

**OLDER WOMEN AND HOMELESSNESS:  
LIVED EXPERIENCES OF ACCESSING SOCIAL AND HEALTH SERVICES**

by

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## **Abstract**

The purpose of this thesis was to explore the experiences of accessing health and social services for older women who have lived experience with homelessness.

Women over the age of 50 with lived experience of homelessness participated in face to face interviews where they were asked to share their experiences with accessing services in the northern British Columbia (BC) community of Prince George.

They spoke about their experiences of loss and identified gaps in, and barriers to, service provision as well as challenging interactions with service providers in the community. They also recounted experiences where services and service provision work well. They shared their hopes for a better future and expressed strength and resilience in the face of many challenges.

Recommendations for incorporating more client centred and trauma informed service provision as well as suggestions for future research are outlined.

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This process has made clear to me the preciousness of relationship and the importance of prioritizing it. We never know how much time we have left to walk on this earth. I have been reminded of this truth often over the last few years.

I've learned that people will forget what you said, people will forget what you did,  
but people will never forget how you made them feel.

-----Maya Angelou  
(greatly admired by my Dad)

To Matyas

I wish you joy and happiness in all that you do. I know that whatever you set your mind and heart on, you will achieve. Be kind and gentle with yourself and others and remember that actions from a place of love go a long way to making things right, just and good. Xo Mom.

## Dedication

### River Run

A river runs through me

A river runs through me that cannot be dammed

A river of grief, loss, pain, loneliness, and fear

A river rich with detritus

A river rich.... runs to the ocean

flashes of

obsidian, red, gold, green, silver,

sluicing, and flowing

feeding the forests around and the waters ahead

A river runs through me that cannot be dammed

It cannot be dammed

because

I will not

stand back from the shore

and let that happen.

-----SLML

June 11th 2017

I dedicate this poem and thesis to women who live at the margins of society. I hope, that in some small way, this research may make some measure of difference.

## **Chapter One: Introduction**

The connection between mental health issues, substance dependence, and trauma is recognized by many health and social service providers, while being intimately understood by individuals affected. There is much literature that discusses this intersection of issues (Mate, 2008; Menzies, 2007, 2009, 2012) and not surprisingly, studies show that women who experience homelessness often have lived experiences with these issues, either at a particular point in time, or repeatedly over the course of their lives (Hopper, Bassuk & Olivet, 2009; Mate, 2008; Menzies, 2007, 2009, 2012).

Awareness of the links between trauma and many issues has led to the concept of “trauma informed practice” and from this knowledge has developed the “trauma informed service” delivery approach. In this research, an attempt has been made to explore how the understanding and knowledge of the interconnectedness of mental health issues, substance dependence, and trauma have been incorporated into practice in northern British Columbia.

The question at the heart of this qualitative exploratory research is “How do older homeless women experience health and social service provision in a northern community?” To explore this fully, the additional question, “What are the health and social services needs of older homeless women in a northern community?” was also asked. In this research a sample of older women who were homeless or had experienced homelessness were interviewed and asked a series of semi structured questions focused around the two main research questions. A thematic analysis of these interviews was undertaken to determine the needs and gaps in service from their perspective. An attempt was made to explore the themes found through a trauma informed lens.

## **Relevance**

### **To Canadian Society**

In Canada, as in many countries in the world today, a demographic shift is underway as the percentage of older individuals continues to expand in relation to the rest of the population (Cummings & McClure Cassi, 2008; Gellis, 2006; Hemingway & McLeod, 2004; Turcotte & Schellenberg, 2007). Paralleling the overall aging demographic, the literature indicates that the number of older homeless persons is also increasing. It is important that planning and preparations take place so that appropriate services and programming are designed to ensure better quality lives for our older population in general, and for the population of focus for this research, older homeless women.

Aboriginal persons in Canada are overrepresented among the homeless population (Menzies, 2007, 2009, 2012), particularly in northern communities, such as in Prince George, British Columbia where this research took place (Pateman, Thandi, & Florey, 2016). Aboriginal people in Canada are left with the legacy of intergenerational trauma stemming from colonization, government and institutional assimilation policies including the Indian Act, the residential school system, the Sixties Scoop, and child welfare policies that continue to this day. Continued systemic discrimination results in the perpetuation of ongoing trauma experienced by Aboriginal people in Canada (Bowen & Murshid, 2016; Brave Heart, 2007; Menzies, 2007, 2009, 2012; Ross, 1992, 1996).

The focus population for this research was older women who have experienced homelessness, and even though the sampling method used was not focused on a specific group or section of older homeless women, a disproportionate number of those who volunteered to be interviewed were Aboriginal women, possibly for the reasons outlined above.

For those who have experienced psychological and intergenerational trauma, the literature points to a strong correlation between trauma, substance dependence, and mental health issues (Bowen & Murshid, 2016; Herman, 1997; Mate, 2008; Menzies, 2007, 2009, 2012; Van Der Kolk, 1987). Structural inequities in society like income disparity and a lack of appropriate health and social programs often exacerbate psychosocial stressors making individuals more vulnerable to mental health, substance use, and physical health issues (Mate, 2008). Many examples of societal and structural inequities are seen which negatively affect older women and include: the continued wage gap between men and women (McLeod & Walsh, 2014), low income, low social assistance and pension rates, a lack of prescription drug coverage, and little access to comprehensive health benefits (Bungay, 2013).

Further contributing realities include inadequate availability of decent, affordable, and safe housing as well as the criminalization of substance use and mental health issues. Rather than ensuring a higher quality of life and well-being for individuals as they age, these can contribute to maintaining the inequity of access to appropriate resources including health and social services. Managing to avoid or escape a cycle of unstable living circumstances, exposure to violence, crime, and poverty can be very difficult. An individual experiencing any or a combination of these issues may end up living at the margins of society and if they are older, female, and of Aboriginal descent, these vulnerabilities can be compounded.

## To the Social Work Profession

A goal of this research was to determine the gaps in, and improvements needed, to the delivery of health and social services, and to make suggestions that might eventually lead to improving the quality of life and wellbeing of older homeless women. As such, this goal fits with a social worker's obligation to honour the inherent worth and dignity of those we work

with, as outlined in the British Columbia Association of Social Workers (BCASW) Code of Ethics (2003) to maintain, work, and advocate for change in the best interest of our clients and for the overall benefit of society. Social workers also have a duty to critically analyze issues to uncover the structural mechanisms leading to the oppression of our clients and to advocate for change to rectify this (Canadian Association of Social Workers (CASW), 2005).

## To Me

My interest in this research topic has its roots in my volunteer and employment experience. I have worked with vulnerable populations in several different parts of Canada and the world and was drawn to becoming a social worker because I saw my values and beliefs reflected in those of the profession.

In recent years, I have worked as a social worker in a health care setting which has been involved in an ongoing study looking at ways to reduce barriers to care faced by vulnerable people. In a process of ongoing evaluation, the organization critically examines how it provides care and looks at ways to improve its services, working to become ever more client centred and towards the goal of equity in health care (Browne, Varcoe & Fridkin, 2011; Browne et al., 2012). This involves staff discussion and education around ways of imbedding cultural safety and trauma informed approaches into the services provided. I believe these are critical goals that each provider of services to vulnerable people likely intends, and should strive, to provide.

Service users I work with tell me of the daily challenges they face being homeless and living in poverty, including the difficulties they meet while accessing services in our community. I marvel at and admire the survival skills and resiliency that service users reveal in their stories. I was interested to know if their experiences were being heard, understood, and integrated into the social and health care services provided to them in our community. I

have been curious about the need for effective integration of service users' perspectives for some time, and was keen for the opportunity to explore this question with a subset of the homeless population: older women who have experienced homelessness.

It is important to me to be involved in working towards greater social justice and equity, to make positive change for individuals, society, and the world. I think it is critical that individuals have a right to self-determination and to be consulted about the services they receive. This meshes with my desire to continue to advocate and try to be an ally in working towards accessible, fair, respectful, non-judgmental, culturally, and trauma informed service provision.

### **Need for This Research**

The literature reviewed for this research confirms the need for further exploration of the topic. Davis-Berman (2011) explains the need for more in depth detailed reports and studies of the experience of being older and homeless that include the perspective of those who are homeless themselves. Salem and Ma-Pham (2015) identify that research on older women and the homeless shelter system is limited and more is needed. McLeod and Walsh (2014) recommend further studies on the trajectory of older women's homelessness for the first time at older age, and on further aspects of aging and homelessness with regards to health accessibility, access, and use of income supports. Bowen and Murshid (2016) call for the extension of trauma informed practice and service provision to include the incorporation of a trauma informed framework lens when addressing or developing wider social policy. They suggest that this is particularly relevant when working with vulnerable populations where there are trauma histories which include: crime, violence, homelessness, substance dependence, and chronic disease. This change in approach would recognize that issues of race, social class, gender, age, sexuality, and ethnicity intersect, and that these multiple

marginalizations and vulnerabilities are predictors of trauma experience. Such an approach would acknowledge the connection of trauma with many health and social problems for which people seek services. These recommendations from the literature underpin my rationale for choosing the topic for my research and for using a trauma informed lens through which to view the data collected and to assist in framing and determining the themes of the data analysis.

### **Researcher Social Location**

I come to the research from a position of privilege as a white employed middle class, educated settler woman and mother. I am not an older person by the Canadian government's definition, nor do I have a diagnosed mental illness or substance dependence issue (Appendix A Definitions). I have always had stable housing, adequate access to food, clothing, finances, social, and health services and I have never experienced homelessness. However, I am an upper middle aged woman and have some degree of understanding, from personal and work experience, of trauma, substance dependence, and mental health issues. However, even with this experience, I readily acknowledge that I cannot fully comprehend these issues in the same way that the participants of this research, older women who have experience with homelessness, will know and understand this reality.

As an outsider researcher, I do not know the experience of older women who have lived homelessness, but I wanted to avoid the tendency of western research towards "problematizing the indigenous" (Smith, 2004, p. 91). I wanted to attempt to avoid power imbalances and disempowering the women who I hope may ultimately benefit from this research or, as Merata so aptly describes, I wanted to avoid doing observer type research or the type of research where researchers are "the ones doing the looking ...giving themselves

the power to define” (Smith, 2004, p. 58). My goal in undertaking this research was to strive to be an ally (Bishop, 2002), by being aware of my research methodology and the potentially disempowering elements of this research process to participants. In addition, my hope was to facilitate the opportunity for older women who have experienced homelessness to have a voice, influence and power over how services are designed and delivered to them, in a client centred, culturally sensitive, and trauma informed way. My intent was to include individuals in the research and results while balancing the practical element of doing research within a limited timeline and level of complexity expected of a master’s thesis.

### **Theoretical Position**

I see the issue of homelessness, trauma, and aging through a social justice, anti-oppression, and structural social work lens (Mullaly, 2010). Trauma and its effects are social problems which can lead to multiple issues. Our current socio-economic system discourages the recognition and acceptance of societal responsibility for “the individual’s problems”, and the structural systems in place that contribute to issues such as substance use, mental health issues, and homelessness. Often individuals facing these issues experience exclusion and discrimination by others who may think that people facing these issues are at fault and have brought the problems on themselves. Often individuals feel guilt and blame themselves. Both blaming the “other” for their situation or internalizing this blame are forms of oppression (Mullaly, 2010).

My hope and intent in undertaking this research was to do so in an anti-oppressive manner. Sakamoto and Pitner (2005) sum up this concept when they say that anti-oppressive projects should involve addressing the needs and strengths of the service users and most importantly must “critically challenge the power dynamics in the service-provider/ service-user relationship” (p. 435). Any intervention or form of assistance that takes the power away

from the person, by not involving them in decision making, design, or planning is not helpful to the individual and could be detrimental. According to Herman (1997), it is clear that recovery will only result from the empowerment of the survivor of trauma. There is usually an inherent power differential between service providers and service users because one group has access to resources and the power to provide them to another group of people who need them. This system in and of itself is disempowering if it results in providers making decisions about what and how they will provide service without consulting service users. Service users can be left feeling unheard and undervalued having been unable to express their opinions and needs. My work experience has shown me that people who are marginalized are survivors, are resourceful and have strengths and assets that are often unacknowledged in social services and policy making (Norman & Pauly, 2013; Sakamoto et al., 2008; Saleebey, 2006). This research attempts to be empowering by listening to, and sharing, the experience of service users.

## Overview

Within this thesis, the key concepts relevant to the research question and topic are defined and discussed. These include the population of focus in this research: homeless, older women. Substance dependence, mental health, and trauma issues often affect health and wellbeing and can lead to the need for health and social services with this population. Several of these terms are more fully defined in Appendix A. These issues and their connection to the need for client centred and trauma informed practice and service provision are also defined and explored in the literature review. In addition, the research design and the lens through which my research was conducted, are explained. The thematic analysis process and findings are discussed; personal reflections about the process as well as some of the challenges and

limitations of the research are reviewed; and finally plans for knowledge transfer and recommendations for practice and further research are outlined.

## **Chapter Two: Literature Review**

### **Homelessness**

In the first half of the twentieth century in the United Kingdom and United States, most homeless persons were middle aged and older men with two thirds being over the age of 50 and a quarter over the age of 60. The profile of homelessness began to change in the 70s and 80s when more young people and women began to be identified among homeless individuals (Crane & Warnes, 2010).

In Canada, the problem of homelessness emerged in the public consciousness as a serious social issue in the 1980s and 1990s, at a time when government spending on new social and affordable housing projects was substantially reduced. Many communities responded to the issue by setting up emergency services such as shelters, food banks, soup kitchens, and day programs, usually run by non-profits, charitable organizations, and churches. Though initially intended to be temporary solutions, charitable and non-profit services are now heavily relied upon in our communities by those in need and even by our governments, who often expect people to access these service organizations prior to government assistance. Sundin and Baguley (2015) indicate that the numbers of homeless people in the Western World have either remained stable or risen over the last decade. This can be attributed to growing structural inequities resulting in lowered incomes, higher levels of unemployment, poverty, and unmanageable housing costs (Crane & Warnes, 2010; Sundin & Baguley, 2015).

While important in crisis situations, stop-gap solutions, like homeless shelters, are not viable civilized long term solutions to homelessness. Shelters offer very little privacy or quiet space and often have no place to keep personal possessions safe. It is very difficult to address mental health or substance dependence issues, look for employment or seek permanent

housing while staying in such a setting. When people are homeless their ability to stay well is compromised and they often become more marginalized and street entrenched making it more and more difficult to get off the street and out of the cycle of homelessness (Gaetz, Gulliver & Richter, 2014; Londerville & Steele, 2014).

On a positive note, making available a variety of permanent affordable, safe, and appropriate housing options to individuals has been demonstrated to have positive outcomes and seems to hold promise as a way forward in addressing homelessness in Canada (Gaetz et al., 2014). Many hopes are pinned on our current federal government (elected in Fall 2015) and the efforts of the Housing First Initiative to bring a change of focus, investment in subsidized housing and programs that will help to alleviate current homelessness. Among communities which have made the issue central, Medicine Hat, Alberta claims to have eliminated homelessness entirely. They are being looked to with optimism as an example of the positive outcomes of taking an approach which makes housing a priority for all (Canadian Broadcasting Corporation [CBC], 2015). However, it remains to be seen if older women's homelessness will be served by this government initiative since women often experience more complex homelessness (Gaetz et al., 2014; Klassen, 2015). Given that the Housing First focus is on chronic and episodic homelessness, "it is quite likely that many women experiencing hidden homelessness will be left out of the equation" (Klassen, 2015).

### **Older in Canada**

People in western industrialized countries are generally living longer lives influencing how aging is perceived as well as defined. Richardson and Barusch (2006) note that as people continue to live longer the age at which "midlife" and "late life" are considered to

begin is being pushed back. The authors suggest that the new midlife may soon be deemed to begin at around 50 and late life at 70.

The total number of Canadians who will be older than 65 is expected to steadily increase and by 2036 the number of persons 65 and over is estimated to reach approximately 11.5 million which will represent 27.2% of the total projected Canadian population at that time (Turcotte & Schellenberg, 2007).

In addition to people living longer, they are healthier, and financially better off today on average, than aging persons of previous generations (Minister of Public Works and Government Services Canada, 2002, 1998). However, there are substantial disparities between regions, communities and individuals within Canada and within British Columbia. Many older persons in Canada, Aboriginal people, people with disabilities, and women, in particular, live in poverty.

### **Older Women**

Although the gap in life expectancy has begun to narrow and is expected to continue to do so over the coming years, women continue to live longer than men in Canada on average (Richardson & Barusch, 2006; Turcotte & Schellenberg, 2007). It is estimated that those 80 years of age, or the oldest old, will equal 3.1 million persons in Canada by 2041. In general, the older an individual is, the more likely they are to be a woman, live alone, live in poverty and have health-related problems (Minister of Public Works and Government Services Canada, 1998; Ministry of Public Works and Government Services Canada, 2002; Turcotte & Schellenberg, 2007).

### **Older Aboriginal Population**

Overall the Aboriginal population is much younger than the non-Aboriginal population in Canada and this trend is likely to continue for some time. In 2001, more than 976,000 Canadians reported they were Aboriginal and of these 4% or 39,600 were Aboriginal seniors (65 years of age or older) (Turcotte & Schellenberg, 2007). Life expectancy among Aboriginal people is lower than the Canadian average at 68.9 years for status males and 76.6 years for status females, differences of 8.1 years and 5.5 years respectively (Minister of Public Works and Government Services Canada, 2002; Statistics Canada, 2015). Aboriginal people continue to represent a large percentage, and often make up the majority, of rural and remote populations, particularly in the northern regions of Canada (Turcotte & Schellenberg, 2007).

### **Aboriginal Homelessness**

Aboriginal people are more likely to experience homelessness than the rest of the Canadian population (Belanger, Weasel Head & Awosoga, 2012; Gaetz et al., 2014; Patrick, 2014). They face ongoing systemic and overt racism and discrimination in addition to experiencing the effects of intergenerational trauma. As a group, Aboriginal people in Canada experience higher levels of poverty, domestic violence, poorer health outcomes, and face systemic and structural violence, and discrimination when accessing services, employment, and housing. All of these factors contribute to the high numbers of Aboriginal persons experiencing homelessness in Canada (Gaetz et al., 2014).

### **Older Homelessness in Canada and Prince George**

Though the literature does not list exact numbers, older persons represent a minority among the homeless population in Canada. However, this should not lull us into thinking that

this is not a serious social issue as it is probably due to higher mortality rates and shorter lifespans among those who are homeless. The average lifespan of 39 years is likely the result of poor living and lifestyle circumstances among those who are homeless (Barken et al., 2015; Trypuc & Robinson, 2009). Estimates are that 6% are over the age of 65 and 9% are over the age of 55 (Barken et al., 2015), still a significant number, and one that is increasing as the size of our older population continues to grow (Barken et al., 2015; Crane & Warnes, 2010; Edmondston & Fong, 2011). In Vancouver 212 people aged 55 years or over were identified as being homeless in 2008 compared with 51 in 2002, and in Edmonton, the numbers increased from 81 in 2000 to 306 in 2008 (Crane & Warnes, 2010). A homelessness count conducted in Prince George, BC, in 2016, revealed that 69% of those who were considered homeless self-identified as being Aboriginal; 47% of those counted were between the age of 45 and 74 and, of this number, 16.6% were women. Of note, 25.8% of the total homeless population were between the age of 55 and 74 and 6.4 % of this number were women (Pateman et al., 2016).

### **Manifestations of Trauma**

As a result of experiencing trauma, a person may have a sense of helplessness at being a victim which may undermine their sense of well-being and their ability to trust (Herman, 1997; van der Kolk, 1987). Many can integrate this experience and move forward with their lives but often trauma leaves lasting and profound effects and many of these consequences can be debilitating, at least for a time. Trauma can be a result of, or end up resulting in, an absence or breakdown in secure stable nurturing connections to others. Herman (1997) and Mate (2008) indicate that human connection is the basis for healthy personality development and, if damaged due to trauma, can have serious and lasting

detrimental effects on an individual. A person's degree of resiliency to stress and trauma is likely dependent on several factors including personality traits, the existence and quality of a social support system, and the incidence, frequency, and severity of the trauma experienced (van der Kolk, 1987). Everyone reacts differently to stressful events but exposure to traumatic events is often associated with emotional, psychological and sometimes even physical health problems as well.

Though the effect of trauma on individuals varies widely, the literature has identified some common characteristics. Survivors of trauma may have difficulties with concentration and focus. They may experience flashbacks and nightmares about their trauma experience. In addition, they may feel a sense of loss of control, helplessness and vulnerability along with difficulty trusting others. Survivors of trauma may develop problems with low self-esteem, mental health issues including depression and anxiety, social isolation, self-stigmatization, hyperarousal, frequent irritability, or some may be emotionally numb and detached. In some cases, survivors experience dissociative states that include memory loss of some, or all trauma experience. On the other hand, there may be a continuous reliving or ruminating on the experience. Some may react with a tendency towards unsafe coping mechanisms or risky lifestyles, including substance use (Gitberg & Van Wyck, 2004; Herman 1997; van der Kolk, 1987). Anda et al. (2006) and Bowen and Murshid (2016) refer to the literature which has linked childhood traumatic experiences with physical, mental health and substance use issues in adult and later life, as well as earlier age of mortality.

In addition, there is now some scientific evidence which seems to show that trauma can be passed on genetically from one generation to another ("epigenetic inheritance") as reported in a study conducted by Rachel Yehuda and her team at Mount Sinai Hospital with 32 Jewish Holocaust survivors and their children (Thomson, 2015). This study may have

particular relevance to the Aboriginal population in Canada and their experience of intergenerational trauma, and this study, given the number of participants who identified as being Aboriginal or First Nations.

### **Trauma and Substance Use Issues**

Van der Kolk (1987) suggests that in trauma there is a very close relationship and interdependence between psychological experiences and physiological reactions. This can explain the strong connection that has been made between trauma and substance use issues (Mate, 2008; Menzies, 2009; Savage, Quiros & Dodd, 2007). Studies reveal that an inordinately high percentage of people with substance use issues have experienced childhood trauma. Nearly two thirds of heavy injection drug users report that they experienced childhood trauma (Mate, 2008). Exposure to trauma can reduce our resilience to and tolerance of stress. However, substances may temporarily help people to cope by dulling the emotional and physical sensations they may have in reaction to it. It is not uncommon for people with substance use issues to explain that they use to numb or soothe the pain; often emotional and possibly trauma related in root cause, but which can manifest itself in physical health issues such as chronic pain (Mate, 2008). It can be argued that the act of using substances, in and of itself, can lead to trauma since it can be a precursor to violence, criminal activities (sometimes undertaken to procure a substance) or traumatic accidents, because of the effects of substance use.

There is some reference in the literature to the connected incidence of trauma and chronic pain. An example refers to a study looking at the incidence of pelvic pain of unknown cause among women which discovered that a substantially large number of patients experiencing pelvic pain had experienced sexual and or physical abuse as children and adults (van der Kolk, 1987). In addition, an article by Otis, Keane and Kerns (2003) notes the close

relationship between chronic pain and Post Traumatic Stress Disorder (PTSD). In a study of US Veterans, the co-occurrence of PTSD and chronic pain was frequently observed. Those who experienced both conditions tended to have increased severity of one or the other issue or even both conditions in combination.

From personal observation, and within the addictions community, it is widely understood that withdrawal from some substances, particularly from opiates, can result in intense and substantial physical pain, which can also translate into frequent or chronic experiences with pain. It would seem plausible to suggest that substance abuse, trauma and chronic pain likely intersect (Browne et al., 2011; Otis et al., 2003). In addition, the concept can be extended to the idea that there is an interconnection between pain and trauma to older persons if there is an intersection seen among younger people with these issues.

### **Trauma and Aboriginal Peoples**

Aboriginal peoples are often among the most marginalized people in the north, in BC and in Canada. Ross (1992) explains that the residential school system was the final statement of the Canadian government in dismissing Aboriginal culture. Taking Aboriginal children away from their home communities and families to residential schools was devastatingly traumatic to Aboriginal communities (Ross, 1996). As deVries (1996) notes, culture is a strength and a protective and supportive force for people, and the disruption of culture with its knowledge, values, spirituality, and lifestyle can be very detrimental to members of the cultural group. Trauma not only shakes the foundation for the individual, but it can also alter an entire cultural system. The result of this form of cultural trauma is being witnessed today among Aboriginal people. Menzies (2009) points to the intergenerational trauma history of Aboriginal people in Canada as a cause of substance and mental health issues resulting in high rates of homelessness among urban Aboriginal men.

