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On The Frontlines: Perspectives of Providers Working with Homeless Women

Benissa E. Salem, PhD, RN, MSN [Assistant Adjunct Professor],
University of California, Los Angeles

Jordan Kwon, B.A. [Research Assistant], and
University of California, Los Angeles

Masha Ames, RN, MSN, CNL [Research Assistant]
University of California, Los Angeles

Abstract

Homeless service providers (HSP) are on the frontlines of caring for the most vulnerable populations to help them navigate out of homelessness, access health and social services. The purpose of this qualitative study was to understand, from the perspectives of HSPs ($N=19$; ages 27–58; $SD=10.37$), their account and experiences in working with homeless women (HW), and opportunities for intervention development and integration. Five focus groups were conducted with HSP in Central City East, Los Angeles. Five main themes emerged which included (a) seeking to establish a therapeutic relationship, (b) internal and external drivers of change, (c) navigating systems, (d) targeted outreach, and (e) program design recommendations. Within these themes, individual and structural-level characteristics emerged. To better equip HW, HSPs' perspectives need to be considered in future interventions to aid women traverse homelessness.

Keywords

women; homeless service providers; homelessness; trauma; focus groups; program development; qualitative methods

Homeless service providers (HSPs) are faced with a significant and substantial role in aiding, guiding and assisting homeless sheltered and unsheltered individuals navigate out of homelessness. On any given night in the United States (U.S.), there are over 560,000 people homeless (National Alliance to End Homelessness, 2014). The population on the streets is aging (Brown, Kiely, Bharel, Mitchell, 2012; Hahn, Kushel, Bangsberg, Riley, & Moss, 2006), making more compelling the need for age-related health and social services. Women are one of the fastest growing populations (Lewis, Andersen, & Gelberg, 2003) among the homeless in urban settings. Challenges experienced include lack of affordable housing (Downtown Women's Action Coalition [DWAC], 2016), along with domestic and interpersonal violence (Sullivan, Bomsta, & Hacksaylo, 2016).

Changing Landscape: Health and Social Delivery Needs

HSPs manage existing and the changing landscape of homelessness. Some have noted population aging among the homeless (Hahn et al., 2006) and earlier onset geriatric syndromes such as falls, cognitive impairment, frailty, major depression, sensory impairment, and urinary incontinence (Brown, Kiely, Bharel, & Mitchell, 2012, 2013) being considerable issues. Frailty is defined as an accumulation of deficits (Mitnitski, Mogilner, & Rockwood, 2001) in three separate domains: namely, physical, psychological and social (Gobbens, van Assen, Luijkx, & Schols, 2012). In a study among 150 homeless adults between 43–73 years of age, correlates of frailty included being a woman ($p<.05$), older age ($p<.05$), poorer nutrition ($p<.001$), low resilience ($p<.05$) and increased healthcare utilization ($p<.001$) (Salem, Nyamathi, Brecht, et al., 2013).

Emergency department utilization is high among homeless adults and increases as the population ages (Ku, Scott, Kertesz, & Pitts, 2010). Older homeless adults are more likely to present with alcohol abuse ($p=.03$), ambulance use ($p=.02$) and be admitted to the hospital ($p=.003$) as compared to their younger counterparts (Brown & Steinman, 2013). Furthermore, mental health is likewise an area of need among homeless women (HW; Rogoz & Burke, 2016; Schmidt, Hrenchuk, Bopp, & Poole, 2015), less than three quarters (64.1%) received treatment for mental health issues (DWAC, 2013).

Given the significant and complex factors involved in homelessness, gatekeepers of health and social services (Biederman & Nichols, 2014) are tasked with meeting the needs of the most vulnerable, helping them navigate larger systems to meet basic necessities, and advocate to access housing and healthcare. A seminal article found empirical support related to competing priorities (e.g., food, shelter, safety); thus, recommendations include taking into account unmet needs (e.g., clothing, shelter, bathrooms; Gelberg, Gallagher, Andersen, & Koegel, 1997). However, limited data exist among HSPs about their perceptions; we sought to understand perspectives of HSPs working with HW and opportunities for intervention development and integration. Thus, the purpose of this study was to understand perspectives of HSPs working with HW and opportunities for intervention development and integration.

