arising from them are discussed under *appreciating precarious engagement*, the organizing concept used in this study for illuminating insights in four quadrants of practice (p.169).

Vision

In this section I:

- Provide an overview of SPHN vision
- Contextualise SPHN vision within national guidance and research
- Contextualise SPHN vision with insights into homeless health leadership

SPHN Vision

My practice vision is to *be available* to homeless people and services to develop health care as responsive and inclusive as developed in the analytical horizons and summarised in Fig 4.2. The irreducible core therapeutic value determined by the realisation of my vision in clinical practice is:

*I therapeutically engage with homeless people
To help them find meaning
In their experiences
Enabling them to meet their health decision
And assist them to make the best decisions,
To meet their life needs.
When necessary this may include
Advocating for their needs*

The creative tension between enabling and advocating for homeless people in the 'real world' environment is a key aesthetic response in achieving the core therapeutic value (Fig 4.3).

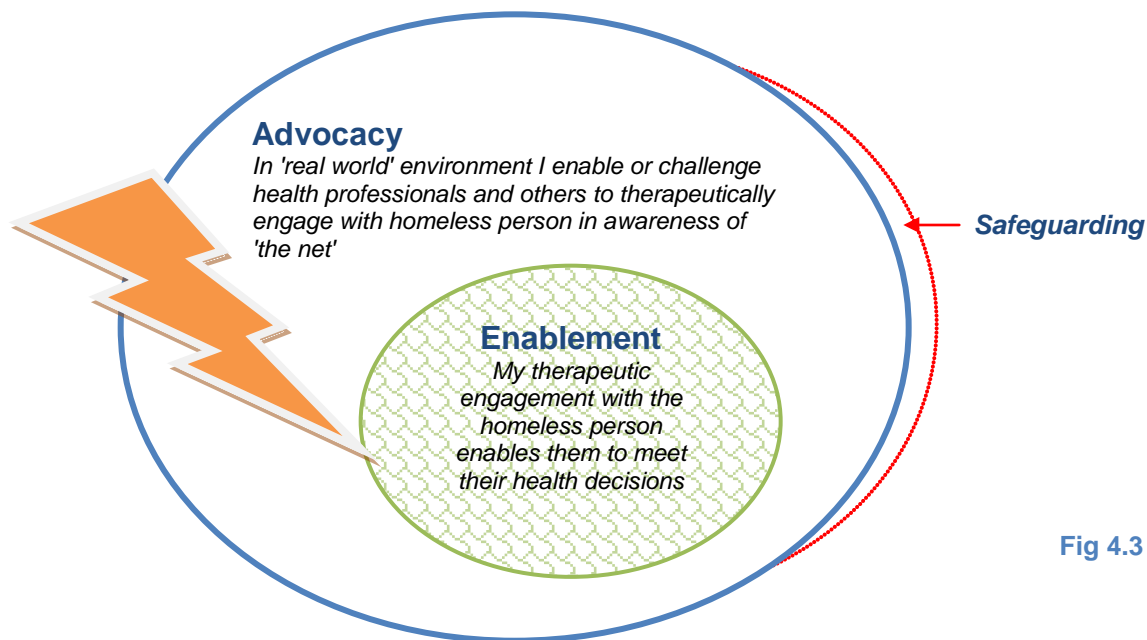


Fig 4.3

Practice implications in the therapeutic net around enablement and advocacy in the SPHN role are shown in AH2 (p.225). Briefly, in health and homelessness, I view enablement as a core process of therapeutic engagement working with the person towards better health and well-being. For example, supporting people with mental health and emotional needs to enable them to continue college education or employment (E.g.Texts:7,15,16), preventing a return to criminality (E.g.Text:7), preventing a return to rough sleeping (E.g.Text:8). But breaking hard walls of service exclusion towards therapeutic engagement with others requires me to be an advocate, acting as necessary to safeguard homeless people from systems neglect or abuse (Texts:8,18) and to prevent re-offending (Texts:9), prevent a return to rough-sleeping (Texts:2,3,8), prevent early hospital discharge (Texts:18), prevent evictions (Texts:5,7,8,9,15) and ease suffering (all clinical texts). *Being available* in this way supports my practice vision by strengthening *the net* of inclusion and requires astute *appreciation of precarious engagement* with health and other services. Hidden outcomes of enablement and advocacy make visible the effectiveness of the SPHN role in health and homelessness and reveal the human cost of holes in the net when other health professionals are unaware of their own net-weaving role. As I reveal these holes to health professionals, perceptions change, sometimes triggering epiphany tears as they see health's role in *the net* and the human person falling through it.³¹⁶

An example of creative tension between advocacy and enablement in homelessness health care occurs at the beginning of the narrative in my practice with Pamela who was discharged without a care plan from hospital. The experience illuminates my unknowing as a way to knowing in nursing

³¹⁶ Lectures to Health Visitor/School Nurse students at University of Bedfordshire January 2009 - December 2012 (E.g. Texts:3 18)

practice (Munhall,1993) where I was challenged by mental health issues, challenged by the homeless persons profession, and challenged by her presenting spirituality. The experience links to, and provides evidence of a dichotomy around which health model is effective in homelessness: should it be a mental health nurse seeing Pamela, a GP, spiritual advisor, SPHN or co-ordinated within a MDT? As I held this creative tension with Pamela, insights about my role emerged. Something vibrant and dynamic occurred in the 'therapeutic space' as we engaged with each other, where meaning about my role unfolded. This 'therapeutic space' was a deep listening space which was to be repeated in nearly all clinical texts throughout the narrative. With Pamela this clinical space became one of enablement rather than advocacy wherein I also discovered a growing awareness of the ontology of homelessness from which health need must be contextualised; I discovered the precarious nature of mental health service engagement where Pamela's trust had been eroded; I discovered 'my own uniqueness' in complexity (Wheatley & Kellnor Rogers, 1996:72) towards *becoming* the practitioner I desired to be within my practice vision; and I felt my own vulnerability, identified through *poise*.

These insights arising from reflective practice enabled me become more knowledgeable about the nature of health and homelessness and my specialist role within it, so that by the end of the narrative having systematically used the Model of Structured Reflection towards my practice vision, I had identified the specialist nature of my SPHN role (AH3.3). In particular, transferrable Health Visitor skills were most valuable for use in enabling and advocacy. They include: safeguarding knowledge, antenatal care, experience of childhood trauma, working with complex situations and working with multi-agency services/ health services. However, mental illness continued to be one of the largest net-holes in homelessness as the narrative illuminates (Texts:5,9,13) and led to my strategic recommendation for a mental health nurse within a Multi Disciplinary Team (see HNA report - Appendix 1).

Contextualizing my vision within national guidance and research

The specialist nature of my role leading to a practice vision of inclusion informs national research. Jones and Pleace (2010) reiterate known barriers³¹⁷ in accessing health services in their recent review of homelessness research but stoke the debate on whether specialist interventions are effective, many of which are only developed in cities known to have large homeless populations. They note,

.. separating out single homeless people from mainstream services automatically compromises the quality of care that single homeless people can receive and they will not become familiar with the NHS services they would use when re-housed (Pleace and Quilgars, 1996; Riley *et al*, 2003; Quilgars and Pleace, 2003). Yet while there is a case for 'mainstreaming', it is still the case that some single homeless people find it

³¹⁷ E.g: bureaucracy, attitudes by health professionals, attitudes by homeless people, mental health and substances, and survival needs outweighing health needs.

difficult to access mainstream services and that it was sometimes difficult for mainstream services to work with them (Jones and Pleace, 2010:73).

My study illuminates engagement difficulties arising within mainstream services in meeting the health needs of homeless people whilst highlighting quality of care provided through the SPHN role as evidenced in the narrative. This is illuminated further in this chapter under *appreciating precarious engagement* (p.287).

My study also contributes to knowledge arising from a national DH (2010) guidance document outlining four models of health care for single homeless people in England. Simultaneous gaps were identified and, as yet, it is not understood how far health needs are met through each model.³¹⁸

We have investigated whether there is a correlation between the size of the local homelessness population and the intensity of services ... the analysis is unable to demonstrate how far the provision is fully meeting the needs of this population (DH, 2010:20).

The SPHN role is contained in Model 2, out of four possible models, and builds on the previous Model 1 [outreach GP/s]. However, my recommendation to commissioners at the end of the narrative in the HNA was for a Multi Disciplinary Team which is Model 3. Furthermore, my research paints a picture of crisis in health and homelessness in a middle-sized PCT where homelessness was relatively invisible to health services at the beginning of my narrative.³¹⁹ Poor outcomes from mainstream services which would have remained invisible are revealed through my role - echoing the ever rhetorical question posed in reflective guidance: "What would have happened had you not been there?" (Text:2,3,5,8,10,13,18).

Contextualize vision with insights into homeless health leadership

The challenge: '*What would have happened had you not been there?*' led to insights about homeless health leadership (Text:11). Nationally and regionally homelessness health leadership was relatively undeveloped during the narrative years. The first national homeless health standards

³¹⁸ Single Homelessness (DH, 2010,p18.) *Models of care for specialist homelessness primary care provision:*
1. Mainstream practices provide services for homeless GP from a mainstream practice holds regular sessions for homeless people in a drop-in centre or sees them in his/her own surgery. May not register patients and no 24/7 provision.2. Outreach team of specialist homelessness nurses An outreach team of specialist nurses provide advocacy and support, dress wounds etc. and refer to other health services incl. dedicated GP clinics. Unlikely to register patients and no 24/7 provision.3. Full primary care specialist homelessness team A team of specialist GPs, nurses and other services (CPN, podiatry, substance misuse specialists) provide dedicated and specialist care. Co-located with a hostel / drop-in centre. Usually register patients and provide 24/7 cover.4. Fully coordinated primary and secondary care A team of specialists spanning primary and secondary care provide an integrated service including: specialist primary care, out-reach services, intermediate care beds and in-reach services to acute beds.

³¹⁹ Even my part-time role in clinical and strategic development covering family and single homelessness shows the extent in which homeless health issues were unrecognised.

were produced in 2011 and makes health services accountable for their care to this vulnerable group (COM/Pathways, 2011). Locally, the medical model as a leadership model was undeveloped across multiagency and health services. Snell et al (2011) in their study of medical leadership notes that whilst strong leadership is needed in health care settings, many of the physicians in her study disengaged from leadership. They lacked key leadership skills including training and multi-agency awareness and were expected to volunteer their time rather than be compensated for their leadership activities. 'Silent' medical voices - a reminder of Belenky et al's model - in homeless health care leadership is currently concerning at a time of GP commissioning and government cutbacks,

A GP practice would want to identify a specific need for a health service for single homeless people that benefits the area it serves before commissioning that service and unless that area has a significant single homeless population it may be difficult to demonstrate a need for specialist homelessness provision (Jones and Pleace, 2010:73).

Through an assertive *use of voice* across agencies, my becoming a transformational leader naturally arose as I built a strong 'momentum of change' (Snell et al, 2011:1), culminating in being *political* - a nursing act of social justice (Warner, 2003) discussed in AH3:p.274. However, homeless health leadership requires more than a charismatic character at local level who voices the needs of vulnerable people, particularly as my part-time role straddled clinical and strategic development, in itself identifying a resource limitation as snowballing occurred in the growing visibility and effectiveness of my role. Nevertheless, the SPHN as a leadership model is cost-effective and ideal for mapping and developing homeless health service beyond a basic Public Health paper exercise.³²⁰ Clinical and strategic development combine to make a stronger net where local street knowledge finds its way to boardroom meetings and eventually university classrooms.

By the end of the narrative my clinical vision required strategic adoption to become a shared vision. In political awareness, I drew senior lead commissioners into the local plight of health need in homelessness through effective dissemination of the HNA report. My recommendation for a Multi-disciplinary Team concludes the narrative (Text 21) and arose through insights in *appreciating precarious engagement* which I now summarise.

Appreciating How Precarious Engagement Affects my Practice Vision

Having discussed insights arising from *vision* as a key BAT theme for developing practice, the remaining BAT themes are discussed in this section as I illuminate my development of *appreciating precarious engagement* in four quadrants of practice: health services, homeless services, the

³²⁰ Part-time: 0.6 equivalent on Band 7

homeless person and my SPHN role. The insights I illuminate particularly mark my transformation in practice. For example, I write about homeless women rather than homeless men, building on my experience as a health visitor with vulnerable women as discussed in professional fore-having (p.31).

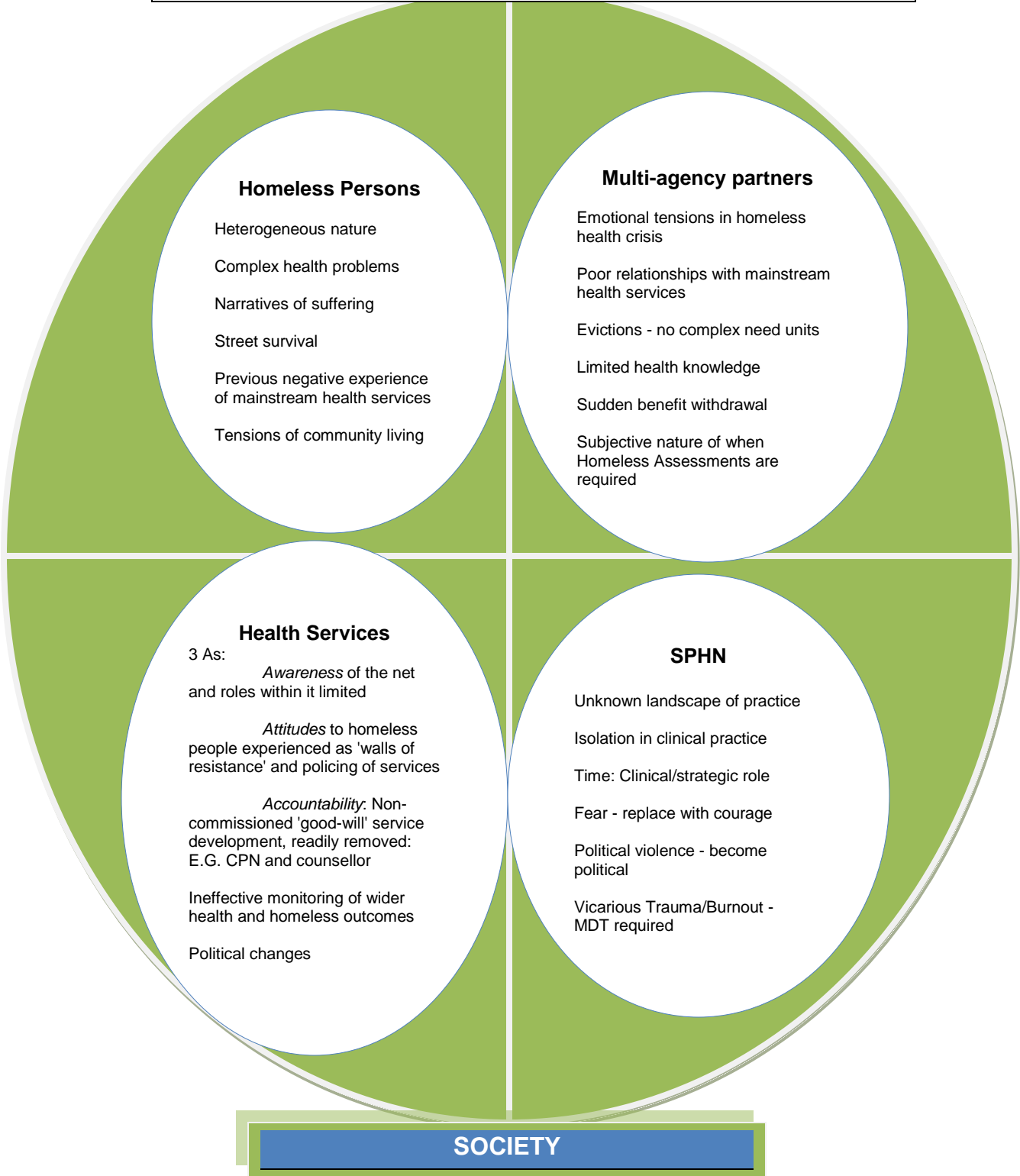
First, I reiterate the concept of precarious engagement below and then summarise key insights that rippled through the narrative about its nature (Fig 4.4).

The significance of precarious engagement in homeless health care became increasingly apparent as reflected in the sequential analytical horizons in the narrative. In AH1:p.170, I weaved precarious engagement into my practice vision, defining it as,

Enabling homeless people to access and sustain engagement through creating an environment of *being available*. Effective health care emerges through strong multi-agency partnerships that combine to hold a homeless person in a net of services, even when they are not held securely by others. Appreciating precarious engagement strengthens the net as other health professionals grasp their unique contribution to net fixing, shaping and building a net of inclusion.

Precarious engagement is in the net, making the net fragile. Why is this important? Before I began the narrative there was nothing to guide me in practice about the nature of engagement; even as an experienced practitioner, I naively believed that if I could engage homeless people in their health needs then accessing services would be as straightforward as it was in my previous Health Visitor role. But engagement in homelessness is complex and multi-layered. Professional others were 'hard to reach' - not simply the homeless person. Increasingly, I recognised that to be an effective SPHN I must work within the creative tension of *appreciating precarious engagement* in four areas of practice (Fig 4.4). *Appreciating precarious engagement in homeless health care* illuminates a holistic multi-agency environment, illuminating its complexity which has not been developed in health research previously.

Knowing Tensions within Four Quadrants of Practice



Appreciating Precarious Engagement in Homelessness Health Care

Fig 4.4

I contextualize *appreciating precarious engagement* within 'society' where homelessness sits - not on the margins but right in the heart of our communities. The insights are a reminder to the reader of the precarious tensions in the net in which the SPHN must practice. Insights ripple through the narrative. Whilst many have been explored in the analytical horizons, in this chapter I pull out significant insights to deepen them in dialogue with an informing literature to show my effectiveness and transformation in practice within each quadrant:

- The Homeless Person
- Health Services
- Multi agency Services
- Specialist Public Health Nurse

I begin with society from which each quadrant can be contextualised.

Society

It is 1st February 2012. The 6.00pm BBC News headline is: "Big freeze across Europe - heavy snow across the continent is causing death from hypothermia, most are homeless". Immediately I am reminded of my shock at Jack's admission to A&E from hypothermia and frostbite, and the 18 survival sleeping bags I bought for rough-sleepers in the first year of my practice (Text:2). Making Jack's hospital admission and near death experience visible to multi-agency partners' was a turning point in the development of local humanitarian services. Assertively, I challenged local lack of provision. Working collaboratively with others, provision developed and included a winter night-cape, yet still it is only open when temperatures are expected to be freezing for three consecutive nights as government guidance suggests (DCLG, 2007b) not, necessarily, on other cold nights. Can you or I imagine what it must be like to live under a bridge or in an abandoned shed when temperatures are just above freezing? What are societies' values? Marginalisation of the homeless increases *precarious engagement* and threatens my values in homeless health care - values which ripple through the narrative as show in Fig 4.5

SPHN: Homeless Health Care Values Are they at odds with society's values on homelessness?
<ul style="list-style-type: none"> • Inclusiveness: no-one in society should be excluded from effective health care • Openness: recognising the uniqueness of each person • Mindfulness: allowing presence to develop in practice where the person is heard • Humility: willingness to learn from the homeless person and <i>work with</i> them towards their health and life needs • Ease suffering: grounding actions in compassion, caring and love for humanity • Collaboration: Building the net <i>with</i> local communities/people involved in homelessness • Guiding other health professionals and challenging prejudices where they exist • Becoming political - voicing needs to improve health access and reduce health inequalities towards social justice

Fig 4.5

In the narrative, I illuminate the relationship and actions of the SPHN practitioner in social, cultural and environmental terms which are based on my values. The shaping of my values was a constant focus of my inquiry. Nurses and other health professionals are embedded in society which shapes our values. For example, during the course of the narrative the only local newspaper reports of people with 'no fixed abode' were: 2 drowning in the river, 3 murders, muggings, and the controversial removal of benches at the town-end of an up-market avenue where homeless people waited each evening for the 'soup-run'. How do press reports make us feel? I recognised prejudices that mitigate against *being available* to homeless people. I walk along a knife edge as evidenced, feeling a constant tension that homeless people are distasteful to society: that they choose homelessness; that they break society rules.

I am reminded of a fellow homelessness nurse whom I met at the UK's first Health and Homelessness conference.³²¹ Bemused, I queried with her how the recent annual rough-sleeping count of 10 in our middle-sized town could be greater than that in her industrial city which was 6. Her reply shocked me. "Our rough-sleepers are placed in B&Bs during the week of the count". If this is true - where is nursing's political voice? Why are nurses so silent? Why are we not awake to our potential for shouting out for political, societal and cultural change at local and national level? If this happened in my Trust, would I speak out? Yes, I do have the courage and moral duty to do so - an aesthetic response in awareness of my political nursing voice.

I muse further on how society could offer an alternative response to homelessness, mindful of the inequalities that exist which Marmot (2009) reports in his strategic review of health inequalities in England. Wilkinson and Pickett (2009) provide international evidence of where equal societies fair better in terms of health and happiness than those where increased inequalities like those in the Britain prevail. They note,

... the quality of social relations in a society is built on material foundations. The scale of income differences has a powerful effect on how we relate to each other. ...the scale of inequalities provides a powerful lever on the psychological wellbeing of us all (Wilkinson and Pickett, 2009:4/5).

They continue,

If Britain became as equal as the same four countries [Japan, Norway, Sweden and Finland] levels of trust might be expected to be two-thirds as high as they are now, mental illness might be more than halved...prisons closed across the country.... what is essential to bring about a better society is to develop a sustained movement committed to doing that (p.261).

Wilson and Pickett's assertion that the quality of social relationships are built on material foundations provide me with more insight into the relationship which society has with homeless

³²¹ Homeless Health Initiative Conference: Opening Doors Nursing and Homelessness, Regents College, London (QNI, 2009)

people as a marginalised group and hence illuminates the precariousness in the net. They note that in societies with higher rates of inequalities an individualist, self-promotion ideal exists rather than one built on community values where materialism is seen in obsessive shopping/spending, overeating, excessive alcohol and incomes.

Archbishop Nicholls (2011) speaks of a similar society; one with 'balance-sheet friendships' where the benefits and risks are evaluated prior to beginning a relationship, and where indifference coexists with fear.³²² My narrative illuminates fear, mine and others, and shows a lack of relationship with homeless people by society in general, particularly where it alludes to the invisibility of homelessness. As I made homelessness visible strategically in practice, responses include shock that "this" could be happening locally (Texts:17,19,21, *Black Monday*³²³).