## **Trauma and Older Persons**

Much of the early research on trauma was done with WWII, and Vietnam War veterans and Holocaust survivors. Studies indicate that in some cases trauma effects can be virtually absent or unrecognized for years and then the process of aging can trigger the symptoms of trauma and PTSD (Aarts & Op den Velde, 1996; Coleman, Hautamaki & Podolskij, 2002). There is also some evidence to indicate that those with a history of trauma have a greater risk and incidence of somatic illness and dementia in their later years (Qureshi et al., 2010).

## **Substance Use and Older persons**

Use of substances can be relatively innocuous and is sometimes reported to have beneficial health effects for older persons, such as alcohol's purported blood pressure and cholesterol lowering, antioxidant, and relaxation effects (Richardson & Barusch, 2006). In some cases, substances such as prescription medications are necessary to treat acute or chronic health conditions such as infections, or for symptom management and pain control. However, moderation is important and under certain circumstances, most commonly in the case of pain management, substances can end up being misused or individuals can become dependent upon them. This dependence can sometimes occur very gradually without an individual recognizing it until they stop using a substance, such as when a prescription medication runs out.

Alcohol is the substance most frequently used by, and the cause of the most negative consequences arising from substance use for, older individuals. Estimates vary widely, indicating that between 3-25% of older persons drink heavily with possibly up to 15% having an issue with "problem drinking." Even higher rates are reported in nursing homes and retirement communities where as many as 49% of residents may have a problem with alcohol

dependence (Richardson & Barusch, 2006). After alcohol, prescription drug use among older persons is the second leading cause of problems stemming from substance use (Richardson & Barusch, 2006).

Research shows that older women are more at risk for problematic prescription drug use than men, particularly in connection to the use of benzodiazepines. This may lead one to query if there is still a tendency, as there was historically, to over-prescribe psychoactive drugs to women. Withdrawal from these types of medications can be particularly difficult and cause serious consequences such as increased depression and anxiety resulting in higher risk for suicidal ideation (Richardson & Barusch, 2006).

Substances and substance use can have cultural significance, and in addition to being an important part of some ceremonies and rituals, the interpretation and perception of problematic use is a social construct, and as such, is highly variable from place to place and among ethnicities, religions, and individuals. Within the context of this research, substance use is of concern when it begins to have detrimental effects on the physical, emotional, and cognitive functioning of an older person (Mate, 2008).

### **Effects of substance use on older persons.**

Some of the resulting detrimental effects of substance use for older persons can include health issues such as; malnutrition, anemia, pancreatitis, gastritis, increased possibility of falls (and resulting bone breakage, which can have a domino, and life threatening, effect on health), motor vehicle accidents, vulnerability to illness due to lowered immunity, chronic disease, decreased cognition, memory decline, and mental health issues such as anxiety and depression among a host of other problems (Gellis, 2006; Richardson & Barusch, 2006). In addition, dependence on a substance can make older individuals vulnerable to all types of abuse and can result in the breakdown of important support

networks and relationships, leading, in turn, to increased levels of isolation, loneliness, inactivity, and difficulty keeping up with daily responsibilities including medication adherence and payment of bills, such as rent.

### **Mental Health Issues and Older Persons**

As the Canadian population ages, larger numbers of individuals with mental health issues will be living longer, and more resources will need to be allocated to assist these persons to have healthy, enjoyable lives (Gellis, 2006; MacCourt, 2008). The DSM-5 (American Psychiatric Association, 2013) defines mental disorders as those seriously impacting and hindering the social, occupational or other important areas of functioning, and is a very similar definition to the one for substance use issues.

Current estimates are that between 15-25% of older adults are living with a mental health issue. Some estimates are that at least 25% of older persons are living with depression and 20% with anxiety. Elevated rates of suicide exist among the very old, particularly among men, and are often a result of late onset depression (Gellis, 2006). It is recognized that older persons are chronically underserved by mental health services for assessment and treatment (Aarts & Op den Velde, 1996; Gellis, 2006; Richardson & Barusch, 2006).

Growth in demand for services is anticipated because of the increasing numbers of mental health issues identified among older individuals. This may be due to more consistent assessment and increased acceptance of mental health problems within society and among older individuals due to public education efforts aimed at reducing the stigma of mental health issues (Gellis, 2006; MacCourt, 2008). As with substance use disorders, an important consideration when working with diverse populations is the idea that the concept of mental health issues or disorders is a social construct. What is considered to be a mental health issue can vary depending on location and cultural context (Littlewood, 2002).

### **The Path to Homelessness for Older Women in Canada**

There is a strong consensus that many of the causes of homelessness are a result of structural inequities (Novac, Brown & Bourbonnais, 1996) and interlocking oppressions existing in society. From a feminist and structural social work perspective, the intersection of multiple layers of oppressions in society, like sexism, heterosexism, ageism, classism, and racism, contributes to older women becoming and remaining precariously housed or homeless (Allen, 2016; Zufferey, 2009).

Many more adult men report being homeless than do women. However, the literature reports that this is not necessarily a true reflection of the prevalence of homelessness or precarious housing for women, but may be indicative of the fact that women's homelessness takes different forms and is underreported. This may be because of its often more episodic and hidden nature due to strategies women use to avoid outright homelessness like couch surfing or exchanging sex for food and accommodation (Novac et al., 1996; Salem & Ma-Pham, 2015; Sikich, 2008). Homelessness may be less visible due to women's purposely hiding to seek safety in escaping intimate and partner or domestic violence (Novac et al., 1996). Women often end up having to choose between living with violence at home and violence on the street (Klassen, 2015). Women may not engage with emergency and social support services to the same extent that men do (Gaetz et al., 2014), for a variety of reasons, including concerns around personal safety and victimization in addition to inappropriate service availability and provision.

Homelessness is more often a first-time experience for older homeless persons (Crane & Warnes, 2010; Davis-Berman, 2011) and often results from economic and personal crisis or from an accumulation of issues and lack of social supports as well as fundamental structural issues. Some causes of homelessness among older persons are similar between

genders such as family conflict and breakdown, substance use and mental health issues, and financial problems. However, the literature indicates that more women than men become homeless for the first time in later life, making this an important gendered and age related social issue regarding this demographic (Cohen 1999; Crane & Warnes, 2010; McDonald, Dergal & Cleghorn, 2007; McLeod & Walsh, 2014). Tutty, Ogden, Giurgiu and Weaver-Dunlop (2014) also suggest that the experience of homelessness and risk of homelessness is gendered. For women homelessness is a result of interlocking oppressions that result in women's increased vulnerability to issues of power leading to greater marginalization (Zufferey, 2009; 2017). The intersection of vulnerabilities such as intimate partner abuse, substance use issues, mental health issues, being a visible minority and having been institutionalized in a prison or facility can all lead to homelessness.

The literature identifies some causes for first time homelessness for women over the age of 50: widowhood (Salem & Ma-Pham, 2015; Washington & Moxley, 2008), sudden rapid deterioration of health, domestic violence and interpersonal conflict, moving to a new community, job loss, family member abuse and neglect, and criminal justice system involvement (Davis-Berman, 2011; McDonald et al., 2007; McLeod & Walsh, 2014; Salem & Ma-Pham, 2015). Facing any of the above situations, complicated by having little or no income, can make it extremely difficult to secure safe and affordable housing. As a result, older women may end up facing the dilemma of having to choose between essentials such as medication, transportation, food, or paying rent (Callaghan, Farha & Porter 2002; Kozak & Hemingway, 2010; McLeod & Walsh, 2014).

This research views the issues of service provision through a trauma informed lens and the path that has led older women to homelessness was looked at from this perspective. The literature indicates that for most women of all ages, oppression and trauma in some form,

have played a part in their lives and a role in their experience with homelessness. In many cases, women may not actually recognize that they are survivors of trauma due to trauma's having been such a regular or "normalized" part of their lives (Covington, 2012). The traumas homeless women have been exposed to may include: structural trauma resulting in poverty and violent traumas from emotional, sexual, physical abuse, crime, and intergenerational trauma, especially in the case of Aboriginal women.

### **Poverty as Structural Trauma**

The literature indicates that 30% of unattached women age 45 to 54 and 40% of women 55 to 64 fall below the low-income cut-off in Canada (Collin & Jensen 2009; McLeod & Walsh, 2014). It is often the structural inequities women are subjected to throughout their lives that result in more women than men living in poverty in Canada (McLeod & Walsh, 2014). These inequities include the ongoing wage gap between women and men and the fact that 60% of Canadians earning minimum wage are women (McLeod & Walsh, 2014; Townson, 2009). Women are more likely to have part time employment and the literature indicates they are more likely than men to spend 30% or more of their income on shelter costs (McLeod & Walsh, 2014; Williams, 2010). Historically, women have often been the stay at home caregivers of young children, older, and ill family members, with little or no financial recognition of this as work and little compensation through government pension plans or employment insurance programs (Ivanova, 2017). Finally, the structural marginalization and oppression of older women due to sexism, racism, and ageism (Salem & Ma-Pham, 2015) contribute to the higher rates of poverty and homelessness they experience.

### **Violence as Trauma**

The relationship between violence and homelessness for women is often very complex. Rates of physical and sexual abuse, in childhood and in adulthood, are high among

homeless women (Novac et al., 1996). Often women may experience homelessness as a result of fleeing violent and abusive living situations (Klassen, 2015; Novac et al., 1996). A resulting unfortunate irony is that often women may form intimate relationships with people to protect themselves from violence, and then these relationships, in turn, end up being abusive. Ultimately, the realities of homelessness put women at increased risk for being exposed to violence (Novac et al., 1996).

As noted earlier, the literature points to a link among mental health, substance use issues and trauma experienced in childhood and adulthood (Callaghan et al., 2002; Crane & Warnes, 2010; Hecht & Coyle, 2001; Kisor & Kendal-Wilson, 2002; McLeod & Walsh, 2014). Studies link traumatic childhood experiences such as abuse and domestic violence with mental, physical health, and substance use issues in adulthood. In a study by Cook, Pilver, Dinnen, Schnurr and Hoff (2013), women who were physically or sexually assaulted decades earlier, report significant mood and anxiety disorders into late adulthood. In addition, the literature indicates that those who have experienced trauma have higher than average rates of adult mortality (Anda et al., 2006; Bowen & Murshid, 2016).

Women of all ages who live in poverty are more likely to be victims of physical and sexual assaults (McLeod & Walsh, 2014; Pavao, Alvarez, Baumrind, Induni & Kimerling, 2007; Wenzel, Tucker, Elliott, Marshall & Williamson, 2004). In addition, having mental health or substance use issues and being street involved increases the risk for women to be victims of all types of violence (Kushel, Evans, Perry, Robertson & Ross, 2003; McLeod & Walsh, 2014; Wenzel et al., 2004). Older homeless women are at particular risk as they are more likely to be exposed to physical and sexual violence and other crimes, such as theft, than men of the same age (McLeod & Walsh, 2014).

Such issues can contribute to a progressive decline in quality of life with age, making older women increasingly more vulnerable to economic downturn, health care and housing costs, which in turn, can increase the risk of exposure to violence and abuse of all types. These factors as well as the intersection of ageism, poverty, sexism, and racism lead to the growing international issue of persons becoming homeless for the first time in their older years (Barken et al., 2015; McLeod & Walsh, 2014; Minister of Public Works and Government Services Canada, 1998; Morris, Judd & Kavanagh, 2005). As our population ages, we can anticipate that more individuals will be identified as having a history of trauma and there will likely be an increasing need for resources and services to address the complex issues that result.

### **Homelessness as Trauma**

It can be argued that the state of being homeless, with its chaos, upheaval and uncertainty, is itself a traumatic experience (Lewinson, Thomas & White, 2014). As well, it is known that most women who are homeless have experienced trauma from interpersonal or intimate violence, sexual or physical abuse (Hopper et al., 2009; Lewinson, et al., 2014; Rayburn et al., 2005; Yeater, Austin, Green, & Smith, 2010) and that the risk of further exposure to violence increases once women have become homeless (Dietz & Wright, 2005; Goodman, Saxe, & Harvey, 1991.; Lee & Schreck, 2005; Lewinson, et al., 2014; Novak, 1996).

### **Older Homeless Women**

Though many have lived their lives at the margins of society, sometimes homelessness is a relatively new experience for older women who find themselves in the situation. For some, dealing with social services and with shelter systems can be unfamiliar

and overwhelming. Systems are often not set up to appropriately and adequately meet the needs of older homeless women (Sikich, 2008). Lengthy waits for help for services and chaos in the shelter systems can be very difficult for this population to negotiate. A study by Davis-Berman (2011) indicates that older women may find shelter systems noisy and intimidating, finding it stressful and difficult to be housed with younger women. They may worry about potential conflict, find the verbal and physical aggression in shelters difficult, and see staff as disrespectful as well as lacking compassion. For multiple reasons, older homeless persons may also have difficulty trusting service providers (Mackelprang et al., 2014). For the above-mentioned reasons and out of fear for their own safety, many older homeless women avoid the shelter system (Davis-Berman, 2011).

Some barriers around health care for older homeless persons are noted in the literature and include not knowing where to go for services, long office waits to get care, lack of money, and transportation to and from health services (Lewis, Anderson & Gelberg, 2003; Salem & Ma-Pham, 2015). Older persons can have unique health needs and these can be exacerbated by homelessness (Salem & Ma-Pham, 2015). Challenges faced by older homeless persons can include difficulty with managing chronic health conditions, safely and securely storing medications and belongings, as well as accessible and appropriate medical care. Difficulty obtaining healthy, appropriate and adequate nutrition, and physical activity (Salem & Ma-Pham, 2015) is of particular relevance for those with existing chronic health issues, like diabetes, but also important for the prevention of illness. In addition, older homeless persons are at increased risk for falls and injuries, and for the growing problem of Sexually Transmitted Infections (STIs) among older persons (Salem & Ma-Pham, 2015). In addition, substance use issues can be more serious and can lead to their own set of unique complications among older homeless individuals (Davis-Berman, 2011; Dietz, 2009).

## **Service Needs**

The literature strongly supports the development of specific services for older homeless adults, as well as indicates that programs housing low income older populations often do not meet their specific needs (Cohen, 1999; McDonald, Donahue, Janes & Cleghorn, 2006; McLeod & Walsh, 2014; Sikich, 2008). Suggestions are that services should include designing shelters to meet the specific needs of this growing population which separate the older homeless female population from the younger, intensive case management to assist older homeless persons with income, social assistance and housing issues in addition to training of shelter and other service provider staff around the specific needs of, and ways of, working appropriately with older homeless persons (Davis-Berman, 2011).

Older homeless women report that one of the most important things for them in regards to shelter stays are their relationships and interactions with the staff. Staff who are non-judgmental and compassionate as well as services with the option to meaningfully participate, are identified by older women shelter users as making a positive difference in their experience. The importance of respect between service user and service provider has been identified in the literature as being critical to this population (Hecht & Coyle 2001; McDonald et al., 2006; McLeod & Walsh, 2014). Also reported as important to homeless women is the desire for autonomy and decision making power, which many say was lost when they became homeless (McLeod & Walsh, 2014; Novak et al., 1996).

## **Trauma Informed Practice and Services**

The literature indicates that trauma informed practice is becoming more widely understood and utilized. Stemming from the research around Post Traumatic Stress Disorder (PTSD) first identified in Vietnam war veterans, then recognized in the adult and child survivors of physical and sexual abuse, it has evolved into a model for providing social

services provision and policy development (Bowen & Murshid, 2016; Elliott, Bjelajac, Fallot, Markoff & Glover Reed, 2005; Harris & Fallot, 2001; Wilson, Pence & Conradi, 2013).

Working with trauma survivors and with an awareness of the impact of trauma has always been a part of the social work profession. Trauma informed practice blends a range of social work theories and practices. It takes an anti-oppressive and strengths based approach (Hopper et al., 2009), viewing trauma as caused by the intersection of different structural injustices and multiple oppressions (Bowen & Murshid, 2016; Zufferey, 2017). It is very much a person centred practice in assessing and providing assistance based on an individual's particular circumstances and needs. It promotes the self-determination (Hopper et al., 2009) and empowerment of individuals, as it calls for service delivery to be designed based on feedback and collaborative input from service users (Levinson, 2017).

For an organization or service to be trauma informed requires an understanding of the role violence and victimization play in the lives of many social service users, particularly those with mental health and substance use issues. Trauma informed services are not about treating the root causes or symptoms of trauma but are about the way in which services are provided to ensure they meet service users' needs in a respectful, appropriate, comfortable, safe, and effective way (Harris & Fallot, 2001). This includes, but is not limited to, services designed to assist with meeting the social determinants of health like, employment, housing, food security, financial assistance, and health (Harris & Fallot, 2001).

### **Trauma Informed Service (TIS) provision to older homeless women.**

Since it is recognized that older homeless women have high rates of mental health and substance use issues, often going hand-in-hand with lived experiences of trauma, this should be taken into consideration when providing services to them. Further, since evidence

suggests that many women who experience trauma may use substances as a coping mechanism and have mental health issues, Elliott et al. (2005) recommend that, as a form of “universal precaution,” all women with these issues should be assumed to be trauma survivors, whether they acknowledge or disclose a trauma history or not (Peck & Capyk, 2012).

Lack of awareness about this interconnection can mean it may be overlooked by service providers and, as a result, needed services and referrals may not be accessed or inappropriate and insensitive service provision may result. Services may be delivered in a confrontational or intrusive style or the environment may not feel safe to service users (Harris & Fallot, 2001). Many survivors of trauma have experienced a resulting sense of loss of control over their lives and the manner in which service is provided can replicate this experience for them (Chambers, 2012). This may inadvertently cause re-traumatization or the exacerbation of trauma effects for the individual. In addition, a negative experience with services and service providers may mean that an individual will leave and not return in the future and, as a result, they may not access the assistance they require (Chambers, 2012; Harris & Fallot, 2001).

A woman who has experienced trauma may have difficulty expressing and modulating her emotions; she may over respond to neutral cues and under respond to danger cues (Covington, 2012). Seeing things through a trauma informed lens is about standing back and asking if the behaviours exhibited by an individual are due to a trauma history (Covington, 2012), normalizing them to the survivor and being able to see these from a strengths perspective for what they are (coping, self-protection, and survival mechanisms) rather than blaming the individual for their behaviours (Peck & Capyk, 2012).

In many settings, the service user is viewed as a passive recipient of service and the service providers as experts and the gatekeepers to accessing resources. This is an inherently hierarchical system with power imbalance where the service providers' views, opinions and knowledge are given more importance. This power over relationship can mirror the experience of trauma for service users (Harris & Fallot, 2001) and thus, continue the pattern of oppression that many older vulnerable women have experienced throughout their lives.

With the provision of trauma informed service, the goal is to build a collaborative relationship where both service user and provider are respected and valued for the equally important knowledge and experience they offer. This ideally involves open and honest communication between service provider and service user and works to ensure that the service user has choice about what service, when, how, and where they will receive service and who they will receive service from (Harris & Fallot, 2001).

The following are 10 trauma informed service principles developed through a consensus process with nine service agencies addressing substance dependence, mental health, and violence-against-women issues;

“Principle 1. Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies.

Principle 2. Trauma-Informed Services Identify Recovery from Trauma as a Primary Goal.

Principle 3. Trauma-Informed Services Employ an Empowerment Model.

Principle 4. Trauma-Informed Services Strive to Maximize a Woman’s Choices and Control over Her Recovery.

Principle 5. Trauma-Informed Services Are Based in a Relational Collaboration.

Principle 6. Trauma-Informed Services Create an Atmosphere That Is Respectful of Survivors' Need for Safety, Respect, and Acceptance.

Principle 7. Trauma-Informed Services Emphasize Women's Strengths, Highlighting Adaptations over Symptoms and Resilience over Pathology.

Principle 8: The Goal of Trauma-Informed Services Is to Minimize the Possibilities of Re-traumatization.

Principle 9. Trauma-Informed Services Strive to Be Culturally Competent and to Understand Each Woman in the Context of Her Life Experiences and Cultural Background.

Principle 10. Trauma-Informed Agencies Solicit Consumer Input and Involve Consumers Designing and Evaluating Services." (Elliott et al., 2005, p. 465-469).

## **Summary**

The above literature review explores the background history of the issue of homelessness and some of the contributing factors to it. It attempts to focus on issues and realities faced by older women with lived experience of homelessness, with the idea that they are likely many of the same issues faced by the women who volunteered to be interview participants for this research. Finally, the concepts of trauma informed practice and trauma informed service provision are outlined, as this is the lens through which the research for this thesis was conducted, as outlined in the following chapter.

## **Chapter Three: Research Methodology**

This research aimed to explore the experience of accessing social and health services for older women with lived experience of homelessness. An exploratory qualitative research design employing a semi-structured interviews and a thematic analysis approach for the data collection and analysis was used. The intent in conducting this research was to do so in a manner that values and involves older women with lived experiences of homelessness by providing them an opportunity to confidentially voice their needs for, and experiences with, service provision. Of paramount importance was to attempt to minimize further harm or traumatization to women who have so often experienced this.

### **Exploratory Qualitative Research**

Since qualitative methods and an exploratory approach can be useful when looking at new issues, hard to study groups, or to determine the meanings people make of their lives and actions (Engel & Schutt, 2005), it was thought to be an appropriate method to use for this research with its target population.

Qualitative research “is any kind of research that produces findings not arrived at by means of statistical procedure or other means of quantifications” (Strauss & Corbin, 1990, p. 17). It provides researchers with the possibility of accessing individual experiences (Corbin & Strauss, 2008) and focuses on “the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2007, p. 37). Its goal is to look at social processes and settings, while considering the different perspectives of those affected, by exploring the lives of individuals and groups within the wider social context (Engel & Schutt, 2005; Shaw & Holland, 2014). An advantage of qualitative research is that it “can effectively give voice to

the normally silenced and can poignantly illuminate what is typically masked” (Greene, 1994, p. 541).

Exploratory research is qualitative inquiry that can be useful for finding out more information on an issue where little is known and few studies have been previously undertaken (Engel & Schutt, 2005; Maschi & Youdin, 2012). Often a relatively unstructured approach (Maschi & Youdin, 2012), it attempts to uncover more information about “social phenomena without expectations” (Engel & Schutt, 2005, p.12) and to develop ideas for possible further research (Marshall & Rossman, 2006).

Since there are few studies based on accounts from this population about this topic, it was thought that further qualitative, exploratory research would be useful to hear directly from older women with lived experiences of homelessness about how and whether their needs are being met. It was hoped that this research would also provide additional orientation with respect to how one might approach further research.

### **Sample Criteria**

Interview participants had to self-identify as female, over the age of fifty, and currently homeless or with lived experience of homelessness in Prince George to fit the sample criteria for this research.

The age for participation in the research was set at 50 and older since it is recognized in the literature that people who are homeless tend to age more quickly; have age related health issues much earlier and live shorter lives on average. For these reasons, some of the literature on homelessness categorizes homeless people who are 50 years of age and up as “older” (Barken et al., 2015; Crane & Warnes, 2010). Given the 50 year old lower limit as indicated previously, I was also concerned that by limiting the age range further (for example

to 65 years of age and older), I might be excluding important voices since the literature also indicates that women tend to make up a small percentage of the older homeless population (Pateman et al., 2016; Novac et al., 1996; Salem & Ma-Pham, 2015).

Women defined homelessness on their own terms, as homelessness for women can take many forms and can often be more hidden (Novac et al., 1996; Salem & Ma-Pham, 2015). In the end, the interview participants included women who identified as having couch surfed with strangers, temporarily stayed with friends or family, or stayed in shelters or transition housing. There was no minimum period of time that women interview participants had to have experienced homelessness in order to meet the criteria for participation in this research.