Homelessness is a traumatic experience (Castellow, Kloos, & Townley, 2015), and for many, seeking safe spaces and privacy is critical (Oudshoorn, Ward-Griffin, Poland, Berman, & Forchuk, 2013). Several investigators have documented perceptions among homeless adults and identified key issues related to lack of compassion and empathy from service providers (Nickasch & Marnocha, 2009; Salem & Ma-Pham, 2015). The literature also reveals a need for health promoting homeless-provider relationships (Oudshoorn, Ward-Griffin, Forchuk, Berman, & Poland, 2013).

Without doubt, negative provider attitudes towards homeless clients can act as barriers to quality healthcare and impact those experiencing homelessness. Homeless clients have listed respect, actively seeking ways to lessen the power differential, a non-judgmental approach, and solidarity as the key components of the patient-provider relationship (Oudshoorn, Ward-Griffin, Forchuk, et al., 2013). Another study of provider perceptions revealed that homeless

women described experiences with service providers as neutral, dehumanizing (e.g., unmet expectations, judged, minimized, alienated, powerless) or humanizing (e.g., cared for, trusted, shared past/identity, empowered; Biederman & Nichols, 2014). Others have noted that positive experiences with primary care providers included offering tailored service and having a perceived choice of provider (Chrystal et al., 2015).

Relationships between providers and those experiencing homelessness are critical; however, these relationships may be challenged for a number of reasons. Providers have previously reported that difficulty navigating services for homeless adults were rooted in having a low self-worth and wariness to start a new clinical relationship (Mills, Burton, & Matheson, 2015). HSPs described barriers that HW experienced related to healthcare access and unmet needs. These included lack of transportation and lack of trust in the health system (Hauff & Secor-Turner, 2014). Furthermore, support services which were needed included trauma-informed care (TIC), case management and accessible nursing staff (Hauff & Secor-Turner, 2014). Among HW, barriers to care included medications being lost or stolen and not having a safe or clean place to self-manage health conditions (Hauff & Secor-Turner, 2014).

Purpose

Given that the population of HW is increasing and HSPs are on the frontlines of working with HW, we sought to understand perspectives of HSPs and their account in working with HW, and opportunities for intervention development and integration.

Methods

The following paragraphs have been guided by the consolidated criteria for reporting qualitative research (COREQ) which focus on the following: (a) study design, (b) research team and reflexivity, and (c) data analysis and reporting (Tong, Sainsbury, & Craig, 2007).

Design, Setting and Sample

A qualitative study utilizing focus groups and guided by a semi structured interview guide (SSIG) was utilized to understand perspectives among HSPs (N=19) in four community-based research sites serving homeless populations in Los Angeles. This study was approved by the UCLA Human Subjects' Protection Committee.

Procedure

During the recruitment phase, the principal investigator (PI) held information sessions at the four recruitment locations during the mutually agreeable, prearranged data collection days and times. An oral screening consent was completed for those who expressed interest in participating in the study. During this time, potential participants were allowed to invite a trusted other to hear the information. The PI did not have a close working relationship with the study participants. Among those interested in continuing the process, the PI screened for eligibility by assessing (a) whether the potential participant worked with homeless women and (b) length of time working with homeless women (≥ 3 months).

For those who could not complete all the procedures on the same day or wanted more time to decide whether to participate in the focus group/survey session, an appointment was scheduled for them to return on another day. For those who have met eligibility criteria, the PI and participant arranged a meeting time within the private space inside these facilities for the focus groups and a brief survey was conducted. Three to five HSPs participated in each focus group. At the beginning of the session, HSPs were asked to provide pseudonyms to maintain their confidentiality.