Homeless people are positioned in these societal tensions that contribute to precarious engagement and the unstable net. Homelessness and health in this context becomes a political issue. Marmot (2009) notes,

Factors that shape health and well-being.... include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors...all these influences are affected by the socio-political and cultural and social context in which they sit. (Marmot, 2009:16)

My voice was an ethical voice to connect society into the homelessness net through storytelling.³²⁴ Boykin and Dunphy (2002) relate justice-making to acts of caring as nurses recognise that the world is 'lived in common' (p.19). Held less precariously by an informed society, homeless people are likely to suffer less as their plight becomes framed within a caring society's values and ideals.

I shall now summarise *appreciating precarious engagement* in four quadrants of my practice, arising from narrative insight that illuminate the effectiveness of my role. Some have already been developed in the analytical horizons.

Homeless Person

This section is organised as follows:

- 'Who are the homeless?'
- Working *with* the homeless
 - Being a peace-maker

³²² Address to seminarians on the Common Good in society: The Roman Catholic Bishops of England and Wales in the document *Choosing the Common Good*, underlines the importance of the practice of virtue in public life (accessed 12th January 2012 @ http://eastangliaseminarians.blogspot.co.uk/2011_03_01_archive.html)

³²³ Word constraints prevent its inclusion in the narrative

³²⁴ Post-narrative, this included six performances of *My Place* across the locality with theatre students from University of Bedfordshire.

- Being with homeless women
- Intellect/social class

Who are the homeless?

Whilst there is increased understanding of health needs in homelessness (Bines, 1994; Wright & Tomkins, 2006; DH, 2010) nurses and other health professionals are not trained effectively about homeless people, riddling the net with holes. Without reflective practice and knowledge of homeless people, prejudices will make engagement precarious.

To achieve the core therapeutic value as an enabler or advocate (discussed on p.226), I have to effectively engage with homeless people. *Having concern for the person* called on mindfulness in practice of the unique situation of every homeless person. Encountering each person, then, is a mystery. Even when I think I know, I hold this knowledge loosely. They are a heterogeneous group. Illness (all clinical texts), survival needs (Texts:2,3,13), offending (Texts:6,7,8,9), substance misuse (Texts:3,7,8,9) and childhood trauma (Texts:3,7,8,9,15) feature dynamically in the narrative as part of the complex fabric of homelessness. Spirituality (AH1:p.165), gender & age (all clinical texts) and the nature of suffering are also holistically illuminated (AH1:p.64 &AH:pp.222-224).

Key insights from understanding the nature and characteristic of the homeless person that contribute to precarious engagement and illuminate creative tension and my development in health practice are summarised below. They were gathered using BAT themes: *Having concern for the person, aesthetic response, and creating a suitable environment*.

Working *with* the homeless person

To support BAT themes of *creating a suitable environment* and *having concern for the person* requires a welcoming therapeutic space wherein presence unfolds. Effective nursing engagement to achieve the core therapeutic value requires working *with* the person (Plews et al, 2005), something I had intuitively learnt from my background as a Health Visitor entering people's homes. My working *with* the homeless is crucial in achieving the core therapeutic and is theoretically underpinned by Freire's (1970/1993) influential work on pedagogy of the oppressed. My greatest teachers in homelessness have been the homeless themselves. Freire recognises that the contradiction between students and teachers is "...reconciled when both are simultaneously teacher and students" (p.53) and that, "...dialogue cannot exist without humility" (p.71).

Positive shifts of energy through *working with* the person arose through mindful practice (Johns, 2009) and the Burford Model of Reflection (AH1:p.162) in which 'presence' (Senge, 2005) developed as seen in all clinical texts. Trust evolved in 'communion' with the person through

dialogue which is humble and has a capacity to love (Freire, 1970:151), something I implicitly recognised in practice (Text:8,18,20). Communion is a concept cited by Rankin and DeLaschmutt (2006) which is discussed in AH1:p.166. When this was achieved in homelessness, disclosure about complex trauma often unfolded (AH2:p.224). Normally, engaging homeless people in dialogue was readily achieved and the notion that homeless people are 'hard to reach' generally proved to be untrue.

An insight arose that those who resisted engagement did so because they perceived the net to be oppressive (Texts:1,5,9). Focus group comments with homeless people for the HNA report included phrases about health services such as "They think we're scum; we are scum" (Appendix 1).³²⁵ In the narrative 'poor' engagement with health services included fear of being sectioned under the mental health act, and anger that this had previously happened (Text:1,5,9). The narrative illuminates the effect refusal to re-engage with adult mental health services and Child and Adult Mental Health Services (Text:15) places on homeless services,³²⁶ left to deal with increased health needs. Weaving hanging, unwoven strands of non-engagement illuminate the effectiveness of my role. Dean states (Text:9) "I can't believe I'm talking to you like this - I don't normally talk to health professionals." *Being available* to construct an effective therapeutic relationship, preventing evictions where possible is the nature of my specialist role (Text:2,8,13,15,20). Engagement, however, being relational is precarious - links to the reflexive nature of the narrative where strands and themes emerge and flow, are left unwoven.

- **Being a Peacemaker**

Holding the creative tension in the dynamic, critical, therapeutic space of homelessness situated in an environment which often felt like a war-zone, illuminated my role as a peace-maker wherein *having concern for the person* strongly resonates within all the clinical texts.³²⁷ Heidi's search for peace following the turmoil of her friend's sudden eviction and death identifies this, as does her need to talk about her own childhood trauma (Text:8). My core therapeutic with Heidi was achieved through enablement and is part of nurses' caring responsibility. Moore (1992) in Newman (1994:41) notes,

Care of the soul...isn't about curing, fixing, changing, adjusting or making healthy....It doesn't look to the future for an ideal trouble free existence. Rather it remains patiently in the present, close to life as it presents itself day by day (Moore, 1992:xv)

³²⁵ Focus group interviews for the Health Needs Assessment (appendix 1);this commented used also in presentations on homelessness and health

³²⁶ Other examples of precarious engagement by health services are clearly provided in narrative texts of Mary (Text:3), Rudi (Text:15), Dean (Text:9) and mother and baby living in TA (Text:12) They illuminate a culture of rejection from: GPs, learning disability team, mental health services, A&E staff, ward discharge teams, including a culture of superficial engagement (Text:3,20).

³²⁷ Text:1,2,5,8,12,15,16

In this way, care of the soul in homelessness resonates with becoming a peacemaker. It is part of my *aesthetic response* and was named through co-creation in reflective guidance. Initially the concept arose from dialogue about my mediation work in hostels and was theoretically informed by the work of Elise Boulding (AH2:pp.228-229). Why is this important? Finding a place of peace within the therapeutic encounter, even when short-lived, restores dignity and re-energises the person leading towards outcomes of work/college placements (Texts:15,16). With Heidi and others it prevented rough sleeping. These are hidden outcomes in homeless health care, often unrecognised in the quantitative 'scientific' environment, preferring instead the recording of treating Heidi's oedematous ankle as a way to demonstrate effectiveness in nursing. I refer again to the opening quote from O'Connell used in this chapter to understand the power story has in revealing the nursing role which seems inherently undervalued.

- **Being with Homeless Women**

Having concern for the person meant knowing the person as I worked *with* them therapeutically. Previously, my nursing career had been dedicated to women, children and to parenting,³²⁸ visiting thousands of women in their homes. The juxtaposition between home and homeless women seemed particularly pronounced to me and it was an area I wanted to learn more about in my development.

Jones (1999) in her notable report from across four UK cities noted that homeless women were a hidden part of the homeless population. Many had abusive relationships and 'disruptive childhoods'. She found that the most common reason for homelessness was domestic violence and being forced to leave the family home. I contextualise this within a quote from the European Consensus Conference on homeless held in Brussels in 2010 noting that,

Homelessness is the result of a complex interplay of structural, institutional, relationship and personal factors.homelessness is not a "chosen" life-style. However, homeless persons are not simply passive victims of external forces and often make choices, albeit between limited options, under difficult circumstances (EU/EC, 2010:2).

Homeless people are not simply passive victims....

A report commissioned by Crisis (2006) found that homeless women were likely to earn income from begging and the sex trade rather than from paid employment, despite seeking normality: sitting with a cup of tea on their own sofa at home. My research concurs with Sycamore (Crisis, 2006) who describes women as a distinct population with different experiences of homelessness, requiring different service needs. My study brings a deeply holistic perspective of the heterogeneous nature of homeless women across an age spectrum of 16 to 54.

³²⁸ See background chapter

In thematic style, I illuminate the health needs and journeys' into/out of homelessness of the six main women in the narrative (Fig 4.6).

	Women's Health Need	Homelessness Trigger	Housing Outcomes	Health Outcome Process
Pamela Age:45 (Text:1)	H/o section under the mental health act. Subsequently diagnosed with a brain tumour	Illness, loss of employment and house	Night-shelter; Sofa-surfing; <i>Post narrative:</i> Hospice	Enablement
Mary 23 yrs (Text:3/4)	Complex health need: Learning disability, epilepsy, asthmatic, psychosis, pregnancy, child in care, substance misuse, domestic violence. H/o childhood prostitution	Evicted from LA accommodation - categorised as intentionally homeless	Cold weather TA; Successful Registered Social Landlord accommodation; Rough sleeping following psychosis when baby was taken into care at birth	Advocacy
Heidi 54 yrs (Text:8)	Sprained ankle, alcoholism, complex trauma, H/o torture Personality disorder	Released from prison	Rough Sleeping; Eva Centre; Housed	Enablement
Dora 30 yrs (Text:10)	Sprained ankle, alcoholism, fear of hospital, children in care	Unknown	Rough Sleeping	Advocacy
Lucy 16 yrs (Text:15)	Mental health, self-harm, sexual health	Escaping violence	Hostel; Goes to live with boyfriend's family	Enablement
Ariella 21 yrs (Text:16)	Bereavement, feeling different in hostel culture	Mother's premature death, unemployed, limited family support	Hostel; Local Authority flat	Enablement

Fig 4.6

Whilst Fig 4.6 provides an overview connecting health and homelessness, it fails to illuminate the intensity of the women's experiences nor my health role working with them as stories do. In stories their daily struggles and suffering, their courage and knowledge and, most of all, their search for peace is illuminated.³²⁹

Like Sycamore (2006), I found that most women wanted a home. However, some did not. Ironically, Pamela (Text:1) found her home with the homeless, being an advocate and living simply in a deep spirituality which, may or may not, have been an associated symptom of her yet to be diagnosed mental illness/brain tumour. Heidi (Text:8) also had a precarious relationship with accommodation; feeling at times it was safer to "sleep under the stars" (see p.154), a reference to the extreme violence she experienced living at home.

The insight I had in my own learning about *being with homeless women* was an appreciation of my own womaness, completing a cycle of being with women as mothers in healthcare practice, leading a mother's spirituality group and being raised by my widowed mother and her sisters.³³⁰ In these spaces and with these women, I had found the 'genius of women', often despite enduring hardship. I draw from Pope John Paul II who wrote,

³²⁹ See also Texts 1,3,8,15,16.

³³⁰ See background chapter

In every time and place... women's dignity has often been unacknowledged and their prerogatives misrepresented; they have often been relegated to the margins of society and even reduced to servitude. This has prevented women from truly being themselves and it has resulted in a spiritual impoverishment of humanity....reflect carefully on what it means to speak of the "*genius of women*" ... in order to let this genius be more fully expressed in the life of society as a whole (Letter of Pope John Paul II to Women, 1995:10)

Women's genius arises in their various roles in a service of love contributing eventually to a civilization of love (JP II, 1995); I view that civilization as one of inclusion. Whilst homeless women have often lost their various roles, the genius of homeless women is seen in their resilience and courage, resonating in the stories: E.g. Pamela's strong advocacy for other homeless people (Text:1), Heidi's voice to safeguard other homeless people (Text:8), Maryanne's ability to love and to protect her unborn child through giving up her addiction to heroine (Text:3/4).

I write to open-up dialogue that changes perceptions so that homeless women are perceived beyond 'bag-lady', a derogatory term used by a Health Visitor as I entered homeless practice. 'Love' is an element of authentic dialogue (Freire, 1970/1993:70), and can only develop from *having concern for the person*. *Being available* to homeless women has been a time of immense growth and humility, listening to their stories through shared womanhood and shared humanity.

- **Intellect/Social Class**

Monitoring homelessness since the establishment of the coalition government, Fitzpatrick et al (2011) states,

... there has been much speculation in the press about 'middle class homelessness', all of the indications are that the expanding risk of homelessness is heavily concentrated, as always, on the poorest and most disadvantaged sections of the community. (p.12)

A key insight arising from *knowing the person* was seeing them as unique human beings without prejudice. Whilst Fitzpatrick's point is important to my practice, the spectrum of intellectual ability and class was apparent in my practice, each person presenting with unique needs. People with borderline learning disability were very evident (Texts:1,3,10), and my initial perspective were challenged and ultimately transformed as I came into contact with middle-class professional people who were homeless and able to knowledgeably articulate their concerns about housing and health services (Texts:1,5,18),³³¹ including previous negative experiences of health services (Texts1,5).

My transformation triggered around "middle-class" homelessness was shared by my reflective guides (Text:18). I want to position this insight using Krumer-Nevo and Benjamin (2010) in their paper on poverty knowledge, showing how social distancing occurs through Othering,

³³¹ Exception: Tristan (Text 18)

... Othering cushions middle-class people leaving their values unviolated and protected from any potentially impinging cultural relativism... (p.698)

Perhaps I, or other health professionals, protect ourselves through the lens of Othering. Yet, given a constellation of circumstances - a culmination of personal and societal circumstances observed in clinical narrative texts, I began to see how homelessness could almost affect anyone.³³² I chose some texts to show that homelessness can affect health and other professionals, and in doing so prevent Othering which I believe I witnessed in practice as a form of exclusion which contributes to oppression - the 'walls of resistance' and 'policing of services' illuminated in the narrative contributing to precarious engagement (Texts:9,10,13).

Health Services

This section is organised as follows:

- Awareness: Raising awareness of 'the net'
- Attitudes: Negotiating 'walls of resistance' /policing of services
- Accountability: Enabling others to reflect on homelessness to be accountable for their service development

BAT themes *knowing services, aesthetic response and creating an environment*, brought about my key insights in this section.

Awareness of the Net

Appreciating the complexity of the multiagency web and enabling it to work as a homogeneous whole was a significant insight in my continuing development that connected local health professionals to the net. In a reflective essay on nursing's call to justice-making, Boykin and Dunphy (2002) emphasize connectedness rather than separateness in creating caring and compassionate communities. They draw on Florence Nightingale to show the importance in nursing of a world 'lived in common'. They note,

There is incredible power in communities of people who gather together through common values and beliefs and who are motivated by compassion. In living the compassionate life, we connect not only with each other but also with the universe. It is this connecting that provides the context for the living of our own life and for the practice of nursing. It is this unity we are called to respond to - as it was Nightingale. In the practice of nursing, justice-making involves choosing actions grounded in caring and compassion. Decisions are guided by caring and an awareness of a world lived in common (Boykin and Dunphy, 2002:19)

³³² Australian research by Casey (2002) is consistent in showing how state failures such as children leaving care cause adult homelessness whilst inner strength is required to begin to seek out support:(In Snakes and Ladders: Women's Pathways into and out of homelessness in Eardley and Bradbury [eds] *Competing Visions: Referred proceedings of the National Social Policy Conference 2001 Report 1 Social Policy Research Centre, University of New South Wales 75-90*)

To *create an environment* to practice with vulnerable people, seemingly without social position, requires a net that is grounded in caring and compassion. To this end, I spoke at clinical and strategic meetings, wrote updates in the PCT newsletter and authored Public Health reports. The PCT received two national recognitions at this time whilst the Local Authority was named as national champions in interventions which I extensively contributed to.³³³

The narrative illuminates how the specialist nature of my role raised awareness of a 'world-lived-in-common' reflected by integration of caring, compassion and justice strengthened the net through protocols, storytelling and making the invisible visible. Some key mainstream health professionals joined collaboratively with me in *awareness* of the developing net: the hospital manager (Text:6,18), pharmacists (Text:14), Health Improvement Team,³³⁴ mental health managers (Texts:19,20) and post-narrative the hospital discharge team. 'New models of decision making' (Boykin and Dunphy, 2002) in connection with others were created so that justice-making could shine out in *the net*. Justice-making became my ethical *aesthetic response* in strengthening and expanding *the net*.

Attitudes: Negotiating 'walls of resistance'/policing of services

In AH1:pp.166-167 and AH2:p.219 I show 'walls of resistance' that made the net precarious. Building on knowledge of exclusion by health professionals (Kelly & May, 1982; Shaw, 2007) I use the term 'policing of health services' in the narrative where nurses and others acted as door-keepers to services, keeping homeless people out.³³⁵ Was it right, for example, that even in Year 3 (Text:20) when my development had significantly evolved, the mental health manager protested about her engagement at Multi-Agency Panel meetings at a time when mental health *disengagement* was already causing significant problems? Attitudes and knowledge gaps contributing to holes in the net are summarised from the narrative in Fig 4.7.

³³³ Text 14: Ask about Medicine Award - Supporting homeless hostels (DH 2007); Also in Shelter Good Practice Guide (2007) Development of an Admission and Discharge Hospital Policy. the Local Authority was named as CLG (2009) national champions for Multi Agency Panel and for training for hostel staff (Health training included: Self Harm, TB awareness, Diabetes in the 21st century; Health and Homelessness, Infection Control).

³³⁴ Health Improvement Team interventions: Health and Homelessness Fair, Health and Homelessness Leaflets, stop smoking initiatives and health resources in hostels and day centres

³³⁵ The narrative illuminates how engagement was resisted at every level: senior managers (E.g.Text:12) A&E staff nurses, GPs and their receptionists (Texts:3,10,11,13), psychiatrists (Text:13), midwives health visitors (Text:3), learning disability teams, social service staff (Text 3) ward discharge staff (Text 6), mental health crisis teams, community mental health teams (Text 13).

**Mainstream Health Services:
Attitudes that contribute to holes in the net**

- Unaware of the net and subsequently how their role could weave the net more tightly
- Othering - prejudices embodied from society
- Lack of compassion for homeless people
- Fear
- Zero tolerance
- Rigid NHS rules
- Unwilling or unskilled in working effectively with multi-agency partners
- Unwilling or unskilled in working effectively with other health disciplines in regard to homelessness
- Lack of political skills required to bring about societal change for homeless people
- Resources - time and training
- Knowledge - lack of nursing research on homelessness

Fig 4.7

In awareness of the attitudes that contribute to precarious engagement I became increasing political, reflected in a shape of focus towards strategic meetings. As such my net weaving moved from catching individual people falling through the net towards grasping the nature of the whole net. Tightening and shaping the net in this way created a tension of how I used my time/expertise most effectively. I aesthetically responded by challenging values in the organisation through my *use of voice*, making others accountable for their services and their practice in *the net* (Texts:11,17,18,19,20,21).

I turned to Wheatley (2006) to justify my political emergence in this way, illuminating cultures in the NHS that contributed to a fragile, precarious net. Wheatley states that a "living network will transmit only what it decides is meaningful" (p.151). She notes that organisations repeat patterns, like fractals, which result in the culture of an organisation. Fractals can be observed in any part of the organisation and reflect its values and how the organisation chooses to do its work (p.129). The repeat patterns limiting my practice vision in homelessness are those of *precarious engagement* starting with limited national and regional guidance which extended to local health service managers and ground clinicians. No-one seemed *accountable*.

Accountability: Enabling others, through reflection, to be accountable for service development

As I grew to appreciate the nature of precarious engagement, I recognised that weaving the net depended on organisations being reflective in order to be accountable. To change, systems need to "learn more about itself from itself" (Wheatley, 2003:145). In *Spider's Web* (Text:19), I inadvertently used the same metaphor as Wheatley, reflecting on my role with senior mental health

managers where I felt like a spider drawing stray, strands together. Wheatley notes, "once we recognise that organisations are webs, there is much we can learn about organisational change from just contemplating spiders' webs" (p.145). My accumulated knowledge enabled me to voice issues, often through storytelling, making the invisible visible to confront limited attitudes and complacency which meant others had to learn to be accountable for their strands in *the net* (Text:19,21). I was then using a constructive voice (Belenky et al, 1986).

Multi-agency Partners

This section is organised as follows:

- Voluntary services
- Housing services

I draw on BAT themes: *creating a suitable environment, knowing services, having concern for the person, aesthetic response*

Voluntary Services

"I'm glad you're here Maria. There was so much blood on the carpet. I can't cope with this on my own." (Text:15,p.205)

In AH1.4 (p.167) I illuminate how I supported homeless services - it was apparent that they were ill-equipped to care for the crisis health needs of the homeless. As I dialogued with them and homeless people about the tensions of hostel life, my role as a peacemaker was apparent, a concept co-created in reflective guidance and later informed by the work of Elise Boulding (AH2:p.229). Peacemaking strengthens the net considerably and was the main contributory factor to the Housing manager's exclamation, "Everyone's talking about your work with them - how do you do it; you must be cloned" (Text:17).

Housing Services

The relational nature between health and housing professionals is a key feature in securing the net. As a net-weaver, I had built excellent collaborative relationship with housing services in multiagency development as evidenced in the narrative but its precariousness was evident in hospital discharges which became less effective when a particular housing officer left (Texts:2 and18), hesitation in completing formal housing homeless assessments, and resources, including my own, prevented a rapid implementation of an updated multi-agency Admission and Discharge Hospital policy. Regarding homelessness assessments, Pawson (2007) in a review of Local Authority homeless prevention, notes 'gate-keeping' by housing staff,

It was standard practice for people presenting as homeless to be informally referred to RDG [Rent Deposit Scheme] help without any formal assessment to determine whether individuals were in fact legally homeless...such practices might be interpreted as unlawful gate-keeping (p.875) [my insertion]

Gaining insights about *the net* through housing knowledge and language became part of my specialist role, which strengthened the net. I support and challenge housing teams to guard vulnerable homeless people. For example, is it good enough that a vulnerable pregnant woman with borderline learning disability was categorized as intentionally homeless and denied social housing when it was her ex-partner who had used her previous home for drug dealing (Text:3)? Her vulnerability did not overrule this housing decision. Does that indicate a caring society?