### **Sampling Method**

A snowball type of sampling (Engel & Schutt, 2005; Marlow, 2005) was used to reach and recruit six women 50 years of age and older who had experienced homelessness in Prince George and who were interested and willing to participate in semi-structured interviews (Creswell, 2013, 2014; Marlow, 2005). The intent at the outset of the recruitment of participants was to interview five to seven women. Six participants were interviewed as this was the point at which there were no new identifiable ideas or themes emerging, and when it seemed that saturation from the collected information was reached (Corbin & Strauss, 2008; Creswell, 2014).

I chose to use snowball sampling in this research design because, as a form of non-probability sampling, it is primarily used in exploratory research with hard to reach populations, when random sampling will not work, which suited this research targeting older women with lived experience of homelessness (Engel & Schutt, 2005; Rubin & Babbie,

1993). I wanted to find research participants not known to me and not referred to me by service provider staff and organizations. The objective was to find a sample of older women service users in an ethical way by avoiding bias and keeping client confidentiality and safety at the forefront. My concern was to avoid a situation where interview participants, thinking that providers might know of the information they shared, could limit accessing certain service providers and agencies for their needs, as a result of their participation in the interviews. Conversely, I wanted to limit the potential of affecting and biasing service provision by providers to interview participants who they might know as having participated in the interviews. Both situations could potentially jeopardize the health and wellbeing of research participants.

Since identified members of the population spread the word about the interviews to other older women who have experienced homelessness, this assisted in finding interview participants who fit the criteria in a less intrusive and public way. In addition, asking one participant to pass the word on to another and have them contact me, avoided the ethical issue of making direct contact with individuals without their consent (Engel & Schutt, 2005).

I felt that snowball sampling was an appropriate way to address these concerns and find interview participants in a way that would minimize the potential for biasing the data or for influencing and impacting participants access to the services they need.

### **Sample Selection**

My first attempt at recruiting participants was done by visiting a Thanksgiving dinner hosted by a non-profit agency held at a church hall. I spoke to several women as they were coming and going from this function; I gave out posters (Appendix E) and explained the purpose of my research, the participation criteria, and provided my personal cell number as contact information. This process led to the recruitment of one participant who contacted me

several weeks later. In the meantime, I visited one drop in centre and one soup kitchen centre several times and spoke to many women and was permitted to put up posters in these agencies by staff. Any time I spoke to individuals about my research and my search for interview participants I purposefully did not mention an honorarium (see Acknowledgment section that follows regarding details of the honorarium process) so as not to unduly influence the recruitment of participants. On one of these visits, I explained my research to an older woman and she decided to come with me immediately to do the interview. Following her interview, this participant told another woman and from that point forward, the word spread from one women to another, and interested individuals contacted me by phone. All except the initial two interview participants were recruited through this snowball sampling method.

### **Interview Setting**

When interview appointments were set up with each participant, they were asked if they would prefer the interview take place in a private or public location. All the prospective interview participants decided to be interviewed in the quiet, private, confidential space I told them I had secured. Nutritious snacks, fruit, meal replacements, and beverages were provided to ensure that participants were not hungry or thirsty and to make the atmosphere as inviting and safe as possible.

### **Confidentiality and Privacy**

Prior to the start of the interview, each potential participant was given a copy of the information and consent letter (see Appendix F) which was read out loud and discussed together with the participant. I chose to do this to ensure participants clearly understood the interview process, and could freely ask questions; this approach was also a way of navigating sensitively around the issue of literacy. In addition, the letter that was read explained the

process for protecting the individual participant's privacy and confidentiality, including the storage and disposal of the interview data.

Participants were asked several times if they had any questions and once I was confident that participants understood the information and the process, had the capacity to consent, and were willing to be interviewed and agreeable to have the interviews audiotaped, they were asked to sign the consent form indicating they understood and agreed to participate in the research. Each participant was given a copy of this information letter and consent form to keep, with my contact information and that of my supervisor clearly identified and pointed out to them. In addition, participants were given the list of counselling resources (Appendix D) and encouraged to access these if they needed to, either during or following the interview. I asked participants to ask questions or to stop the interview at any time they felt they needed to.

### **Voluntary Participation**

It was explained to participants that participation was entirely voluntary and they were free to discontinue their participation or to withdraw their interview from the research at any point during or after the interview, and that this choice would remain confidential.

Each participant was asked if they would like to provide their contact information so that I could provide them with a copy of their interview transcription and thematic analysis for their review and feedback. I also let them know that they would be able to access a copy of the completed thesis at the university library or by contacting me.

### **Acknowledgment**

Participants were then given an envelope containing two grocery store gift cards totalling \$20, equivalent to BC's current minimum wage of \$10.45 per hour, for a little under 2 hours, the estimated maximum time the interviews would take. As well, interview

participants were given two bus tickets, to assist with transportation costs to and from the interview. It was explained that interview participants were receiving this in recognition and appreciation for their time, ideas, and input given, which were vital to this research proceeding. This was given to participants prior to the interview to avoid unduly influencing their continued participation in the interview. Participants were advised that even if they decided to discontinue participation in the interview process, the gift cards and bus tickets were theirs to keep.

### **Data Collection**

Once interview participants were comfortable and settled, and the paperwork was completed as above, the interviews proceeded. To begin, several demographic questions (Appendix B) were asked of each interview participant followed by a series of semi-structured interview questions (Appendix C). All 6 participants agreed to the audiotaping of their interview and completed the interviews without deciding to withdraw from the research. The demographic information and thematic analysis of the data are outlined in the findings in Chapter 4. Semi structured interviews were chosen as a data collection method because they can provide a structured flexibility to gathering information allowing for the ability to follow up and explore further the answers participants might give to the set questions asked (Alston & Bowles, 2013; Shaw & Holland, 2014).

### **Data Handling and Storage**

The audio recordings, interview transcriptions and associated research, journal notes (discussed further in this chapter under the section on reflexivity), and drafts were securely stored on my password protected computer and in a locked cabinet in my home office throughout the research and writing process; all the information associated with the

interviews will continue to be stored this way. All potential identifying information about interview participants and service providers has been removed from the research data, interview transcriptions, and the thesis document to try to ensure confidentiality and safety for all. All stored electronic files will be deleted and paper files will be shredded and disposed of by a professional bonded company a maximum of 5 years after the completion of the thesis.

### **Data Analysis**

Thematic analysis was chosen to examine the participant interview data because it offers a systematic approach to search for meaningful patterns while providing a way to manage and examine large amounts of data in context (Braun & Clarke, 2006; Lapadat, 2010). It is useful for “immersing oneself in the data, for organizing and summarizing, and for focusing the interpretation” (Lapadat, 2010, p.1). This approach was thought to be suited to the goal of this exploratory research to look at the “experiences, meanings and the reality of participants” (Braun & Clarke, 2006 p. 9). It was used in a “contextualist” way by attempting to place interview participants’ experiences within the wider social context, during the data analysis and in the discussion of the findings (Boyatzis, 1998; Braun & Clarke, 2006).

As a novice researcher, thematic analysis seemed an appropriate approach to examining the data since it “does not require the detailed theoretical and technological knowledge” required by some approaches and “it can offer a more accessible form of analysis, particularly for those early in a qualitative research career” (Braun & Clarke, 2006, p. 9). However, as noted later in the “Researcher Reflection” section, the process of thematic analysis was more complex than I had anticipated.

Braun and Clarke's (2006) article outlining their six phases of thematic analysis was used as a guide for the step by step process of analysing the information gathered from the interviews. A lens of trauma informed practice (Elliott et al., 2005; Harris & Fallot, 2001) guided the development of the semi-structured interview questions, as well as assisted in the examination and discussion of the findings of the thematic analysis.

### **Thematic Analysis Steps**

The first step was to familiarize myself with the data. The data collected from research interview participants were transcribed from the audio recordings by a hired professional transcriptionist. The transcriptionist signed a confidentiality agreement prior to receiving any of the audio recordings to be transcribed.

I reviewed and compared the transcriptions to the original audio recorded interviews to check for accuracy and make any changes necessary. I did this by listening to each interview while reading along with the transcript and made the needed corrections. At times, voices were not easily heard and words were not clear and this led to a few errors in transcription. Comparing the transcriptions to the recordings gave me a chance to carefully listen to the interviews, and to get a sense of the essence of what participants were saying in their answers to my interview questions and in telling their stories. It also allowed me to begin to hear some of the key ideas and emergent themes that were repeated throughout the interviews.

The second step was generating initial codes. I read through each of the six transcript documents and highlighted ideas, statements, and concepts that initially struck me as important. Then I went through the transcripts a second time and assigned labels or “initial codes” (Boyatzis, 1998), to the highlighted sections in the margins of the document in comment boxes next to the relevant section of text. A running list of these codes was created,

with a short one-or two-word description (Boyatzis, 1998; Braun & Clarke, 2006) as a code legend in a separate document.

As I moved forward from one interview to the next, previously identified codes were assigned to new material if appropriate and new codes were created and assigned as needed. In many cases, statements by participants ended up being labeled with several different codes as sections of the interviews were often made up of a combination of ideas and elements that could stand alone or overlapped. As I reached the sixth interview transcription, I was no longer coming up with any new codes, and so this was my point of saturation (Corbin & Strauss, 2008; Creswell, 2014).

The third step involved searching for themes. This involved going through each interview transcript again and searching for codes I had generated earlier, by using the navigation search tool of the word processing program. At this stage, codes were combined where sections of texts initially had multiple codes; codes were narrowed down to the most fitting or “key code” for each item of text. Each section that fit under a code was cut and pasted into a new document named by that code. Each of these documents made up of text from the various interviews were reviewed and, where necessary, excerpts were reassigned and moved to other codes. Codes were also combined with one another if there were enough threads and similarities between the excerpts of text to fit together. These documents then became the initial themes. Two key themes were initially identified: “Loss and Strengths” (which later became “Loss and Disempowerment”), and “Strengths -taking back the power.” Several other themes were also identified at this stage, which were later expanded into more than one theme, or renamed multiple times, but began as: “Positive Experiences,” “Negative Experiences”, and “Unmet Needs.”

The fourth step was reviewing the themes. This step involved refining and combining themes further. It was important to accurately capture the key ideas, and even if an idea was raised only once in the data, if it was informative and important, it was captured under a theme. At this stage, text was sorted through again and coded material was moved around to the most fitting theme heading. This process of reviewing the material and refining the themes was done several times. Also, I spent more time thinking and becoming clear about my themes and excerpt examples. In some cases, it was not obvious where sections of text fit best and I had to rethink my definition and names for some of the themes.

The fifth step was finalizing the theme names and defining the themes. It was at this point in the thematic analysis that I could clearly identify and explain each theme and finalize the selection of examples from the interview data to highlight each theme. The three final overarching themes, subthemes, and subtheme components, thus identified were:

1. Loss and disempowerment

2. Navigating Services

a) What is Working

b) What is Not Working

subtheme components: Barriers, Interactions, and Gaps

3. Resilience

The sixth and final step of the thematic analysis was producing the report. This involved an analysis for each theme and subtheme, and creating a summary and explanation of the interview text excerpts to put the theme headings into context, including identifying the purpose and meanings captured in each theme.

## **Summary**

The information collected in the interviews was examined and the issues identified were categorized into themes using thematic analysis. An inductive approach was attempted to avoid fitting the identified themes “into any ‘pre-existing ideas’ held by the researcher” (Braun & Clarke, 2006), and aimed to uncover “lived experiences and meanings” and to “capture the idioms and contents of an individual’s views, experiences and sentiments” (Luborsky, 1994 p.190). The data analysis moved from the narrow (significant statements) to broader (meaning) analysis, to summarize the essence of what and how individuals have experienced service provision (Moustakas.1994).

## **Methodological Integrity**

### **Member Checking**

When asked, all six participants had initially indicated that they wanted the opportunity to review their interview transcript for accuracy and completeness, a process called ‘member checking’ (Creswell, 2014). Participants’ contact information was collected at the time of the interviews and my cellular number was provided so research participants could contact me with any questions about the research or to call me if they did not hear from me to review the transcripts of their interview. I wanted to ensure that they had a way they could reach me if I could not reach them. Once the transcripts were ready several attempts were made to contact each woman in the manner they had indicated in the interviews, to provide them with a copy of their transcribed interview and to do “member checking” to ensure their words and voices were accurately captured. Although I was able to leave messages for each of the participants, only three got back in touch. Two of the participants wanted to see their transcribed interview and these were provided to them. A few weeks later,

I attempted to make contact again with these participants several times to see if they had corrections or changes they wanted made. One of the participants returned my call with a correction; a word was misheard on the recording and this was corrected in the original transcript. None of those reached were interested in reviewing the themes that I identified in their interviews.

### **Reflexivity -The Place of the Researcher in the Research**

The research method for this thesis is influenced by the concepts of researcher reflexivity and researcher location in “the space between” (Corbin Dwyer & Buckle, 2009). This research attempted to collect information from first-person reports in the form of descriptions, prompted by semi structured interview questions, with the intention of gathering the meanings and essences of individuals’ experiences (Creswell, 2014; Moustakas, 1994), through a process of thematic analysis. While attempting to minimize my personal influence on the data, I recognize that suspending my own experience and opinions is not realistic or even possible. The research process of data collection and analysis used was filtered through who I am personally and who I am as researcher. “How we write... and how we do research” is a reflection of “the cultural, social, gender and class and personal politics that we bring to the research” (Creswell, 2013 p. 215). I tried to be very self-aware: one of the ways I attempted to do this was to make notes in a journal, to use as an audit trail for the data, but also to note my feelings and thoughts around the impact of my social location on how interviews unfolded, on the interview data collection process, and on the outcomes. In this way, I attempted to reflect on the part I played within the research process, and how I influenced the interviews and the subsequent thematic analysis of the data (Creswell, 2013). I acknowledge that my life, work as a social worker, education, and family situation interacted with the research, and the way I saw and interpreted the data, which inevitably impacted the

findings, interpretations, and conclusions I came to (Creswell, 2013; Shaw & Holland, 2014). I can identify both as an insider (being a service provider with work-related experience with homeless individuals), but ultimately as an outsider, as I have never been homeless or lived many of the experiences that the women I interviewed have lived. For this reason, the concept of researcher occupying the “space between” resonates for me because “the intimacy of qualitative research no longer allows us to remain true outsiders to the experience under study and, because in the role as researchers, it does not qualify us as complete insiders” (Corbin Dwyer & Buckle, 2009 p.61), therefore we can only ever occupy the space between.

### **Triangulation -Audit Trail**

Attempts were made to adhere to the seven steps of triangulation, as outlined by Farmer, Robinson and Elliott (2006) “sorting, convergence, coding, assessment, review for completeness, comparison and feedback” (p. 372). This was done by reviewing the journal notes I made following the interviews that summarized the key points from the interviews. The data was sorted by ideas and then these were examined for convergence in themes which served to triangulate the data (Creswell, 2014). As well, any “discrepant information that runs counter to the themes” (Creswell, 2014, p. 202) was noted and attempts were made to provide a “rich thick description” of the themes and various perspectives to “add to the validity of the findings” (Creswell, 2014, p. 202).

## **Chapter Four: Research Findings**

### **Demographics**

Some demographic information was collected during the interviews from the six women participants who had personal experience with being homeless. This data was gathered using a series of questions (Appendix B) to have some sense of the background of the lives of the participants. This was felt necessary for the purposes of setting the context in which to understand the outcomes of the thematic analysis of the interviews held with the participants.

Figure 1 lists some of the demographic and other information collected. The six women interview participants for this research ranged in age from 51 to 68 years of age. Four of the six participants self-identified as being of Aboriginal or First Nations heritage and all four stated they had First Nations status. Two of the participants identified as being of Canadian background. Two spoke of currently being in relationships with men though they were not living with them and the other four indicated they were single. One was widowed 29 years ago. All except one had stayed in a shelter or in transition housing or had couch surfed with acquaintances or friends in the past 6 months and all identified as having been homeless at least one time, and in most cases, repeatedly over the last 5 years. Two had just recently found market housing, two were living in transitional housing and two were staying in shelters. One participant was in receipt of Old Age Security (OAS) and Canada Pension Plan (CPP) benefits. The other five participants were receiving provincial social assistance with two being on regular provincial hardship assistance, one with provincial Persons with Persistent Multiple Barriers (PPMB) status and two with provincial Persons With Disability (PWD) status. One participant completed elementary school, three participants had completed up to grade 10, another finished grade 11, and one participant had some college

training. Two were currently taking courses with the Street Humanities program through the College of New Caledonia (CNC) in Prince George, BC. Five of the six participants had children; four had adult children and one participant had one child, a teenager.

Figure 1. *Demographic Information*

<b>Age</b>	<b>Ethnicity</b>	<b>Shelter</b>	<b>Income</b>	<b>Education</b>
68	Aboriginal	Shelter	OAS/CPP	Elementary
53	Aboriginal	Shelter	PPMB	Partial HS
51	First Nations	Shelter/Transitional	SA	Partial HS
60	Canadian	Transitional	PWD	Partial HS
55	Canadian	Housed (1 year)	PWD	Some college
53	First Nations Status	Housed (1 month)	SA	Partial HS

Notes: OAS = Old Age Security; CPP = Canada Pension Plan; PPMB =BC Persons with Persistent Multiple Barriers; SA = BC Regular Social Assistance; PWD = BC Persons with Disabilities.

## **Themes**

Three overarching themes were identified through the process of thematic analysis of the data from the six participant interviews: #1-Loss and Disempowerment, #2 -Navigating Services, and #3 -Resilience. Under the theme Navigating Services, two subthemes were identified: a) What Is Working and b) What Is Not Working. Under the subtheme, What Is Not Working, three subtheme components were identified: (i) Barriers, (ii) Interactions and (iii) Gaps (Figure 2 and Table 1).

### **Theme #1 -Loss and Disempowerment**

During the interviews, most of the participants identified experiences of loss and disempowerment which were impactful events influencing the course of their lives and playing some role in leading them to periods of homelessness and their current circumstances. Though not directly asked or explored during the interviews, references to experiences of grief and trauma were interwoven throughout the responses and stories. Elements of this are seen in the following excerpts under the theme of Loss and Disempowerment.

Figure 2. *Themes*

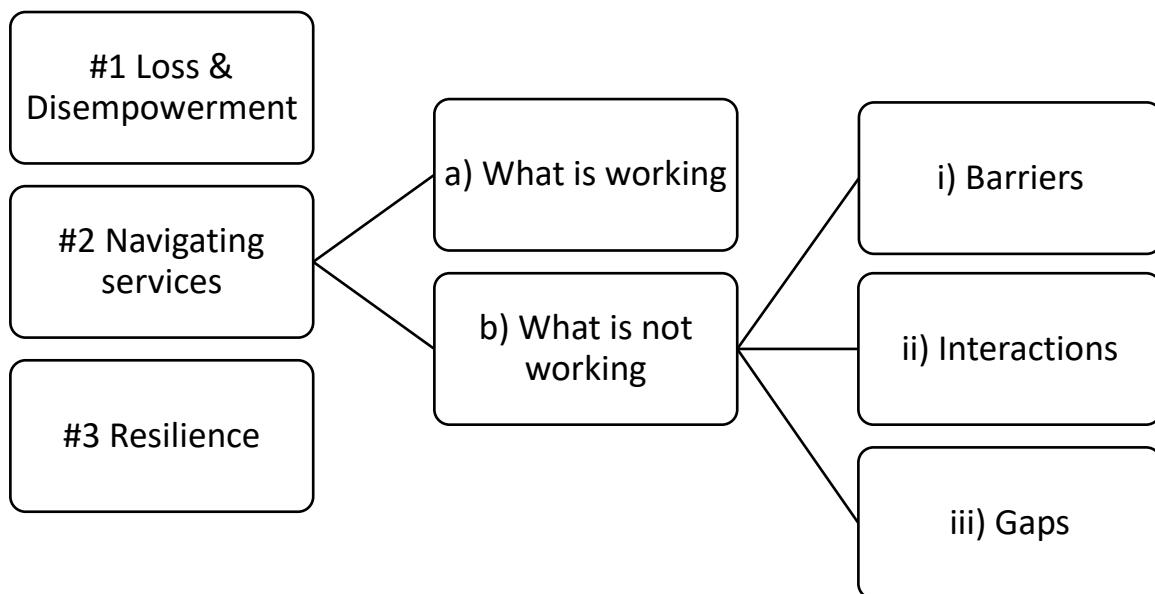


Table 1. *Themes, Subthemes and Subtheme Components*

<b>Themes</b>	<b>Subthemes</b>	<b>Subtheme components</b>	<b>Topics</b>
#1 -Loss and disempowerment			Housing; Employment; Relationships; Autonomy; Health care.
#2 -Navigating Services	a) What is Working		Supports; Shelters; Health care; Activities.
	b) What is Not Working	(i) Barriers	Connecting with services; Bureaucracy; Client centred services; Poor fit.
		(ii) Interactions	Police; Lawyers; Health care; Shelters; Service users.
		(iii) Gaps	Things to do and places to go; Housing; Transportation; Storage; Health care; Free resources; Service user input.
#3 -Resilience			Education; Employment and volunteer work; Self identified strengths; Growing older; Advocacy and self esteem.

### ***Housing***

One participant highlighted the loss of stable, safe housing, which she had been so happy to have, due to health issues (poorly controlled diabetes), as well as her limited income through the provincial PWD social assistance program.

I'm used to not having a permanent residence because I did live at [residence]. I had an apartment there. They actually made me go back to [shelter name] from the apartment which is too bad because I had my own nice place there. They said because of my diabetes and my sugar going so high and stuff like that. They're worried I'm going to pass out and go into a coma because it's already happened four times.

I thought at [residence] I was settled there. You know, I made it all homey and cozy and everything and now my room is just, there's nothing in there, just my bed and I have a dresser in there. I'm tired of feeling like I don't have a permanent residence. Because they kind of made me move back to [shelter]. But again, it works a little better because I was having trouble supporting myself at my apartment...paying my cable bill and food.

### ***Employment***

A participant spoke of her inability to work anymore due to her health issues.

Well, I did like a lot of seasonal work .... picking and peeling logs. Yeah, and other than that I did mostly chamber maid and waitress... Lived on tips. But that's been a long time. My legs are screwed and you know, ... I walked today just to [pharmacy] from 7<sup>th</sup>. Anyway, I got home and my legs I barely made those stairs. And I get sometimes really weak, I don't know what it's from, but that's how I was today and I barely made it. Like I used to walk all the time and my legs never bothered me. They feel weak plus I get a lot of pain in the back here and in my knees now so I've got to lose some weight for sure. Maybe that's why my sugar is up too. Yeah, cause really the stuff that I'm eating there is not the healthiest.

### ***Relationships***

One participant reported that periods of episodic homelessness began for her when her husband died nearly 30 years ago. He was the breadwinner and looked after paying the bills.

I've had a lot of experience. Since my husband died, I find myself homeless a lot of times. I couldn't cope. I'm not used to doing stuff, like my husband did everything. We had our own home. He paid the bills and I just, he told me he'd look after those, he said my job was to look after the home and the kids. And that's what I did. I didn't even know how to pay bills or nothing. So now I gotta learn to budget and I hate that word.

Another participant spoke of the breakdown of her marriage; "Married but separated. [for six years]. Yeah, he wanted a divorce but I wouldn't give him one." This same interview participant spoke of family dissolution resulting in no contact with her grandchildren for some time., in response to the question "Do you have any grandchildren?"

Yeah, but I haven't seen them because they were taken away by my son-in-law. He kidnapped them. I had them for, well since they were little, but I haven't seen them since they were little. But one is here though. Apparently, she turned out really good ... It's been a long, long time. Well, she's, I think she's 21 and I have a granddaughter that lives in Vancouver and she's just messed up [unclear]. She's 22.

This participant spoke of wanting to live in closer proximity to her daughter. "I'm hoping to move to the Island, actually. It's so expensive just to move and even if I don't move there, I just want to go visit my daughter."

Another interview participant reported that she had no family she could rely on at all. "Single. No children, no dependents. No support system of any kind. I have a half-sister and half-brother that disowned me upon my mom's death."

Another interviewee described relationship breakdown as being directly connected to her loss of housing.

I shouldn't have been homeless. No, because both times it was my boyfriend. We split up and yeah, well I had to leave cause he's packing up clothes so I had to leave too...because I couldn't afford to get a place right away.