The SSIG was developed by the PI building upon previous research. The majority of the SSIG focused on understanding barriers and challenges experienced by HSP when working with homeless women, trying to help homeless women access services, and solution-oriented recommendations. Upon completion of the focus groups, participants received a US \$20 gift card to a neighboring vendor or the money was donated to the employment facility. In total, five focus groups were conducted and each lasted about 1 hr and 15 min.

Data Analysis

Sample characteristics were described with frequencies, percentages and means related to chronological age, ethnicity/race, birthplace, and number of locations for agency employment.

The PI has previously published qualitative research studies working with homeless populations (Salem & Ma-Pham, 2015; Salem, Nyamathi, Idemudia, Slaughter, & Ames, 2013). Software utilized during this process included Microsoft Word, Excel and PowerPoint. During the data analytic process, the research team met regularly to discuss the themes and to compare categories for similarities and differences.

Four methods ensured trustworthiness of the data and they included: (a) credibility, (b) confirmability, (c) dependability, and (d) transferability (Creswell & Miller, 2000; Shenton, 2004). The PI had prolonged historical engagement in the sites and was able to locate gatekeepers, build trust and rapport with participants in order to gain credible information (Creswell & Miller, 2000). A close collaboration with the PI and four community-based partner sites was critical in order to gain a greater understanding of the participant's perspective (Creswell & Miller, 2000). In addition, individuals were genuinely encouraged to be forthright in the focus groups (Shenton, 2004).

The article and findings were scrutinized and critiqued by senior-level, PhD-prepared peers and underwent debriefing with the research team (Shenton, 2004). The research team developed a coding grid which included the focus group number, pseudonym, line number for raw data, line-by-line coding, preliminary codes, categories and themes. Research team members met in person and by phone regularly to go over categories, subcategories, themes and diagrams. Themeing the data allowed for categorization (Saldaña, 2013) and clustering of subthemes and themes based on repetitions, similarities and differences (Ryan & Bernard, 2003). Furthermore, exhaustiveness of the data was conducted by the PI and research assistant (RA), which included identifying occurrences of categories, consistency in coding, and diagramming relationships between main themes, subthemes and elements of the themes.

In this study, **confirmability** included use of an audit trail in which the PI kept a research log of all activities, developed a data collection chronology, and recorded data analysis procedures clearly (Creswell & Miller, 2000; Shenton, 2004). Next, **dependability** included describing the plan and strategy for data collection (Shenton, 2004). All five focus group recordings were transcribed verbatim by an independent transcriptionist. The transcripts were de-identified by the PI with each identifiable word or phrase replaced by numbers.

Transferability included describing the total number of participating community-based organizations, total number of people involved, data collection methods, length of each session, total time for data collection (Shenton, 2004).

Results

Table 1 reports sociodemographic characteristics of the sample. The mean age of HSP (N=19) was 41.42 (ages 27–58; SD 10.38). The majority were African American/Black (47.4%), Mexican-American (31.6%), Anglo/White/Caucasian (15.8%), or South Asian (5.3%). Likewise, less than half were legally married (36.8%) and about two-thirds reported having children (63.2%). HSP self-reported being case managers (31.6%), social workers (15.8%), and dorm coordinators (10.5%), and so forth. In their lifetime, over half (63.2%) had worked in at least one agency.

Theme 1: Establishing a Therapeutic Relationship

HSP described establishing a therapeutic relationship with HW that included: (a) seeking to establish trust, (b) managing hostility and anger, (c) not taking responsibility for actions, (d) lack of provider empathy, and (e) emotional sensitivity. Across three of the focus groups, an important theme was seeking to establish trust with women experiencing homelessness. One provider described that sometimes women do not follow through with healthcare appointments because they are afraid or do not trust. In fact, a provider described that trust was gained over time.