This insight I gained about my role on systems coherence between health and housing is nourished by Wheatley & Kellner-Rogers (1996:88) in their work on systems organisation,

not so much looking for the shape
as being available
to any shape that may be
summoning itself
through me
from the self not mine but ours

Being available in health and homelessness requires shaping a shared practice net wherein "life pursues a path of differentness to a destination of wholeness" (Wheatley & Kellner-Rogers 1996:90).

Specialist Public Health Nurse

This section is organised as

- Poise
- Reflective Practice and Reflective Guidance

Poise

The precarious nature of engagement was often emotional, fearful, unsettling, and uncertain with limited support. I had to develop *poise* to see things for what they were, unclouded by emotional tension. When tension did occur I learnt to work through it; taking time out in practice to recover and reflect on practice if necessary (Text:8). I learnt to categorise fear in order to become more courageous (AH2:p.165). Courage became the springboard to a growing political voice as I became more alert to my unique practice knowledge.

Yet, poise is a key skill not generally taught to nurses. To effectively work with homeless people and other vulnerable communities, health staff must be aware of poise to see how they are personally contributing to holes in the net. One needs to know how to work and live with poise. One needs to be a reflective practitioner.

Reflective Practice and Reflective Guidance

A Blessing of the Senses

May your body be blessed

May you realise your body is a beautiful friend of your soul

And may you be peaceful and joyful and recognise that your senses are sacred thresholds.

May you realise that holiness is mindful gazing, feeling, hearing and touching.

May your senses bring you home

(O'Donohue, 1997:104)

Reflective practice brought me home - a knock on my door that I answered because I wanted to live nursing practice creatively. Each day in homelessness my senses were alight; I needed to mindfully gaze, alert to feeling, hearing and touching to bring me to new understandings. O'Donohue (2007) speaks of senses as thresholds of transformation where life realises itself, reaches out and lifts itself to greater heights rather than remain on the 'safe side of its habits and repetitions that never engages with risk of its own possibility' (p.204). Reflective practice brought me in touch with my senses to draw meaning from homelessness practice. I learnt to write creatively, to co-create, to perform, to be an artist, to mix with reflective colleagues - to celebrate nursing in new and tangible ways. This celebration was my support in the hard landscape of homelessness. It was part of my becoming.

For my concluding insight on reflective guidance, I draw on Jarrett (2009) who describes the reflective space as,

... instrumental in my quest towards desirable practice. I have used this space to explore and manage my emotions and the issues contained in the text that have arisen when working with people.....without such a space, I feel I would not have remained in this job for so long.(p.234)

Jarrett is also a specialist nurse in advanced nursing practice with vulnerable groups [adult disability]. My insight is that specialist nurses require a place to dwell safely to inhabit our specialist practice more deeply in order to understand its nature. Dialogue and guidance brings deeper meaning to advanced day-to-day practice. *Weaving the net* in homelessness has been a joint work of art through reflective guidance.

Development of Voice

Belenky et al (1986) offered a theoretical framework for me to situate my voice. To be heard I had to be assertive in order to discourage the marginalisation of homeless people; yet even now I may not always be heard. The narrative marks my general movement towards a constructed voice which was informed, passionate and political. I developed a constructed voice because of the precarious nature of engagement as evidenced within the texts. Arguably its emphasis is only necessary because of precarious engagement where things of practice are emotional, political and uncertain and when an informing literature is limited. Passion hallmarks the constructed perspective - which others most frequently voiced about my effectiveness in practice.

Wong (2010) notes that there has been little empirical work related to health professionals' voice until their recent nursing study where voice or 'speaking up' was identified as an outcome of authentic leadership that enhanced patient quality outcomes.³³⁶ They noted Field's (2002) perspective on organisational development where voice was considered a civic behaviour 'extra' to positional role. Voice in this context displayed the employees motivation to go further than required for their organisations by "expressing helpful recommendations to others, suggesting changes that improve group performance, or communication one's opinions even when those opinions differ from others" (p.891).

Recognising precarious engagement, I used my voice significantly to create an environment to *be available* in homeless health care as a reflection of my empowerment in nursing practice. In figure (4.8) I have highlighted aspects of *effective voice* developed through appreciating precarious engagement in each quadrant as evidenced in the analytical horizons.

³³⁶ Authentic leadership theory is described by Wong et al (2010) as having four key components: balanced information processing where others perceptions are explored; authentic behaviour where leaders are clear and open about their views; relational transparency in sharing information with others; self-awareness where the leader develops insight into their strengths and weaknesses

Summary of Use of Voice in Appreciating Precarious Engagement in the Being Available in Homeless Health Care Model



Use of Voice in Four Quadrants of Appreciating Precarious Engagement

Fig 4.8

The reflective voice in homeless health care practice (Fig 4.8) summarises the nature of *use of voice* towards inclusion. My reflective voice was *the* key tool for net weaving to create an environment for *being available*.

In this section I have shown how an inclusive environment in homeless health care requires appreciation of precarious engagement to make the net stronger for homeless people by effective use of voice.

Reviewing the Net: 2011/12

Will a Hollywood ending conclude the study (Clandinin and Connelly, 1990) or perhaps I too *fall through the net* between World Class Commissioning and a medical model of care. I finish this chapter with a short update of an evolving net.

Public Health Office 2009-2010

*She struggles to grasp my fingers
"Tell Maria to let go of her baby"
... Perhaps she means the net!*³³⁷

World Class Commissioning flew into the NHS,³³⁸ and strategic leadership to secure the health care net for homeless people was grasped by two full-time vulnerable community commissioners - an annual spend of £90-100K. This was in addition to a senior vulnerable community commissioner, mental health commissioners and practice based commissioners who all had a growing responsibility for addressing homelessness. The Multi-Disciplinary Team (Text:21) did not emerge as expected; a reminder that my practice is shaped by relational patterns and the wider political agenda. I warmly introduced the new commissioners to homelessness knowing how strong strategic securing was required at the very top-end of the net. Riding on the crest of our local homelessness development, the new commissioners arranged "*their*" Health and Homelessness Conference (January, 2010), believed to be the first PCT homeless health conference in England. A DCLG speaker gave an excellent key address but surprised many, including myself, by declaring that the time of the SPHN was over contrary to later DH (2010) guidance. Aware of the oppressive public statement about my role, presumably prompted by the new local commissioners, I reminded

³³⁷ A senior commissioner's request to my Public Health Manager that I let go of homelessness (Jan, 2010)

³³⁸ For a definition of WCC please see p.264 footnote

the audience in my own key address of the words of her DCLG predecessor Louise Casey.³³⁹ Casey's words contextualised and illuminated the vast evolvement of *the net* since 2005 to show that homelessness health development was part of an unfolding local narrative. In this way, drawing on Fay (1987), I chose not to avoid the challenge but welcome it, viewing myself with a constructive voice that ably illuminated my unique, local, homeless health knowledge to a large audience.

These new women intended to re-weave *the net* locally beginning with a top-down approach. If I let go, would more holes emerge? Wheatley (2006) enlightened me. She reminded me that I craved companions, not competitors on the journey; and that the "...essential structure of any network is horizontal not hierarchical, ad hoc, not unified" (p.182). She taught me about *the net's* resilience - when one part goes down another picks up. In homelessness, the strange attractor³⁴⁰ - the meaning shared by all who work in it - is the hope of making things better, reducing health inequalities for those without a home. Homelessness would move forward at a different pace as the new NHS vulnerable communities commissioners worked around my Public Health recommendations in HNA reports.

³³⁹ I use these in Chapter 1: "It is clear that many Primary Care Trusts and GPs have had limited contact with housing departments, little or no involvement in the development of homelessness strategies and may not view housing providers as the natural partners of health. This underlying situation is likely to limit health agencies understanding of the potential role they can have in preventing homelessness". (Casey, 2003:16)

³⁴⁰ According to Wheatley organisations self-organise around a shared meaning which she calls the strange-attractor.

A Representation of the Evolving Net: Homeless Health Care (2011)

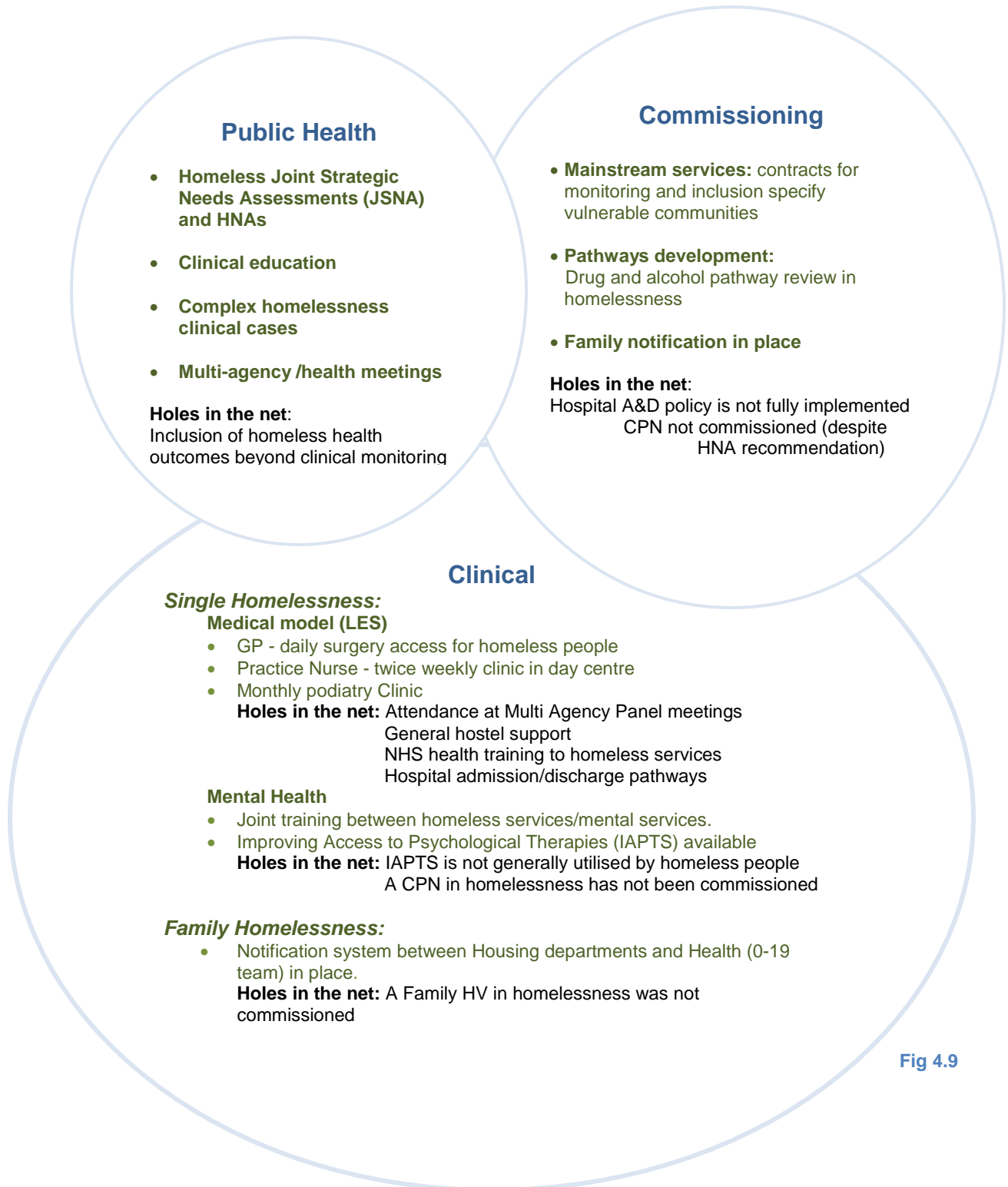


Fig 4.9

Given the emergence of homelessness on the Government agenda (DH, 2010) how apposite that this study captured homelessness academically and practically when it did, illuminating the emergence of three core strands in my practice that contributed to a colourful and strong net-ropes: clinical, public health and commissioning (Fig 4.1). My post-narrative story, however, lies in Public Health (Fig 4.9) where I lead the JSNA in health and homelessness in which I have recommended a review of mental health and 0-19 children's services for our homeless communities. My role includes other vulnerable communities: immigration removal centre detainees, offenders, young offenders and health inequalities.³⁴¹ On homelessness, and in the spirit of this thesis, I write a story to invite you, the discerning reader, to draw your own hermeneutic insights about current homeless health care services - from your new horizon developed from this study.

*She sits on the shelter step, shivering
From freezing temperatures
From Huntingdon's
From re-living her rape experience
Aged 9
Incest!*

*They said *She* doesn't engage
They said *She* is heading for prison
- An alcohol triggered
ASBO breach³⁴² -
Yet here *She* is
Slipping into her story
With me
Asking for help,
Her eyes are beautiful*

*Later,
The eyes of 20 ex-Mayors
Peer down
In the same meeting-room
In the same Town Hall
20 of us, at least,
I'm impressed that a magistrate has come!
Belenky would call it
Constructive knowing
A voice, my voice
Weaving strands of knowledge together
That 'holds' the meeting
Like a conductor of a choir
Showing how to sing the song with passion*

³⁴¹ The NHS commissioning/provider split and World Class Commissioning impacted on my clinical/strategic dimensions in my role as a Specialist Nurse. I have adamantly kept nurse in my title, resisting a change to 'Public Health Manager' in the most recent health reforms where Public Health 'turns' inwards to Local Authorities as we enter the phase of Practice Based Commissioning from April 2012.

³⁴² ASBO Anti-social behaviour order

Afterwards the outreach worker
Remarks on an 'awe' around me
Perhaps it's from my practice challenge to shelter staff not to evict *her* for smoking in the bedroom
Perhaps from my political challenge to the Local Authority about no complex needs accommodation
Perhaps from awakening the silent health commissioner from her daze to show *her* 'precarious engagement'

I hear:

We haven't got specialist psychologists

The practice nurse is not a counsellor

We have IAPTS³⁴³

But homeless people tend not to use them

The alcohol nurse

With his tricky accent

Could provide motivational interviewing

It reminds me of the sympathetic GP

Prescribing sleeping tablets for incest

this morning

In the evening
At the shelter
My nursing students dress in chefs' hats
To serve dinner

She shivers still

After dinner
Around the table
They all chat together
Rabbits no longer caught in the glare

Kerry reads her poem in class
Ending
'It is our absolute duty to prevent
crisis in ways that are just'³⁴⁴

And later, *She* escapes a custodial sentence,
I'm pleased the magistrate came.

³⁴³ Improving Access to Psychological Therapies

³⁴⁴ Kerry Du Fraisse, SCPHN student (School Nursing) University of Bedfordshire: From her poem *The Night Shelter* Appendix 6

Re-reading the poem, I am drawn to the document Inclusion Health (DH, 2010b:6) where two of its ten principles are:

Focus: to increase the understanding and visibility of the health needs and outcomes of socially excluded groups; and to establish clear accountability at local and national levels

Voice: to provide a strong 'voice' and advocacy for the most disadvantaged and those who work with them, ensuring that strategic planning and commissioning processes adequately address their needs

I aspire to these values which I seek to bring out in this study and which continue to develop as I write the Joint Strategic Needs Assessment in homelessness weaving my knowledge around the gaps which remain. I do it with robust national guidance (DH, 2010;COM/Pathways, 2011). I do it mindful that health funding evidence speaks. This is the next part of my Public Health journey to strengthen the net.

In the introductory paragraph, I open the Joint Strategic Needs Assessment on Homelessness by illuminating the local net in action using the words of a Salvation Army coordinator after my recent multi-agency panel meeting....

*I value the **connections** which we have across church, agency and with professionals like yourselves.
We are so well-placed compared to many towns.*

(Centre Coordinator, The Salvation Army, September, 2011)

I conclude Chapter 4 with 10 messages to the Government:

10 Key Homeless Health Messages for the Government

1. Recognise, respect, promote and value the constellation of skills which the SPHN (Health Visitor) can bring to homeless health care:
 - Weaving and strengthening the net as a skilled multi-agency professional
 - Mapping single and family homelessness beyond a Public Health 'paper exercise'
 - Providing a comprehensive clinical and strategic health model - a first-step approach towards a MDT, if required
 - Providing accessible psychological support to homeless people, mindful of complex trauma
 - Guarding the vulnerable
 - Educating health peers
2. Homeless nurses have the right not to work in isolation but to be part of a medical or clinical team that weaves social and medical models of health care. This is particularly important in medium or smaller sized PCTs where humanitarian facilities are less developed.
3. Mental health services seem particularly precariously engaged in homelessness. They need to be reflective and accountable organisations. The SPHN homelessness leadership model (Graded: Consultant Nurse Band 8a) would contribute to their accountability as indicated in this study.
4. To support psychological well-being of homeless people, primary care clinicians should have access to psychologists experienced in: trauma, torture, CSA, rape, street violence. Psychologists unaware of 'the net' could, like other disconnected health professionals contribute to precarious engagement.
5. Universities are key organisations for preventing and reducing homelessness. I found the most effective lectures that bring paradigm shifts beyond seeing homelessness through a 'drug and alcohol lens' to health professionals were:
 - Concepts of home and homelessness (10 min exercise to reflect on students own home)
 - Storytelling from the street (reflective texts)
 - Homelessness placements
6. Reflective practice and guidance is imperative to net-weaving in health care
7. Measuring health outcomes must include qualitative indicators shown in this narrative
8. Supporting the health and well-being of parents whose children have been removed from their care should be reviewed. Many seem to be over-represented in homeless.
9. Complex needs accommodation is required for those whose multiple needs are not easily met by hostels. It should include hospital discharge beds for those residing in night shelters and those who are rough-sleeping.
10. Homeless health nurses have a right to claim their political voice and be heard by politicians

SUMMARY

In this chapter, I have presented the findings from my narrative journey of self-inquiry and transformation. They culminate in SPHN: Homeless Health Care Model and my appreciation of precarious engagement, a concept which arose from the Being Available Template to illuminate the net and my effectiveness to weave it more tightly through use of voice. I have shown how I strove towards a constructive voice (Belenky et al, 1986) as a developmental process and present a summary of the 'Reflective Voice in Homeless Health Care' (Fig 4.8). I have provided an update of the local net and my role within it since the narrative was concluded. Finally, I presented 10 key messages for Government.

In Chapter 5, I conclude the thesis with reflections on the research process and implications for practice

5 From Being to Becoming a SPHN Homelessness

Introduction

My PhD journey has lasted for seven years and the creative tension between exhilaration and sadness stirs within as I begin this concluding chapter of the thesis. Have I achieved what I set out to achieve in 2005? The aim of this chapter is to reflect on that question in the light of the study title "Weaving the Net in Homeless Health Care: A Reflexive Narrative of Being and Becoming a Specialist Nurse (Homelessness)".

The chapter is organised as:

- Narrative Construction - contributing to narrative knowledge
- Benefits and challenges of narrative construction
- Limitations
- Transferability of Findings as 'Audiencing'
- Implications for practice and future research
- Concluding remarks

Narrative Construction - Contributing to Narrative Knowledge

Like Jarrett (2009) and Johns's other PhD students, I am one of a handful of pioneers using this genre of narrative inquiry. Since Jarrett's (2009) thesis, narrative construction has evolved from reflective practice to narrative and onto performance (Johns, 2010). My reflections in this section are a contribution to narrative knowledge from my experiences of using narrative construction. I begin by summarising Johns's approach contextualised with other forms of narrative inquiry and progress to insights about the power of the researcher in this form of inquiry.

Contextualised with other narrative approaches

Narrative construction is clear in its intent to illuminate the *becoming* of the practitioner as *transformation* through a process of self-inquiry, emanating from my unique Forestructure of Understanding (Heidegger 1962) (see p.15). Mattingly (1988) notes of *becoming*,

'... the way that actors form and attempt to carry out commitment in their lives.... a process of becoming....Heidegger (1962) is profoundly right to notice that the fundamental issue (for a human life) is not being but becoming.'(p.71)

Mattingly (1988) studied the quest by occupational therapists for patient narrative towards becoming at a time of a major disability whilst Johns's narrative genre looks at transformation of the

practitioner, and is unlike other narrative approaches as discussed in chapter 2 (p.44). For example, Lorde (1994) and Frank (1995) wrote illness narratives; Aloï (2009) explored narrative therapy as social reconstruction where nurses empower patients to redefine themselves in oppressive situations by 're-authoring' their stories (p.713) and Kucera et al (2010) explored nursing narratives to create a model of Advanced Nursing Practice.

Elements of these narrative approaches used in health care filter into my study but due to its transformative intent, Johns's genre goes beyond appreciating, interpreting and developing an understanding of experience (Jarrett, 2009). I did not appreciate the scope of transformation through the dialogical movements at the outset of my research; my transformation ripples through the narrative and is reflexively framed in the analytical horizons and in Chapter 4. In practice, for example, by the end of the narrative I extensively knew *the net* and its precariousness in four quadrants. In research, I was able to illuminate my effectiveness through the BAT framework towards a SPHN model for health and homelessness. Narrative Construction therefore was not simply a narrative for readers about nursing experiences - it successfully illuminated my effectiveness, marking transformation through learning development. Johns (2009) notes,

Narratives are always process focused not outcome focused: they are not judged in terms of whether desirable practice has been achieved. It is the moment to moment unfolding that is vital for narrative, the mindful excursion through experience (p.103)

In the extreme human experience of homelessness (European Commission, 2010), the richness of my experiences in their moment-to-moment unfolding, illuminated the effectiveness of my role. To grasp this richness called for an understanding of the philosophical influences that shaped my practice development. In Chapter 2, I mapped an eclectic philosophical bricolage (Denzin and Lincoln, 2005): reflective practice and guidance, feminist empowerment theory, critical social science theory, hermeneutics, self-inquiry drawing on autoethnography and autobiography. Akin to Johns's (2004) and Jarrett's (2009) philosophical bricolage it provided a diverse canopy for me to find meaning in homeless health experiences rather than simply espousing abstract theoretical concepts. Indeed, as I have said elsewhere in this study, Johns's philosophical influences felt like a 'coming home to nursing' for me, providing me with a strong theoretical underpinning beyond that of my Christian ideological perspective coupled with evidence based practice.

Mindfulness through experience acted as the essential feature in shaping the narrative to show my effectiveness in practice; arguably the narrative plot (Aristotle, 1934; Polkinghorne, 1988) was unnecessary. But through the plot, *falling through the net*, I was able to guide the reader in the unfolding drama of complex day-to-day practice. Holding the tension of a plot with its neat beginning, middle and end, I was also mindful of feminist narrative theorists who dismiss plot (Cixous, 1995) or ask, "What happens when the plot cannot be identified?" (Tamboukou, 2011:3). To accommodate this, I resisted directly connecting insights from one text to another to show

homelessness as an indeterminate practice terrain. You can decide whether I achieved this balance effectively as you dialogue with the narrative.