Another spoke of the difficulty of having to carry her belongings with her all the time and not having her own place to keep them safe and getting along with others. "Well, I was

packing my stuff around. And then the ignorance of people that you thought were your friends. You find out that they really aren't."

### ***Autonomy***

One woman talked about the challenge of not having control over time and activities when homeless, as well as the challenge of not having her own space to do things when and how she wants.

Yeah, just put your feet up and watch a movie if you want or eat whatever time you want. Or take a bath whenever you want. Eat the food you want. Instead of having a certain time to eat. You're on the clock all the time. It's like you're at work but you're homeless. You have to .... run over here, get some sandwiches, then I gotta run over here. It's like you're on a clock. If you want to eat, you've got to run.

Another spoke of not being able to do things for herself like she can when she was housed. "Oh yeah, when I have my own place, I do all those things [cook, grocery shop], I do my own laundry."

Another participant referred to her loss of independence without a home and kitchen, since she cannot cook the food that she might be able to get from the food bank. "Well, I can't right now 'cause I don't have a place to cook."

When asked about what it is like having to stay in a shelter, one participant said "I'm very frustrated in there. I don't like being there. It's hard." Another one said:

Oh, I hate it but there's nothing I can do about it. Well, you know what, when I get a home, I'm going to look after it, because being homeless is terrible. I will not go through that again. I know. It's degrading. It's terribly degrading being homeless. Living in a shelter at my age.

Another interview participant talked of the difficulty following someone else's imposed rules: "I'm sick of rules. Like at [residence], I thought oh my God, there's so many rules here, but they said I was a model tenant."

Another spoke of homelessness as “It’s a rough life.” She recently has secured housing after many months of homelessness and because of it reported that “I’m so happy right now.”

Another talked about the challenge of not having a choice of where to stay and having to stay in a shelter with some people who talk about their substance use:

Cause I used to be an addict once upon a time. But I just get frustrated and I tell them drugs don’t belong in here when there are people who are trying to stay clean. Go talk about your drugs elsewhere, so we don’t have to hear it. It just gets very frustrating.

Another participant relayed the challenge of having to stay in a place where others use drugs and alcohol, but also to the fact that she felt avoided by other women:

Very rough. Well, you know, there’s women that drink and do drugs and when they get mad, it’s pretty rough. And basically, I keep to myself because other women they all know that I’m Christian and I just noticed that they don’t, they shy away from me, that’s all. It’s sad it’s like that, that’s okay, it’s their choice.

### ***Health care***

One woman talked about lack of control regarding her health care:

Yeah, they got women doctors. So, I go there. It’s okay. They’re very good there because they don’t do anything you don’t want to do like I’ve never had that with male doctors before. They never gave me options or anything. They just told me I had to do this. They even told me I had a sickness, one said I have diabetes and I didn’t even have diabetes. That’s a doctor told me that. I argued with him about it. He said “you have diabetes.” I said “no, I don’t.” And he said “yes you do” and we argued back and forth like that. Can you imagine that? Argue with a doctor.

### **Theme #2 -Navigating Services**

Many of the issues that came out of the interviews were to do with experiences and what did and did not work for participants when navigating through systems to meet their daily needs such as for food, shelter, clothing, finances and health care.

### **Subtheme a) What is Working**

There were many instances mentioned during the participant interviews of positive experiences navigating and accessing services and interacting with service providers. These examples of service access and delivery working well are highlighted below as the subtheme “What is working” with examples quoted from the participants’ interviews.

#### ***Supports.***

Several women spoke of the availability of places to get free prepared food and free food hampers in the community:

You can’t starve in this town. Like you can go to [ shelter name ] or stay overnight there and have breakfast. Or you can have breakfast at [soup kitchen name], go in the sandwich line at night. On weekends, you can go and get sandwiches at 2:30 every Saturday and Sunday. [ shelter name] has good meals and the [drop in centre name]. But you just have to walk around.

Another spoke of sources of food: “There’s a lot of places like [organization name] kitchen for meals and sandwich lines. Even a vegetable line.”

Another spoke of getting assistance from an advocate’s office for “my income tax and to get clothes. And just to use the phone. It is good.”

Several interviewees talked about securing transportation assistance. One spoke of the assistance provided to older woman who have mobility issues at one of the shelters: “They always help those elderly women. They can’t walk good sometimes, they always give taxi vouchers for those older women to go to their appointments, or they’ll take them there themselves.” Another spoke of her personal experience with this. “Well, actually they [shelter] usually drive me places. Especially, you know, if I ask them. Or they give me a bus chit, so that’s really handy.” And another also mentioned receiving assistance with bus tickets. “They [shelter] usually give me bus tickets when they have them.” Another

participant spoke of her positive interactions with the bus drivers. “Oh yeah, the bus drivers, they’re always teasing me.”

### ***Shelters.***

One participant spoke highly of the treatment of the clients by the staff at one shelter:

They’re very good with all age groups. As far as I could see, they get along with everybody, they treat everybody with respect. Yeah, but it’s nice to be treated with respect because most of us, we’re not used to that. They try to help us in every way they can. In some ways, they’re strict which is good. It’s only expected, but you know, in a shelter especially where there’s drinking and drugs, it gets rough. But they always can phone the police, so that’s okay. There’s nobody really at risk so that’s the good part.

Another participant talked about the willingness to examine, take feedback and improve services on the part of some agencies:

“I think [shelter name] tries. Yeah, and like a lot of places, they’re always trying to better themselves. Especially the [drop in centre], I’ve seen so much stuff they did to improve. People can give their opinions. They used to have a [comment] box.”

Yet another spoke of having had to use a transition house in town. “Oh I liked it there. Yeah, they’re really nice. I felt safe.”

### ***Health care.***

Several of the participants mentioned they were happy with aspects of their health care. One spoke highly of her doctor because she felt he was thorough and efficient:

Oh, good. He’s a good doctor. I like him. He gets right on top of things. He says okay I want you to go get x-rays on that leg of yours because it sounds like it’s broke, or I mean something’s wrong inside my leg.

Another woman reported being happy with her health care because she can now access a female provider which was very important to her and makes the difference in the frequency or likelihood that she will access health care:

I find it’s good. Before I didn’t feel comfortable with male doctors because I felt like they couldn’t understand how I talked to them and like try to explain stuff and they

don't understand. But now that I'm going to a female doctor. I feel a lot better. I could tell them what's bothering me and they understand.

Another participant said, in reference to her family physician: "He's a nice person, he tries to be nice."

Another interviewee expressed satisfaction with care for her diabetes in the past: "Oh the diabetes centre in the hospital. Actually, I should go see them to get all checked out again. They're really nice."

One participant preferred to access health care services from a female health care provider who regularly comes to a women's drop in centre, where she spends time and volunteers, rather than having to go for appointments at a medical office or clinic. "I see a doctor through where I volunteer at the [drop in centre]. They're really good. I just see her and she just faxes it in. I like the way I am doing it. Because then I don't have to deal with them [doctors office /medical clinic]."

### ***Activities.***

One woman was very pleased to be participating in a collaboration between a shelter and a local college that provided education and other helpful benefits:

I have a bus pass, until the end of March. Yeah, I 'm in this program now and they give me a bus ticket so I can access all these places now, but before that, I had to scrounge around to get bus tickets and just to go up to [food bank]. Plus, you get supper every night too. Yeah, tonight, like when I go there, they buy you dinner.

One participant spoke of the challenge of trying to keep busy during the day and that the library is one of the places where she spends her time. "I go to the library. I love the library."

Another spoke of a regular event she attends. "Yeah, I went to the Elder's luncheon at the [organization name]. My sister and I always go. And they have a really good lunch."

An interview participant explained that she had very recently found housing. When asked if she found it on her own she responded, “No, they found it” in reference to assistance she received from a local Housing First program.

Two of the participants mentioned their appreciation of an organization for women in the sex trade, and one spoke in detail about the services provided by them.

They’re doing pretty good. I think they’ll need more funding ‘cause they don’t get enough funding for us, sometimes we can do treatment, or a program or something and maybe get paid.. We do a lot of stuff. We do art …we can watch movies or if somebody needs to sleep, they can sleep. I like that place a lot better than [another agency name]. Too bad [drop in centre] it’s small.

### **Subtheme b) What is Not Working**

The interviews also revealed many challenges that participants experience in accessing services. Examples of these taken from the participant interviews are grouped under the subtheme “What Is Not Working” and include: barriers encountered navigating existing services, issues arising from interacting and communication with service agencies and service providers, and gaps in the existing services or the absence of services to meet their day to day needs.

#### **Subtheme component (i) Barriers.**

This subtheme component encompasses examples of the challenges interview participants identified in trying to access services that do currently exist in the community. In some cases, this may be due to the way the service is delivered such as the processes, rules, and eligibility criteria that must be navigated to gain access to these services. Of course, services and agencies have their reasons for having policies, rules and systems in place. This research did not explore these from the service provider perspective but was focused on the clients’ experience with service provision.

***Connecting with services.***

An interviewee described her difficulty getting timely service or responses, and missed opportunities to connect with service providers with the following example.

Well, there's a lot of services, but they don't seem to get back to you, like with mental health [services], I called I don't know how many times. They never got back to me for over a month or something, then, she was busy that day and I wanted to go do some things. But anyway, she got busy and then I haven't seen her since.

Another participant spoke of the difficulty getting through on the phone to make an appointment with her family doctor: "I just gotta go, [in person, into the office] I was trying to get hold of him this morning but he's hard to get hold of. Yeah. they just, they're so busy all the time."

The challenge one interview participant identified was the location of some of the services she and others rely on and the difficulty getting to them: "But they should have [food bank] down here where they used to."

***Bureaucracy.***

An interviewee describes how she finds her physician's office to be very rigid about appointment times and lateness:

What makes me mad about them is I've been there, I get there either early or right on time and if I show up there, which has happened I think twice in the last year, and oh shit, there goes my brain injury, I don't know what I was talking about. Oh yeah, if I show up two minutes late I have to re-book my appointment...That makes me really mad.

A participant interviewee described the eligibility barriers she faced trying to get food assistance from the food banks as a single person:

Yeah, the [agency name], I was pretty regular there for a while, 'cause it helped supplement the food I was eating, healthy food. 'Cause really, you get a lot of health food from the food bank. I can't do it anymore because I have to renew a card. I forgot to mention on my bills to them ...well I didn't want to mention it really cause it's to the cash store, right. Yeah, well they said I'm making enough money that I

shouldn't have to go to the food bank, but like I can still access the bread line. That's the impression I got... And then with my cable and everything, they still said I'm just right on the line or something. You're only allowed to make so much money.

Another participant mentioned the intrusiveness of the process required when seeking food assistance:

No. The first question is what is your income? How much and then, you know, like sometimes I run out of food and it happens to anybody. So, I go and ask for food and I gotta fill out a questionnaire and then bring a letter or a bill ... like why can't they just help us once or twice and tell us after that you have to start producing stuff. Like help a person out instead of just, you know, that's very degrading when we have to go ask for help. And then they give us the third degree. They just ask what's your income and why are you here? How much do you get? What are your bills?

Onerous requirements for paperwork was identified as a barrier to accessing needed services by several participants, such as with finding housing and accessing financial assistance, and personal identification. One participant spoke of looking for housing and encountering landlords wanting applications completed with references from their previous tenancies. The challenges this poses for many older women can include not having references as they may have been living under a partner's tenancy in the past, owned their house and lost it, or have no references due to unsuccessful tenant landlord relationships.

Yeah. It's just where I used to stay before. I had to get phone numbers and dates and I've got them in storage but I don't know where. So, I'm just trying to guess dates now. I've got a couple phone numbers so I'm okay now, I just have to submit that.

Another interview participant described a barrier encountered getting paperwork completed by a doctor, a requirement for applying for PWD status and many other Ministry of Social Development and Social Innovation (MSD & SI) benefits.

I don't know what's going on. Well, I have been trying and nothing's been done. Like I did a survey thing with the [clinic] downtown on [street name]. They keep telling me they're going to help me apply for disability and they haven't done anything. Yes, like I've been battling with that for years.

In addition, one interview participant spoke of having finally found a doctor to take her on as a patient but the physician did not feel that she knew the patient well enough to fill out the paperwork that is required to apply for disability assistance.

I just got a doctor now at the [office] ‘cause it was hard for me to get in to see a doctor. I had to go back to [community], hire someone to take me to [community] to see my doctor and to get back to Prince George, so it was pretty costly, \$100 for two ways... the doctor I’m seeing now cannot fill in my book for disability because of the fact that she don’t know nothing about me.

Some participants spoke of the challenges faced trying to access services from the Ministry of Social Development and Social Innovation office and one participant described:

It was awful. I don’t know, they don’t care if you’re on assistance or not. They just like, they don’t care. They don’t care if you get through or not. I waited this last time for two months before I could get help. ‘Cause I was working or whatever, they didn’t believe me ... they wanted an ROA so I took that in so then they kept telling me they didn’t get it, so, I thought oh my God. What they told me to do I did and it was still, went on and on and on.

Another participant’s response when asked about how it is to go to the MSD & SI office said:

I find it so stressful. I can’t deal with them. I get very angry with them. I swear at them because they piss me right off. I just can’t deal with them. They make me wait and wait and wait, or go get this paper and do this work, do that work. Like I can’t run all over the place when I’m very ill. But I have to. I find it easier to talk with them on the telephone than to deal with them face to face. The waits on the phone are...they’re usually 45 minutes to 35 minutes. I’ll phone another day when it’s not so busy.

### ***Client centred service.***

One participant said she feels there is unequal treatment and assistance by service providers and agencies:

I had a bad experience from [shelter name] they stole \$60 from me...and they couldn’t even help me, like they said they help everybody and they helped my cousin. He owed \$500 on an instant loan and they paid it off for him and I asked them to pay my storage fee, \$60 and they didn’t want to help me. Yeah, so I said thanks a lot, I said every time I ask you guys for help, you don’t help me. I asked

them for a warm coat, oh we don't have any. My cousin goes there, I need a coat, oh here's one, it's a brand new one, it might fit you. So, I asked for boots, oh we don't have any. Yeah, they have favorites.

A participant recounted an incident where false assumptions made about behaviours she was exhibiting, could have resulted in her eviction from her supported housing situation:

I almost got kicked out of [removed name] because I was walking down the hallway and I was staggering and they thought I was drunk. Yeah, no my sugar was just high. Like its weird cause when it goes really high, I get really tired and it's high right now, too. But like I said, it's 27, but I mean it's been a lot higher.

An example of a bureaucratic barrier to client centred health care is short medical appointments and limits on how many issues a patient can raise in one appointment. It can discourage patients from going to the doctor if they do not feel validated or heard, and feel frustrated when all their concerns are not addressed:

He [physician] will only deal with one thing per visit. When you have multiple issues, that's hard to keep it to one thing. Then he gets frustrated, and he says, to be fair it's only supposed to be one per patient. How often do you want to see me? Can I see you in an hour? You know. Some of it's ridiculous too and it has to do with how they're paying the doctors. The doctors have gone through all that specialized training and they should be getting paid for it but perhaps they're being overpaid and being greedy, some of them too. Very few, like the previous place I had which was the clinic, allowed you three things per visit. Even with three things, I'd have a paper full. One thing is bothering me which leads to another thing which leads to another thing.

Another interviewee indicated her strong preference for female medical and mental health counsellors and spoke of the reality that there is often no choice in whom they can see. For some this means that they will choose to not access this service.

I've tried going to a couple guys[name of agency] and somebody else but they don't seem, I didn't like them. I got not very good vibes from them. So, I swore off men counsellors. You know, so I don't want a male doctor either. I just don't like having checkups with a male doctor. I don't feel comfortable with that. Never did. In the past I just felt I didn't have any say in anything.

***Poor fit.***

An interviewee described the situation she was facing in not being able to access homeless shelters with a pet. For her, this presented a barrier to her being willing and able to access service, but it also points to a gap in service availability as many older women who are homeless have pets for companionship or security.

When shelters do not accommodate client pets, a client can be faced with the heart wrenching decision of giving up her pet or finding a place to sleep where the pet can stay with her which can include unsafe situations or even sleeping outside. In order to be client centred, some flexibility is required to take into consideration individual circumstance and need.

Well, with women that do have a pet, they should allow them to keep their pet with them because irregardless, you've got nowhere to go and I can't, I'm not just going to give my dog away when he's part of my family. I've had him since he was a puppy and he's only a little tiny dog. He's got his kennel. He's not a barking dog. ... Like he's a clean dog, I take him out when he needs to go pee and I clean up behind him.... That's not a problem. ...It's so stupid because I can have him during the day and I can't have him at night. That don't make sense. Something's wrong there. I think it's just them, they don't want me to have my dog there. I don't take him to the kitchen. He doesn't beg for food from anybody and he's a well-mannered dog and he's well looked after. They wanted me to find somewhere to keep him. And I've asked people, I said okay if you can't do that, then I'll sleep outside with my dog.

A barrier for some women to accessing services such as shelters (that can lead to women couch surfing or unsafe situations) may be due to women using drugs or alcohol. This situation may reflect a gap in service and suggests the need for wet and dry shelters. “They’re supposed to be no drinking but the women they do and it kind of makes it rough for those of us who don’t drink.”

One participant spoke of a barrier to housing she encountered that also indicates a gap in service caused by a shortage of viable housing options. She felt she had to turn down an

offer of housing for her own well being as she is trying to stay clean and sober and change her life. This situation often arises where clients feel they are faced with choosing between shelter, their autonomy or health.

They wanted me to move into [building name] but I don't want to move there. I've heard a lot of rumours that those women they're still drinking, living there. So I don't want to be around that at all. It's enough that I'm downtown now. So, I told them I don't want it. I said first of all I heard rumours about this place, and then I said it's on the [number] floor. I said what's going to happen if there's a fire or something below me. How am I going to get down? I don't mind a place like that a high rise, but not the [higher floor levels] floor.

### **Subtheme component (ii) Interactions.**

Interview participants recounted some good experiences but also many unpleasant ones involving interactions and communication when accessing needed services. Though negative interactions can be categorized as a barrier to accessing service, it was felt that due to the frequency of it coming up in the interviews, its importance to the interview participants and its critical relevance to client centred and trauma informed service provision, it is a sub theme component of its own. Examples from interview participants describe interactions that were a result of poor communication skills or disrespectful and discriminatory attitudes. In some cases, participants experienced outright confrontational or even threatening interactions with service agencies, providers and other service users. This situation is the opposite of client centred or trauma informed practice and service provision. Clients may be less inclined to access services and even give up on trying to obtain needed services due to the types of interactions described below.

#### ***Police.***

Several interviewees spoke of negative interactions with the police.

No, I've had bad experiences cause I'm an alcoholic. I don't drink now, I haven't drank for two years but when I did, I ended up in the drunk tank and they weren't

very nice there. Then again I wasn't either. I was drunk, right. ...that was a long time ago. ... they were pretty rude. But yeah, when you're drunk they treat you like shit.

Another participant also recounted an interaction with police where she felt threatened.

Oh gee, when I used to be drinking a long time ago, when I was young and up at the drunk tank they're pretty rough. My friend [name removed] she got, they put a phone book on her face and they were punching her like that, so they wouldn't leave bruises she said. So, I just told that cop, I saw him going like that, he was getting mad because I wouldn't answer the questions and then I said, "Don't even think about hitting me." I said "If you do, I'll make a big stink about it." Then he said "oh I wasn't going to hit you." I said "liar." So, they never touch me.

### ***Lawyers.***

A participant recounted her poor experience with a lawyer who worked on her residential school settlement;

It wasn't good. I didn't like him. I was terribly disappointed with his service. He never talked to me once. And that woman who was working with him, ... she told me I didn't have to talk to the lawyer, then I just left and then I thought about it and then I thought well, how's he going to know what I want? I found that very strange.

### ***Health care.***

Several participants spoke of incidents where unpleasant interactions took place with health care professionals when accessing care for their medical issues. One participant described two separate incidents with different physicians: "I consider arguing with my ex-doctor a bad experience. Another physician, a male doctor even told me you can leave right now if you want, in a mean way. I told him I'm not going through that again."

An interviewee described how she experienced the interaction between staff and patients at the health care office she attends: "They're always putting natives down. They laugh at natives and discuss us, just cause we're natives. Like they mistreat them because of their health issues." This participant later went on to say: "I think they should have meetings

with their boss or whatever, their boss have meetings with them and make sure that everything is done right or whatever. Like we don't have to be treated like that."

Several participants mentioned negative experiences with the staff at the Emergency Department, as well as the wait and processing times while accessing services there. One participant recounted feeling poorly treated and discriminated against for her health issues by staff during a hospital admission.

Yeah, and they put me down to another room and I don't know, the whole time the nurses were real bitches there. I'm sorry but yeah. They're really ignorant and rude and made me feel like a piece of shit, to be honest with you. Like they wouldn't come near me or nothing 'cause I have a health problem that is contagious but I take care of it so nobody's going to get it. Yes, they were, [treating me] really badly. And I'm normally a really good person, easy to get along with, you know. And I tried to be nice to them and they starting being really rude with me so I started being rude back because I ended up staying there like a week and a half or something.

Another participant recounted a similar experience with the hospital staff.

The nurses were kind of ignorant. Like I was coughing and that one nurse covered her mouth, like really rude. I just looked at her and I was in a lot of pain. I said oh my God you're ignorant. I thought nurses were supposed to be nursing, nice. You're sick already and you're in there and you don't want to be in there. They should be at least courteous. I had to be admitted to the hospital and I think they put me in a room. But I didn't like it, the nurses were really ignorant. They should, because you know the people that go there, they're already sick or they're hurting. They need a little of, like, you know, compassion. Not rudeness.

### ***Shelters.***

A few of the participants spoke of their experiences as women over the age of 50 in some of the shelters in town. When asked how they found the services, some reported positive experiences as outlined earlier, but there were also negative experiences, along with some mixed and contradictory experiences: "It was alright. They treat people pretty bad there, they're rude and they're mean. But then again they're funny and they always joke around. I find them kind of rude."

Another interviewee described some of her shelter experiences.

They're pretty mean there, they're not very nice. Like how do you say that? [shelter name] they're nice to you, you could tell [a different shelter] you could tell when they don't seem to like you. They don't smile, they're not polite at all. They're just abrupt. I don't think that's right. I feel like telling them you shouldn't be here if you're going to have an attitude like that.

Two separate participants described similar interactions with some shelter staff:

Some of them are very rude, some of them are just not very nice workers, even at [agency name], ...], we ask her to do something and she treats us older people like we're, she's better than us. She's not very nice at all. She favors a lot of other people and nobody likes that woman, [staff name], in that shelter. Not one girl likes her. So we all put in a complaint about her. I get very angry and it's an instant hate with that tone. ... she treats us like we're a piece of shit, like we're nothing, we're nobodys. She's better than us. She uses a power trip as far as I'm concerned.

And the other participant said:

It's bad. They look down at you. They treat you like a kid. And they do things that you're not supposed to do, like they either kick you out or they tell you go for a walk cause they're trying to correct something. They always talk like they're not helping, they're bringing you down instead of helping you. And it's hard for most of them, they lose their stuff when it's not necessary. Just goes in the garbage. And I don't think they keep stuff confidential. They laugh at clients. They talk about clients. Like it's getting worse. It's not helpful, like it used to be really good but it's gotten worse now. .... Now it's just not good at all. I don't know why. And there's a lot of times where those employees, like they're power tripping. Like they shouldn't bring their problems to work cause they mistreat the clients ... And a lot of times they're not doing stuff they're not supposed to do. Sometimes I hear some of those workers swear and I know there was a few times where there was money taken from the clients. And that's not fair that, we're not being treated equally, like I even like do a lot of stuff with cleaning and stuff in there, we're always the same people cleaning. And like I am always doing it to help them cause they give me a place to say. But most of the time, the staff is no good. I hate to say it but it's the truth. ...some of them are good and some of them are not. Most of them don't belong there. Like there's a few ladies that are really good which is the outreach.