Power in the Research Process

In most narrative inquiry approaches the researcher sets the agenda to shape how stories are revealed (Jarrett, 2009). Jarrett cites impact of self on formulation of narrative construction as a form of power. To some extent, I disagree. My experience of illuminating self has been to write "coherent stories of moments or events that you do not know what they will become" (Tamboukou, 2011:5) as they progressed through the Six Dialogical Movements. As noted above, my narrative was shaped by unfolding experience through mindful practice, practice vision, guidance and to a lesser extent the plot. Significantly, Freshwater (2002) notes that the self has an agenda in reflective practice research which may be embroiled with the unconscious self; again, this illuminates the necessity of reflective guidance. As I begin now to summarise the challenges and benefits of narrative construction, my reflections about guidance are also explored.

Benefits and Challenges of Narrative Construction

Jarrett (2009) identified several benefits and challenges about narrative construction which are evident in my narrative, and which I précis here: For example:

- It generates 'knowledge and meaning which is local and context specific' (p.237) and therefore not transferable; its strength lays in its strong resonance evidenced through audience response
- The voice of marginalised people is heard. To this, I add that if I were to do this study again I may include the voices in a more direct way, for example performance of interview with direct involvement from the homeless person to add coherence
- There is a parallel development of supervisor and supervisee

Regarding the latter, in my study group, guidance included inter-professional reflective practitioners uniting nursing and teaching PhD students in a process of co-creation and meaning where a wider horizon of our mutual practice fields were shared. I now look at other benefits and challenges in Narrative Construction which are organised as:

Benefits

- Becoming a mindful practitioner
- Illuminating transformation in the process of becoming
- Guidance and Co-creation

Challenges

- Guidance: managing the tension of challenge
- Being a research practitioner
- Will my narrative be heard?

Benefits

Becoming a mindful practitioner

Early in the narrative process I was described as a 'sophisticated' mindful practitioner (Guidance, July, 2006). I attribute this to my professional experiences to date and to a Christian ideology of awareness of God in the present moment (De Mello, 1990). Emptying of 'self' in this way brings awareness of sacredness in the small as well as larger life events and is an integral part of the spirituality of Saint Therese of Lisieux (Udris, 2009) which I was familiar with from an early age. In practice this resonated with Johns's (2004) Buddhist ideals of Bodhisattva which inspired his vision of mindful practice as an "ability to pay attention to self within the unfolding moment in such a way that one remains fully available to ease suffering and nurture growth" (p.18). In particular, the 1st-4th dialogical movements developed my awareness of mindful practice and of writing it into reflective texts to illuminate minute but valuable 'taken-for-granted' details of homelessness health care. Mindful practice was *the* core skill of engaging with others: the weak and vulnerable, the powerful and the strong. It heralds social justice as 'little things' of practice evidenced through narrative construction draw deeper meaning. van Manen (2007) notes,

Even our gestures, the way we smile, the tone of our voice, the tilt of our head, and the way we look the other in the eye are expressive of the way we know our world and comport ourselves in this world. On the one hand, our actions are sedimented into habituations, routines, kinesthetic memories. We do things in response to the rituals of the situation in which we find ourselves. On the other hand, our actions are sensitive to the contingencies, novelties, and expectancies of our world. (p.22)

Throughout the narrative small gestures are seen to impact profoundly on practice. For example, my gestures and tone of voice created the invitation to the homeless person to enter into the nurse's world to begin the process of the nurse hearing the suffering of the homeless person.

Mindful practice illuminated through storytelling also prompts what Sparkes in Bochner and Ellis (2002) notes as "...aesthetic merit, impact and ability to express complex realities" (p.211) as a feature of autoethnography. Mindfulness, observed by audiences, draws them into the 6th dialogical movement, moment by moment. This will be developed to promote social justice in my post doctoral period.

Illuminating transformation towards becoming

I rhetorically ask myself, had I not come into this PhD study of self-inquiry and transformation, how would I have experienced being a SPHN in homelessness? Would I have been compassionate, creative and morally challenging? Would I, as Johns (2010) writes in the second edition of *Guided Reflection* "...revolutionised homeless health care through her work... she is a talented story-teller, weaving words, art and poetry into poetic prose" (p.x). These words about my practice, sitting amongst others that introduce fellow reflective practitioners on their journeys of becoming, trigger further reflections on what I have *become*. In their light, I do believe I would have been compassionate, creative and morally challenging - it is the nature of whom I am arising from my life experiences as my background chapter shows - but it is the scholastic process of Johns's narrative construction which has brought to me a profound and deeper appreciation of self and how I function in the world as a nurse and a human being. van Manen (2007) notes,

Transformatively, phenomenology has practical value in that it reaches into the depth of our being, prompting a new becoming. (van Manen, 2007:.26)

Although van Manen speaks of phenomenological research, his words I believe, equally apply to reflective practice and guidance. The stories I lived and told were also of my humanness and fragility, my wholeness and strength *reaching into the depth of my being* in what is an indeterminate and complex area of health care. There was no easy way in a *becoming* process. Whilst BAT has already been used to extensively show my transformation in Chapter 4, I want to reflect here on voice as an area that particularly *reached into the depth of my being* to show my *becoming*.

- **Voice**

Johns (2010) notes of voice,

The majority of practitioners I have worked with in guided reflection are women, and as such it is crucial to pay attention to the struggle women have within patriarchal-dominated organisations such as the health service to have their voice heard and valued. (p.296)

Voice is used in this study as a metaphor for empowerment against oppression where voice is denied or unheard. In the process of this study, I have entered still places to reflect on my voice to understand where it has been oppressed or valued in my life; this process has not always been visible in the narrative. For example, I became intrigued by whether the early absence of my father from my childhood home had made me less or more aware of patriarchal-domination in the health service (Johns, 2010). My mother's voice did not become patriarchal to compensate for his absence and consequently I valued the feminine voice as trustworthy, caring, kind, and humorous with its own authority; any rigidity within my mother's voice lay in upholding Roman Catholic 'rules' and values. In terms of voice that meant she guided my sister and me to 'speak-up' for people who needed help. But pre-narrative 'speaking-up' - courage to use my voice - had caused me to struggle

in nursing practice, leaving two consecutive posts because of it when I was a young mother. I did not recognise patriarchal power at the root of it then, nor did I have the skills of transactional analysis to understand the process of communication that could draw others into adult-to-adult communication (Stewart and Joines, 1987) which I gained in the narrative process (Text:12). The narrative subtly illuminates weaving voice effectively through constructive knowing marking political resilience in awareness that I do inhabit a patriarchal-dominated health service environment (Johns: in class June 2008).

Theoretically, I underpinned my understanding of use of voice through Belenky's et al's (1986) perspectives but it was Johns's narrative construction process that brought about the emergence of consciousness so that I could use voice effectively in homelessness practice. He notes,

Developing the practitioner's constructed voice is always the intent of guided reflection expressed in narrative form. (Johns, 2010:297)

I engage with Freire (1971) and Belenky et al (1986) to develop this further. Freire's concept of teacher-partner is noted by Belenky et al who use a similar metaphor of teacher-midwife to show a process that gives birth to knowledge through teacher support of student thinking. Both metaphors replace the traditional teaching stance which Freire refers to as a banking system wherein the teacher deposits knowledge in the student's learning bank. Rather than 'anaesthetise' the student, the teacher-partner/teacher-midwife "encourage students to use their knowledge in everyday life" (Belenky, et al 1986:219). Guided reflection was a process that enabled me to nurture, care for and place my ideas and values in an environment that helped them grow (Belenky et al, 1986); in this way Johns's narrative construction process lends itself to that of teacher-midwife. My transformation in this respect occurred through a process of understanding self to a greater extent, through the process of self-inquiry and reflective guidance so that I holistically developed authentic and unique knowledge to voice my nursing story.

Guidance and Co-creation

The process of guidance and co-creation in the fourth dialogical movement developed and sustained my practice vision of inclusion in diverse ways. Most importantly, it provided 'Anam Cara' or soul friends (O'Donohue, 1997) with whom I could honour and deepen nursing knowledge at a time when I was isolated in clinical practice, a feature noted by Kucera et al (2010) in their narrative study of advanced nursing practice and also identified by Queen's Nursing Institute, Homeless Health Initiative (QNI, 2007) in regard to homelessness nursing. The nurse educationalist, Pickard (2004) deepens my insight. She states, "I have been caring for students and now they reveal themselves to me—inviting me to deeper understandings of care" (p.184). The guidance group provided me with care as I revealed myself to them through reflective texts. With them I learnt to

manage my own suffering arising from homelessness practice and to be creative about practice (Fig 5.1).

Acknowledging my suffering in practice through reflective practice

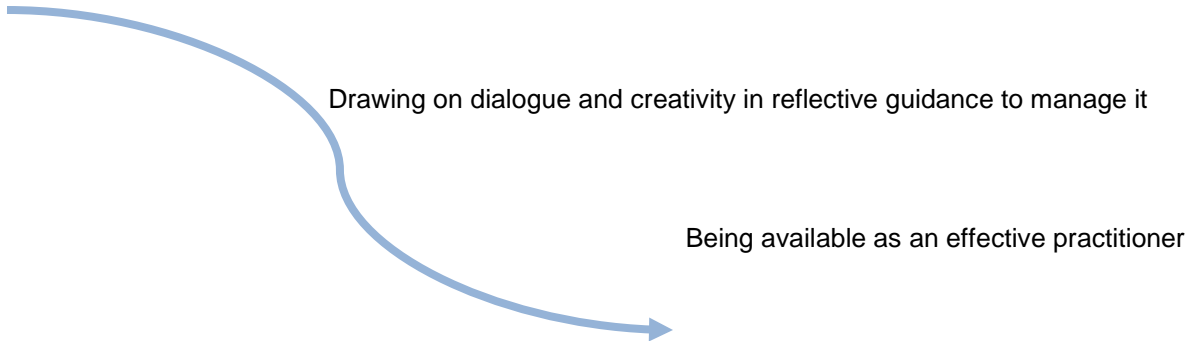


Fig 5.1 Managing suffering through reflective guidance to sustain my practice vision

Through the lens of reflective practice and guidance, my journey in homelessness could be summarised as a journey of managing my own feelings where I walked a knife-edge to bring those on the edge of society towards inclusion in services. Johns (2010) in his vision as a guide notes,

I guide you to draw insights from your story to inform your future practice...I help you to awaken your senses, arouse your passion from its slumber, to open your mind to possibilities.... I hold you when you stumble across the hard wall of reality. I help you to become free in joyful harmony with a community of inquiry where we co-create and learn through our mutual stories (p.92)

In that community of inquiry I opened myself energetically to working creatively with nurse and teaching academics, artists, photographers, storytellers, performance mentors. Marek (2001:54) in his work as an art therapist notes that, "only by embracing all parts of ourselves are we able to know the wholeness of the world and our inherent inseparability and interdependence within it." With others, I learnt *to become*, embracing new ways and other ways that had lay dormant since school days. In this way, I more ably grasped homelessness and my connecting part within it. When intense suffering prevailed, I drew on art, photography and poetry to enhance mindful practice (Marek, 2001); its meditative effects were therapeutic and communicated inner turmoil that I witnessed, incorporating what Newman (1994) calls a complex, holistic dynamic involved in caring in the human health experience, rather than knowledge based wholly on objectivity and control. Johns's BAT enabled me to provide holistic practice and to value theory and art in my developing practice.

Kate Goodrich (reflective guidance workshop January, 2006) provided two sessions on photography. In response, I photographed the cherry tree in my garden as a symbol of my narrative over the course of a year (Fig 5.2). In Japan, hanami excursions (flower watching) usually occur when the cherry tree is in blossom. The cherry tree is a symbol of new birth and awakenings, of the transience and shortness of life and of sacrifice.³⁴⁵

Cherry Tree Symbolism

New awakenings and rebirth are symbolized by a cherry tree. It was used metaphorically to show that life of a person is short. The short-lived nature of cherries and their extreme beauty are often associated with mortality. Blooming of cherries is considered a sign of good fortune and is also a symbol of love and affection.

<http://www.buzzle.com/articles/tree-symbolism.html> (accessed 31/5/12)



The cherry tree in my garden, shown overleaf (Fig 5.2), was a constant symbol of:

- Heidegger, (1962) being-in the-world with a strong sense of past, present and future: The transient nature of seasons reflected in my practice, my narrative and my life.
- Belonging in a home that anchors me to 'bend with the storms and continue towards the light' (O'Donohue, 1998, pxvi). Home is key part of my philosophical rooting, living in awareness of others on this earth.
- The concept of rhizomatic validity (Lather, 1986) where roots below the surface of the tree are complex like my practice/ research; yet they provide one fragrant, fruitful tree of knowledge in my study
- The seasons of homelessness where environmental conditions contribute to poor health.
- Suffering held within the nature of nursing as we make ourselves open and vulnerable (Newman, 1994)

³⁴⁵ Originally, the purpose of hanami excursions was to ponder the transient nature of life, as the cherry blossom blooming season is so short. This concept ties in with Buddhist thinking about the nature of life. Cherry blossoms were associated the kamikaze suicide flyers who sacrificed themselves during war actions. [www http://serendipityandthesailor.blogspot.co.uk/2012/03/hanami.html](http://serendipityandthesailor.blogspot.co.uk/2012/03/hanami.html) (accessed 31/5/12)



Cherry Tree Reflections: Homelessness Research and Practice

Fig 5.2

Challenges

Guidance: Managing the tension of challenge

There is always a tension in challenge - a pause, a new perspective, a defense of an existing one. Challenge makes guidance dynamic, and is "intrinsic to reflection" (Bulman and Schultz, 2008:149). In the process of narrative construction, I recognised that guides also require mindfulness and poise to be effective so that challenge is not experienced as oppressive. The potential for oppression occurred sufficiently for me to consider over a four-week period discontinuing my study. The insight I gained in this experience was the potential for passive as well as active abuse within group guidance (Rolfe et al, 2001). Passive abuse occurred when others remained silent and looked significantly uncomfortable at the guide's aggressive response to my reflective text. My reflections about oppression were redirected, this time to within group guidance.

Occurring mid-narrative which Bolton (2005) has identified as the conflict stage of a group's plot, Text 15 marked a turning point to place 'house-rules'³⁴⁶ into guidance which were previously left to the authority of the guide (Bolton, 2005). Transference, counter-transference, projection and introjection have been acknowledged as important psychoanalytical processes to grasp within guidance (Bolton, 2005; Rolfe et al 2001) but it seems that, so far, they focus on the student rather than guides. Yet, my guide's angry response to what I termed 'caustic mothering' (Text:15) seemed to say that it was too abhorrent a concept to contemplate with parenting - that I was using a pre-reflective middle-class response to the practice experience. In homelessness practice, traumatic background circumstances were issues that unfolded in the therapeutic space; it often provided meaning to being homeless. Freshwater et al (2010) drawing on Sereny's (1998) story of Mary Bell who murdered a child, provides clarity,

Sereny suggests that the circumstances wherein a child becomes a killer cannot be divorced from an understanding of her own terribly damaged life. In other words, despite attempts to understand the desirable behaviour of all citizens that enables us to label the individual who falls from grace as deviant there is no getting away from the fact that these so-called deviant cases also have a story (p.503).

Unlike the story of Mary Bell, text 15 is not about a deviant teenager but illuminates Lucy's personal narrative of extensive physical abuse and subsequent episodes of severe self-harm; this had a profound and transformative effect on me from my background experience of being a Health Visitor. My intention to bring it to guidance and dialogue about it resulted in being hastily and unjustly pre-judged.

Challenges became more sensitive as a result of expressing my concerns. I too became more mindful of psychoanalytical processes arising within groups. Now, students do not always read their

³⁴⁶ The nature of challenge changed significantly as a result of my *use of voice* to express my concerns: no challenge until my reading of each page was completed, executing challenge with sensitivity

reflective texts but may be asked what the significant issues are held within it. Others do read them or have group members read texts to provide another perspective around hearing their own written words read by others. I believe the fragile and powerful nature of group guidance is better managed as a result of my 'caustic' experience of guidance. Learning, in this respect, has been a mutual process between the guides and those guided (Jarrett, 2009).

Becoming a Research Practitioner

The Government's call to make the National Health Service a "centre of research excellence with a thriving research culture" (DH, 2006c:7) encourages nurses to become researchers. The 'convenience' of Johns's narrative construction approach offered research support, training and skills. But, I also felt an emotional, financial and liminal tension of being a research practitioner. Wisker et al's (2003) paper on effective supervisor dialogue for PhD students notes,

Research is a dialogue with other experts. Postgraduate research needs boundaries, to be realistic in its aims and outcomes, and manageable in its scope. A lifework for some students, a stage in their development as researchers or in their professional development, a vehicle for change and professional advancement for others. It is an all-consuming activity (Wisker, 2003:383-397).

The demands of research as an all consuming activity were something I had to actively manage. I continually 'lived' reflective practice research and homelessness at a time when caring demands in family life with old and young were intense. Ellis (2001) in her unpublished PhD on continuing professional education for nurses cites this as an obstacle in post-graduate nurse studies. Personal tenacity and capacity for undertaking PhD research is vital. It includes financial management. The NHS did not pay for my attendance at international conferences unlike PhD student colleagues who were funded by their academic institutes; nor did the NHS pay academic fees for six years of the study. It is a costly process, and as the academic intensity grew I had to reduce my work hours to effectively accommodate it and family life. I was in a financial position to be able to do this but many other nurses, perhaps those working in homelessness, may not be. Arguably, my contribution to homelessness nursing research is particularly valuable because of this.

Jarrett (2009) found combining practice with academic research to be a less stressful option than being a researcher alone. I, however, felt a liminal tension between academia and practice and between health and housing/homelessness landscapes in practice. In a European review of increasing surveillance and control in public spaces Doherty et al (2008) found that homeless people "confine themselves to liminal spaces – the edges, the dark corners and the hidden recesses" (p.300). These places, richly steeped in developing practice knowledge had the potential of extra stress because of the dual role of practitioner/researcher so whilst narrative construction was supportive it also held a heavy 'all consuming' time commitment (Wisker, 2003).

Will my Narrative be heard?

In guidance (January, 2008) Johns and I discussed storytelling as a key methodological influence in the narrative process, inspired by Okri (1997).³⁴⁷ This mirrors Clandinin and Connelly's (2000) principle that a good narrative 'shows not tells'. Is this sufficient for an academic audience? Jarrett (2009) experienced difficulties in her first attempt to defend her study until she and Johns's through co-creation, inserted analytical pauses into Chapter 3, akin to my analytical horizons. This relieved the academic tension and helped examiners mark her learning development.

However, I recently approached a national homeless charity to invite them to review some of the narrative pages. They refused citing the interpretative nature of my study as the reason, but want to be informed of dissemination events. Arthur Frank (1997), renowned author of illness narratives raises the issue of responsibility that the 'interpretive community' has for understanding narrative. The interpretative community he refers to are the caregivers in medical research. This resonates with why the homeless voluntary sector, amongst others, should welcome interpretative research in homelessness health nursing research. Freshwater et al (2010) also note,

An individual story presents as a fiction in a world that reveres facts. It appears to sidetrack the serious world of research rather than supplement it. However, if we are really intent on understanding the blighted lives of people who are excluded from the hegemonic control of the dominant voice we have to listen carefully to how well the stories of individuals resonate with us no matter how uncomfortable this might be. (Freshwater et al, 2010:505-506)

As identified, facts are revered and narratives, however uncomfortable, maybe judged as 'lower-level' research. Yet, homeless people vociferously wanted their voices to be heard alongside mine in this study. In a small Canadian narrative inquiry study Kirkpatrick and Byrne (2009) used stories from people who were moving on from homelessness after experiencing a major mental health illness. They also note that *use of voice* for nurses is a key action "... speaking out against homelessness has been called both a professional responsibility and a moral responsibility" (p.74). Furthermore they ask, "What is the role for nursing?" (p.74). If nurses are to speak out and to illuminate their role in homelessness as I have done in this study then key others must be ready to listen. Narrative research cannot be dismissed to the margins along with those who are vulnerable, no matter how 'uncomfortable this might be' (Freshwater et al, 2010:506).

³⁴⁷ See Ch 2, p.80 where I strove to apply three of Okri's storytelling principles in narrative construction

Limitations

Limitations of narrative construction where they exist are a consequence of being a new genre of narrative research. The researcher must be well grounded in complex reflective frameworks whilst presenting a complex practice field to others. Reflective frameworks, held loosely, work well for the research practitioner to illuminate practice but Narrative Construction does not lend itself to traditional qualitative language used for example by Boswell and Cannon (undated, p305) in their critique of qualitative research. I have not posed a hypothesis or a research question to be answered. Instead, the dialogical movements lend themselves to the unfolding of mindful practice and praxis in learning development. In critiquing narrative construction the principle that knowledge generated from a constructivist paradigm comes from deep reflection to bring about meaning rather than achieve a scientific explanation (Denzin and Lincoln, 2005; Mason, 2010) must be appreciated by nurses and others. Research limitations in this respect will become minimal as narrative construction develops into a readily recognised field for practice researcher.

Ethics

Selection of Texts

The selection of reflective texts for inclusion in the narrative was challenging. There were many profound experiences which I wanted to include that illuminated the therapeutic skills necessary in homeless practice, revealed moving life narratives of homeless people, and showed the impact of my role in joint consultations (e.g. with psychiatrists). But as the narrative flowed, the plot moved on from its beginning towards a middle and end. In this respect it guided my choices to show strategic responses as homelessness awareness developed within health services.

In the clinical selection of practice stories some homeless groups (e.g. Eastern Europeans) were excluded not simply because of language barriers which in itself would have been insightful, but because it represented my practice - they tended to use the night shelter's Breakfast Club and had daily access to outreach workers and a weekly GP clinic, rather than routinely utilise my day centre clinic. Similarly, where key health workers were already involved with homeless people and those people were effectively accessing services such as substance misuse services, my role was less active. Wiklund-Gustin (2010) notes about narrative data,

The criteria for inclusion automatically meant that some voices would be excluded. Giving a voice to everyone thus appears as mission impossible....researchers could benefit on who will be heard and who will not in relation to criteria for inclusion (p.34).

Wiklund-Gustin's emphasis relates to narrative research respondents, whereas Narrative Construction was based on my practice experience where homeless people were part of my reflections - not research respondents. On most occasions, I chose experiences where health and homelessness was articulated in the therapeutic encounter in a way that deepened my growing

insights. When informed of my narrative intent the homeless people involved became energised as if some value had, at last, been placed on their experience - they would be heard. Philanthropically, they provided their stories to prevent others suffering in a similar way.

Conflict of Interest

During my PhD transfer process, one examiner commented that writing a study about myself could be perceived as promoting the role of the SPHN above other homelessness models, prompting a conflict of interest (COI). Indeed, the NHS Confederation/RCGP report (RCGP, 2011) appears to uphold this when they say commissioners of services could have a COI when their judgment is influenced by being a member of a peer or professional group. Crigger (2009) defines the concept of COI as "prime facie a breach in adherence to the moral principle of fidelity, through which trust is developed" (p.261). In this study, I am not receiving financial or other rewards and do not feel I need to declare a COI. Reflexivity and authenticity flow through my study which Crigger cites as ways of avoiding COI. Rather than promote my role in the narrative, I believe I have illuminated its tensions in a complex environment, in fact heralding the need for a multi-disciplinary team (MDT) in my conclusion of the HNA report (Text:21). If there has been any intentionality on my part it has been to endorse nursing at the apex of my career, as a unique and awe-inspiring place of being-in-the-world, journeying with others at critical times in their lives. I draw further insight on my intentions for doing this study from van Manen (2007:21) who, when writing on the phenomenology of practice, cites Rilke's words,

If I were to tell you where my greatest feeling, my universal feeling,
the bliss of my earthly existence has been,
I would have to confess: It has always, here and there,
been in this kind of in-seeing,
in the indescribably swift, deep, timeless moments
of this divine seeing into the heart of things.

(Rainer Maria Rilke, 1987)

I have navigated a discovery process (van Manen, 2010) to see into the heart of homeless *things* through exploring my nursing practice which no other researcher could have done in the same way. As the RCGP (2011) report clarifies, the inherent difficulty lies in distinguishing COIs that need to be declared, from others. This requires sound judgment and accountable management.

Audiencing

I have borrowed the term audiencing from Johns (2010), instead of 'transferability of findings and generalisation' because a narrative - either written or performed - requires an audience to partake of the process (Okri, 1997). Distinguishing differences between stories and theories, Ellis (2004) in

her novel about ethnography argues that "a story's generalization is always being tested not through traditional ways...but by readers who determine whether a story speaks to them. Readers provide theoretical validation by comparing their own lives to ours...similar... or different" (p.194). Mattingly (1998) also expresses the power narratives have in 'understanding, interpreting and communicating experience... to say something about who we are' (Mattingly, 1998:25), to others.

'Audiencing' is taken from Parker-Fuller's (2003) concept of 'Audiencing the audience' where she argues of the paucity of studies on the efficacy of performing with a view to ensuing social action. This relates to the sixth dialogical movement (Johns, 2010) with its aim of social action through dialogue. I have participated keenly in the sixth movement, disseminating or drawing on narrative texts in conferences, lecture rooms, hospitals, substance misuse treatment centres, classrooms, town halls, church halls and voluntary services premises (Appendix 5). The effects have been profound: where some have been moved to tears or compassionately silenced, others accountable for service provision condemned the subversive nature of my narrative.³⁴⁸

Okri (1997) notes storytelling's power to 'spring hidden truths' (p.43) which are transformative. In 2009, having read three texts from the narrative to University of Bedfordshire, theatre students produced a play called 'No Place' which they performed on six occasions to health, housing and homelessness professionals, as well as the public. An elderly vicar's wife said she found the experience profound, particularly in relation to a student's performance of being made homeless because she was gay. The performance, she expressed, had dramatically changed her perceptions about homosexuality; the student had written a moving love-letter to 'her father', asking him to accept her sexuality.³⁴⁹ With my narrative too, hidden truths should drift quietly into the soul of the reader (Okri, 1997) to achieve its transformative social justice value (Bohm, 1996).

Implications for Practice

The Importance of *Appreciating Precarious Engagement in Homeless Health Care*

My narrative has provided a way to explore the health world as it was illuminated through my homelessness practice contextualised within four quadrants. *Appreciating precarious engagement* has implications for practice beyond health services to social services, housing, police, probation services and the voluntary sector. The hermeneutic nature of narrative means that professionals from each service area can critique it, tempered by their own experience to gain insights into their

³⁴⁸ Health Commissioners at the PCT's Homeless Health Conference, Jan 2009

³⁴⁹ A Homelesslink SNAP survey (2011) found that approximately 7% of clients in an average project for homeless people identify as being lesbian, gay, bisexual or transgender (LGBT) although this is considered to be an underestimation. Parent and or familial intolerance and prejudice are thought to contribute to homelessness. ([www http://homeless.org.uk/lgbt](http://homeless.org.uk/lgbt), entitled LESBIAN, GAY, BISEXUAL AND TRANSGENDERED PEOPLE - accessed 10/06/12)

practice and note limitations in the study from their perspective that could lead to further research (Boston and Cannon, undated, p.303).

The local nature of my study where *the net* and its precarious nature is illuminated has wider implications for general nursing practice. Boswell and Cannon (undated, p.299) note,

Not all nurses will strive to carry out research activities, but it is important that all nurses become familiar with using research results to advance the discipline of nursing and ultimately improve nursing care.

The DH (2010) and COM/Pathways (2011) developed parallel research to mine and guidance in health and homelessness but interacting factors as seen in the four quadrants of *appreciating precarious engagement* were not significantly identified. My insights provide knowledge for mainstream health services to progress further towards holistic care for homeless people. *The net* metaphor makes the complexity of homelessness and precarious engagement easier to grasp - it is not simply illuminating the specialist role but the whole environment where each discipline plays a vital role. When seen from this perspective, the study:

- Provides meaning about the ontology of homelessness and the patient experience
- Provides a holistic model to enable mainstream health professionals to engage in mindful practice with homeless people
- Develops meaning around 'Advanced Nursing Practice' from the Specialist Nurse role

I will now discuss each of these points further.

The Ontology of Homelessness and the Patient Experience

Katz & Mishler (2003) identify the importance of developing knowledge of the patient's experience of health care, noting that ill people 'enter into the professional world with its process of diagnosis, care and treatment' (p.41). They cite Mattingly's (1998) anthropological narrative study about the nature of occupational therapy practice with paraplegic patients as a way of developing greater knowledge on patient experience. Mattingly observes therapists searching for 'therapeutic emplotment' within a patient's narrative of their debilitating illness. Narrative construction loosely reveals the narratives of homeless people with unique stories of homelessness. As I listened to the voices of homeless people's past and current suffering, my appreciation of precarious engagement developed as evidenced in successive analytical horizons.

In this way, I became a witness enabling others in health services and elsewhere to grasp the ontology of homelessness in which health needs should be considered. Freire (1970) heralds witness as a revolutionary aspect of dialogue towards liberation of the oppressed. Illuminating the

patient experience, and the effects of homelessness on the person, brought about dialogue in the boardroom for local action towards an inclusive and stronger net (Texts:17,19,20,21).

Provides a holistic model to enable mainstream health professionals to engage in mindful practice with homeless people

van Manen (1990) reminds me that gestures, tones of voice and the way that we look at each other express the way we know our world. His quote is an invitation to mindful practice, particularly to those whom society excludes. My narrative insights gained about mainstream services are a challenge to the way care is provided to homeless people where 'walls of resistance' to engagement exists (AH2). Holistically engaging requires appreciating *the net* and precarious engagement in four quadrants - a concept that I believe will enable other health practitioners to open the therapeutic and strategic space and become net weavers in homeless health care. Yet, I cautiously promote 'my model', for as van Manen (2007) notes of phenomenological research,

... through the reflective methods of writing, the aim is not to create technical intellectual tools or prescriptive models for telling us what to do or how to do something. Rather, a phenomenology of practice aims to open up possibilities for creating formative relations between being and acting, between who we are and how we act, between thoughtfulness and tact.(van Manen, 2007:13)

Such words resonate with reflective practice from which mindful practice, key to engagement, emanates.

Develops evidence for Advanced Nursing Practice

Narrative insights provide evidence of effectiveness in advanced nursing practice and contribute to an area of nursing cited by health minister Ann Milton in 2010 as requiring evaluation, particularly in primary care (Sell, 2010). One of the difficulties of evaluating effectiveness has been the way advanced nursing practice evolves locally to meet the needs of local populations. Since then, four generic aspects have been used to frame advanced practice (DH, 2010c:5):

- Clinical/direct care practice
- Leadership and collaborative practice
- Improving quality and developing practice
- Developing self and others

In addition to these generic benchmarks, my research expands knowledge on advanced practice in SPHN (Homelessness) where in practice, I drew on the following:

- Health Visitor model of care with midwifery experience
- Counselling skills
- Minor illness training
- Nurse prescribing
- Teaching
- Public Health skills
- Political skills
- Policy skills

In these *doing* rather than *being* skills I was guided to consider whether *being* a certain type of person was necessary to work with the homeless and what development she [or he] might require (reflective guidance, June 2012). Whilst this is illuminated in the narrative I will summarise both as follows:

To be a net-weaver and change the nature of homelessness from marginalisation to inclusion required agency and use of voice to shift forces that constrained practice. E.g. being open to hearing about the patient's experience of complex trauma; being a peace-maker (Morrison, 2006); being courageous in managing political challenges and violence from within health services; managing marginalisation in the practice field (Kucera, 2010; QNI, 2007). To do this effectively, a practice vision was pivotal to flow with the challenges of practice as explored in this study. However, clinical limits of my practice centred on my experience around mental illness - the narrative provides evidence to why I believe a CPN or psychologist should be readily available in homelessness rather than simply using generic mainstream services (AH2:p.220). This supports national guidance (DH, 2010; DH, 2007a). A CPN alone, however, will not have the skills required to be a SPHN (Homelessness) as shown in the narrative.

In being a SPHN, I noted a growing love for the homeless community illuminated as an evolving element of *voice* with homelessness people (AH3:p.277). Freire (1970) notes that humility and the capacity to love make communion with the oppressed possible. van Manen (1990) also speaks of love in phenomenological research,

I experience the undeniable presence of loving responsibility: a [person] who calls upon me may claim me in a way that leaves me no choice...When I love a person I want to know what contributes toward the good of that person. So the principle that guides my actions is a sense of the pedagogic Good; at the same time I remain sensitive to the uniqueness of this person in the particular situation. (van Manen,1990:6)

Love is a vital force required in securing an inclusive net.

Future Research

I have laid a strong foundation in this study to academically develop further reflections of practice from my journals. This includes my experiences with homeless parents, my work in joint consultations between homeless people and health practitioners, and reflections of two more homeless HNA reports in mental health and homeless families. These were recommendations I put forward in the JSNA public health report to further tighten the local net. Publishing papers in health and other journals will continue to bring meaning around the ontology of homelessness and health need where key others can grasp their role in strengthening the net of inclusion for vulnerable people.

Conclusion

It may be helpful to remind ourselves that the word "practice" has long been used in contrast with the term "theory." Valuing the theoretical life over the life of practice hints at high commitment to truth and contemplating the good life. Thus, theory can mean a rebuttal of practice, but it can also be seen in the service of practice, following practice, or as the essence of practice itself (van Manen, 2007:14).

I have written this study in the service of practice, traversing the homelessness landscape through practice and theory to identify my 'becoming' towards my practice vision as SPHN (Homelessness). I contend that the complexity of health and homelessness practice can most ably be captured through Johns's process of narrative construction where theory and experience mingle through the dialogical movements, towards a holistic ways of knowing in nursing practice (Carper, 1978; Munhall, 1993; Wilber, 1998).

In many respects my journey is only beginning; now, I can devote time to Johns's 6th dialogical movement to show the insights from my unique journey to others, making visible the invisible terrain of homelessness particularly in health services. At times this will be through narrative performance which I have begun in education (University of Bedfordshire). I have also become confident in research in my Public Health role as I engage with vulnerable communities in a widening practice field of health inequalities. I delight in *using my voice* courageously and constructively yet I know I am vulnerable, and often at the mercy of passing political NHS winds which may at times silence me.

I conclude with my beginning. My thoughts return to the Stragraddy farm where my mother was born and to the well that my grandmother used each morning as she and my grandfather raised their six children. Gazing on it (Fig 5.3), I sense coherence and 'seek connection' (Wheatley & Rogers, 1996:88) in my own life narrative. Intrigued by the ivy framing the well I am stunned to read its Celtic symbolism as interweaving and growth and that it is considered a sacred symbol for

consciousness, development, expansion and rebirth (<http://www.whats-your-sign.com/celtic-meaning-ivy.html> - accessed 10th June 2012). This strongly resonates with becoming. Wheatley & Rogers (1996:89) develop my insight,

Life is motion, "becoming, becoming". The motions of life swirl inward to the creating of self and outward to the creating of the world. We turn inward to bring forth a self. Then the self extends outward, seeking others, joining together...in constant motion all creation discovers original newness.



McFadden's Well, Stragradddy
(Photographs: Grace Fordham, April 2011)



In the course of this study, I have swirled inwards to reflect on the love and care I embodied by the hearth near my grandparents well and I have swirled outwards drinking knowledge from a PhD well shared with a nursing and teaching community, where, in a joint dance we weaved a net through reflective practice and guidance where "meaning expanded as we join life's cohering motions" (Wheatley & Rogers, 1996:88). It produced a model of homeless health care, through appreciating precarious engagement in homelessness arising from Johns's Being Available Template. Through

narrative construction homeless people were drawn into the dance. With this concluding thought I draw on Charon's (2006b) words about narrative in medical practice to illuminate how we are all responsible for one another in our efforts to become,

Acts of reading and writing, telling and listening - whether in fiction, conversation transcripts medical visits or the embodied wordless gesture of my young patient grieving for her father - put us in the presence of these efforts, futile though they may be, to give voice, to tell, ultimately what it means for us to be within the grey immensity of human lives - in time, in language in freedom in bodies and in one another's care (p.199)

I sense the narrative's continual becoming;

a process of future transformation in

a bigger narrative

where homelessness fails to exist

for the sick and the vulnerable

because the nature of an informed society

holds homeless people

in its net of care.



APPENDIX 1
Health Needs Assessment Report

[..\\..\\Chapter 1\\amalgamate ch 1\\HNA Appendix 1.pdf](#)

Appendix 2

EMAIL FROM CHAIRMAN OF THE EHTICS COMMITTEE

January 2007

Dear Maria

As far as I can see, the only matter of an ethical nature which could arise from your research, which is essentially introspective in nature, is that you will be reflecting on actual experience which involves other people. These people could potentially be identified by someone who is 'in the know' about them since you will inevitably disclose a lot of personal information about them in order to set the scene and describe your interaction with them. I would urge you therefore to change as many of the details about them as you can in telling the story of your experience with them, although clearly some details will have affected your interaction with them and it would destroy the validity of the narrative if you change those.

I can-not see any other ethical issues: in particular I think you can analyse your own behaviour in any way you choose without raising matters that might concern an ethics committee (I suppose if you analysed yourself to the extent to generating some kind of mental illness, that could be a problem; but that seems hardly likely in this case!)

If you want to meet to talk about this I will be happy to meet you...just let me know

With best wishes

RD

Appendix 3
Health and Homeless Leaflet

[..\Homeless DL 300609.pdf](#)

Appendix 4
Focus Groups
Information Sheet

(PCT logos removed)

Patient Information Sheet for
Homeless and Health Focus Groups

15th September 2005

Dear Focus Group respondent

This information sheet is provided to help you decide whether or not you would like to participate in a focus group entitled, 'Health Care Needs and Your Experience Around Access to Health Services for People who are Currently Homeless or Recently Homeless'. It is important for health care practitioners and managers to understand health experiences and access to services from your perspective so that we can respond with insight to develop appropriate and caring services.

I have worked as a Specialist Nurse and Health Visitor with homeless people since November 2004; my colleague *SB*, also a Specialist Health Visitor, will be facilitating the groups with me as discussed in this sheet. A University of Luton research and health lecturer is guiding us in the process. Our findings will be presented to the Primary Care Trusts for whom we work. The focus groups have been approved by the local Research Governance Committee in the PCT.

You are invited to attend one focus group which will last approximately one hour from 11.30 -12.30. Ten groups are being held at the following venues: *[venue list removed to maintain confidentiality]*

The group will consist of around six respondents. Discussions in your focus group will be led by myself and *SB*. For those of you who have young children, they are warmly invited to attend with you. Refreshments will be provided and it is hoped you will find the experience positive and useful. The group discussion will take the form of an opening question where you will be invited to contribute with your experiences of health care. The advantage of gathering information in a group is that other people's experiences may help you to identify and remember issues which are similar or different to yours. In this way we can build a local picture of health care needs and gaps in services.

Confidentiality will be paramount throughout the process and each participant shall be made aware of their responsibility not to repeat information they have heard during the focus group when it is finished. You do not have to disclose anything you feel uncomfortable about sharing with others. Your name and other details which disclose your identity will not be used in final reports. The discussions will be recorded. *SB* and I are the only people who will hear the recordings which will be used to compile the written data. All data will be kept securely locked in a filing cabinet and tapes will be destroyed when our report is completed. If you would like to see the final draft written report another meeting can be arranged for this.

We do not envisage any problems as a result of the focus group. They will possibly help you to reflect on your experiences in a different way giving you a deeper understanding of health and homelessness. We shall highly value what you say. The final document with our recommendations for improvement of services will be presented to Health managers.

If you would like to take part in a focus group there will be an information event *[details removed]*. A consent form is enclosed for you to sign and return during the information event where you will have the opportunity to ask questions. Further information regarding your rights in participating in a focus group can be obtained from *RS* in Clinical Governance at PCT headquarters, Tel...

We look forward to meeting you.

Appendix 5 Associated Work

Publications

- Fordham, M. (2011) *Yarl's Wood Immigration Detention Centre: A Health Needs Assessment Report of the Adult Population*: NHS Bedfordshire
- Fordham, M. (2010) Falling through the Net. In Johns *Guided Reflection Advancing Practice* 2nd Edition. Oxford: Blackwell Sciences
- Fordham, M. (2010) *Homeless People in Central Bedfordshire: A Health Needs Assessment Report* NHS Bedfordshire
- Fordham, M. (2009) Building Bridges in Bedfordshire: Being a DHS Lay Associate. In *DHS Tercentenary Celebrations English and Irish Province*: Northampton: DHS
- Fordham, M., (2008) *Homeless People in North Bedfordshire: A Health Needs Assessment Report*. NHS Bedfordshire
- Fordham, M. in Johns C. & Delmar C. (2008) Building Bridges in Homelessness: Phronesis in Nursing Practice In *The Good, The Wise and the Right Clinical Nursing Practice*. Denmark: University of Aalborg
- Fordham, M. (2006) Mirror Image - Reflective Practice. Letter of the Month *Community Practitioner* 2006 79 2 15
- Fordham, M. (2005) Professional Career Development; Career Profile - Maria Fordham Specialist Publish Health Nurse *Independent Nurse* 18April 2005 28
- Conroy, M.F. (1986) A framework for the Neighbourhood Study *Health Visitor* 159 (11):333-334

Conference Platform Presentations and Performances

- *Balancing the Clay* - 16th International Reflective Practice Conference. University of Bedfordshire, Putteridgebury, Bedfordshire [7th July 2010]
- *Health and Homelessness in Bedfordshire* – NHS Bedfordshire Health and Homeless Conference. [31st Jan 2010]
- *Spaghetti Junction* – written by Maria Fordham and performed at:
 - The 15th International Reflective Practice Conference University of Limerick Pre Conference Workshop [24th June 2009]
 - University of Bedfordshire First Year Performing Arts students [April 2008]
- *No Place* - Written and performed by University of Bedfordshire theatre students following my preliminary presentations to them on Health and Homelessness plus introductions to multi-agency services. Six performances to: health and homelessness services [April 2008 - July 2008]
- *Building Bridges in Homelessness, mindful of phronesis in nursing practice*. Denmark: Aalborg University of Aalborg: 13th International Reflective Practice Conference, [paper presented: May 30 2007]
- *RAW* - written by Christopher Johns and performed at:
 - The 13th International Reflective Practice conference in Denmark with Christopher Johns, Maria Fordham, Louise Jarrett and Bella Madden [June 2007]
 - Inaugural professorial lecture at University of Bedfordshire, Luton with Christopher Johns, Maria Fordham, Louise Jarrett and Bella Madden [December 2007] .
- *Regaining an Effective Voice in Professional Practice* 11th International Reflective Practice Conference. Iceland: Reykyvek [Paper presented: 31 May 2005]

Awards/Best Practice

- Communities and Local Government award to Bedford Borough Council - Training to hostels (Health training was included in hostel training) awarded to Bedford Borough Council [2009]
- Communities and Local Government Multi Agency Panel for Rough Sleepers – Best Practice Site – awarded to Bedford Borough Council on behalf of members [2009]
- Shelter, Good Practice: Bedford PDT: on developing a Admission and Discharge Hospital Protocol for homeless people [2007]
- Department of Health: 'Ask about Medicines Award for Excellence' Maria Fordham, Jackie Smith and Sajida Khatri for 'the safe management of medicines in homeless hostels' [2007]

Local Presentations and Education

2009 - current:

- University of Bedfordshire: Health, Home and Homelessness - 3 sessions each year including outreach homeless sessions for SCPHN students to night shelter.