### ***Service users.***

Several interview participants spoke of challenges they face in their interactions and relationships with some of the younger women living on the street or in the shelters. These experiences can be barriers to older women because in order to avoid these difficult

interactions, the women sometimes also avoid accessing needed services. One participant said, “There’s a couple younger ones, they don’t like me. I ignore them, they ignore me”. An interview participant spoke of rude interactions: “Oh, they’re very disrespectful. They’re very disrespectful. They call me cunt or [unclear] whore. Excuse me? You don’t see me standing out there. But yeah.” And another participant described threatening interactions with other clients: “Oh, they’re ignorant. That’s the only problem I had with being homeless is you have to put up with those certain women that are just ignorant. And they’re nasty.”

### **Subtheme component (iii) Gaps.**

The final subtheme component identified under the theme “what is not working” is that of “Gaps”. Missing or non-existent services or service delivery were recurrent issues raised in the participant interviews. As mentioned earlier, there is often an overlap between the subthemes of gaps and barriers. Barriers that participants spoke of are often indicative of gaps in services or service delivery and often point to a problem with providing services in an accessible client friendly manner.

### ***Things to do and places to go.***

A participant referred to issues related to rules at homeless shelters around access to the shelter and dorms. This points to a gap in services for those who are older or sick and would like the opportunity to rest during the day.

Years back when we were there, we could come and go which was nice. We can’t even do that anymore now. They lock the dorms. From 10:30 in the morning to 7:00 in the evening which is just sort of all day and when we ask them to even put something in our room for us, they won’t do it. Sometimes some of them are good and sometimes... There used to be couches and stuff, they took all that out too. They just have chairs and tables now. And most of the time there’s seniors sometimes in there. Like there’s a senior in there now, they won’t even let her... Sometimes they won’t [let her go to lie down in the dorm]. And there’s a lot of girls that are sick, they won’t let them go in.

Another participant spoke similarly about the rule of no access to shelter rooms during the day.

There's a woman there, she's a native woman, she's got to be close to 100 but they still won't let her go in the rooms during the day to go have a nap. So, she's just got to fall asleep at the table. So that's not right.

The requirement for people to leave the shelters during the day means the clients have to find things to do and places to go to stay warm and out of the elements. Several participants referred to this and one said; "Yeah, some of us we're searching for a place where, you know, that makes time pass by quicker."

Another spoke of a resource that just received additional funds to stay open.

I like going in there, making things and they're all so nice there. And the dinners. Because of all those homeless people, they have nowhere to go. They get kicked out of their shelters where they sleep and then so they have no place to go except for [drop in centre] and [soup kitchen].

### ***Housing.***

One woman voiced her concerns about the type, size and scarcity of subsidized housing or assisted living accommodation options for older persons in Prince George. "And then those old folks home, they put you in a mini room. The closets are that big. Where your clothes is."

Another participant suggested a solution to the affordable housing scarcity. "Yeah, I think they should have more places like [transition house], they're all \$375 a month and I think they should have like a big building like the men's shelter." When asked about finding housing for the shelter allocation amount from social assistance her response was; "For \$375, you can't." She listed the options to rent for this amount that she was aware of;

Rooming houses, the floor at [shelter] or [apartment building], [transition house], [shelter] upstairs. Yeah. And not very many, they should have a big building for

women that are older and I think just these poor women, you know, want to live, right. And to see the depression when they come downtown. It's terrible.

One participant spoke of social assistance rates being too low to be able to afford housing and this had led to a period of homelessness for her: "Cause it's usually direct deposit but they don't give me enough to live on. My rent when I was renting his trailer while he goes to town, it was \$500 a month. So it's stupid. It's hard to live."

Another participant spoke of social assistance being too low to be able to afford the apartment she recently moved into with her son but that she was fortunate to be getting a rental subsidy for the time being through a community program:

It's the government, they just don't give enough. Like um, good thing for [program name], they're helping me for a year 'cause I have my son now and they're giving me a supplement. So that helps out with my rent, then I have more money for food, plus I can go to the food banks.

Another participant reported: "It's very hard, like the rent is way higher than you get from income assistance. Way higher. And that makes it hard. Whereas on my own I had to always rent a place, like a rooming house or something."

The need for separate shelter arrangements for younger and older women was also identified as a gap:

Yeah, I think that they should have a part in there, in [shelter], for the younger women, like when they get to stay on this side. Like this side is way better than the big room where you've got to go share. But if you scrimp on the rules and that, then they put you back over the in the big one. So you had to earn your way. And I think they should put the younger women and us older women separate cause those younger women, I think they have to be in by 1:00 so they're coming in at 1:00 in the morning and even 7:00, you know, going in and out, in and out. Can't sleep. The doors are closed. If you're out you can't get back in until 7:00.

Yeah, and even if you get to come in at 7:00 or you do, you can't come to bed, you have to stay up (laughs). And then they're all mad. They get angry with the workers and that and I said well gee it's your own fault. They don't want them to stay out there all night.

One participant mentioned crowding at a shelter: “Yeah, they crowd the room though, they put a mattress on the floor. I think if the fire department seen that, they would disallow that. It’s not safe.”

### ***Transportation.***

Many participants mentioned the difficulty and expense of getting around to appointments, to find housing or to be able to access the social and other services that they rely on to get by. This represents a gap in service due to the unaffordability of transportation and represents a barrier making it more difficult to access services.

As a brain injury survivor, one of the participants spoke of having been connected to a support service in the past but due to her mobility issues and lack of affordable transportation said: “I haven’t gone since I was at [apartment building]. It’s too hard to get there.”

Another spoke of the expense of travelling on the bus system which limits her access to services. When asked if she had a bus pass she responded that she did not know how to apply for the seniors bus pass program (discounted rate of \$45 a year). “Well, I haven’t filled an application so I pay \$48 a month for a senior bus pass.”

When asked about how she gets to places another participant responded: “Oh, it’s really hard like um, I have to scrounge around and get bus tickets here and there.”

Another mentioned that a shelter gives out bus tickets but:

They can only give you so much at the shelter, … it’s not fun trying to get tickets or whatever to get around where I want to go. At times like when I need to be at the hospital, I can’t sometimes. I’m always walking ‘cause it’s hard trying to get where you want to go.

***Storage.***

One participant who was homeless and staying at a shelter, spoke of renting a storage locker to keep some of her belongings. “Yeah, I have stuff in storage. Gotta pay a monthly fee for it. It’s my personal papers and some stuff that’s just household stuff. Furniture … the big stuff is gone.”

Another interview participant who just recently found housing, talked about the limited locked storage options at a shelter and the challenge of having to carry all her belongings around with her.

Yeah, we have lockers. They give us a bin, plastic tote, and we got two lockers, about yea big. You just put a code in. So you’re only allowed limited stuff and otherwise stuff gets thrown in the garbage. Um, the biggest challenge for me was when I was staying at [shelter name] I had to pack my stuff all over with me. And I couldn’t get … more clothes or dishes or anything I wanted, … ‘cause I had nowhere to store it and so that was a big thing for me.

Another participant also mentioned the challenge posed by lack of storage when homeless:

I got lots of stuff stolen because they didn’t have lockers … some had lockers, or you can store it down in the basement at [shelter name] but if you wanted something out of there, you had to take everything. Yeah, they didn’t want you going down there and getting stuff out all the time.

Another participant response to whether they had experienced a gap in resources and services in the community said: “Yeah, transportation and lockers.”

***Health care.***

One participant described being flown to a hospital in Vancouver for health care, but then becoming stranded there when she was discharged from hospital.

Oh, they just flew me to Vancouver… I stayed there a couple days then I had to find my own way back up here. Stayed on skid row three nights. They told me before I left that they’d fly me down but I’d have to find my own way back here. Like I was too much in pain to comprehend that..

Many of the participants spoke of the challenge of finding a family doctor, and going without a family physician for long stretches of time after moving to Prince George, or when their doctor retired:

I used to have Dr. [name] but he retired... Yeah, that was hard. I was doctor-less for about six months almost a year, Yeah. Um, I went over to that, you know that pharmacy or whatever over here. Right there. They told me to go to see Dr. [name] Yeah, so he's taking new patients.

Another participant's experience:

For a long time, I couldn't find a doctor. ... what I ended up doing to find a doctor was I went through the medical buildings, door to door, to find a doctor that would accept patients and I tried like five others before I finally found mine. ... But my old doctor that I used to have here in Prince George before I went to Vancouver, when I come back and asked, [doctor name] was the doctor, asked him if I could come back on, he said I have 5000 patients already. Unless you're here once a year to see how your general health is, I can't take you on. No matter if I like you and you're my old patient or whatever the scenario, I'm so overwhelmed with patients I couldn't possibly look at your case. Which is terrible. For somewhere that has a university supposedly training doctors, why do we not have doctors?

Several interview participants mentioned that they had not had regular or recent eye or dental care. In further discussion, it became evident that this aspect of health care is often overlooked and that there are often financial barriers for older homeless women to access these services. In response to the question about whether they had had a recent appointment with these services, several participants said they had not but realized that they needed to access them. In response to whether they had been to an ophthalmologist recently "No. I haven't. I should though, right? I've noticed since I've been getting older, I have to wear reading glasses now so I should go get them checked." Another responded; "No. that's what I need." During the interviews, the issue of dental care also came up with several participants.

Oh yeah, like right now, oh my God, my teeth, this down at the bottom, right here, is aching. The top over here, oh my God, my teeth are, I owe the [business name] Dental \$50 so it's just, it's a hassle. Because I missed an appointment. So, I have to go pay that. I'm going to go do that this month. I always say that this month.

There's certain dentists now, they take down people's status cards, so you've got to be careful who you go to 'cause you still have to end up paying. And sometimes they don't even tell you until after it's done. You know, why didn't you tell me this 'cause I don't have any money.

Another spoke of her dental care; "I got to switch back to where I was before cause this [business name] dental place, new place, I don't like it cause they only call you when they're ready and that's like maybe twice a month. That's no good."

Another participant spoke of the challenges with eating the prepared food due to dental issues faced by many women accessing cooked meal services:

Yeah, better meals or hire a better cook 'cause the girl that's cooking there, usually serving us raw potatoes, half cooked and half raw, or carrots half cooked and half raw. Like the girls are bitching 'cause the majority of us don't have teeth.

One participant spoke of the assistance she received through a local agency denture program which was very helpful to her; this example points to an underlying gap in the system whereby dental care is not adequately funded by the government, and the not-for-profit sector must attempt to fill the gap: "Yeah, they helped me get my dentures... that really helped because welfare only paid half."

#### ***Free resources.***

Some of the participants spoke of the limits to accessing free resources from not for profit service agencies in the community which likely points to the gaps in funding, public donations and scarcity of resources.

"Yeah. Well, [thrift store], I got a table for free." Another participant spoke about the fact that this agency assists with start-up kits when people are moving into housing. "They do and that's a once in a lifetime thing too." Another participant spoke of assistance she was able to secure from a place she wanted to keep secret.

I buy my own stuff because you have to qualify [meet certain eligibility criteria to get assistance]. That's why I always know where to go and I even found out some other place that I'm not going to mention where I can get furniture free and it can be delivered. I just found that out not long ago and I'm really happy with that.

Speaking about access to clothing, one woman stated:

To try and get something, like clothing to keep warm, winter boots or winter coat. And I usually get told just like certain cheap stuff we can get, if it's over \$15.00 we can't have the boots. Like that's crazy.

Several interview participants mentioned the challenges accessing food hampers at some places as a single woman without dependents: "They say oh you've got to have family or they don't help you. Or you can go to stand in a line-up at this place to get food, so I just basically stay wherever I get to eat".

### ***Service user input.***

Interview participants were asked if they are ever consulted for their opinion on how services are delivered. One participant simply responded "No" in general; another said "No" that their feedback by the Ministry of Social Development and Social Innovation (MSD & SI) regarding service provision has never been asked for. Two others responded with respect to meetings held at a shelter they have stayed at saying that:

No, they don't. [seek out clients input or feedback] Sometimes they put on a meeting but nobody attends them. No matter that you voice your opinion, ... nothing happens. We have been to meetings where we've talked about the dealing and all that goes on in there. The girls get kicked out for a certain period of time, 24 hours, and then they're allowed back in and it's still the same thing. Why let drug dealers in a shelter, you know, cause they're dealing in drugs, they're selling their dope in there.

Another spoke about the challenges one of the shelters has holding meetings for clients.

They have client meetings and they're allowed to voice their opinion and everything. ... They wouldn't listen anyways because like it's hard, it's really hard to

get along with other women (laughs). So you know and then they're not even there to see the results anyways. Well some of them.

One interview participant commented; "I think that would make a difference [if service users were asked for their input and feedback on services] because then the more answers the better. Cause they're the ones that are coming to the service, needing the service."

Another spoke of trying to advocate for change and approaching shelter services with feedback but to no avail.

Like the AC is still on and like a few times, there's one senior and two girls, two of us got sick. And we keep asking them, it's still on. I don't understand that. I'm sure ways to go around it and fix it. For them to be like running a shelter and it's not done yet. Yeah, they don't monitor enough.

Another participant sounded discouraged when she spoke of her own and fellow service users' efforts to advocate for change at the shelter: "I don't know. I think something should be done because we talk to the manager and whatever like it seems like they don't want to do anything. Yeah, it's just getting worse."

### **Theme #3 -Resilience**

The previous themes outlined interview participants' positive experiences with social and health services in the community, but also challenges, stigma, discrimination and barriers they faced while accessing these same or different services. At the same time, many of the women interviewed spoke of determination to undertake actions to help others and to work towards a better future for themselves. Patterns of resilience, perseverance, compassion and hope for a better future ran through many of the participant interview accounts. The following examples demonstrate these strengths under the theme "Resilience."

### ***Education***

Five of the six participants indicated that they wanted to continue their education and skills training.

When asked about her level of education, one participant indicated that she had plans to return to school: “I’m equivalent to a Grade 11 student. Yeah, I was taking up social work as well. I’m going back to school hopefully in January, to get my social work. To be a childcare worker.”

Two interview participants were currently attending the Street Humanities program at the local college. One of them has her child living with her again after several years of separation and she recently started this program:

Right now, I’ve got income assistance and I am planning on going, like I’m taking a course at night. It’s Streets for Humanity and it’s for people that want to get back into college life and get more education. That’s what I want to do.

Two of the interview participants voiced an interest in pursuing training in computers. One explained that she felt people should be provided with opportunities to improve themselves and not be limited by lack of opportunity because they cannot afford computers and internet access. She spoke of the value to society of providing computer training to those who cannot afford it like herself. She explained that if she were to get a computer and training she would like to give back by volunteering her services to train others or help them to access information and services online.

Why should I become a mushroom in the dark, just because I can’t afford it (a computer and the internet) and I’m not allowed to afford it... just because you’re broke doesn’t mean you can’t use your brain cells to take a class or two. What’s wrong with learning new things, hey they might even get a job in the end from it. ...there’s a lot of people like me even that will take on 10, 15, 20 people and show them how to run around the keyboard, how to run around the screen and use the computer free of charge. I don’t need money, I’d be happy, you give me a computer, I’m happy that I’m using it. .... I’ll show some other people how to use it in

exchange. So it's kind of trade system. If you help me, I'll help you and I'll help the other 10 people that need help. And everything snowballs, instead of snowballing in a negative way, it snowballs in a good way.

The other interview participant indicated: "I don't do computers because I'm not very good at it. I think that's why I want to go back to school, the main reason to learn how to use computers."

In addition, this participant spoke of her frequent visits to the library because of her ongoing love of learning and reading. She spoke of the loss of her book collection due to her loss of housing as she was not able to store these books. "I read, I do lots of reading. I used to have major books. I gave most of them away. I used to have lots of books. Mostly Christian and about learning English and just learning stuff. Heritage, that's another one."

### ***Employment and volunteer work***

None of the interview participants were currently working in paid employment, but several had periods of work within the last few years and two had worked in the service industry as recently as 3 to 6 months ago. One of the participants interviewed volunteered regularly with agencies where she also accessed services, as a way of giving back for the help she has received and to keep busy:

I volunteer lots and like before when I was working, we were feeding the homeless. I'm going through a lot of stuff right now. I have lost lots of family members so we've been through a lot and I volunteer here and there and I keep busy. I'm a people person ... they seem to like to talk to me.

Aside from enjoying giving back and helping people she was hopeful that her volunteer work could lead to employment opportunities:

Like I want to do a lot of stuff where, like to volunteer somewhere where ... maybe they can hire me on the payroll. Yeah, that's what I've been kind of looking into because they have to do a criminal check and stuff so I have a good background.

During a stable period in her life another participant had plans to start volunteering but then had a health crisis which set her back with her housing situation and also with her volunteer plans, but she was still hopeful for the future: "Something like that I'd like to get into. I got to the point though, just before I moved to [apartment building], ... where I was ready to go volunteering and doing this and that and then something happened."

Another participant also described wanting to spend time volunteering:

I'd like to even go spend time with the elderly that need somebody to watch over them anyhow. Play some cards with them on my spare time or something. Or show them something, maybe they'll show me something, maybe I'll learn to crochet from them, or how to do a preserve I've never done before. In the meantime, I can show them how to use the computer or how to play a game or something simple on the computer, so they're comfortable. How to use a cell phone or how to access their bank account and their information on the Internet that should be available to them. So they can show me things. We can learn from each other.

### ***Self-identified strengths***

When asked what they felt their strengths were, several participants had responses. One said: "Uh, my biggest strength is to help my Aboriginal people. My people and others." Another participant mentioned her perseverance with figuring things out and her realization that respect and kindness towards others is important:

Yeah, I know how to access that, like in the past I didn't know how to do anything. I had to learn. I really had to learn and I found out that I have to be, you know, treat people with respect in order to get back respect. Because I see meanness and stuff like that all around me and then I become part of it and then I act like they do and I don't get good ....

Another spoke of the strength she finds in spirituality:

Well, being a prayer warrior is my greatest gift. My strength is my faith in God. I know through God all things are possible. That's what it says in the Bible and that's what I believe because I've been through a lot. Even my counselor told me I've been through a lot and she said now you're a very strong person. A lot of people tell me that, I said what do they mean strong person? Because I've been through so much, a lot of it is sexual abuse as a child and I don't know how in the world I survived. The Lord certainly was looking after me and I thank him often for that.

She went on to speak of her past and evolution of spirituality for her:

Yeah, because in residential school we had to go to church every morning, twice on Sunday but now I broke away from that, from Catholicism, now I'm a Christian. And I find it much better now. I don't go to church necessarily, sometimes I do but not often. Like we don't need to go to church to talk to God, so that's what I learned so that's what I do, I read my Bible often.

A different participant said: "I'm resourceful and strong. Nobody else is going to help. You have to do it yourself, fight for yourself." Another participant responded: "I always try to keep, try to think positive, always. Do stuff in a positive way."

A participant spoke of learning from her life's challenges and experiences, staying positive and wanting to pass this experience on to help others:

Years back when I was 20, 21 I didn't know what to do or whatever. But I learned from my mistakes and I try not to go there. But I'm slowly getting the hang of it and hopefully things will get better in the future. So it's getting better..., especially with friends or family or friends or even a stranger ... I would help in any way .... I used to do a lot, ... there's a few people of my people that were illiterate so I am that kind of person, I always like to help.

### ***Growing older***

Two of the interview participants were just recently housed in market housing. Two other participants were staying in shelters and two in transitional housing. All the women interviewed had hopes and intentions of either staying, or eventually being, housed independently. At the same time, all mentioned the difficulty finding appropriate, safe, decent and affordable housing in Prince George.

Participants were clear that they had no desire to be homeless now or as they get older. Participants generally had a hopeful outlook about the future and the possibility of avoiding homelessness as they age. When asked about whether she had any concerns about this, one participant responded; "No, because I know when I'm getting older I'm not going to be in a shelter. I know that for a fact. Cause either way, one of my daughters will take me in."

This participant was staying in a shelter at the time, and reported that neither of her daughters could house her as they did not have stable living situations.

This is another participant's response to whether she had concerns about being homeless and growing older:

Uh, well, sort of I sometimes think about it, but I'm pretty strong. I'm a pretty outgoing person that deals with a lot of stuff. Like I say I always deal, like try to think of it in a positive way. I don't let it bother me (laughs).

Another participant's response showed her determination for a better future:

And I want to get out of that mode because I don't want to be, it's not good to be homeless, especially at my age, I should be a good example for others. Instead I'm in a shelter and I don't like that one bit.

During the interview, this participant reported that she had been homeless episodically for many years but was adamant when she said: "... that's the last time I'm going to be homeless. I'm going to make darn sure it doesn't happen again. I know how to get out of it now."

### ***Advocacy and self esteem***

A participant spoke of how she stands up for herself and others when she witnesses things she does not feel are just. In this instance, she was speaking of the clinic where she receives care: "Sometimes, I always speak my mind. I always tell them it's wrong. I don't just blurt it out, I just say excuse me, like I just speak my mind. I just try to correct it."

Another spoke of organizing a unified complaint against a shelter worker.

And I told them it's not necessary to do that. ...a few times already and I got a lot of people to, like I sort of did a petition, sort of, cause it's not good. And I'm hoping that scared them a bit because I never seen that [name] there anymore after that. ... most of them, they shouldn't be there when they don't want to be there.

When asked about her experience with services at MSD & SI, one participant described a scenario dealing with the bureaucracy of accessing her monthly social assistance cheque and her self-advocacy skills:

I said okay if I can't get through with you, then I want to talk to the supervisor. I said excuse me supervisor, can I please talk with you and he says well in a half an hour. I said fine, I'll wait right here for half an hour. I said ... how the hell am I supposed to get back to [community name] ... Am I supposed to hitchhike? I said ... I can't get any of the paperwork you want because it's all in [community]. So they said okay, well this time we'll release it but then you gotta bring in all this paperwork. So I did. And again, because I didn't check off that there was no warrant for me, they have my cheque again. ... So I had to go and wait in that line, and I can't stand up that long, I sat down and waited and waited and finally got in. She brought me my paper and I checked it off and I said oh my God it was that simple, you couldn't do it? She said we're not allowed to. .... So then she goes, your cheque you're going to have to pick it up tomorrow ... I said no I can't do that you have to get it done as soon as possible... and then the supervisor released it. I said because I'm not going to come back here again tomorrow, I can't do that. I said, so you could've just put my cheque in my account instead of making me have to come all the way back here again. I said so no I'm not going to keep doing this. I've never had to do this living in [community], never. My cheque is always in my account, always.

Another participant described her challenges but ultimate success with navigating Service Canada and Revenue Canada systems:

Well, I went to the government office, I didn't know, I found out on Friday I could contact them myself. I asked them to change my address and they didn't. And I told them I need my income, how much I got, to do my income tax. So she got a hold of them but she forgot to change my address and then there's the mail strike and then the government send me a letter and they said because we send numerous letters to you, they sent two, and I phoned at taxation and they told me they can't mail the papers just yet because of a mail strike might happen so finally on August 14<sup>th</sup> I got the papers. Then August 23<sup>rd</sup>, I had my income tax filed and then I phoned, I didn't know what else to do after that, I didn't know so Friday I just went to that government office and ... I showed her that letter ..., I said I don't know what I have to do, phone them or what? She said yes you should because she said they're the ones withholding the money from you. So she just dialed the number for me and then I waited about 10 minutes and that was it. I did it! I did something for myself. I was very proud of myself for that.

One of the participants expressed an attitude of positivity when she discussed her hope of getting into seniors subsidized housing, but also a feeling of confidence in her abilities to come up with an alternate plan should this housing not come about:

Well, there's always a back-up plan. Now nothing seems hopeless anymore. It's just I didn't know how to access things. I didn't even know how to do a lot of things but I learned. So I'm not worried anymore. Everything is worked out. I was never positive like this in the past. [Being homeless] Sometimes it's a blessing. Cause it wakes you up. It is a wake-up call. That's what I took it as. Oh Yeah, I'll find something.

Older women participants in this research spoke of their positive and negative experiences accessing social and health services in the interviews held as well as their experience with loss and their strengths and resilience. The findings from the participant interviews are discussed in more detail in the next chapter.

## **Chapter Five: Discussion**

In this chapter I will discuss the research findings presented in Chapter 4 in relation to my own work experience and the literature; describe the challenges and limitations of the research; review my reflections on the research process; make recommendations for practice arising from the findings; explain the plan for knowledge transfer; and make recommendations for possible future research.

### **Summary of Findings**

The overarching themes identified through a process of thematic analysis of the six participant interviews were Loss and Disempowerment, Navigating Services, and Resilience.

The interviews and the themes identified reveal some of the types of services accessed, how older women participants experience accessing these services and how their voices and needs are considered and integrated into service provision in a northern British Columbia community. Missing services and issues with service provision were revealed in the interviews and are reflected in the subtheme components of Barriers and Gaps and some recommendations for improvements to service delivery are summarized in subsequent paragraphs. Under the subtheme component, Interactions, some excerpts from the participant interviews demonstrate examples of the power imbalance experienced by some clients of services but also the resilience of the older women participants interviewed.

The experiences of loss, barriers and gaps in service, difficult interactions with service providers, and resilience mirror my work experience. Many of the issues shared by participants in the interviews were similar to those my work clients often ask me to assist

with. These represent the challenges that older homeless women and other vulnerable people face every day when navigating systems to access services they need to get by.

The findings also reflect what the literature explains about the interconnected relationship between homelessness and trauma history, substance use, and mental health challenges, since many of the interview participants alluded to or openly referred to having experienced these issues.

### **Theme #1 -Loss and Disempowerment**

The interview excerpts under the theme of “Loss and Disempowerment” point to the experiences of trauma in addition to loss and include the following elements: loss of family relationships (due to family breakdown, distance, or death); grief; loss of trust; loss of employment (sometimes due to health issues); loss of income; loss of housing and belongings; loss of power and autonomy due to homelessness; loss of ability to self-direct activities of daily living (such as cooking, laundry, bathing, food choices, and mealtimes); having to rely on others to provide services at their discretion, on their timelines and rules; exposure to drug use, verbal and physical violence; loss of mobility due to health issues or transportation difficulties; and loss of control around health care. In addition, some participants identified loss of pride or feelings of shame about being homeless.

Women spoke of experiences which indicated, though not explicitly stated, that they had a sense of disempowerment or loss of control over their own lives. The examples they gave often indicated being in positions of power imbalance and powerlessness when having to request assistance for their everyday essential needs from those service agencies and service providers who are in positions to either help or deny help.

Many of the losses alluded to in the research interviews were remarkably similar to many of the reasons for homelessness identified by individuals surveyed during a Prince

George homelessness count (Pateman et al., 2016), and observed through my work experience.

### **Theme #2 -Navigating Services**

In the interviews, participants spoke of both positive and negative experiences with services and this is captured by the theme, “Navigating Services” under the two subthemes: What is Working, and What is Not Working which has three additional subtheme components: Barriers, Interactions, and Gaps.

#### **Subtheme (a) -What is working.**

Some responses to the interview questions described positive experiences with services and service providers. Several participants mentioned that there were many sources of food assistance in the community in the form of prepared meals, special holiday suppers, and food hampers. Some participants described positive experiences at shelters and transition homes and felt that staff and management were kind, helpful and trying their best to make improvements. Others described good experiences at two drop in centres where they could pass the time with craft, educational and cultural activities, companionship, and refreshments. Others spoke of how they were enjoying the challenge of Street Humanities, an innovative education program offered through the College of New Caledonia (CNC). Several described some good experiences with their family physicians or with health care services. A few participants described receiving very useful assistance to successfully find housing through an outreach program run out of one of the shelters. Others spoke of several service agencies where they could access limited free clothing, furniture, bus tickets, rides, as well as free income tax filing services.

### **Subtheme (b) -What is not working.**

Many responses to the interview questions described negative experiences with accessing services and with service providers. These were found to fit under the subtheme components Barriers, Interactions, and Gaps.

#### ***Subtheme component (i) Barriers.***

Interview participants spoke of experiencing barriers to accessing services. These included difficulties contacting services, government, and doctors' offices sometimes due to having little access to phones because of financial and living constraints (phone lines being busy, long hold times, long waits for or very impractical and inconvenient service call back times, etc.) These challenges have been discussed in the news and by advocates as well (Brend, 2017). Response times from agencies and availability of service agency staff were often described as barriers making it difficult for participants to obtain access to the services they needed.

Due to challenges with transportation, unstable living situations, and limited phone access, participants spoke of difficulties they sometimes face getting to appointments, and the barriers that the consequences posed for them.

Participants talked about the inflexibility of some health service offices. Some dental and doctors' offices charge for missed appointments, or will not make allowances for lateness; some will refuse to see clients again if they miss an appointment, or if they do not pay the associated fine. Several participants mentioned the common rule that due to physicians' limited appointment times, only one or two issues can be addressed during each appointment.

Several also mentioned the barrier they encounter when they have paperwork to fill out, sometimes due to literacy and comprehension issues. This included having to have forms

filled out by physicians (with associated fees sometimes charged), applying for housing (providing landlord references), identification, social assistance, OAS and CPP applications.

The lack of choice in providers (particularly with regards to the gender of counsellors or health care providers) can mean clients may decide not to access health care or other critical and needed services.

The accessibility of locations of services was mentioned as a barrier, for example when food banks and other services are not downtown near shelters or other commonly accessed services or are out of reach for clients.

Bureaucracy, computer literacy issues, telephone, processing wait times and eligibility requirements for assistance from non-governmental and government programs like the MSD & SI were identified as big barriers for many, and are also reflected in the news and by community advocates (Brend, 2017).

Women indicated that they may avoid accessing services if they are trying to stay clean from substance use and they perceive a risk that accessing an available service may mean being triggered to relapse.

#### ***Subtheme component (ii) Interactions.***

The examples under the subtheme component of “Interactions” include uncomfortable and unpleasant experiences interview participants described when interacting or communicating with service providers and agencies. These experiences included situations when interview participants were trying to access services they needed to meet basic needs, including emergency services to keep individuals safe such as hospital care and police encounters.

Some participants spoke of experiences in which staff at the hospital were rude, discriminatory, and lacking compassion and sensitivity, at the emergency department or

when being admitted to the hospital. Others experienced disrespect and rudeness from nurses and doctors. Another participant spoke of witnessing discrimination where service users were being treated unequally, rudely, were laughed at, and talked openly about by service agency staff because they are Aboriginal.

In addition, participants described some staff at shelters as being patronizing, unfriendly, uncaring and abrupt with shelter users. Some interview participants reported that they felt services were provided unequally whereby some people were favoured and treated better than others.

Underlying these experiences relayed in the interviews was the importance of how the interactions made participants feel. It was often about how participants experienced interactions and felt they were treated by others, particularly by those they rely on for services to meet their basic needs and the social determinants of health such as, income, food, shelter, and health care.

#### ***Subtheme component (iii) Gaps.***

Excerpts from the participant interviews under the subtheme component of “Gaps” identified several missing aspects in service and service provision. A shortage of places to go and things to do during the day was mentioned by several women. Of concern was the lack of places to rest or nap during the day if an older woman was tired or not feeling well and needing to lie down to rest. Several women interviewed mentioned that shelters would not allow women to access the rooms during the day to sleep.

Talked about by several interview participants was the unaffordability and the inconvenience of public transportation including HandiDART, a door-to-door transportation service for persons with disabilities who are unable to use the regular public bus. The BC

seniors bus pass program does not cover the cost of \$2.25 per one way fare, the routes are convoluted and long, and waits sometimes lengthy.

Interview participants spoke of housing issues, high rental costs and low supply of affordable, supported or subsidized housing options.

Low provincial income and disability assistance rates with their limited shelter assistance, transportation, dental, and eyewear benefits, and inadequate federal Old Age Security rates, were spoken about by participants, and are reflected in the experiences of those I work with and are reported by advocacy organizations and in newspaper articles (Citizens for Accessible Neighbourhoods & BC Poverty Reduction Coalition, 2017; Klein & Reano, 2017; MacLeod, 2017a; MacLeod, 2017b).

Also mentioned by several interview participants, was the issue of storage of personal effects. Related to this was the issue of not being able to keep personal belongings due to lack of affordable storage solutions or a lack of storage space at shelters, when housing is lost. There are few options for assistance with coverage of moving and storage expenses. As a result, homeless women must carry their belongings around with them during the day or risk losing them.

Mentioned in the interviews and encountered in my practice are issues to do with family physician shortages, gaps in coverage for dental, dentures, eye glasses, medical equipment and supplies, and prescription medications for older women, if they have aged out of social assistance and do not have First Nations Status health benefits.

Many non-profit service organizations do their best to assist clients, but are usually constrained by a lack of financial support. They must place limits on free resources such as bus tickets, rides, clothing, toiletries, food hampers, furniture, and household items such as bedding and kitchen items to those seeking assistance.

Finally, women interview participants indicated that they are rarely asked for input or feedback from the social and health services they access in the community. The prevalence and significance of this is outlined in the literature (Elliott et al., 2005; Hopper et al., 2009; Lived Experience Advisory Council, 2016; TIP Project Team, 2013).

### **Theme #3 -Resilience**

The theme of “Resilience” ran through the participant interviews. Women spoke of advocating for themselves or on behalf of others for improving services as well as to successfully navigate through governmental bureaucracy to get assistance, like MSD & SI for social assistance and Service Canada for; Old Age Security (OAS), Guaranteed Income Supplement (GIS), and Canada Pension Plan (CPP). Several women spoke of their pride in being able to successfully stand up and advocate for themselves, and, as a result, their increased self-confidence.

Women participants demonstrated hope and determination for a better future for themselves. Some spoke of wanting to give back to the service agencies from which they received assistance by volunteering to help others. Others talked of their interest, and in some cases current endeavours, towards continuing their education and skills training, and some were wanting to find employment. Many of the interview participants were confident that they would not be homeless as they got older and that, somehow, they would be housed.

They described their personal strengths including their spirituality, resourcefulness, being independent, and their ability to stay positive.

### **Challenges and Limitations**

There were several challenges and limitations encountered while planning and undertaking this research. I have listed the challenges as finding interview participants,

contacting interview participants, and honorariums. As well, there were some issues that needed careful thought and special consideration during the planning and interviewing: conflict of interest, re-traumatization, and capacity. The limitations identified were the age range of the interview participant sample, and the applicability of the research to other communities and population groups.

## **Challenges**

### **Recruiting participants.**

It took some time and effort to find potential interview participants. My initial strategy included putting up posters and spending time at a Thanksgiving community dinner and at drop-in centres where meals are provided and leisure activities take place. I approached visibly older women and explained my research to see if they might be interested in further information and in participating in the interviews. As I had hoped, after finding the first participant, the process of recruiting other participants became easier, as participants spread the word to other women, and the process of snowball sampling began. My sample of interview participants for this research was composed of the first six women who were willing to participate, fit the age, and experience-with-homelessness criteria, and with whom I managed to connect at an appointed time and date for the interview.

### **Contacting.**

Connecting and follow up with interview participants proved to be a challenge. In several instances, it took multiple attempts and calls to set up the interviews. Five out of the six women did not have a phone and used a community messaging service or agency number where messages could be left for them, or email. In several instances, we played “telephone tag” where messages were left back and forth but connecting did not happen. In some other

cases, appointments were cancelled by potential participants and sometimes appointments were rebooked several times before they took place.

Being homeless, having unstable housing and limited finances and often without easy telephone access, the women interviewed were often difficult to contact, both to set up the interviews, but also in follow up after the interviews to offer copies of the transcripts and thematic analysis. This often meant multiple messages being left back and forth and, mostly unsuccessful, attempts to reach the individual.

### **Honorariums.**

The fact that refreshments, bus tickets, and an honorarium in the form of grocery store gift cards were provided to participants may have biased the participation as this fact was likely passed along from one interview participant to other potential participants, and may have influenced their interest and willingness to take part in the interviews. Since a snowball selection was used, whereby participants spread the word to one another, the sample of individuals interviewed was not random. Women who were interviewed may have approached those in similar situations or locations as themselves, thus potentially introducing a bias to the data collected.

When conducting research with a population that is vulnerable and has limited financial resources, providing material supports to participants could be viewed as introducing an ethical challenge to recruitment (e.g., an incentive to participate could be considered coercive, given participant circumstances and need for material resources). However, I made the decision that it was only fair to have some reasonable degree of recognition and compensation for the time given by the women who agreed to participate in the interviews.

**Special considerations: conflict of interest, re-traumatization, and capacity.**

An initial challenge proved to be finding individuals who fit the criteria and would be willing to be interviewed.

I grappled with the ethics of having women I knew (through my work as a social worker in the community) participate in interviews for my research. After weighing the pros and cons in the search to find a balance between ethics and effective gathering of useful information, I made the deliberate choice not to interview women who I knew I had worked with. Although interviewing women I knew would have made the process of finding participants easier, I decided that my approach was more straightforward, potentially less fraught with ethical dilemmas, and most importantly would provide more anonymity, confidentiality and perception of safety for the women interviewed.

Further, I did not discuss my search for research participants with fellow staff or clients or put up recruitment posters at my workplace to try to avoid having to turn away women that I knew. However, during the interviews one participant spoke of her experiences accessing services from my workplace and another referred to a clinic that I could infer was my workplace. Although these participants may have accessed services from my workplace, they had not accessed services from me and we did not speak about where I worked. Since the research was being undertaken for my studies I felt it was ethical to continue with the interviews with these participants. I approached the interviews realizing that it was possible that participants may access services from me or from my co-workers in the future. I was careful to explain that the research I was conducting was for my own personal education and not affiliated with any organization, my employer, or a paid job. It was also explained that participation or information shared in the interviews would be used in a confidential way so

as not to identify the individuals who shared the information. In this way, I sought to protect participants' privacy and not impact their future access to services.

### **Avoiding re-traumatization.**

Serious consideration was given to the possibility that interviewing individuals might delve into sensitive, emotionally laden memory and reminiscence, which could lead to re-traumatization or could trigger or exacerbate substance use and mental health issues for participants. In abiding by our code of ethics, social workers have an obligation to conduct research in a responsible and purposeful manner and to "strive to protect research participants from physical, mental or emotional discomfort, distress, harm or deprivation" (CASW Code of Ethics, 2005). For this reason, the demographic information collection and the semi-structured interview questions were designed to try to minimize the possibility of re-traumatization or triggering of those interviewed. Though I watched carefully for it, I was not aware of any serious issues coming up for interview participants during the interviews. In addition, each of the women was provided a list of counselling resources (Appendix D) at the beginning of the interview; they were also reminded of these resources after the interviews and encouraged to access them as needed following the interviews.

### **Participant capacity and vulnerability.**

For the purposes of this research, I felt it was important to attempt to capture the varied voices of those who fit the participation criteria with the understanding that this was likely to include women who had histories of substance use, mental health, and cognitive issues.

My intent was to make every effort to ensure that each participant had capacity prior to beginning the interview process. I felt confident in my ability to assess this because of my work and personal experience. The determination of ability to consent was based on a lack of

obvious visual signs of cognitive impairment or intoxication due to substance use (without administering intrusive cognitive or substance use tests). There was no evidence of cognitive impairment among the participants I interviewed.

### **Limitations**

There are two main limitations of this research identified; age range and applicability. Since the research was conducted in a small city in northern British Columbia, and many of the services that women access here are specific to this community, the information and findings may not be entirely applicable to other places, thus limiting its relevance to other communities and other populations of older homeless women. At the same time, some services accessed by interview participants, are provided by not-for-profit and by governmental agencies, that exist province and even Canada wide.

Due to various possible reasons, including the sampling method used and the limited sample size, this research did not capture the experiences of women over the age of 68, since all but one of the participants were in their 50s. It would have been informative to have interviewed more women over this age. Older women who have experience with homelessness may have reported different experiences, barriers, and gaps to services than younger women. There is a small but important and significant number of homeless women above the age of 68 in our community, and I know from my own work experience that they often have very complex issues and needs (Davis-Berman, 2011; Dietz, 2009; Pateman et al., 2016; Salem & Ma-Pham, 2015).

In addition, as our population ages, this number of older women facing homelessness may increase in the future, unless our social programs are expanded to keep pace with the growth of this older demographic (Cohen & Franco, 2015; Killian, 2015; Morgan, et al., 2015; Morgan, 2017).

### **Researcher Reflection**

I came to this research with very little experience planning and undertaking qualitative research. The prospect of doing the interviews was daunting and locating research participants was beyond my comfort zone. In the end, it was a positive experience as I enjoyed meeting and talking with the women participants of this research. The thematic analysis process of organizing my data and thoughts was much more complicated and difficult than I had anticipated. As well, I realize that undertaking social work from a structural orientation also impacted the categories, codes and themes that I ultimately identified in the participant interviews.

In reflecting on, and in reviewing my journal notes made during the research process, there were a few things that struck me. In addition, with the benefit of hindsight, there are several ways I could have undertaken the research process differently as described below.

#### **Expectations and Assumptions**

It was challenging to try to suspend my own expectations and predetermined ideas around the outcomes of the research. Though I tried to suspend judgmental or leading comments, I realized in listening to the interview recordings that due to my inexperience, this was challenging to do, and not always accomplished (Alston & Bowles, 2013).

I expected complaints, so I was surprised by the number of good things women participants had to say about services in the community and by their positive outlook on life and for their future, as well as by their resilience. What also struck me was the amount of emotion underlying many of the responses in the interviews and how this indicated the critical importance of how people are made to feel during and after the interactions they have.

### **Trust.**

Though a process was put in place to try to ensure that the information shared by participants would remain confidential, and participating would not affect the women's access to services in the community, many potential participants approached were unwilling to take part. They did not share their reasons for not wanting to participate and I did not feel it was appropriate to ask or to probe further.

The mere mention of "social work" or "social worker" can bring up unpleasant experiences and traumatic memories for individuals, and make some people think automatically of children and family services and child apprehension. This can affect the dynamics between interviewer and participant, and alter the perceptions of power differential and level of trust. I wondered at times whether this may have had something to do with the lack of interest in participating in the interviews.

As well, despite my efforts to ensure privacy and confidentiality, it is quite possible that participants may not have felt at ease to share their thoughts freely and those who did participate in the research may have limited what and how they discussed issues in the interviews. Why would older women with experience with homelessness trust me, a stranger asking them questions about services, institutions, organizations that they rely on to meet some of their most basic needs? Or was it a rare and welcome opportunity for interview participants to share their experiences with someone who they saw as neutral? Either way, my privilege, social location, gender, age, education, and class most certainly affected how the interviews unfolded.

I cannot assume that I got full responses to my questions or that they were not filtered through some degree of distrust. I cannot know for certain how comfortable the participants

were to express their true sentiments about accessing services. At the same time, I believe I did get some quite genuine, impactful, and informative responses.

### **Done differently.**

At the outset, I was hoping to capture the experiences of a wider age range of women participants in this research. In the end, the voices of women beyond their late 60s with experiences of homelessness are missing from this research. This may be partially because people over the age of 65 usually represent a fairly small percentage of the overall homeless population, and older women represent an even smaller percentage than older men. This is reflected in the homeless statistics for Prince George, BC (Pateman et al., 2016). In addition, as outlined in the literature review in Chapter 2, it is known that homelessness seems to accelerate aging and reduce longevity, likely because of the difficult lives people who experience homelessness experience. To try to include this upper age group in this research, I could have made the sample size larger, used a targeted sample selection strategy, or looked more widely in my search for participants. I could have targeted this population age group by seeking assistance from shelters, or other service providers and agency staff. However, if not done carefully, involving service provider staff could have impacted participant anonymity and may have contributed to biasing the results.

### **Personal Reflection**

In my job as a social worker, it can be difficult to not feel overwhelmed and discouraged in the face of the challenges that vulnerable populations face in simply trying to live and get by. My work days are spent advocating and working through bureaucracy, trying to problem solve, and make repairs with a patchwork quilt of solutions to temporarily fill holes that exist in the system. Many of the experiences interview participants shared with me

during the research phase mirror the realities of my clients at my work, who are facing the systems in place. However, this research reminded me that there are good things happening in this community and these are being experienced, observed, and appreciated by service users. Some services may need some fine tuning to improve the way they are provided, but much good intention exists and good work is being done by many good people with their hearts in the right place trying to help. Even more of an impact for me was the evident positivity and strength residing in many of the women I interviewed, reminding me of their incredible resilience in the face of, what often seem to me to be, insurmountable challenges. Sometimes I become mired in the injustice, unfairness, and inequity and I forget about the hope and good things that are happening. The interviews with the amazing women participants was a reminder to me of the good being done, and the dreams and resilience within the clients that I work with daily.

Still, it is the older clients that I work with that concern me the most; the cracks they fall through are numerous and deep. I see a lack of resources and money put into providing services such as senior's subsidized and supported housing, life skills support and home care services and other arrangements to best suit the individual needs of older persons (Cohen & Franco, 2015).

In my view, the solutions involve closely listening to older homeless people, with respect for their ideas and feelings, recognizing them as the experts of their own lives, to truly get a sense of their needs and to design services that fit and address these needs. It is one thing for the government to say that older people should be encouraged to live independently for as long as possible, and an entirely different thing to put in place the resources to ensure they have housing and can successfully maintain quality independent living. Resources need to be mobilized for older people to have the supports they require to

live long, productive, and independent lives (Cohen & Franco, 2015). For older homeless women, this starts with securing affordable, decent, appropriate housing.

## **Recommendations for Practice**

### **Advocacy**

Service users, providers of services, and the social work profession can provide leadership to continue advocating for increased government investment in improving the social determinants of health for older women which can in turn reduce poverty and homelessness among older women. We should continue to push for improvements, such as: the reduction or elimination of Medical Services Plan (MSP) premiums; for universal Pharmacare to make prescription medications free for older people (Killian, 2015; Morgan et al., 2015; Morgan, 2017); wage equity for women (Ivanova, 2017) ; universal childcare; government compensation for time spent childrearing or caregiving of the sick and elderly by a family member, both of which usually fall to women; fairer Canada Pension Plan rules around eligibility and contributions (Ivanova, 2017); free or affordable transportation for older persons; increased provincial welfare and disability rates (Brend, 2017; Citizens for Accessible Neighbourhoods (CAN) & BC Poverty Reduction Coalition, 2017; Klein & Reano, 2017; McLeod, 2017a; McLeod, 2017b); more affordable and subsidized housing; increased numbers of publicly funded spaces and options in assisted living and complex care; more low barrier housing options; increased resources put towards publicly funded supported living, home support and home care services (Cohen & Franco, 2015); reducing violence against women and elder abuse; increased funding for addictions and mental health services for older woman; and homeless shelter services tailored to older women (Hopper et al., 2009).

In addition to working towards minimizing the gaps in services and service delivery for older homeless women, the findings of this research around the themes of loss and disempowerment and barriers to access, support the need for continued and improved efforts at trauma informed service provision for older homeless women in our community.

### **Trauma Informed Service-Service Providers and Organizations**

A recommendation of this research is for service agencies and providers to continue to use or adopt a trauma informed service approach, described in the literature reviewed in Chapter 1, as a “universal precaution” (Elliott et al., 2005). It should be assumed that women who experience homelessness will often have histories of substance misuse and mental health issues, combined with trauma histories, as the literature indicates (Peck & Capyk, 2012). This approach includes providing services in a non-confrontational, non-hierarchical, or non-intrusive way (Harris & Fallot, 2001). It attempts to give service users a sense of self-efficacy and control by providing choice and opportunity for input (Chambers, 2012; Elliott et al., 2005; Hopper et al., 2009; Lived Experience Advisory Council, 2016; TIP Project Team, 2013), rather than providing services in an autocratic manner which may mirror trauma experiences for women (Harris & Fallot, 2001). It means providing positive, compassionate experiences to clients so that they will not avoid accessing a service thus endangering their health and wellbeing (Chambers, 2012; Harris & Fallot, 2001). It may include the need to shift perspectives to be able to view behaviours exhibited by service users as coping mechanisms. Rather than defining individuals by their behaviours, it involves making efforts to understand the root reasons for these coping mechanisms. This means not labeling or blaming, and most importantly, not excluding people from access to services, but instead providing services in ways that diffuse and deescalate these behaviours, and provide safety and comfort to service users (Peck & Capyk, 2012). Trauma informed services treat service

users in a collaborative, cooperative, and consultative manner, providing them with a say in how and what services are provided (Elliott et al., 2005; Hopper et al., 2009; Levinson, 2017; Lived Experience Advisory Council, 2016; TIP Project Team, 2013; Wilson et al., 2013).