2009

- Bedfordshire Drugs and Alcohol Treatment Services - Health Needs Assessment Report: Health and Homelessness in Bedfordshire -
- NHS Bedfordshire Commissioning Consortia - Health Needs Assessment Report: Health and Homelessness in Bedfordshire -

2008

- Health Improvement Group sub group of the Bedfordshire Partnership Board - Health Needs Assessment Report dissemination
- Bedfordshire Community Health Services, Senior Management Board - Health Need Assessment Report dissemination

2005 – 2007

- Bedford Pilgrim Housing Association team meeting – 'Homelessness and Health'
- Bedford Supported Housing Forum – 'Homelessness and Health'
- Bedford Borough Council - Cold Weather Provision Working Group –'Homelessness and Health'
- Bedford Hospital Discharge Management Group – 'Homelessness and Health'
- Bedford Hospital A&E Sister's Meeting – presentation on role/discharges/homelessness
- Bedford PCT Shared Care Drug treatment Service – presentation on role
- Bedford PCT Health Visitor's Speakers Day – ' Family Homelessness'
- Bedford PCT meeting HV Lead/CP Lead - Families in B&B accommodation
- Bedford PCT – Health Visitors on B&B accommodation/Notification System
- Bedford PCT - Counselling services 'setting up a fast track system for Homeless people'
- Bedford PCT - Clinical Nurse Managers Forum role presentation
- Mental Health Services Discharge Planning Group – facilitated
- Mental Health Service Case review Weller Wing - facilitated
- Kings Arms Project The Night Shelter and Barton House - Role
- Prebend Street Day Centre – Role of the Nurse in homelessness
- Holy Cross Youth Confirmation Group – Homelessness
- Daughters of the Holy Spirit AGM 2005 – Homelessness
- Community Mental Health Team manager meeting – Homelessness
- Floating support meeting - Anglia Care Trust Client Group

Health Training facilitated for Homeless Services

- *End of Life Care for Homeless People* jointly facilitated by East of England with Borough Council Rough Sleeping co-coordinator and myself on organizing team (*forthcoming*)
- *Self-Harm* with a mental health manager
- *TB and Homelessness* with the TB Specialist Nurse
- *Diabetic Care in the 21st century* with the Diabetic Specialist Nurse
- *Health and Homelessness*
- *Safe Prescribing in Hostels* - PCT pharmacists

Education for Homeless People

- 2011: Tenancy sustainment for former rough sleepers: Session 6 - Health-wise. Bedford Borough Council- Outreach support
- 2006-2008: Annual Health and Homeless Fairs
- 2007-2009: Woodenhill Drama for homeless people who would like to perform - three training sessions

Homeless Health Champion

- 2009-2010: Mentoring of 1st Homeless Health Champion - a former rough sleeper

A SPCHN (School Nurse) Student's Reflections on the Night Shelter

No shoes left outside the door
Nor set ideals or expectations
Value judgments challenge me
An idea of the true meaning of poor
For my colleagues and I
An evening of revelations

Inside the sound of laughter
A welcome of unconditional love
Scenes that will not be forgotten
Memories of the man shaking
Who had lost his glove

Food brought to the table
Camaraderie - tangible for all to feel
Yet some could not smile
They were unable
Their first night at the Shelter seemed unreal

What life events had brought them here?
Shattered dreams?
Or life's simple grind?
One face filled with absolute fear
As to what that night he would find

The beds were clean; provision made
Warmth for the night against the cold
How could I this young man aid?
Before he too looked old

The jobs we have can make us forget
Yet do it right we must
A fatherless nations, children's needs unmet
Our absolute duty to prevent
Crisis in ways that are just.

Kerry Du Fraisse 06/11/2010

References

- Alexander, K. (2005) Performance Ethnography: The reenacting and Inciting of Culture. In Denzin, N. & Lincoln, Y.S. (eds) *The Sage Book of Qualitative Research*. 3rd Ed. London: Sage
- Aldrige J., (2007) Picture this: the use of participatory photographic research methods with people with learning disabilities *Disability & Society*, 22 (1): 1 - 17
- Aloi, J.A. (2009) The nurse and the use of narrative: an approach to caring. *Journal of Psychiatric and Mental Health Nursing* 16 (8): 711-715
- Aristotle (1934), Nichomachean Ethics 114 (20):163 *Politics and Constitution of Athens* translated by Rackham, Cambridge: Harvard University Press
- Arman, M., Rehnsfeldt, A. (2007) The 'Little Extra' That Alleviates Suffering *Nursing Ethics* 2007 14: 372
- Atkins, S. & Murphy, K. (1995) Reflective Practice. *Nursing Standard* 9:31-37
- Bachelard, G. (1958/1994). *Poetics of space* (M. Jolas, Trans.). Boston, MA: Beacon Press.
- Bateson, M.C. (1994) *Peripheral Visions: Learning Along the Way*. New York: Harper Collins
- Baudrillard, J. (1997) *Art and Artifact*. London: Sage
- Belenky, M. F., Clinchy, B., Goldberger, N., Tarule J. (1986) *Women's Ways of Knowing The Development of Self, Voice and Mind*. New York: Basic Books
- Bellman, L.M. (1996) Changing nursing practice through reflection on the Roper, Logan and Tierney model: the enhancement approach to action research *Journal of Advanced Nursing* 24:129-38
- Benner, P. (1984) *From Novice to Expert*. Menlo Park: Addison
- Benner, P. (1994) *Interpretive Phenomenology*. California: Sage
- Benner, P. (1991) The role of experience, narrative, and community in skilled ethical comporment. *Advances in Nursing Science* 14:1- 21
- Bentz, V. & Shapiro, J. (1997) *Mindful Inquiry in Social Research*. London: Sage
- Bines, W. (1994) *The health of single homeless people*. Discussion Paper 9 University of York: Centre of Housing Policy
- Blackwolf, G. & Jones G (1996) *Listen to the Drum* Blackwell Publishing, Oxford
- Boal, A. (1979) *Theatre of the Oppressed*. London: Pluto Press
- Bochner, A. (2000) Criteria Against Ourselves, *Qualitative Inquiry* 6 (2): 266–72.
- Bochner, A. (2001) Narrative's Virtues, *Qualitative Inquiry* 7:131–57.
- Bochner A. & Ellis, C. (2002) *Ethnographically Speaking* Oxford: Altamira Press
- Bohm, D. (1996) *On Dialogue*. Nichol, L. (Ed). London: Routledge
- Bolton, G. (2005) *Reflective practice writing and professional development*. London: Sage
- Booth T, Booth W, McConnell D (2005) The prevalence and outcomes of care proceedings involving parents with learning difficulties in the family courts. *Journal of Applied Research in Intellectual Disabilities*. 18 (1): 7-17.
- Borglum, D. (1997) *The Long Shadow of Good Intentions*. New York: The Buddhist Review
- Boswell, C. & Cannon, S. (undated) . *Learning: Critique process in nursing research* [www.http://samples.jbpub.com. Site accessed 11th July 2012]
- Boud, D., Keogh, R., Walker, D. (Eds) (1985) Promoting Reflection in Learning: a Model. In: *Reflection: Turning experience into learning*. London: Kogan Page
- Boyd, E. & Fales, A. (1983) Reflective Learning: key to learning from experience. *Journal of Humanistic Psychology*, 23 99-117
- Boykin, A. & Dunphy, L. (2002) Justice-Making: Nursing's Call *Policy Politics Nursing Practice* 2002 3: 14 Site accessed June 2, 2011
- Breaky, W., Susser E. & Timms, P. (2001) Mental Health Services for Homeless People in Thronicroft, G. (Ed) *Measuring Mental Health Needs* 2nd Edition. London: Gaskell Publishers
- Buck, B. (2002) *Repeat Homelessness and Domestic Violence*. Scotland, Shelter
- Bulman, C. and Schultz, S. (2009) *Reflective Practice in Nursing* (4th Ed). Oxford: Blackwell Publishing

- Burnard, P. (1995) Nurse Educator's perceptions of reflection and reflective practice: a report of the descriptive study. *Journal of Advanced Nursing* 21:1167-1174
- Burrows, D.E. (1995) The nurse teachers role in the promotion of reflective practice. *Nurse Education Today*, 15:346-350
- Burton, A.J. (2000) Reflection: nursing's practice and education panacea? *Journal of Advanced Nursing* 31 (5):1009-1017
- Burrell, K., Jones, L., Sumnall, H., McVeigh, J., Bellis, M.A. (2005) *Tiered approach to Drug Prevention and treatment among young people*. London: National Collaboration Centre for Drug Prevention
- Butler, R. (2005) Baudrillard's Light Writing Or Photographic Thought *International Journal of Baudrillard Studies* 2:1
- Camilli, V., Martin, J. (2005) Emergency department nurses' attitudes toward suspected intoxicated and psychiatric patients *Topics in Emergency Medicine*, 27 (3):13-316.
- Cara, C. (2003) A pragmatic view of Jean Watson's caring theory. *International Journal of Human Caring* 7(3): 51-7.
- Carper, B. A. (1978) *Fundamental Patterns of Knowing in Nursing. Advances in nursing science*. 17 (4): 73-86
- Carson, A. (2001) "That's another story": narrative methods and ethical practice, *Journal of Medical Ethics*. 27:198-202
- Carson, R. (1994) Teaching ethics in the context of the medical humanities. *Journal of Medical Ethics* 20: 235-8
- Care Services Improvement Partnership, (2005) *National Social Inclusion Programme first annual report* England: National Institute for Mental Health
- Casey, A. (2000) *Snakes and Ladders: Women's Pathways Into and Out of Homelessness*. Melbourne: University of Melbourne
- Casey, L. (2003) Not just bricks and mortar *Community Practitioner* 76 (1):1-10
- Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.
- Cath, A. (1995) Parents with Learning Disability. In: Reder R, Lutey, C. (1996) *Assessment of Parenting: Psychiatric and psychological contributions*. London: Routledge
- CETHV [Council for the Education and Training of Health Visitors] (1977) *An investigation into the principles and practice of Health Visiting*. London: CETHV
- Chamberlain, C. & Mackenzie, D. (1992) Understanding contemporary homelessness: issues of definition and meaning. *Australian Journal of Social Issues* 27: 274-297
- Charon, R., (2001) *Narrative Medicine model for Empathy, Reflection, Profession and Trust* [The Patient-Physician Relationship] *JAMA*, 286 (15):1897
- Charon, R. (2006) *Narrative Medicine Honoring the Stories of Illness*. Oxford: Oxford University Press
- Charon R. (2006b) The Self-Telling Body *Narrative Inquiry* 16 (1): 191-200.
- Chase, S E. (2005) Narrative Inquiry. In Denzin, N.K. & Lincoln, Y.S. (eds) *The Sage Handbook of Qualitative Research*. 3rd Ed. London: Sage
- Chatman, S. (1978) *Story and Discourse: Narrative structure in fiction and film*. Ithaca: Cornell University Press
- Citron, K., Southern, A. and Dixon, M. (1995). *Out of the Shadow: Detecting and Treating Tuberculosis Amongst Single Homeless People*. London: Crisis
- CIVITAS, (2010) *Homeless Health: A Blight on This House* Grand Committee Room, House of Commons, 21 April 2009. CIVITAS
- Cixous, H. (1995) Castration or decapitation? In G. Bolton *Reflective practice writing and professional development*. London: Sage
- Cixous, H. (1996) Sorties: out and point attacks ways out/forays. In Cixous and C. Clement (eds) *The Newly Born Woman*. London: Tauris
- Clandinin, D. & Connelly, F.M. (2000) *Narrative Inquiry. Experience and Story in Qualitative Research*. San Francisco: Jossey-Bass

- Clandinin D. & Connelly, F.M. (1990) *Stories of Experience and Narrative Inquiry* Educational Research American Educational Research Association
- Clough, P. (2000) 'Comments on Setting Criteria for Experimental Writing', *Qualitative Inquiry* 6 (2): 278–91.
- College of Medicine/Pathways (2011) *Standards for commissioners and service providers* Version 1.0 May 2011
- Connelly, J. & Crown, J. (1997) *Homelessness and ill health: Report of a working party of the Royal College of Physicians*. London: Royal College of Physicians
- Conquergood, D. (1985) Performing as a Moral Act: ethical dimensions of the ethnography of performance. *Literature in Performance* 5:9.
- Connor, A. & Howett, M. (2009), A Conceptual Model of Intentional Comfort Touch *Journal of Holistic Nursing* American Holistic Nurses Association 27(2):127
- Cook, J., Vickers, M., Walters, S., Gorton S. (2004) *The Vital Link: Preventing Family Homelessness*. London: CPHVA
- Cope, M. (2001) *Lead yourself. Be where others would follow*. London: Momentum Books
- COREC (2001), *Governance Arrangements for NHS Research Ethics Committees*. London: Central Office for Research Ethics Committees
- Cotton, A. (2001) Private thoughts in public spheres: issues in reflection and reflective practices in nursing. *Journal of Advanced Nursing* 36(4):512-19
- Cox, H., Hickson, P. and Taylor, B.(1991) Exploring reflection: Knowing and constructing practice. In G Gray and R Pratt (Eds) *Towards a discipline in nursing*. pp 373-90. Melbourne: Churchill Livingstone
- Cowling, W. R. (2000). Healing as appreciating wholeness. *Advances in Nursing Science*, 22 (3):16-32.
- Crane, M. (1997) *Home Truths Challenging the Myths of Older Homeless People*, Crisis, London
- Crane, M. & Warnes A.M. (2000) Evictions and Prolonged Homelessness *Housing Studies*, 2000; 15 (5):757-773
- Crane, M. & Warnes A.M (2001a) The responsibility to care for single homeless people *Health & Social Care in the Community* 9 (6):436–444
- Crane, M. & Warnes, A.M. (2001b) Primary Health Care Services for Single Homeless People; defects and opportunities *Family Practice* 2001;18: 272-276
- Crane, M. & Warnes, A.M. (2004) Developing homelessness prevention practice: combining research evidence and professional knowledge *Health and Social Care in the Community* 14(2):156-166
- Crigger N. (2009) Towards understanding the nature of conflict of interest and its application to the discipline of nursing *Nursing Philosophy* (2009), 10, 253–262 2009 Blackwell Publishing Ltd
- Crisis (2009) *Crisis' Submission to St Mungo's Call for Evidence Mental Health and Street Homelessness*. London: Crisis
- Crisis (2006) *Homeless Women: Still being failed yet striving to survive*. London: Crisis
- Crisis (2003) *Statistics about Homelessness*. Fact Sheet 7. London: Crisis
- Crisis (2002a) *An exploratory visit ...* London: Crisis
- Crisis (2002b) *Ill Health in the Adult Single Homeless Population: A review of the literature*. London: Crisis
- Crisis (2002c) *Critical Conditions Vulnerable Single Homeless People and Access to GP Services*, London: Crisis
- Crisis (1996) *Still Dying for a Home* Crisis London: Crisis
- Cronenberg, D. (Director) McGrath, D. (2002) *Spider* Capital Films, UK
- Crocombe, S. (2008) *The Health of Homeless People in Nottingham: an exploratory study. Dissertation for Master of Nursing Science*. University of Nottingham: School of Nursing Faculty of Medicine
- Daiski, I. (2007) Perspectives of homeless people on their health and health needs priorities *JAN Original Research*. Oxford: Blackwell Publishing Ltd
- Davis, S., Kennedy, P. Greenish, W. Jones, L. (2011) *Advanced liver disease in a homeless population* London: DH, St Mungo's, Marie Curie

- Davis, S. (2011) *Advanced liver disease in a homeless population* - powerpoint presentation to Homeless Health Initiative May 2011.
- DCLG (1999) *Coming in from the Cold: The Government's Strategy on Rough Sleepers*. London: Department of Communities and Local Government
[www.communities.gov.uk/archived/general-content/housing/coming]
Site accessed 28 December 2010].
- DCLG (2003a) *Supporting People* London: Department of Communities and Local Government
[www.communities.gov.uk/housing/housingmanagementcare/supportingpeople]
Site accessed 28 December 2010]
- DCLG (2003b) *More than a Roof* HMSO London
- DCLG (2006) *Places of Change – Challenging Homelessness Through Hostels Capital Improvement Programme* HMSO [<http://www.communities.gov.uk/youthhomelessness/prevention/schools>].
Site accessed 28 December 2010]
- DCLG (2007a) National Statistics: Housing Statistics. London: CLG
- DCLG (2007b) *Severe Weather Conditions for rough sleepers, Letter to Local Authorities, November 2007* [Site accessed 27 May 2011 <http://handbooks.homeless.org.uk/streetreachdeliveringquality/engagement/coldweather/>]
- DCLG (2008b) *Rough Sleeping 10 Years On: From the Streets to Independent Living*. London: Department of Communities and Local Government
[www.communities.gov.uk/publications/housing/roughsleeping/discussion]
Site accessed 31 December 2010].
- DCLG (2008a) *Statutory Homelessness in England: The experience of families and 16-17 year olds*. London: Department of Communities and Local Government
- DCLG (2009) *End Rough Sleeping Champions: 2009-2010*. London: CLG
- Delmar C. & Johns, C. (Eds) (2008) *The Good the Wise and the Right Clinical Nursing Practice*. Aalborg: Aalborg Hospital, Aarhus University Press
- Denzin, N. (2003) Reading and Writing Performance. *Qualitative Research* 3 (2):243-268
- Denzin, N. & Lincoln, Y.S. (Eds) (2005) *The Sage Book of Qualitative Research*. [3rd Edition] .London: Sage
- De Mello A., (1990) *Awareness*. New York: Double Day
- Dewey, J. (1963 [1938]) *Experience and Education*. New York: Capricorn Books
- Dewey, J. (1933) *How we think*. Chicago: D.C. Heath Publishers
- DH (2011) *Health Visitor Implementation Plan 2011–15 A Call to Action*. London: DH
- DH (2010) *Health Care for Single Homeless People*. London: DH Office of the Chief Analyst
- DH (2010b) *Inclusion Health improving primary care for socially excluded people*. London: DH
- DH (2010c) *Advanced Level Nursing: A Position Statement*
- DH (2009) *New Horizons: A shared vision for mental health*. London: Department of Health
- DH (2007a) *A Good Practice Guide – Getting through – Access to mental health services for people who are homeless or living in insecure accommodation* HMSO London
- DH (2007b) *Review of the Health Inequalities Infant Mortality PSA Target*. London: DH
- DH (2006) *Improving Lives; Saving Lives*. London. Department of Health
- DH /DCLG (2006b) *Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation*. London: DH
- D H (2006c) *Best Research for Best Health: A New National Health Research Strategy*. [www.dh.gov.uk/prod_consum_dh/groups/dh_4127152.pdf - Site accessed 6 June 2012]
- DH (2004) *National Service Framework for Children, Young People and Maternity Services*. London: DH
- DH (2003a) *Tackling Health Inequalities: a programme for action*. London:DH
- DH (2003b) *'Discharge from hospital: pathway, process, and practice'* Department of Health, January 2003 [www.dh.gov.uk/assetRoot/04/11/65/25/04116525.pdf - Site accessed 4/5/2011]
- DH (2002) *Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide*. London, HMSO
- DH (2000) *Framework for the Assessment of Children in Need and Their Families*. London: DH
- DH (1999), Caldicott Guardians' *Health Service Circular 1999/012*, HMSO

- DH (1998) (Acheson Report) *Independent Inquiry in to Inequalities in Health Report* HMSO
- DH/ODPM (2004) *Achieving Positive Shared Outcomes in Health and Homelessness*. London: DH and Homeless and Housing Support Directorate
- Doherty, J., Busch-Geertsema, V., Karpuskiene, V., Korhonen, J., O'Sullivan, E., Sahlin, I., Tosi, A., Petrillo, A. and Wygnański, J. (2008) Homelessness and Exclusion: Regulating public space in European Cities *Surveillance & Society* 5(3): 290-314 Surveillance and Inequality (eds. Monahan and Fisher) (www.surveillance-and-society.org. Site accessed 6th June 2012]
- Doyle, P. (1988) *The God Squad*. London: Corgi Books Transworld
- Dreyfus, H. & Dreyfus, S. (1986) *Mind Over Machine*. New York: Free Press Ethington, K. (2004) *Becoming a Reflexive Researcher using ourselves in research*. London: Jessica Kingsley
- Dreyfus H., L., (1995) *Being in the World. A commentary on Heidegger's Being and Time*. Division 1 Massachusetts: The MIT Press
- Durgahee, T. (1996) Promoting reflection in post graduate nursing: a theoretical model. *Nurse Education Today* 16:419-26
- EC /EU (2010) Policy Recommendations of the Jury *European Consensus Conference on Homelessness* 9 - 10 December 2010, Brussels
- Edelsky, C. (1981) Belenky MF, Clinchy B., Goldberger N., Tarule J., (1986) *Women's Ways of Knowing, The Development of Self, Voice and Mind*. New York: Basic Books, Harpur Collins, New York
- Ellis, C. (1995) *Final Negotiations: A Story of Love, Loss and Chronic Illness*, Philadelphia: Temple University Press
- Ellis, C. (2000) 'Creating Criteria: An Ethnographic Short Story', *Qualitative Inquiry* 6(2) 273-7.
- Ellis, C. (2004) *The ethnographic I: a methodological novel about autoethnography*. Walnut Creek, CA: Alta Mira
- Ellis, L. B. (2001) *Continuing Professional Education for Nurses: An illuminative Case Study. Unpublished PhD thesis*. University of Sheffield: Faculty of Medicine
- Ethington, K. (2004) *Becoming a Reflexive Researcher: Using Ourselves in Research*. London: Jessica Kinglsey
- EU/FEANSTA (2010) *European Consensus Conference on Homelessness: Policy Recommendations of the Jury*. Brussels: EC
- Farrelley-Hansen, M. (2001) *Spirituality and Art Therapy*. London: Jessica Kingsley
- Fay, B. (1987) *Critical Social Science*. Cambridge: Policy Press
- Farely-Hansen, M. (2001) *Spirituality and Art Therapy*. London: Jessica Kinglsey
- FEANTSA (2007) *Meeting the Health Needs of Homeless People* FEANTSA Policy Statement 14
- Fejes, A. (2008) Governing through reflection: a discourse analysis of reflective practices. *Journal of Advanced Nursing* 64 (3): 243-250
- Fields, D.L.(2002) Taking the Measure of Work: A Guide to Validated Scales for Organisational Research and Diagnosis: CA: Thousands Oak, Sage. In Wong, C. A., Spence Lashinger, H. K., Cummings G. (2010) Authentic Leadership and nurses 'voice behaviour and perceptions of care quality *Journal of Nursing Management* 18:889-900
- Finley, S. (2005) Arts Based Inquiry: Performing Revolutionary Pedagogy. In Denzin, N. & Lincoln, Y.S. (eds) *The Sage Book of Qualitative Research*. 3rd Ed. London: Sage
- Fitzpatrick, S. (2006) *Homeless Research Initiative: A possible ESRC programme*. University of York: Centre for Housing Policy
- Fitzpatrick, S. & Christian J. (2006) Comparing Homelessness Research in the US and Britain *International Journal of Housing Policy*. 6 (3): 313-333,
- Fitzpatrick, S., Pawson, H., Bramley, G., Wilcox, S. (2011) *The Homelessness Monitor Tracking the Impacts of Policy and Economic Change in England 2011-2013 Year 1: Establishing the Baseline* Report Summary. University of York: Institute for Housing, Urban and Real Estate Research, Heriot-Watt University & Centre for Housing Policy
- Fordham, M. (2005) Regaining a Professional Voice in the Public Arena, Paper submitted for 13th *International Reflective Practice Conference*. Iceland: Reykjavik