Bowen and Murshid (2016) call for taking a step further, to encourage a wider social policy change to incorporate a trauma informed framework lens when working with marginalized populations where trauma histories are prevalent. Such a lens recognizes the intersection of age, gender, race, social class, sexuality, and ethnicity, and that these multiple marginalizations and vulnerabilities are predictors of trauma experience. It would acknowledge the connection between trauma and the many health and social problems for which people seek services. Ultimately, it would be an approach to working with vulnerable people, like older homeless women, with the view that they likely have experienced at least one form of trauma and often, multiple interconnecting traumas.

### **Self-Reflective Service Provision**

Being trauma informed and providing trauma informed service delivery requires organizations and staff to be receptive to being self-reflective and willing to make change (Hopper et al., 2009). It requires an openness to criticism and to welcoming feedback from service users. It involves continual self-assessment and reflection, periodic operational review and evaluation, and implementing mechanisms for seeking input and ongoing feedback from service users. Service users should be sought out and encouraged to play active roles in the organization of service delivery, by sitting on boards and participating on service user improvement committees, for service organizations. A willingness to be more client centred, trauma informed, and practice oriented may require education and a philosophical shift on the part of organizations, management, administrators, and front line staff.

## Social Work

The social work profession has always worked in an inherently trauma informed way (Wilson et al., 2013) and can continue to take a leadership role in promoting the expansion of this practice lens to the wider social service realm by encouraging staff and organizational support and training, and by facilitating staff engagement in regular self care practices (Hopper et al., 2009).

## Knowledge Transfer

A community meeting will be organized within four months of the defence of this research, inviting service providers and service users to participate, as a mechanism to disseminate the information collected and discuss the issues identified during the interview research with service users. The hope is that the themes compiled can be used as a launching off point to examine the way service is provided to older homeless women in the community, and to find strategies to encourage the integration of the clients' voice in the way services are delivered, and to make service provision trauma informed, client centred, and gender and age appropriate. The community gathering will be conducted using a guide made up of the extraction of themes and commonly raised issues from the interviews in this research. These will be used to encourage and stimulate discussion among the participants.

Staff from a range of agencies providing services in the community will be invited by letter to participate in the community gathering. This will include community advocates and shelter staff; health care and social service professionals such as social workers, mental health and addictions counselors, as well as doctors, nurse practitioners, nurses, policy makers and possibly politicians. The letter of invitation will encourage the recipients to spread the word and to suggest colleagues they know who may be interested in participating.

Every attempt will be made to contact the older women service users interviewed for this research to invite them to participate. A broader invitation will be issued, using various methods such as posters, word of mouth, and through various social service agencies, to advertise the event to try to encourage attendance by older women who have experienced homelessness and use or have used services.

The hope is that from this event, some ideas for positive changes might be discussed and implemented by agencies providing services to older women experiencing homelessness in our community.

### **Recommendations for Future Research**

This research topic exploring the experience of accessing services by older women homeless women was chosen due to the gap in information around the topic, in the literature in general, but also specifically in relation to the northern BC context. This research touches on some aspects of the issue of service provision to older homeless women but is in no way exhaustive. There remains much room for additional research to be undertaken on the wider subject of whether the community is meeting the needs of older women experiencing homelessness adequately and appropriately in a trauma informed manner.

According to the literature, further study of the experience of older homeless individuals from their own perspective is still needed (Davis-Berman, 2011). In particular, research is needed to explore the specific experiences of homeless women accessing services such as shelters (Salem & Ma-Pham, 2015), but also addressing health and income support accessibility issues for older homeless women (McLeod et al., 2014). Further research that can contribute to the discussion on these topics and move towards making client centred and

trauma informed service delivery and provision improvements for older homeless women is needed.

Additional research focusing on women experiencing homelessness who are older than 60 would also be important. Only one of the interview participants for this research was over this age, though I had hoped at the outset to interview more. It would be beneficial to be able to determine whether there are differing issues of concern that older women face as they continue to age.

It would also be interesting to supplement this research with the views of advocates working side by side with older women experiencing homelessness who assist with navigating the services, to see how their perspective compares to the findings of this research and to hear of the gaps and barriers they identify as being faced by this population. In addition, it would be useful to compare these views to the perspective of decision makers and administrators in government and non-profit agencies to see how they perceive the effectiveness of service delivery by their agencies. A possible method to try to gather this information could be the administration of a questionnaire to a wide range of service users, service providers, advocates, administrators, and policy makers.

### **Conclusion**

Recognition of the importance of our older population is critical to ensure they are valued for their ongoing contributions to society, and to ensure that the services are in place to allow older people to remain vibrant and engaged members of our communities. The social work profession, and the wider society, have an obligation to seek out the views and needs of older persons, including those who are the most vulnerable among them, such as older homeless women, the focus of this research.

This research recognizes that the problem of homelessness among older women is partly a result of a complex combination of interlocking oppressions found within the structures of society (Sokoloff & Dupont, 2005; Zufferey, 2017). The intersection of sexism, ageism, classism, and racism contribute to the reality that most older women with experiences of homelessness have encountered physical, sexual, emotional, and structural violence throughout their lives (Allen, 2016). This research reinforces the perspective that these different forms of oppression should be viewed through a trauma-informed lens. These interlocking oppressions reinforce one another (Allen, 2016) and can result in mental health issues, poverty, and housing insecurity or homelessness.

Suitable and needed services for older homeless women are not afforded the importance and financial support that some other issues relating to other population groups might get. This results in services being inadequate and inappropriate, and thus engenders a reluctance on the part of older women to access them. These overlapping issues of oppressions and neglect have led to women experiencing homelessness being pushed to the margins of our society where they usually have little voice or power over many aspects of their lives. This includes having little decision making power over the services they have access to or how these services are provided to them.

This research attempted to give older women with lived experience of homelessness the space to describe their experiences accessing services they rely on. Their experiences were organized into themes and barriers and gaps in services were identified. These issues were viewed in relation to those I encounter working with women with lived experience of homelessness and other vulnerable people. Some improvements in service provision, arising from the interviews and my work experience, are suggested to make services more client centred and trauma informed.

The intent and hope of this research was to identify improvements that are needed and can be made to the current models of delivering services to homeless older women (Mullaly, 2010). As well, it was hoped that sharing the findings may lead to more awareness and positive changes to push back against oppression and neglect, and to help improve older homeless women's lives in this community.

It is important that social work and other professions continue to incorporate and advocate for trauma informed and client centred approaches within their respective practices. A gendered and structural social work perspective seeks an understanding of power that enables women to resist and challenge domination, and oppression (Zufferey, 2009). To appropriately advocate on the behalf of homeless women, or to facilitate their own advocacy, social workers and other social and health service providers need to ensure they correctly understand the wishes, views, and needs of their older women clients (Hemingway & MacLeod, 2004). If for no other reason than self-interest (since most of us hope to live long and fulfilling lives in a place that values our contributions), we should each be encouraging a society which facilitates a high quality of life, happiness and wellbeing for older community members. It is my sincere hope that this research will, in some small way, contribute to understanding the need for more comprehensive trauma informed and client centred service provision for those living at the margins: older women experiencing homelessness in our community.

## References

- Aarts, P. G., & Op den Velde, W. (1996). Prior traumatization and the process of aging: Theory and clinical implications. In B. M. van der Kolk (Ed.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 359–378). New York, NY: Guilford Press.
- Allen, A. (2016). Feminist perspectives on power. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*. Retrieved from <http://plato.stanford.edu/archives/fall2016/entries/feminist-power/>
- Alston, M., & Bowles, W. (2013). *Research for social workers: An introduction to methods*. Oxon, England: Routledge.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th Ed.). (DSM-5). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (2006). *Guidelines for psychological practice with lesbian, gay, and bisexual clients*. Retrieved from <https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>
- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. C., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174–186.
- Barken, R., Grenier, A., Budd, B., Sussman, T., Rothwell, D., & Bourgeois-Guéris, V. (2015). *Aging and homelessness in Canada: A review of frameworks and strategies*. Hamilton, Canada: Gilbreia Centre for Studies on Aging, McMaster University.
- Belanger, Y., Weasel Head, G., & Awosoga, O. (2012). *Assessing urban Aboriginal housing and homelessness in Canada*. Ottawa, Canada: National Association of Friendship Centres (NAFC) and the Office of the Federal Interlocutor for Metis and Non-Status Indians (OFI).
- Bishop, A. (2002). *Becoming an ally: Breaking the cycle of oppression in people*. Halifax, Canada: Zed Books.
- Bowen, E. A., & Murshid, N. S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *Perspectives From the Social Sciences*, 10(2), 223–229.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.
- Brave Heart, M. Y. H. (2007). The impact of historical trauma. The example of the native community. In M. Bussey & J. B. Wise (Eds.), *Trauma transformed: An empowerment response*. New York, NY: Columbia University Press.
- Brend, Y. (2017, April 14). BC welfare phone wait times drag on despite promised fix. *Canadian Broadcasting Corporation* (CBC). Retrieved from <http://www.cbc.ca/news/canada/british-columbia/welfare-wait-times-bc-1.4083406>
- British Columbia Association of Social Workers (BCASW) and British Columbia College of Social Workers (BCCSW). (2003). *BCASW code of ethics*. Retrieved from <http://www.bcasw.org/about-bcasw/casw-code-of-ethics/>
- British Columbia Office of the Auditor General. (2009). *Homelessness: Clear focus needed*. (Report: 2008/09:16) Victoria, Canada: BC Office of the Auditor General.
- Browne, A. J., Varcoe, C., & Fridkin, A. (2011). Addressing trauma, violence and pain: Research on health services for women at the intersections of history and economics. In O. Hankivsky (Ed.), *Health Inequities in Canada—Intersectional Frameworks and Practices* (pp. 401–423). Vancouver, Canada: UBC Press.
- Browne, A. J., Varcoe, C., Wong, S., Smye, V., Lavoie, J., Littlejohn, D., Tu, D., . . . O'Neil, J. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *International Journal for Equity in Health, 11*(59), 1–15.
- Bungay, V. (2013). Health care among street-involved women: The perpetuation of health inequity. *Qualitative Health Research, 23*(8), 1016–1026.
- Callaghan, M., Farha, L., & Porter B. (2002). *Women and housing in Canada: Barriers to equality*. Toronto, Canada: Women's Housing Program, Centre for Equality Rights in Accommodation. Retrieved from: <http://www.equalityrights.org/cera/docs/barriers.htm>
- Canadian Association of Social Workers (CASW). (2005). *Guidelines for ethical practice*. Retrieved from <http://www.bcasw.org/about-bcasw/canadian-association-social-workers/>
- Canadian Broadcasting Corporation. (CBC Radio). (2015, May 14). Medicine Hat becomes the first city in Canada to eliminate homelessness. *As It Happens*. Retrieved from <http://www.cbc.ca/radio/asithappens/as-it-happens-thursday-edition-1.3074402/medicine-hat-becomes-the-first-city-in-canada-to-eliminate-homelessness-1.3074742>
- Chambers, J. (2012). What do clients rights have to do with trauma informed care? In N. Poole & L. Greaves (Eds.), *Becoming trauma informed*. Toronto, Canada: Centre for Addiction and Mental Health.

- Citizens for Accessible Neighbourhoods (CAN) & BC Poverty Reduction Coalition. (2017). *Sharing our realities: Life on disability assistance in British Columbia*. Retrieved from <http://bcpovertyreduction.ca/wp-content/uploads/2017/04/SOR-Final-for-Web.pdf>
- Cohen, C. (1999). Aging and homelessness. *The Gerontologist*, 39(1), 5–14.
- Coleman, P. G., Hautamaki, A., & Podolskij, A. (2002). Trauma, reconciliation and generativity: The stories told by European war veterans. In D. W. Webster & B. K. Haight (Eds.), *Critical advances in reminiscence work: From theory to application* (pp. 218–232). New York, NY: Springer.
- Collin, C., & Jensen, H. (2009). *A statistical profile of poverty in Canada*. Ottawa, Canada: Library of Parliament.
- Cook J. M., Pilver, C., Dinnen, S., Schnurr, P. P., & Hoff, R. (2013). Prevalence of physical and sexual assault and mental health disorders in older women: Findings from a nationally representative sample. *American Journal of Geriatric Psychiatry*, 21(9), 877–886.
- Corbin Dwyer, S., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, 8(1), 54–63.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.
- Covington, S. (2012). Curricula to support trauma informed practice with women. In N. Poole & L. Greaves (Eds.), *Becoming trauma informed* (pp. 263–274). Toronto, Canada: Centre for Addiction and Mental Health.
- Crane, M., & Warnes, A. M. (2010). Homelessness among older people and service responses. *Reviews in Clinical Gerontology*, 20(4), 354–363.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative & mixed methods approaches* (4th ed.) Thousand Oaks, CA: Sage.
- Cummings, S. M., & McClure Cassie, K. (2008). Perceptions of biopsychosocial services needs among older adults with severe mental illness: Met and unmet needs. *Health & Social Work*, 33(2), 133–143.
- Davis-Berman, J. (2011). Older women in the homeless shelter: Personal perspectives and practice ideas. *Journal of Women & Aging*, 23, 360–374.

- deVries, M. (1996). Trauma in cultural perspective. In B. M. van der Kolk, *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 398–413). New York, NY: Guilford Press.
- Dietz, T. (2009). Drug and alcohol use among homeless older adults: Predictors of reported current and lifetime substance misuse problems in a national sample. *Journal of Applied Gerontology, 28*(2), 235–255.
- Dietz, T., & Wright, J. (2005). Age and gender differences and predictors of victimization of the older homeless. *Journal of Elder Abuse and Neglect, 17*(1), 37–60.
- Edmondston, B., & Fong, E. (Eds.). (2011). *The changing Canadian population*. Kingston, Canada: McGill-Queen's University Press.
- Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Glover Reed, B. (2005). Trauma informed or trauma denied: Principles and implementation of trauma informed services for women. *Journal of Community Psychology, 33*(4), 461–477.
- Engel, R. J., & Schutt, R. K. (2005). *The practice of research in social work*. Thousand Oaks, CA: Sage.
- Farmer, T., Robinson, K., & Elliott, S. J. (2006). Developing and implementing a triangulation protocol for qualitative health research. *Qualitative Health Research, 16*(3), 377–394.
- Gaetz, S., Gulliver, T., & Richter, T. (2014). *The state of homelessness in Canada: 2014*. Toronto, Canada: Homeless Hub Press. Retrieved from <http://www.homelesshub.ca/>
- Gellis, Z. (2006). Older adults with mental and emotional health problems. In B. Berkman & S. D'Ambruoso (Eds.), *Handbook of social work in health and aging: Education policy practice and research* (pp. 129–139). Oxford, England: Oxford University Press.
- Gitberg, M., & Van Wyck, L. (2004). In S. Harrison & V. Carver (Eds.), *Alcohol and drug problems: A practical guide for counsellors* (pp. 415–434). Toronto, Canada: Centre for Addiction and Mental Health.
- Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46*, 1219–1225.
- Greene, J. (1994) Qualitative program evaluation: Practice and promise. In N. K. Denzin and Y. Lincoln (Eds.), *Handbook of Qualitative Research* (p. 541). Thousand Oaks, CA: Sage.
- Harris, M., & Fallot, R. (2001). Using trauma theory to design service systems. *New Directions for Mental Health Services, 89*(spring), 3–22.

- Hecht, L., & Coyle, B. (2001). Elderly homeless: A comparison of older and younger adult emergency shelter seekers in Bakersfield, California. *American Behavioral Scientist*, 45(1), 66–79.
- Hemingway, D., & MacLeod, T. (2004). Living north of 65 years: A community-based process to hear the voices of northern seniors. *Rural Social Work*, 9, 137–146.
- Herman, J. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York, NY: Basic Books.
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2009). Shelter from the storm: Trauma-informed care in homelessness services settings. *Open Health Services and Policy Journal*, 2, 131–151.
- Human Resource and Skills Development Canada. (2003). Retrieved April 1, 2013, from <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=3>
- Ivanova, I. (2017). *Poverty and inequality among British Columbia seniors*. Vancouver, Canada: Canadian Centre for Policy Alternatives (BC office).
- Killian, C. (2015, March 16) Yet another case for universal pharmacare. *The Tyee*. Retrieved from <https://thetyee.ca/Opinion/2015/03/16/Universal-Pharmacare/>
- Kisor, A., & Kendal-Wilson, L. (2002). Older homeless women: Reframing the stereotype of the bag lady. *Affilia*, 17(3), 354–370.
- Klassen, J. (2015, March). Counting women in: A gender based analysis of homelessness [Web log post]. *Rabble.ca*. Retrieved from <http://rabble.ca/blogs/>
- Klein, S., & Reano, P. (2017, March 30). Decades of frozen welfare rates leave families in deepening poverty. *The Tyee*. Retrieved from <https://thetyee.ca/Opinion/2017/03/30/Frozen-Welfare-Families-Poverty/>
- Kozak, J., & Hemingway, D. (2010). *Understanding personal health decision trade-offs of older women: Findings from a pilot study*. Centre for Health Aging at Providence & UNBC. Retrieved from <http://www.womennorthnetwork.com/wp-content/uploads/2016/08/Older-Women-Health-Summary-of-Pilot-Study-Findings-July2010.pdf>
- Kushel, M. B., Evans, J. L., Perry, S., Robertson, M. J., & Moss, A.R. (2003). No door to lock: Victimization among homeless and marginally housed persons. *Archives of Internal Medicine*, 163(20), 2492–2499.
- Lapadat, J. C. (2010). Thematic Analysis. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.) *Encyclopedia of Case Study Research* (pp. 926–927). Thousand Oaks, CA: Sage.

- Lee, B. A., & Schreck, C. J. (2005). Danger on the streets: Marginality and victimization among homeless people. *American Behavioral Scientist*, 48, 1055–1081. doi:10.1177/0002764204274200
- Levinson, J. (2017). Trauma informed social work practice. *Social Work*, 62(2), 105–113.
- Lewinsohn, T., Thomas, M. L., & White, S. (2014). Traumatic transitions: Homeless women's narratives of abuse, loss and fear. *Affilia: Journal of Women and Social Work*, 29(2), 192–205.
- Lewis, J. H., Andersen, R. M., & Gelberg, L. (2003). Health care for homeless women. *Journal of General Internal Medicine*, 18(11), 921–928.
- Littlewood, R. (2002). *Pathologies of the West: An anthropology of mental illness in Europe and America*. Ithaca, NY: Cornell University Press.
- Lived Experience Advisory Council. (2016). *Nothing about us without us: Seven principles for leadership and inclusion of people with lived experience of homelessness*. Toronto, Canada: Homeless Hub Press. Retrieved from [www.homelesshub.ca/NothingAboutUsWithoutUs](http://www.homelesshub.ca/NothingAboutUsWithoutUs)
- Londerville, J., & Steele, M. (2014). *Housing Policy Targeting Homelessness*. Toronto, Canada: Homeless Hub Press.
- Luborsky, M. R. (1994). The identification of themes and patterns. In J. F. Gubrium & A. Sankar (Eds.), *Qualitative methods in aging research* (pp. 189–210). Thousand Oaks, CA: Sage.
- MacCourt, P. (2008). *Promoting seniors' well-being: A seniors' mental health policy lens toolkit*. Victoria, Canada: British Columbia Psychogeriatric Association. Website and print versions. Retrieved from [http://seniorspolicylens.ca/?page\\_id=43](http://seniorspolicylens.ca/?page_id=43)
- Mackelprang, J. L., Klest, B., Najmabadi, S. J., Valley-Gray, S., Gonzalez, E.A., & Cash, R. E. (2014). Betrayal trauma among homeless adults: Associations with re-victimization, psychological wellbeing and health. *Journal of Interpersonal Violence*, 29(6), 1028–1049.
- MacLeod, A. (2017a, February 10). Disability rates far too low for “dignified standard of living,” report finds. *The Tyee*. Retrieved from <https://thetyee.ca/News/2017/02/10/BC-Disability-Rates-Too-Low/>
- MacLeod, A. (2017b, February 21). BC government hikes disability rates by \$50, maintains freeze on welfare. *The Tyee*. Retrieved from <https://thetyee.ca/News/2017/02/21/BC-Budget-Disability-Rates-Welfare/>
- Marlow, C. R. (2005). *Research methods for generalist social work*. Belmont, California: Brooks/Cole.

- Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research*. Thousand Oaks, CA: Sage.
- Maschi, T., & Youdin, R. (2012). *Social worker as researcher: Integrating research with advocacy*. Boston, MA: Pearson.
- Mate, G. (2008). *In the realm of hungry ghosts*. Toronto, Canada: Vintage Canada.
- McDonald, L., Dergal, J., & Cleghorn, L. (2007). Living on the margins: Older homeless adults in Toronto. *Journal of Gerontological Social Work*, 49(1/2), 19–46.
- McDonald, L., Donahue, P., Janes, J., & Cleghorn, L. (2006). *In from the streets: The health and well being of formerly homeless older adults*. Toronto, Canada: Institute for Life Course and Aging.
- McLeod, H., & Walsh, C. A. (2014). Shelter design and service delivery for women who become homeless after age 50. *Canadian Journal of Urban Research*, 23(1), 23–38.
- Menzies, P. (2007). Understanding Aboriginal intergenerational trauma from a social work perspective. *Canadian Journal of Native Studies*, 27(2), 367–392.
- Menzies, P. (2009). Homeless Aboriginal men: Effects of intergenerational trauma. In J. D. Hunchanski, P. Campsie, S. Chou, S. Hwang, & E. Paradis (Eds.), *Finding home: Policy options for addressing homelessness in Canada* (ch. 6.2). Toronto, Canada: University of Toronto Press. Retrieved from [www.homelesshub.ca/findinghome](http://www.homelesshub.ca/findinghome)
- Menzies, P. (2012). An intergenerational trauma informed approach to care for Canada's Aboriginal peoples. In N. Poole & L. Greaves (Eds.), *Becoming trauma informed* (pp. 175–187). Toronto: Centre for Addiction and Mental Health.
- Ministry of Public Works and Government Services Canada. (1998). *Principles of the national framework on aging: A policy guide*. Retrieved from <http://publications.gc.ca/collections/Collection/H88-3-21-1998E.pdf>
- Ministry of Public Works and Government Services Canada. (2002). *Canada's aging population*. Prepared by Health Canada in collaboration with the Interdepartmental Committee on Aging and Seniors Issues. Retrieved from <http://publications.gc.ca/collections/Collection/H39-608-2002E.pdf>
- Morgan, S. (2017, May 10). Steve Morgan: Canada needs universal pharmacare plan. *Times Colonist*. Retrieved from <http://www.timescolonist.com/opinion/columnists/steve-morgan-canada-needs-universal-pharmacare-plan-1.19150564>
- Morgan, S., Martin, D., Gagnon, M., Mintzes, B., Daw, J., & Lexchin, J. (2015). *Pharmacare 2020. Summary of recommendations: moving from principles to policies*. Retrieved from [http://pharmacare2020.ca/assets/pdf/Moving\\_From\\_Principles\\_To\\_Policies.pdf](http://pharmacare2020.ca/assets/pdf/Moving_From_Principles_To_Policies.pdf)

- Morris, A., Judd, B., & Kavanagh, K. (2005). Marginality amidst plenty: Pathways into homelessness for older Australians. *Australian Journal of Social Issues*, 40(2), 241–251.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Mullaly, B. (2010). Challenging oppression and confronting privilege. Dons Mills, Canada: Oxford University Press.
- National Aboriginal Health Organization (NAHO). Retrieved from <http://www.naho.ca/publications/topics/terminology/>
- Norman, T., & Pauly, B. (2013). Including people who experience homelessness: A scoping review of the literature. *International Journal of Sociology and Social Policy*, 33(3/4), 136–151. <http://dx.doi.org/10.1108/01443331311308203>
- Novac, S., Brown, J., & Bourassa, C. (1996). *No room of her own: A literature review on women and homelessness*. Ottawa, Canada: Canadian Mortgage and Housing Corporation.
- Ogborne, A. C. (1997). Theories of addiction and implications for counselling. In S. Harrison & V. Carver (Eds.), *Alcohol and drug problems: A practical guide for counsellors* (2nd ed.) (pp. 3–18). Toronto, Canada: Addictions Research Foundation.
- Otis, J. D., Keane, T. M., & Kerns, R. D. (2003). An examination of the relationship between chronic pain and post-traumatic stress disorder. *Journal of Rehabilitation Research and Development*, 40(5), 397–406.
- Pateman, K., Thandi, A., & Florey, L. (2016). Prince George point in time homelessness count community report. Prince George, Canada: Community Partners Addressing Homelessness.
- Patrick, C. (2014). *Aboriginal homelessness in Canada: A literature review*. Toronto, Canada: Canadian Homelessness Research Network Press.
- Pavao, J., Alvarez, J., Baumrind, N., Induni M., & Kimerling R. (2007). Intimate partner violence and housing instability. *American Journal of Preventative Medicine*, 32(2), 143–146.
- Peck, B. K., & Capyk, S. R. (2012). Building community capacity for trauma-informed practice. In N. Poole & L. Greaves (Eds.), *Becoming trauma informed* (pp. 253–262). Toronto, Canada: Centre for Addiction and Mental Health.
- Public Health Agency of Canada. (2015). *Report from The Canadian Chronic Disease Surveillance System: Mental illness in Canada*. Ottawa, Canada: Public Health Agency of Canada.
- Qureshi, S. U., Kimbrell, T., Pyne, J. M., Magruder, K. M., Hudson, T. J., Petersen, N. J., . . . Kunik, M. E. (2010). Greater prevalence and incidence of dementia in older veterans

- with posttraumatic stress disorder. *Journal of the American Geriatrics Society*, 58, 1627–1633.
- Rayburn, N., Wenzel, S., Elliot, M., Hambarsoomiams, K., Marshall, G., & Tucker, J. (2005). Trauma, depression, coping, and mental health service seeking among impoverished women. *Journal of Consulting and Clinical Psychology*, 73, 667–677.
- Richardson, V. E., & Barusch, A. S. (2006). *Gerontological practice for the 21<sup>st</sup> century: A social work perspective*. New York, NY: Columbia University Press.
- Ross, R. (1992). *Dancing with a ghost*. Markham, Canada: Octopus Publishing.
- Ross, R. (1996). *Returning to the teachings*. Toronto, Canada: Penguin Books.
- Rubin, A., & Babbie, E. (1993). *Research methods for social work*. Pacific Grove, CA: Brooks/Cole.
- Sakamoto, I., & Pitner, R. (2005). Use of critical consciousness in anti-oppressive social work practice: Disentangling power dynamics at personal and structural levels. *British Journal of Social Work*, 35(4), 435–452.
- Sakamoto, I., Khandor, E., Chapra, A., Hendrickson, T., Maher, J., Roche, B., & Chin, M. (2008). Homelessness—Diverse Experiences, Common Issues, Shared Solutions: The Need for Inclusion and Accountability. Toronto, Canada: Factor-Inwentash Faculty of Social Work, University of Toronto.
- Saleebey, D. (Ed.). (2006). *The strengths perspective in social work practice* (4th ed.). Boston, MA: Pearson/Allyn & Bacon.
- Salem, B. E., & Ma-Pham, J. (2015). Understanding health needs and perspectives of middle-aged and older women experiencing homelessness. *Public Health Nursing*, 32(6), 634–644.
- Savage, A., Quiros L., & Dodd, S-J. (2007). Building trauma informed practice: Appreciating the impact of trauma in the lives of women with substance abuse and mental health problems. *Journal of Social Work Practice in the Addictions*, 7(1/2), 91–116.
- Service BC. Ministry of Labour and Citizens' Services. (2017). *BC stats*. Retrieved from <http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demographics>
- Shaw, I., & Holland, S. (2014). *Doing qualitative research in social work*. London, England: Sage.
- Sikich, K. W. (2008). Global female homelessness: A multi-faceted problem. *Gender Issues*, 25, 147–156. doi:10.1007/s12147-008-9062-8
- Smith, L. T. (2004). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed Books.

- Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class and gender. Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*(1), 38–64.
- Statistics Canada. (2015). *Aboriginal statistics at glance* (2nd ed.). Retrieved from <http://www.statcan.gc.ca/pub/89-645-x/2015001/demo-eng.htm>
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Substance Abuse and Mental Health Services Administration (SAMHSA). n.d. *Substance use disorders*. Retrieved from <http://www.samhsa.gov/disorders/substance-use>
- Sundin, E. C., & Baguley, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: A systematic review and meta-analysis. *Social Psychiatric Epidemiology, 50*, 183–194.
- Thomson, H. (2015, August 21). The study of survivors finds trauma passed on to children. *The Guardian*. Retrieved from <https://www.theguardian.com/science/2015/aug/21/study-of-holocaust-survivors-finds-trauma-passed-on-to-childrens-genes>
- TIP Project Team. (2013). *The trauma informed practice guide*. Retrieved from [http://bccewh.bc.ca/wp-content/uploads/2012/05/2013\\_TIP-Guide.pdf](http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf)
- Townson, M. (2009). *Canadian women on their own are poorest of the poor*. Toronto, Canada: Canadian Centre for Policy Alternatives.
- Trypuc, B., & Robinson, J. (2009). *Homelessness in Canada: A funder's primer on understanding the tragedy on Canada's streets*. King City, Canada: Charity Intelligence Canada.
- Turcotte, M., & Schellenberg, G. (2007). *A portrait of seniors in Canada*. Statistics Canada. Retrieved from [www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf](http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf)
- Tutty, L. M., Ogden, C., Giurgiu, B., & Weaver-Dunlop, G. (2014). I built my house of hope: Abused women and pathways into homelessness. *Violence Against Women, 19*(12), 1498–1517.
- van der Kolk, D. (1987). *Psychological trauma*. Washington, DC: American Psychiatric Press.
- Washington, O. G., & Moxley, D. P. (2008). Telling my story: From narrative to exhibit in illuminating the lived experience of homelessness among older African American women. *Journal of Health Psychology, 13*(2), 154–165.
- Wenzel, S., Tucker, J., Elliott, M., Marshall, G., & Williamson, S. (2004). Physical violence against impoverished women: A longitudinal analysis of risk and protective factors. *Women's Health Issues, 14*(5), 144–154.

- Williams, C. (2010). *Economic well-being*. Ottawa, Canada: Statistics Canada.
- Wilson, C., Pence, D. M. and Conradi, L. (2013). Trauma informed care. In *The encyclopedia of social work*. National Association of Social Workers and Oxford University Press. doi:10.1093/acrefore/9780199975839.013.1063
- Woman. (n.d.) In *Merriam-Webster's collegiate dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/woman>.
- World Health Organization (WHO). (2016). *Mental health: Strengthening our response. April 2016* [Fact sheet]. Retrieved from <http://www.who.int/mediacentre/factsheets/fs220/en/>
- Yeater, E., Austin, J., Green, M., & Smith, J. (2010). Coping mediates the relationship between posttraumatic stress disorder (PTSD) symptoms and alcohol use in homeless, ethnically diverse women: A preliminary study. *Psychological Trauma: Theory, Research, Practice, and Policy*, 2, 307–310.
- Zufferey, C. (2009). Making gender visible: Social work responses to homelessness. *Affilia: Journal of Women and Social Work*, 24(4), 382–393.
- Zufferey, C. (2017). *Homelessness and social work: An intersectional approach*. New York, NY: Routledge.

## Appendix A: Definitions

### **Homeless/Homelessness**

The Canadian Homelessness Research Network (CHRN) describes homelessness as “the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it” (Gaetz et al., 2014). This includes the unsheltered, the emergency sheltered, provisionally sheltered, and those who are precariously housed or at risk of homelessness (Barken et al., 2015).

“Prestariously housed” means that due to “external hardship, poverty, personal crisis, discrimination, a lack of other available and affordable housing, insecurity of tenure or the inappropriateness of their current housing (which may be overcrowded or does not meet public health and safety standards) residents may be “at risk” of homelessness” (Gaetz et al., 2014).

Homeless and homelessness will be used interchangeably in this research to identify those who are living in emergency shelters, insecure or precarious housing situations, including couch surfing or “sleeping rough” (sleeping outside) (Sundin & Baguley, 2015).

### **Women**

The Merriam-Webster dictionary defines “woman” as “an adult female human being.” (Woman, n.d.) The American Psychological Association defines “gender identity” as “one’s sense of oneself as male, female, or transgender” (2006). For the purposes of this research the term woman will refer to those who self-identify as female or as a woman.

### **Older Persons/Older women**

To find an agreed upon and consistently used definition in the literature for people in their later years of life is challenging. Statistics Canada defines those 65 or older as “older

persons" (Turcotte & Schellenberg, 2007) and is the minimum age for eligibility for many government and service agency benefits, programs and discounts. However, for the purposes of this research I will focus on women over the age of 50 and use the term "older person or older women" to reflect this age group for the reasons outlined below. The average life expectancy for women in northern British Columbia is 81.91 years as compared to the provincial average for women of 84.64 years (Service BC Ministry of Labour and Citizens' Services, 2017). Aboriginal people make up a substantial part of the population in the northern regions of Canadian (Human Resource and Skills Development Canada, 2003; Turcotte & Schellenberg, 2007) but a disproportionate number of the population experiencing homelessness in northern British Columbia. The average life expectancy in Canada in 2009 was 81.1 years however the average life expectancy for those with registered Indian status in Canada in 2001 was 70.4 years (Human Resource and Skills Development Canada, 2003). A review of the literature on aging and homelessness indicates that 50 is the widely accepted age for defining homeless persons as older. Numerous studies point to evidence indicating that people experiencing homelessness tend to have shorter lifespans and experience aging related health and disability problems approximately 10 years earlier than the general population due to the challenges of lifestyles and living circumstances they face (Barken et al., 2015; Crane & Warnes, 2010). In line with this, the 2009 British Columbia Office of the Auditor General reports the average lifespan of those who experiencing homelessness in Canada as 45 years.

### **Aboriginal/ Aboriginal peoples**

"Aboriginal Peoples" is the "collective name for all of the original peoples of Canada and their descendants. Section 35 of the Constitution Act of 1982 specifies that the

Aboriginal Peoples in Canada consist of three groups – Indian (First Nations), Inuit and Métis” (National Aboriginal Health Organization (NAHO).

For the purposes of this research the terms Aboriginal or Aboriginal persons will refer to those who self-identify as aboriginal, status Indians, non-status Indians, Inuit and Metis people.

### **Mental Health Issue**

The World Health Organization (WHO), defines mental health as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2016).

The Canadian Chronic Disease Surveillance System (CCDSS) states that “Mental illnesses are characterized by alterations in thinking; mood or behaviour associated with significant distress and impaired functioning” (Public Health Agency of Canada (PHAC), 2015. p. 3) and can be the result of a mixture bio psychosocial, economic and genetic factors and can range from short term intermittent or long term chronic issues (PHAC, 2015).

For the purposes of this research the term “mental health issue” will be used to indicate problems with mental health or a state where total mental wellbeing is absent, as described above, and may indicate the possible presence of mental illness.

### **Service Provider**

In this research this term will refer to those employed or in volunteer positions providing health or social services.

## **Service User**

For the purposes of this research this term will refer to those persons who access and use health and social services. The focus population of this research is older women service users who have lived experience with homelessness.

## **Substance Dependence/Substance Dependence Issue**

Substance use disorder is listed as a mental illness in both the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (American Psychiatric Association, 2013) and the CCDSS (Public Health Agency of Canada, 2015). In the latest edition of the DSM the terms “substance abuse” and “substance dependence” have been replaced by the term “substance use disorder” which is measured on a continuum from mild to severe. In the manual each substance is referred to as a separate disorder such as alcohol use disorder or opiate use disorder. A diagnosis of “substance use disorder” is used when use is recurrent and results in social and functional impairment, loss of control, risky use, health problems or disability, and failure to meet major life responsibilities such as those at work, school or home (DSM-5, 2013; SAMHSA, n.d.)

“Dependence” as defined by Mate (2008) is “any repeated behaviour...., in which a person feels compelled to persist, regardless of its negative impact on...(the individuals life) and the lives of others and involves....states of mind such as craving and shame and behaviours such as deception manipulation and relapse” (p. 214). Substance dependence is often a result of complex interactions between biopsychosocial and even spiritual contributing factors (Ogborne, 1997).

In this research the term “substance dependence” or “substance dependence issue” which is a combination of the above terms, will be used to refer to all of the above resulting symptoms and consequences.

## **Trauma**

Trauma is a result of exposure to shocking events or prolonged periods of stress. It is the result of overwhelming experience inflicted on, or by, an event that an individual has no control over (Herman, 1997; van der Kolk, 1987). It can include interpersonal trauma, from physical or emotional abuse, intergenerational trauma, as experienced by Aboriginal people in Canada, or trauma experienced during events like wars, natural disasters or accidents. Each individual reacts differently to stressful events but exposure to traumatic events is often associated with short term or enduring negative emotional, psychological and physical health consequences. This is the definition of trauma that will be used in this paper.

## **Trauma Informed Practice / Trauma Informed Service**

This following is the definition of Trauma Informed Practice (TIP) and Trauma Informed Service (TIS) to be used in this research. TIP and TIS are services, and a manner of delivering them, which are sensitive to and aware of the special needs of trauma survivors. This type of practice and service provision “adopts a universal assumption of inclusion.... it assumes that all consumers receiving services are trauma survivors” (Harris & Fallot, 2001. p. 4) and views the consumer “as a whole person” whose symptoms are “interconnected and embedded” with her history of trauma (Harris & Fallot, 2001.p. 13).

### Appendix B: Demographic Questionnaire

Contact info for follow up purposes:

Name:					
Address:					
Preferred mode of communication		Tel	Texting	Voicemail	email
Ok	NOT OK	to leave voicemail message identifying who I am and why I am calling			

Demographic Information:

Age ( 50 +)	

Self-identified heritage/ancestry:

Canadian	Aboriginal	Asian	European	other

Marital status:

single	in relationship	common law	married	separated	divorced	widowed
Other						

Family:

	#	Adult	Under 18
Children			
Grandchildren			
Current dependents			

Education –what level of education do you have?

	partial	completed	certificates/diplomas/degrees-other notes
Elementary			
High School			
College or university			
Trades/profession			
Other			

Source of income:

Employment income	CPP	Work pension
EI	OAS	Other
CPP disability	GIS	
BC-SABC-PWD	CPP Survivors Benefit	

Work History:

	Yes	No	Length of time/ start & end date	Type of work
Currently employed				
Unemployed				
Work at home				

Housing Situation:

	Yes	No	Length of time in current location

Housed			
are you happy with your current housing/are you planning to stay			
Homeless			
staying in shelter			
couch surfing			
staying with family or friends			
Other			

When did you last have your own place to live? Within the last:

0-6 months	6 mos to 1 year	1-2 years	2-3 years	Other

How many times have you moved in the past?

0-6 months	6 mos to 1 year	1-2 years	2-3 years	Other

How would you rate your health and wellness today?

	very poor	poor	satisfactory	good	very good	excellent
physical						
mental						
emotional						
spiritual						

If any of these are poor or very poor explain:

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## Appendix C: Semi Structured Interview Questions

Social determinant of health domains

1. What kind of services do you use in the community – for physical wellbeing, for emotional wellbeing, for mental wellbeing, spiritual wellbeing? For other needs?

Food security:

Groceries stores/ convenience stores	Food Banks	Other
cook for self	AWAC	
Farmers market	ASA P	
	Firepit	
	St Vincent de Paul Society	

Money/Financial:

Employment	BC- MSD & SI Office for:	Federal Gov't (Service Canada) for:
Work pension	SA	CPP
Band	PWD	CPP-D
	Other	OAS
		GIS
		EI

Bank /Personal Bank account	
Loans/credit	
cheque cashing stores	
other	

Health services:

Hospital ER	Dental care- and dentures	Other

Family Dr's office	Eye exams /glasses	
Walk in clinics	Counselling	
Specialists		
Pharmacy		
Public health office		

#### Housing services:

Shelters/ transition	Subsidized housing	Market housing	Housing assistance/advocacy
AWAC	BC Housing-		ASAP advocates
ASAP	Aboriginal Housing -		Housing First Program AWAC, Ketso Phoenix, Asap
Phoenix	<u>PGNFC Tse Koo/ Friendship</u> Lodge		
Amber House	Northern Health Seniors Housing		
	Elizabeth Fry housing		
Other			

#### Legal and Safety:

RCMP/Police	Jail	Other
Court	lawyers	
Probation	legal aid/native courtworkers	

#### OTHER services accessed:

Spiritual services, Churches, temples, traditional ceremonies	Household items Furniture/ clothing/ kitchenware	Seniors /Elder organizations & programs	Transportation Bus HandiDART	ID- BC Service Card, Status Card BC care card
	Stores			Service BC
				Service Canada-
Other				Government offices

2.

When accessing these services:

- i) What is the most important thing for you?
  - ii) How is it for you accessing these services?
  - iii) How do the staff/service providers treat you? How does that make you feel?
  - iv) What makes accessing these services a bad experience?
  - v) What makes accessing these services a good experience?
  - vi) How could it be better, what could be done to make the experience better for you?
  - vii) How could these community services be improved? What works /what doesn't work so well?
3. Do you feel all of your needs are being met in this community?
- a. Which ones are and which ones are not being met?
  - b. What services do you need but are not available in our community or for whatever reason you cannot access?
4. How do you manage/get by?
- a. What skills do you use to manage without stable housing?
  - b. What are your greatest strengths and gifts?

- c. Are family and friends a help to you?
5. How do you think your voice is included in the way services are provided?
  6. How should you have a say and what would you say re social service, health care and other service provision?
    - a. Do any of the services you access ask for your opinion on the way services are offered or delivered?
    - b. How would you like your wishes and needs to better included?
  7. The following 4 questions are adapted from Davis Berman (2011) study questions
    - a. If you have stayed in shelters describe your experience in the shelter system.
    - b. What is good what is bad about staying in a shelter?
    - c. If you are currently staying there what is keeping you in the shelter system?
    - d. Have you experienced threats or violence while homeless?
  8. Are there any issues and concerns you have with being 50 and over, homeless (or having issues with unstable housing) and growing older.
  9. What is your vision for yourself as you get older?
  10. Is there anything else that you want to say about being over 50, a woman and being homeless?

## **Appendix D: Counselling and Mental Health Resources**

CRU (Community Response Unit)-250-565-2668

Crisis Line – 1-800-784-2433

UHNBC Hospital Emergency (ER) - Edmonton St.

RCMP- Car 60- **911**

Family Physicians Offices – various locations

- CINHS – for patients – 365 George St. Ph: 250-564-4422
- Blue Pine Clinic – for patients - 102-1302 7th Ave. Ph: 250-596-8100

Prince George Native Friendship Centre – Healing Centre- 1600 3rd Ave. Ph: 250-564-3568

SOS Society, 193 Quebec St. Ph: 250-564-8302

Elizabeth Fry Society, 1575 – 5th Ave. Ph: 250-563-1113, *24 Hour Crisis Line*-250-562-5868, 1-866-563-1113

Canadian Mental Health Association (CMHA), 1152 - 3rd Ave. Ph: 250-564-8644

Nechako Day treatment program, 1350 Alward St. Ph: 250-565-2387

## Appendix E: Poster

# If You:

- live in Prince George,
- are a women 50 years and older,
- have experienced homelessness,
- are interested in being interviewed

about your  
**experiences**  
**accessing social and health services**  
in Prince George.

Please text or call me:

Sari Legate

Cell: 250-552-6964

I am a UNBC masters of social work student conducting  
research for my master's thesis.

SariLegate (text or call)  
cell: 250-552-6964

## Appendix F: Information and Consent Form



### Information Letter / Consent Form

*October 2016*

MSW Thesis Title: Accessing social and health services: the experience of older homeless women in downtown Prince George, B.C.

**Who is conducting the study?**

*Sari Legate*

University of Northern British Columbia  
Prince George, BC V2N 4Z9  
*legate@unbc.ca* (250) 552-6964

Dear Participant,

Hello, my name is Sari Legate. I am a Master's of Social Work student at the University of Northern British Columbia (UNBC) in Prince George, BC. I am doing interviews with older women (50 years and older) who have experienced homelessness for my thesis research. I am doing this research study as part of my studies, not as part of my role as a social worker or for my job.

**Why are you being asked to take part in this study?**

The purpose of the study is to learn about the experience of accessing social and health services for older homeless women in Prince George. I want do this by interviewing women 50 years of age and older like yourself who have experienced homelessness. This is to be able to determine gaps in, and possible ways to improve, the provision of social and health services to older homeless women in Prince George.

**What will happen during the project?**

Each interview will take approximately 45 minutes to 1.5 hours. The interviews will take place at a time and place that you and I agree on. There are a series of questions that you will be asked. The interview will be audio recorded and I will take written notes during it with your permission.

**Will you be paid for taking part in this research study?**

You will be offered a gift card as a thank you in recognition for your time given for the interview, as well as bus tickets to assist with getting to and from the interview location.

### **Participation is voluntary.**

Participating in the interview is completely voluntary. Your written and/or verbal consent will be required before the interview begins. You do not have to answer questions that make you feel uncomfortable. As well you are free to end the interview at any time without any consequence to you. If you choose to end the interview the audio recording and any notes made will be removed from the study and securely destroyed. Whether you finish the interview or not you are welcome to keep the gift card and bus tickets.

### **How will your privacy be protected?**

To the best of my ability I will ensure that your name and identity, as well as your participation in this research project, will be kept confidential. Your audio recording and any notes taken and transcriptions of the audio recordings will not have your name attached to them. The audio-recordings will be stored and uploaded onto a secure password protected site and written documents will be kept in a locked cabinet in my locked home office. All audio-recordings and data will be destroyed by shredding paper files and deleting digital files, five years after the completion of my thesis. A hired transcriber (who has signed a confidentiality agreement), my UNBC master's supervisor Dawn Hemingway and I will be the only ones with access to the audio recordings and documents.

### **Limits to confidentiality**

If, during the interview, you reveal that there has been an incident that involves abuse and/or neglect of a child (or that there is a risk of such occurring) or threats of harm to others or to yourself, by law, I have to report this information to the authorities.

### **Is there any way that participating in this study could harm you?**

I do not think there is anything in this study that could harm you. Some of the questions asked may seem sensitive or personal. You do not have to answer any question if you do not want to. If, at any point in the study, you feel uncomfortable or upset and wish to end your participation, please let me know and your wishes will be respected. A list of counselling resources will be given to you and assistance with accessing these services will be provided should you feel you need them.

### **Will being in this study help you in any way?**

I do not think taking part in this study will help you directly. However, in the future, others may benefit from what is learned from this study and it may lead to improvements in the way services are provided to homeless older women.

### **Study Results**

You are welcome to review your interview once it has been written out. The results of this study will be reported in a graduate thesis and may also appear in other documents and publications. You are welcome to a copy of the finished thesis. A copy will also be available

at the UNBC library to look at. A community meeting will be held within 4 months after the thesis is finished. This will be set up to present and talk about the findings of the study. You and the other research participants, the public and community social and health service agencies will be invited to attend.

**Questions**

If you have any questions about this project please contact;

**Student researcher:**

Sari Legate at 250-552-6964 (cell), [legate@unbc.ca](mailto:legate@unbc.ca)

**UNBC Thesis supervisor:**

Dawn Hemingway, Tel: 250-960-5694, [Dawn.Hemingway@unbc.ca](mailto:Dawn.Hemingway@unbc.ca)

**Concerns about the project or your rights**

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, please contact the UNBC Office of Research at 250-960-6735 or by e-mail at [reb@unbc.ca](mailto:reb@unbc.ca).

Thank you,

Sari Legate

250-552-6964 (cell), [legate@unbc.ca](mailto:legate@unbc.ca)

**CONSENT**

I have read or been described the information presented in the information letter about the project:

YES                    NO

I have had the opportunity to ask questions about my involvement in this project and to receive additional details I requested.

YES                    NO

I understand that if I agree to participate in this project, I am free to end the interview or withdraw from the study at any time or up until the report completion, with no consequences of any kind. I have been given a copy of this form.

YES                    NO

I agree to be audio-recorded.

YES                    NO

Follow-up information can be communicated to me by phone or sent to me at the following e-mail or mailing address:

YES                    NO

Phone/ email/ mailing address information:

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Signature: \_\_\_\_\_

Name of Participant (Printed): \_\_\_\_\_

Date: \_\_\_\_\_