- Fordham, M. (2005) *Regaining A Professional Voice in Public Places* paper presented at the 11th International Reflective Practice Conference Reykjavik, Iceland - hosted by the Icelandic Nurses Association
- Fordham, M. (2007) *Building Bridges in Homelessness* paper presented at the 13th International Reflective Practice Conference - Aalborg, Denmark hosted by Aalborg Hospital
- Fordham, M. (2008a) *Building Bridges in Homelessness - Phronesis in Nursing Care*. In Delmar C., Johns C. (Eds) *The Good the Wise and the Right Clinical Nursing Practice*. Aalborg: Aalborg Hospital, Aarhus University Press
- Fordham, M. (2008b) *A trilogy of reflections: health and homelessness* - presented to University of Bedfordshire 1st year BA performing arts students
- Fordham, M. (2009) *Spaghetti Junction* Performed in Pre Conference Workshop, 15th International Reflective Practice Conference: University of Limerick
- Fordham, M. (2010a) *Health Needs Assessment: Homelessness and Health with performance of Balancing the Clay* Key Speaker at the Health and Homeless Conference NHS Bedfordshire
- Fordham, M. (2010b) *Balancing the Clay: the Six Dialogical Movements*. Paper presented at the 16th International Reflective Practice Conference: University of Bedfordshire
- Foster, L. (2010) *An Accidental Tourist*. In Johns, C. (2010) *Guided Reflection a narrative approach to advanced professional practice*. Oxford: Wiley Blackwell
- Foucault, M. (1973) *The Birth of the Clinic*. New York, Vintage Books
- Frank, A. W. (1991) *At the Will of the Body, Reflections on Illness*. New York: Mariner Books Houghton Mifflin
- Frank, A. W. (1995) *The Wounded Storyteller Body, Illness and Ethics*. Chicago: University of Chicago Press
- Frank, A. W. (2000) *Illness and autobiographical Work: dialogue as Narrative Destabilization* *Qualitative Sociology*, 23 (1): 135-156 Human Science Press Inc
- Fredriksson, L. (1999). *Modes of relating in a caring conversation: A research synthesis on presence, touch and listening*. *Journal of Advanced Nursing*, 30: 1167-1176.
- Fredriksson L. & Lindstrom U. (2002) *Caring conversations – psychiatric patients' narratives about suffering*, *Journal of Advanced Nursing* 40 (4): 396-404 Blackwell Science Limited
- Freshwater, D. (2002) *Guided Reflection in the Context of Post-Modern Practice*. In Johns. C. (2002) *Guided Reflection Advancing Practice*. Oxford: Blackwell Publishing
- Freshwater, D. J. Cahill, E. Walsh and T. Muncey (2010) *Qualitative research as evidence: criteria for rigour and relevance* *Journal of Research in Nursing* 2010 (15): 497 www.jrn.sagepub.com/content/15/6/497. Site accessed 2 March 2011
- Frid, I., Ohlen J., Bergbom I. (2000) *On the Use of narratives in nursing research* *Journal of Advanced Nursing*, 32 (3): 695-703. Oxford: Blackwell Science
- Freire, P. (1970/1993) *Pedagogy of the Oppressed*. Penguin Books London
- Freire, P. (2007) *Pedagogy of Hope*. London: Continuum
- Frost, M. (1999) *Health visitor perceptions of domestic violence: the private nature of the problem*. *Journal of Advanced Nursing* 30 (3): 589–596.
- Gadamer H-G. (2004/1975) *Truth and Method* (2nd revised Ed translated Weinsheimer J., Marshall D G.) London: Continuum
- Gadamer, H-G. (2000/1960). *Truth and method* (J. Weinsheimer & D.G. Marshall, Trans.). New York: Continuum. In Picard, M. (2004) *Unfolding the Blanket of Understanding in the Listening Space; a phenomenological exploration of 'being-with' in the nursing student-teacher relationship*. PhD Dissertation: University of Maryland
- Gadow, S. (1980) *Existential advocacy: philosophical foundations of nursing*. In *Nursing Images and Ideals: An Opening Dialogue with the Humanities*, (ed. Stuart F. Spicker and Sally Gadow). New York: Springer.
- Gaydos, H., L. (2005) *Understanding Personal Narratives: an approach to practice* *Journal of Advanced Nursing*, 2005 49 (3): 254-259. New York: Blackwell Publishing Ltd
- Gaydos, H.L (2004a) *Making Special; a unique framework fro understanding the art of holistic nursing*. *Journal of Holistic Nursing* 2005; 22 (2):152-164

- Gaydos, H.L. (2004b) The Living End: Life Journeys of Hospice Nurses. *Journal of Hospice and Palliative Care Nursing* 2004; 6 1 1-10
- Gaydos, H.L. (2001) On calling and character: Caring as an archetypal act. *International Journal of Human Caring* 2001 5 (1): 8-13
- Geanellos, R. (1998) Hermeneutic Philosophy Part 1 implications of its use as methodology in interpretive nursing research. *Nursing Inquiry* 5:154-163
- Geertz, C. (1968) Thinking as a Moral Act: Ethical dimensions of Anthropological Fieldwork in the United States *Antioch Review* 28:139-158
- Gibbs, G., Farmer, B. & Eastcott, D. (1988) Learning by Doing. *A Guide to Teaching and Learning Methods*. FEU, Birmingham Polytechnic
- Gilbert, T. (2001) Reflective Practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing* 36 (2):199-205
- Gilbert, P. (2008) *Guidelines on Spirituality for Staff in Acute Care Services*. Staffordshire University: CSIP/NIMHE
- Gilbert, P., Kaur, N., Parkes, M. (2010) Let's get spiritual *Mental Health Today*. Brighton: Pavillion Company October 2010 pp 28-33
- Gilligan, C. (2001) *In a Different Voice*. London: Harvard University Press
- Goldstein, J. (2002) One Dhama: The Emerging Western Buddhism. In Johns, C. (2004) *Being Mindful Easing Suffering*. London Jessica Kingsley
- Gore, B. (2005) *Spider silk is stronger than steel* (Wow Science) Franklin Watts Ltd, New York
- Graham, M.M. (2010) Finding my voice? *17th International Reflective Practice Conference*. Putteridgebury University of Bedfordshire
- Greaves, L. Varcoe, C., Poole, N. Morrow, M., Johnson, J. Penderson, A., Irwin, L. (2002) *A Motherhood Issue: Issues on Mothering Under Duress*. Canada: Status of Women
- Griffiths, S. (2002) *Health Care of Rough Sleepers: sleeping rough in Oxford*. London:CLG
- Groom, J (2002) Working with Deliberate Self Harm Paitnets in A&E. In Johns,C. (2002) *Guided Reflection; advancing practice*. Oxford: Blackwell Science
- Greenhill and Redican (2002). In Cook, J., Vickers, M., Walters, S., Gorton S. (2004) *The Vital Link: Preventing Family Homelessness*. London: CPHVA
- Griffiths, S. (2002) *The Health of Rough Sleepers in Oxford*. ODPM
- Hadlow, J. & Pitts, M. (1991) The understanding of common health terms by doctors, nurses and patients. *Soc Science Med*. 1991; 32 (2):193-196.
- Hakesley-Brown, R. Malone B (2007) Patients and Nurses: a powerful force *Online Journal of Nursing* 2007 2(1)1091-3734
- Hall S., Powney J., Davidson P (2000) *The Impact of Homelessness on Families*: University of Glasgow,The Research in Education Centre
- Hall, D. M. B. (Ed) (1989) *Health for all Children: A Programme for Child* .Oxford: Medical Publications
- Hall, D.M.B (Ed) (1991) *Health for all Children* [2nd edition]. Oxford: Oxford Medial Publications
- Hall, D.M.B. (Ed) (1996) *Health for All Children*. [3rd edition]. Oxford: Oxford Medical Publications
- Hall, D. M.B.& Elliman, D. (Eds) (2003) *Health for All Children*. 4th edn. Oxford: Oxford Medical Publications
- Halligan, A. (2009) Homeless Health: A Blight on This House *Grand Committee Room, House of Commons, 21 April 2009*. CIVITAS:
- Hansen, F. (2008) Phronesis and Eros - the existential dimension of phronesis and clinical supervision of nurses. In Delmar C. & Johns C. (Eds) *The Good the Wise and the Right Clinical Nursing Practice*. Aalborg: Aalborg Hospital, Arhus University Press
- Hargreaves, J. (1997) Using Patients: exploring the ethical dimension of reflective practice in nurse education. *Journal of Advanced Nursing* 25:223-228
- Henderson, A. (2001) Emotional labor and nursing: an under-appreciated aspect of caring work *Nursing Inquiry* 8 (2):130-138
- Hebblethwaite, A., Colman, M., Hames, M., Forsyth A., Donkin, M. (2007) Investigating the Experiences of People who Have Been Homeless and are in Contact with Learning Disability Services *Learning Disability Review* 12 (3): 25-34

- Heidegger, M. (1962) *Being and Time* (Trans Macquarrie J. & Robinson E. 2008). Oxford: Blackwell Publishing
- Higgs, J. & Tichen, A. (2001) Towards Professional Artistry and Creativity in Practice. In *Professional Practice in Health, Education and the Creative Arts* pp 273-290. Blackwell Publishing Oxford
- Higgins, S. (2001) Interpreting research: a critical review of four PND studies. *Community Practitioner* 74 (1): 25–27.
- Hills, E. (2003) Self Esteem in the lived experience of Homelessness (Unpublished dissertation) University of Nottingham in Crocombe S. (2008) *The Health of Homeless People in Nottingham: an Exploratory Study*, Dissertation for Master of Nursing Science: University of Nottingham: School of Nursing, Faculty of Medicine
- HHI (Homeless Health Initiative) (2008) *Homelessness Briefing Spring 2008* Queens Nursing Institute
- HL/H C (2008) A Life Like Any Other, Human Rights of Adults with Learning Disability Committee on Human Rights *Seventh Report of Session 2007-08 House of Lords Paper 40 -I HC 73-I* Vol 1. London: HMSO
- H M Government (2006) *Information Sharing Vision Statement*. London: Department for Constitutional Affairs, HMSO
- Hodgetts, D., Radley, A., Chamberlain, K., Hodgetts, A. (2007) Health Inequalities and Homelessness: Considering Material, Spatial and Relational Dimensions *J Health Psychology* 12: 709-724
- Holdaway, G. (2008) Lectio Divina *The Oblate Life* [ISBN 0814631762www.wikipedia Site accessed 10/4/2010]
- Hollins, S., Attard, M.T., von Fraunhofer, N., Sedgwick P. (1998) Mortality in people with learning disability: risks, causes, and death certification findings in London. *Developmental Medicine & Child Neurology*. 1998; 40: 50-6.
- Holloway, I. and Freshwater, D. (2007) Vulnerable Storytelling. Narrative Research in Nursing. *Journal of Research in Nursing*. 12 (6): 70-14
- Holly, M.L. (1989) Reflective writing and the spirit of inquiry. *Cambridge Journal of Education*. 19 (1): 71-80
- Holman Jones, S. (2005) Autoethnography: Making the personal political. In Denzin, N. & Lincoln, Y.S.(eds) *The Sage Book of Qualitative Research*. 3rd ed. London: Sage
- Holman Jones, S. (2002) The Way We Were Are and Might Be: Torch Singing as autoethnography. In Bochner and Ellis) *Ethnographically Speaking*. New York: Alta Mira Press
- Homeless Link (2009) *Survey of Needs and Provision (SNAP) Report*. London: Homeless Link
- Hooks, B. (2000) *Where we Stand Class Matters* London: Routledge
- Howett, M., Connor, A. & Downes, E. (2010) Nightingale Theory and Intentional Comfort Touch in Management of Tinea Pedis in Vulnerable *Journal of Holistic Nursing* 2010 28: 244
- Howie, JGR., Heaney DJ, Maxwell M, Walker JJ. (1997) A comparison of a Patient Enablement Instrument against two established satisfaction scales as an outcome measure in primary care consultations. *Family Practitioner* 1997;15:165–171.
- Howie JGR, Heaney DJ, Maxwell M, Walker JJ, Freeman GK, Rai H. (1999) Quality at general practice consultations: cross-sectional survey. *British Medical Journal* 1999; 319:738–743
- Hugman, R. (2005) *New approaches in ethics for the caring professions*. Hampshire: Palgrave Macmillan
- Hulatt, I. (1995) A sad reflection. *Nursing Standard* 9 22-23 in Private thoughts in public spheres: issues in reflection and reflective practice. In nursing *Journal of Advance Nursing* 36 (4): 512-519
- Hundozi-Hysenaj H, Boshnjaku-Dallku I, (2008) *Journal of Paediatric Neurology* 2008; 6(1):43-6
- Jameton, A. (1992) *Nursing Ethics and the Moral Situation of the Nurse*. Chicago: American Hospital
- Jansen G. J., Dassen T.W. N., Groot Jebbink G., (2005) Staff attitudes towards aggression in health care: a review of the literature *Journal of Psychiatric and Mental Health Nursing* Blackwell Publishing 12:3-13
- Jarrett, L. (2009) *Being and Becoming a Reflective Practitioner: through guided reflection in the role of a spasticity management nurse specialist* a PhD dissertation. London: City University
- Jasper, M. (2009) Using reflective journals and diaries. In Bulman, C. and Schultz, S. *Reflective Practice in Nursing* (4th Ed). Oxford: Blackwell Publishing
- Johns, C. (2010) *Guided Reflection Advancing Practice* 2nd ed. Oxford: Wiley-Blackwell

- Johns, C. (2009) *Becoming a Reflective Practitioner 3rd ed.* Oxford: Wiley-Blackwell
- Johns, C. (2007) Towards Easing Suffering Through Reflection. *Journal of Holistic Nursing* 25(3): 204-210
- Johns, C. (2006) *Engaging reflection in practice a narrative approach*, Blackwell Publishing, Oxford
- Johns, C. (2004) *Being Mindful Easing Suffering* London: Jessica Kingsley
- Johns, C. (2002) *Guided Reflection Advancing Practice*. Oxford: Blackwell Science
- Johns, C. (1998) *Becoming an effective practitioner through guided reflection* PhD thesis, The Open University
- Johns, C. (1995) Framing learning through reflection within Carper's fundamental ways of knowing in nursing *Journal of Advanced Nursing* 95(22): 226-234
- Johns, C. & Freshwater, D. (Eds) (1998) *Transforming Nursing through reflective practice* Oxford: Blackwell Science
- John Paul II (1987) *Sollicitudo Rei Socialis* Encyclical Letter December 30th 1987
[www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/sollicitudo-rei-socialis. Site accessed 1st January 2009]
- Johnsen, S., Cloke, P., & May, J. (2005) Day centres of homeless people: Spaces of care or fear? *Social & Cultural Geography*, 6:787-811
- Jonasdottir, H. (2005) Individual Experiences of Communication with Health Care Providers During Chemotherapy Period My Reflective Stance in a Hermeneutic Study. Paper presented 13th *International Reflective Practice Conference*, Reykjavik, Iceland
- Jones, A. (1999) *Out of sight out of mind homeless women*. York: Centre for Housing Policy University of York
- Jones, B. & Jones, G. (1996), *Earth Dance Drum*. Salt Lake City Commune A-Key Publishing
- Jones, A. & Pleace, N. (2010) *A Review of Single Homelessness in the UK 2000-2010*. University of York: Crisis
- Katz & Mishler (2003) Close encounters: exemplars of process-oriented qualitative research in health care *Qualitative Research* 2003 3: 35 [www.qrj.sagepub.com/content/3/1/35 - accessed 5 July 2012]
- Kearney, M. (1987) *Mortally Wounded: stories of soul pain, death and healing*. New York: Touchstone
- Kearney, R. (2004) *On Paul Ricoeur the Owl of Minerva*. Aldershot: Ashgate Publishing Co
- Kelly M. & May, D. (1982) Good and bad patients: a review of the literature and a theoretical critique. *Journal of Advance Nursing* 7:147-156
- Kieffer, C. (1984) *Citizen Empowerment: A Developmental Perspective*. *Prevention in Human Services*. 84(3): 9-36
- Killian, K. (2008) Working With Trauma Survivors Helping Till It Hurts? A Multimethod Study of Compassion Fatigue, Burnout, and Self-Care in Clinicians *Traumatology* 2008 (14):32
- Kirby, C. & Slevin, O. (2003) Ethical Knowing: The Moral Ground of Nursing Practice. In Basford, L. & Slevin, O. *Theory and Practice of Nursing*. London: Nelson Thornes
- Kirkpatrick, H. and Byrne, C. (2009) A narrative inquiry: moving on from homelessness for individuals with a major mental illness. *Journal of Psychiatric and Mental Health Nursing* (2009) 18: 68-75
- Knott, M. & Latter, S. (1999) Help or Hindrance? Single, unsupported mothers' perceptions of health visiting. *Journal of Advanced Nursing* 30 (3): 580-588.
- Koch, T. & Harrington, A. (1998) Reconceptualising rigour: the case for reflexivity. *Journal of Advanced Nursing* 28: 882 890
- Kralik, D., Koch, T. (2001) Chronic Illness: reflections on a community based action research programme. *Journal of Advanced Nursing* 361:23-31
- Kralik, D., Koch, T., Wooton, K.(1997) Engagement and Detachment: understanding patients experiences with nursing. *Journal of Advanced Nursing* 26:399-407
- Krumer-Nevo M. & Benjamin, O. (2010) Critical Poverty Knowledge: Contesting Othering and Social Distancing in *Current Sociology* 58: 693 58: 693. accessed via Sagepub.com: on April 22, 2011
- Kucera, K., Higgins, I., McMillan, M. (2010) Advanced Nursing practice: a futures model derived from narrative analysis of nurses' stories *Australian Journal of Advanced Nursing* 27(4): 43-53

- Kuo A., Inkelas M., Lotstein D., Samson K., Schor E. & Halfon N. (2006) Rethinking well-child care in the United States: an international comparison. *Paediatrics* 118:1692–1702.
- Lane, R. (2005) *The Road to Recovery; A Feasibility Study Into Homeless Intermediate Care*. London: Homeless Intermediate Care Steering Group
- Landau, J. (2007) Enhancing resilience: Families and Communities as Agents for Change *Family Process* 46(3): 351-365
- Langellier, P. (1998) Voiceless bodies; bodiless bodies: The future of personal narrative performance. In S.J. Daily (Ed.), *The future of performance studies: visions and revisions* (pp207-213)
- Langellier, K. (1999) Personal Narrative, performance, performativity: two or three things I know for sure. *Text and Performance Quarterly* 19:125-144
- Latchford, Y. (2002) New Ways in Health Visiting. In Johns, C., (2002) *Guided Reflection Advancing Practice* Blackwell Publishing, Oxford
- Lather, P. (1986) Issues of Validity in Open Ideological Research: Between a Rock and a Soft Place *Interchange* 17 (4): 63-84
- Lather, P. (1993) Fertile Obsession: Validity after Poststructuralism. *The Sociological Quarterly*. 34 (4): 673-693
- Lathlean, J. (1996) Ethical Issues for Nursing Research: A methodological focus. *N T research* 1 (3):175-183
- Lauer, M. (2008) Replacing the Revolving Door A Collaborative Approach to Treating Individuals in Crisis *Journal of Psychosocial Nursing* 46 (6): 25-32
- Lazzell, P. Transformational Leadership. In Johns, C. (2010) *Becoming a Reflective Practitioner* [third edition]. Oxford: Wiley Blackwell
- Lazenbatt, A., Sinclair M., Hunter, P. & Orr, J. (1999) A strategy to target the health needs of prostitutes. *British Journal of Community Nursing* 4 (4): 167–173.
- Lefebvre, H. & Levert M. J. (2006), Sudden and Unexpected Health Situation: from suffering to resilience. *Illness Crisis and Loss* 14 (4):337-354
- Lemos, G. (2000) *Homelessness and Loneliness*. London: Crisis
- Lindh, I; Barbosa da Silva, A; Berg A and Severinsson E. (2010) Courage and nursing practice: A theoretical analysis *Nursing Ethics* 2010 17:551
- Little, M, Shah R, Vermeulen M, Gorman A, Dzenoletas, Ray J, (2005) Adverse perinatal outcomes associated with homelessness and substance use in pregnancy *CMAJ* 2005;173 (6)
- Linnell, S., James, S. (2010) Involving men in targeted primary health care: men's health MOTs *Community Practitioner*, 83 (5) 31-44
- Logstrup, K.E. (1997) *The Ethical Demand*. London, Paris: University of Notre Dame Press
- Lorde, A. (1980) *The Cancer Journals*. San Francisco: Spinsters
- Lynn, F. (1998) The Pain of Rejection. In Johns, C. (2002) *Guided Reflection Advancing Practice*. Oxford: Blackwell Publishing
- Mackintosh, C. (1998) Reflection: a flawed strategy for the nursing profession. *Nurse Education Today* 18:553-557
- MacNiven-Johnson, G. (2009) *Father Damien*. London: CTS Biographies
- Maguire, N., Johnson, R., Vostanis, P., Keats, H., Remington, R (2009) *Homelessness and Complex Trauma A Review of the Literature*. Southampton: University of Southampton
- Mantzoukas, S. & Jasper, M. (2004) Reflective Practice and daily ward reality: a covert power game. *Journal of Clinical Nursing* 13:925-933
- Manjusvara (2005) *Writing Your Way*. Birmingham: Windhorse Publications Ltd, Birmingham
- Marek, B. (2001) Each Time A New Breath: Buddhism, Art and Healing. In Farrelly-Hansen, M. (Ed)(2001) *Spirituality and Art Therapy Living the Connection*. London: Jessica Kinglsey
- Markos, P. & Stawser, S. (2004) The Relationship between Learning Disabilities and Homelessness in Adults *Guidance and Counseling* 2004; 19(2):46-56
- Marmot, M. (2010) *Fair Society, Healthy Lives* Marmot Review report. London: DH
- Maslow, A.H. (1954) *Motivation and Personality*. New York: Harper
- Mason, M. (2010) Sample, Size and Saturation in PhD Studies Using Qualitative Interviews *Forum Qualitative Social Research* [<http://www.qualitative-research.net/index.php/fqs/article/view/1428/3027> - accessed 5th July 2012]

- Mattingly, C. (1998) *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge: Cambridge University Press
- May, R. (1975) *The courage to create*. New York: Norton, 1975.
- McAllister, M., Creedy, D., Moyle, W., Farrugia C. (2002) Nurse's attitudes towards clients who self-harm. *Journal of Advanced Nursing* 40(5), 578-586
- Merton, T. (1955) *No Man is an Island*. Tunbridge Wells: Burns and Oats
- Michael J. (2008) HEALTH FOR ALL *Report of the Independent INQUIRY into access to healthcare for people with learning disabilities* DH, London
- Miller, A.(2005) *The Body Never lies – the lingering effects of cruel parenting* W., W., Norton and Co., New York
- Mishler, E. (2005) Patients stories, narratives of resistance and the ehtics of humane care: a la recherche du temps perdu. *An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 9(4) 431-451 [www.http://hea.sagepub.com Site accessed July 18 2010]
- Morrissey, M. (2007) Building Bridges [www.howstuffworks.bridges/com.htm. Site accessed 2nd Jan 2006]
- Morrison M.L. (2006) The Life and Work of Elise Boulding: Honouring Women as Peacemakers *Journal of Women and Social Work* 21 2 169-183 [www.http://aff.sagepub.com/content 21 (2):169 Site accessed March 26 2012]
- Morse, J. (2002) Writing my own experience. *Qualitative Health Research*. 2002 12:1159-1160
- Munhall, P. (1993) 'Unknowing': towards another pattern of knowing in nursing. *Nursing Outlook*. 41(3):125-8
- National Homelessness Alliance (1997). In Lemos (2000) *Homelessness and Loneliness The want of conviviality*. London: Crisis
- Navarro J. (2008) *What Every Body is Saying*. New York: Harper Collins
- Naughton, M. & Nolan, (1998) Developing Nursing's future role: a challenge for the millennium. *British Journal of Nursing* 7:983-986
- Newman, J. H. (1957) *Autobiographical Writings* (Ed Tristran, H. New York: Sheed and Ward 1957). New York: Sheed and Ward
- Newman, M. (1994) *Health as Expanding Consciousness* [2nd Edition]. London: Jones and Bartlett
- NHS East of England (2007) *The NHS Commissioning Framework 2008/9*. NHS: East of England
- Nicholls V. (Archbishop) (2011) Faith in Society: Renewing Social Responsibility: A lecture to seminarians at Oscott College Birmingham on 28 March 2011 www.peterjennings.co.uk/faith-in-society-renewing-social-responsibility. Site accessed 28 April 2012]
- Niemeyer, R. A. (1999) Narrative Strategies in Grief Therapy, *Journal of Constructivist Psychology*, 12(1): 65 – 85
- Nouwen, H. (1979/2005) *The Wounded Healer*. London: Darton, Longman & Todd
- Nouwen, H. (2003) *A retreat with Henri Nouwen Reclaiming our humanity*. London: Darton Longman, Todd
- Nussbaum, (1986) cited in Phelan (2005:12) *On Discernment: the wisdom of practice and the practice of wisdom in teacher education* University of Calgary
- O'Donohue, J. (1997) *anamcara Spiritual Wisdom from the Celtic World*. London: Bantam Books
- O'Donohue, J. (2000) *Eternal Echoes Exploring the Hunger to Belong* London: Bantam Books
- O'Donohue, J. (2004) *divine beauty The Invisible Embrace* London: Bantam Books,
- O'Donohue, J. (2007) *Benedictus A Book of Blessings*. London: Bantam Press
- O'Dowd, J. (1992) Five years of heartsink patients in general practice *BMJ*. 1988 August 20; 297(6647): 528–530. In Shaw (2007) Doctors, "Dirty Work" Patients, and "Revolving Doors" *Qualitative Health Research* 2004 14: 1032
- O'Luanagh, P.O. (2002); Baudier and Pallais-Baudier (2005). In Wilson, P. Furnivall, J., Barbour, S.R., Connelly, G., Bryce, G., Phin, L. & Stallard, A (2007) The work of health visitors and school nurses with children with psychological and behavioural problems. *Journal of Advanced Nursing* 61(4): 445-455
- ODPM (2002) *Addressing the Health Needs of Rough Sleepers*. London: ODPM

- ODPM (2003) *More than a roof: progress in tackling homelessness*. London: ODPM
- ODPM (2004) *Achieving Shared Positive Outcomes in Health and Homelessness*. London: ODPM
- ODPM (2005) *Homelessness and Health Information Sheet: Number 4 Hospital Discharge*. London: ODPM
- Okri, B. (1997) *A Way of Being Free*. London: Phoenix
- Parker-Fuller, L. (2003) Audiencing the audience: playback theatre, performance writing and social activism. *Text and Performance Quarterly* 23:288-310
- Pawson, H. (2007) Local Authority Homeless Prevention in England: Empowering Consumers or Denying Rights? *Housing Studies* 22(6): 86-883 Rutledge
- Peckover, S. (1999) Domestic violence: on the health visiting agenda? *Community Practitioner* 71 (12): 408-409.
- Pennebaker, J.W., Mayne, T.J., & Francis, M.E. (1997). Linguistic predictors of adaptive bereavement *Journal of Personality and Social Psychology*, 72, 863–871
- Perkins, S. & Evans, S. (2005) *A Toolkit for Health Needs Assessments*. Bedfordshire: NHS Bedfordshire
- Perlis, R. (2005) Misdiagnosis of bipolar disorder. *The American Journal of Managed Care* 11:S271-S274
- Picard, M. (2004) *Unfolding the Blanket of Understanding in the Listening Space; a phenomenological exploration of 'being-with' in the nursing student-teacher relationship*. PhD Dissertation: University of Maryland
- Picard, C. (1997) Embodied Soul. The Focus for Nursing praxis *Journal of Holistic Nursing*.15.(1): 41-53
- Pinar, W. (1981) Whole Bright Deep with Understanding, Issues in Qualitative Research and Autobiographical method *Journal of Curriculum Studies* 1981 13(3): 173-188
- Platzer, H., Blake, D. & Ashford, D. (2000) Barriers to learning from reflection; a study of the use of groupwork with post registration nurses. *Journal of Advanced Nursing* 31 5 10001-8
- Pleace N. (2002) *Rough Sleepers and Homeless People – Access to General Medical Services Research Findings Register summer number 690:1* www.refer.nhs.uk/View
- Pleace, N. Jones, A. and England, J. (1999) *Access to General Practice for People Sleeping Rough* York: CHP/DH
- Plews, C. Bryar, R. Closs, J. (2005) Mothers Perceptions of Health Visitor Support Received During Home Visits *Journal of Clinical Nursing* 14 (7): 789-97.
- Polkinghorne, D. (1988) *Narrative Knowing and the Human Sciences*. New York: State University Press
- Polkinghorne, D. (1983) *Methodology for the Human Sciences systems of inquiry*. New York: State University Press
- Poulton, B., McKenna, H., Keeney, S., Hasson, F., Sinclair, M. (2006) The role of the public health nurse in meeting the primary health care needs of single homeless people: a case study report. *Primary Health Care Research and Development*, 7 (2):135-146
- Power R., French R., Connelly J., George S., Hawes T., Klee H., Robinson D., Senior J., Timms P. & Warner D. (1999) *Promoting the Health of Homeless People: Setting a Research Agenda*. London: Health Education Authority
- Pritchard J .E. (2005) Strengthening women's health visiting work with women *Journal of Advanced Nursing* 51(3): 236–244
- Public Health Report (2007). NHS Bedfordshire
- QNI (2009) *Briefing: Assessing homeless families' health needs*. London: QNI
- QNI (2007) *Facing the Future A Review of the Role of Health Visitors*. London: QNI
- QNI/HHI (2008) *Homelessness Briefing Spring 2008* Queens Nursing Institute
- Quilgars, D, Johnsen, S. and Pleace, N. (2008) *Youth homelessness in the UK A decade of progress?* Joseph Rowntree Foundation
- Quilgars, D & Pleace, N (2010) *Meeting the needs of households at risk of domestic violence in England: The role of accommodations and Housing related support services*: London DCLG

- Rainer Maria Rilke, (1987). In van Manen (2007) *Phenomenology of Practice Phenomenology & Practice*, Volume 1 (2007) 1:11 – 30
- Rankin, E. A. & DeLashmutt M. B. (2006) Finding Spirituality and Nursing Presence: The Student's Challenge *Holistic Nursing* 2006 24: 282
- RCN (2011) *Spirituality in nursing care - a pocket guide*. London: Royal College of Nursing
- RCGP [Royal College of General Practitioners] NHS Federation (2011) *Managing conflict of interest in clinical commissioning groups*, executive summary. London: RCGP Centre for Commissioning
- Reason, P. & Rowan, J. (1991) Issues of validity in new paradigm research. In *Human Inquiry* (eds (Reason & J. Rowan). Chichester: John Wiley
- Rich, A. & Parker, D.L. (1995) Reflection and critical incident analysis: ethical and moral implications of their use within nursing and midwifery education. *Journal of Advanced Nursing* 22:1050-1057
- Richardson, M. (1997) Participatory research methods: with learning difficulties. *British Journal of Nursing* 6, 1114-21.
- Richardson, L (2000) 'Writing: A Method of Inquiry'. In Denzin N. & Lincoln Y.(eds) *Handbook of Qualitative Research*, pp. 923–48. Thousand Oaks, CA: Sage
- Riessman, C. (2008) *Narrative Methods for the Human Sciences*. London: Sage
- Richardson, L. & St Pierre, E.A. (2005) *Writing: A method of Inquiry*. In Denzin, N. & Lincoln, Y.S. (eds) (2005) *The Sage Book of Qualitative Research*. 3rd ed. London: Sage
- Ricoeur, P. (1985) *Time and Narrative Vol3*. (Trsn Blamey K.& Pellaur, D.[1988]).London: University of Chicago Press
- Ricoeur, P. (1980) Narrative time. *Critical Inquiry*, 7:160–190
- Rifkin, J. (2010) *The Empathic Civilisation* RSA Animate [www.theRSA.org. Site accessed:10 October 2010]
- Robbins, S. (2002) Is your Audience Ready to Hear You? *Harvard Management Communication Letter*, Harvard Business School Publishing Corporation, Harvard
- Robinson, C. (2003) *Healing and Stability: Addressing the needs of Homeless people with mental disorders*. Sydney: university of Western Sydney
- Rokach A. (2008) How Do The Homeless Cope With Loneliness? *Psychology Journal*, 2008, 5 (4): 215-227
- Rolfe, G., Freshwater, D., Jasper. M. (2001) *Critical reflection for nursing and the helping professions*. Hampshire: Palgrave Macmillan
- Rolheiser R., (2006) *Home - the Place from which to Understand* Rolheiser Column Archive 08-13 www.ronrolheiser.com
- Ross, D. (1991) *The Origins of American Social Science*. Cambridge: Cambridge University Press
- Ruddick, S. (1980) Maternal Thinking. *Feminist Studies*. In Belenky MF, Clinchy B., Goldberger N., Tarule J., (1986) *Women's Ways of Knowing, The Development of Self, Voice and Mind*. New York: Basic Books, Harpur Collins, New York
- Rutledge, T. (2005) *Embracing Fear: How to Turn What Scares Us Into Our Greatest Gift*. San Francisco: Harper Collins
- Sandelowski, M. (1991) Telling Stories: Narrative Approaches in Qualitative Research Image: *Journal of Advanced Nursing Scholarship* 23:161-166
- Scanlon, C. & Adlam, J. (2008) Refusal, social exclusion and the cycle of rejection: A cynical analysis? *Critical Social Policy Ltd*. 28(4): 529 – 549
- Schon, D.A. (1983) *The reflective practitioner. How professionals think in action*. Aldershot: Ashgate Publishing Ltd
- Schwind, J. (2010) 16th international Reflective Practice Conference Metaphor Reflections In my Healthcare experience
- Schwind,J. (2009) Metaphor-reflection in my healthcare experience *Aporia: The Nursing Journal* 1, (1): 15-22
- Senge, P. (2006) *The Fifth Discipline; the art and practice of the learning organisation* (Revised Ed.) London: Random House Business Books

- Senge, P., Scharmer, C.O., Jaworski, J., Flowers, S. (2005) *Presence - Exploring Profound Change in People, Organizations and Society*. London: Nicholas Brealey
- Shaw, I. (2004) Doctors, "Dirty Work" Patients, and "Revolving Doors" *Qualitative Health Research* 28 14:1032
- Shelter (2007) *Good Practice Guide: Homelessness Early identification and Prevention*. London: Shelter
- Smith, I. D. (2010) in Fabian Society Policy Report (2010) Hardest to Reach? The politics of multiple needs and exclusions. *Fabian Society Report 63* London: Fabian Society
- Smith, J., M. (2003) *Defining Homelessness: The impact of legislation on the definition of homelessness and on research into homelessness in the UK*. London: Centre for Housing and Community Research
- Smith, E., North, C & Spitzangel, E. (1991) Are hard to interview street dwellers needed in assessing psychiatric disorders in homeless men? *International Journal of Methods in Psychiatric Research*. In Thronicroft G. (Ed) *Measuring Mental Health Needs 2nd Ed* London: Gaskell
- Smith, J. & O'Sullivan, A. (2004) *Longitudinal Research and the evaluation of homelessness interventions in the UK*, Centre for Housing and Community Research. London: Metropolitan University
- Snell, A., Briscoe D., and Dickson G. (2011) From the Inside Out: The Engagement of Physicians as Leaders in Health Care Settings *Qualitative Health Res* published online 22 February 2011 accessed via Sage 30/3/11
- Social Exclusion Unit (SEU) (1998) *Rough Sleeping Report*. London: HMSO
- Social Exclusion Unit (2002) *Reducing Re-offending by ex-prisoners*. London: HMSO
- Social Exclusion Unit (2002a) *Young Runaways*. London HMSO NP 36
- Social Exclusion Unit (2004) *Report on Mental Health and Social Exclusion*
- Sparkes, A. (2002) Autoethnography: Self Indulgence or Something More? In Bochner A. & Ellis, C. (2002) *Ethnographically Speaking* Oxford: Altamira Press
- Spears, L. C. (1995). *Reflections on leadership: How Robert K. Greenleaf's theory of servant-leadership influenced today's top management thinkers*. New York: John Wiley.
- Steinbeck J., (1937) *Of Mice and Men* Bantam Books New York
- Stewart, I & Joines, V. (1987) *TA Today A New Introduction to Transactional Analysis*. Nottingham: Lifespace
- St Basil (2006) Brochure: *Schools Training and Mentoring Project STaMP*. Birmingham: St Basil's
- Street, A. (1992) *Inside Nursing: a critical ethnography of clinical nursing*. Albany: State University of New York Press
- Street, K., Harrington J., Chiang, W., Carins, P., Ellis M., (2004) How Great is the risk of abuse in infants born to drug – using mothers? *Child Care, Health & Development* 30 (4): 325-330, Blackwell Publishing, Oxford
- Sundin, K., & Jansson, L. (2003). "Understanding and being understood" as a creative caring phenomenon: In care of patients with stroke and aphasia. *Journal of Clinical Nursing*, 12: 107-116. In Connor A and Howett, M. (2009), A Conceptual Model of Intentional Comfort Touch *Journal of Holistic Nursing* American Holistic Nurses Association 27 2 June 2009 1
- Social Exclusion Unit (2006) *Reaching Out: An Action Plan on Social Exclusion*. London: SEU
- Social Exclusion Unit (2001) *Preventing Social Exclusion*. London: SEU
- Spry, T. (2001) Performance Ethnography: An embodied Methodological Praxis *Qualitative Inquiry*, 2 (6): 706–732
- Strauss, A. & Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, California: Sage
- Sully, P., Wandrag, M. & Riddell, J. (2008) The use of reflective practice on masters programmes in interprofessional practice with survivors of intentional and unintentional violence *Reflective Practice*. Routledge 9(2):135-144
- Sycamore, R. (2006) *Homelessness and Women in 2006*. London: Homeless Link
- Tamboukou, M. (2011) *Portraits of Moments': Visual and Textual Entanglements in Narrative Research*. University of East London: Centre for Narrative Research

- The Fabian Society (2010) Hardest to Reach? The politics of multiple needs and exclusions. *Fabian Policy Report 63*. London: Fabian Society
- Tilley, S. (1995) Notes on narrative knowledge in psychiatric nursing *Journal of Psychiatric and Mental Health Nursing 2*: 217-226
- Tillman – Healy (2002) *Qualitative Inquiry in to Art History A Tribute to Arthur P. Bochner* [www65.rdlins.edu/~tillmanarthistory.pdf p12 Site accessed 2 March 2009]
- Tolle, E. (2005) *The Power of Now*. London: Hodder and Stoughton
- Universal Nations (1948) *United Nations Universal Declaration of Human Rights 1948* - Article 25:1
- Udris J. (2009) *The Gift of St Therese of Lisieux*. Herefordshire: Gracewing
- UKCC (1999) *Practitioner-client relationships and the prevention of abuse*. London: UKCC
- van Manen, M. (1990) *Researching Lived Experience*. New York: State University Press
- van Manen, M. (2007) *Phenomenology of Practice Phenomenology & Practice*, Volume 1 (2007) 1:11 – 30
- Vickers, M. (1991) Health and Living Conditions of Homeless Families in Oxford City. Oxford: District Health Authority
- Vostanis, P. & Cumella S. [Eds] (1999) *Homeless Children Problems and Needs*. London: Jessica Kingsley
- Wall, S. (2008) -A Critique of Evidence-Based Practice in Nursing: Challenging the Assumptions *Social Theory & Health*, 2008, 6: 37–53
- Walsh F. (2007) Traumatic loss and major Disasters: Strengthening Family and Community Resilience *Family Process 46*(2): 207-227
- Walters, S. (1997) *An Exploratory Study of the Impact of Homelessness on Young Mothers MSc Dissertation*, Nottingham: University of Nottingham, Department of Midwifery Studies
- Warner, R.J. (2003) A Phenomenological Approach to Political Competence: Stories of Nurse Activists *Policy Politics Nursing Practice 2003 4*:135
- Watkins, K.E. Paddock,S .M., Zhang, L. Wells,K.B. (2006) Improving Care for Depression in Patients With Comorbid Substance Misuse *American Journal of Psychiatry 163*:125-132,
- Watson , J.(1997) *The Theory of Human Caring Retrospective and Prospective*. Nursing Science Quarterly 10(1): 49-52
- Watson, J. (2004) In Johns, C. (2004) *Engaging Reflection in Practice*. Oxford: Blackwell Science
- Welldon, E.V. (1988) *Mother, Madonna, Whore: The Idealization and Degeneration of Motherhood*. London: Free Association Books
- Wheatley, M.J. (2002) *Turning to one another: simple conversations to restore hope for the future*. San Francisco: Barrett-Koehler
- Wheatley, M.J. (2005/ 2007) *Finding Our Way: Leadership for an Uncertain Time*. San Francisco: Barrett-Koehler
- Wheatley, M.J. (2006) *Leadership and the New Science. Discovering Order in a Chaotic World* San Francisco: Barrett-Koehler
- Wheatley, M., Kellnor- Rogers M. (1996) *A Simpler Way*, Barrett-Koehler, San Francisco
- While A. E. (1987) The early history of health visiting: a review of the role of central government (1830-1914) *Child: care, health and development*, 1987, 13, 127-136 University of London
- White J. Patterns of knowing: review, critique, and update. *Adv Nurs Sci*. 1995;17(4):73–86.
- Wiklund, L. (2008) Existential aspects of living with addiction - Part 1: meeting challenges. *Journal of Clinical Nursing*, 17: 2426-2434
- Wiklund-Gustin, L. (2010) Narrative Hermeneutics: in search of narrative data *Scandinavian Journal of Caring Sciences* 2010 24:32-37
- Wilber, K. (1998) *The Eye of Spirit: an integral vision for a world gone slightly mad*. Boston: Shambhala
- Wilber, K. (2007) *Integral Spirituality: A Startling New Role for Religion in the Modern and Postmodern World*. Boston: Integral
- Wilkinson, R. & Pickett, K. (2009) *The Spirit Level Why More Equal Societies Almost Always Do Better*. England: Penguin Group
- Williams, R. (1997) Health Visitors ideologies regarding health promotion for men *British Journal of Community Nursing 2* (5): 238 - 248

- Williams, M. & Cheal, B. (2002) Can we measure homelessness? A critical evaluation of the method of 'capture-recapture' *International Journal of Social Research* 5 (4): 313-331
- Wilson, P. Furnivall, J., Barbour, S.R., Connelly, G., Bryce, G., Phin, L. & Stallard, A (2007) The work of health visitors and school nurses with children with psychological and behavioural problems. *Journal of Advanced Nursing* 61(4):445-455
- Wilson, R. & Pickett, K. (2009) *The Spirit Level Why More Equal Societies Almost Always Do Better*. London: Penguin
- Wiman, E. & Wikblad K. (2004) Caring and uncaring encounters in nursing in an emergency department *Issues in Clinical Nursing* 13: 422-429
- Wind, Edgar (1958) *Pagan Mysteries in the Renaissance*. 2nd ed., New York
- Winterson, J. (2001) *The Powerbook*. London:Vintage
- Wisker, G., Robinson, G., Trafford, V. Warnes, M. & Creighton, M. (2003) From Supervisory Dialogues to Successful PhDs *Teaching in Higher Education*, 8 (3): 383-397
- Wong, C. A., Spence Lashinger, H. K., Cummings G. (2010) Authentic Leadership and nurses 'voice' behaviour and perceptions of care quality *Journal of Nursing Management* 18: 889-900
- Woodhouse A (1997) Parents with learning disabilities: does everyone have the right to have children? *Journal of Intellectual Disabilities*. 1 (3):141-146.
- Woolfe, V. (1945) *A room of one's own*. London: Penguin Books
- World Health Organisation (2000) *Munich Declaration: Nurses and midwives: a Force for Health* The Second WHO Ministerial Conference on Nursing and Midwifery in Europe
<http://www.eur.who.int/aboutwho/policy/20010828-4> accessed 27 September 2009]
- World Health Organisation (2006): "Review of Evidence on Housing and Health" - prepared for the Fourth Ministerial Conference in Environment and Health.
- Wright, L. M. (2007) Softening Suffering Through Spiritual Care Practices: One Possibility for Healing Families *Journal of Family Nursing Volume* 14(4): 394-411
- Wright, N. (2002) *Homelessness A Primary Care Response*, London: Royal College of General Practitioners
- Wright, N. & Tompkins, C. (2006) How Can Health Services Effectively meet the health needs of homeless people? *British Journal of General Practitioners* 2006 April 1 56 (525): 286-293
- Zahourek, R.P. (2005) Intentionality: Evolutionary Development in Healing. *Journal of Holistic Nursing*. 23 1 89-109
- Zerwekh, J. (1995) Making the connection during home visits; narratives of expert nurses. *The Hospice Journal* 10: 27-44