Trust is built. It took me almost a year for some women – I found out it's harder for the women then sometimes it is for the men to make their approach to you. For me, it took me about a year for some women to actually open up and share with me what their issues was and how we can actually assist them, and if we could at all.
(Participant A)

Across several of the focus groups, HSP described how anger and bitterness were oftentimes projected at them when working with the population. In fact, some shared that they could sense when clients were upset and questioned how to make things easier and more comfortable for the person. One person said,

One of my challenges is the anger that comes through our doors. A lot of people come here and they are so angry. And I know they're not angry at us. They're angry at their situation but they take it out on us, you know. (Participant B)

Another person said while anger was present, it is important to look beneath the surface of the situation:

Now they come in with attitudes and mad at the world and angry and you know rolling their eyes, and but it's kind of like, it's deeper than that. It's not... directed towards us. It just kind of like, I'm here. I don't want to be here. I have to be here. I have kids. What are you guys going to do? (Participant C)

Another continued to share,

But, that's my only challenge is that when they come out angry and hostile and want to get physical you know, sometimes we do have people that want to kill themselves. ...But they'll come to us and tell us so that's them reaching out for help. And so we have to make that call. But that's my challenge that I deal with a lot is the anger and hostility that comes with their mental illness. (Participant B)

Although being on the receiving end of anger is challenging for many HSPs, some of them described how they manage. One provider described that they had to "keep a level head" given that they do not know what this person is going through. Several HSPs mentioned a lack of taking responsibility.

They're homeless or they're in a situation. But, it's like they don't take any responsibility for that. Not everyone, but a big chunk of people don't want to take responsibility for that. And they want to feel like everyone else should be doing those favors, like giving them what they need. (Participant D)

Another person shared the following:

...They're not taking responsibility for their actions. So they feel like they're the victim. You know, I'm homeless, I don't have anywhere to go. I have children you know. You guys are supposed to help. You guys are supposed to make my situation better. And I feel that as long as you have that victim mentality, it's like woe is me, you know I can't do anything for myself. Like I'm a single parent. My baby's father left me with three children. What am I supposed to do? (Participant C)

Several providers described how homeless women described a lack of empathy shown by providers. Previous experiences and other interactions with providers may affect future perceptions HW have with providers. One provider shared,

And she urinated on herself. So we call the paramedics and she wanted to go. And the paramedics asked her where are you sleeping tonight? And she said, I don't like to go to the shelter. And kept asking her questions like, well you just want to go to the ER because you want a place to sleep? Yeah. And so, so they wouldn't take her. And we ended up getting a taxi voucher for her, getting her to the hospital and she stayed for three days. (Participant E)

Another provider questioned the root cause:

But for a lot you know, maybe in the health realm, maybe they're treated poorly because they're homeless. (Participant F)

Given the observed lack of sensitivity, a HSP recommendation was to develop specialty training for working with populations experiencing homelessness which is further described under HSP structural-level recommendations. Some providers described being emotionally

sensitive when working with women experiencing homelessness and their families. One woman shared:

I was crying like a baby. I really was. And now...I don't try to take it home with me. But then there are certain cases that just hit home and you get really emotionally sensitive about it. (Participant C)

Theme 2: Internal and External Drivers of Change

HSPs described internal and external drivers of change at the individual-level which included: (a) building empowerment, (b) client motivation, and (c) job fulfillment. Other HSPs shared that they do their utmost to have an attitude of encouragement and empowerment. One shared,

...We always encourage our ladies because ... we're not here to judge because we all have our walk in life...We've all made bad decisions. We've all made mistakes that we're still learning from and our thing is we are here to help. (Participant C)

HSPs also described the importance of speaking the truth. One HSP said,

...What we do around here is we really speak the truth. We speak the truth with a population that we deal with here. And sometimes we have to meet them where they at... (Participant G)

In several of the focus groups, HSPs described an existing, internal driving force and the need to keep motivated. One person said,

People think that people aren't motivated. But, I see so many people who are... (Participant L)

Another shared that being proactive was helpful to make change. One HSP mentioned,

It's like it comes a lot quicker for them. But I think that has a lot to do with them being proactive you know, keeping in touch with the people that are working with them. (Participant H)

Across the focus groups, HSPs described reasons which motivated them. One person shared,

...The people that I work with. I enjoy being here. I mean there's times where I'll have a day off and I'll come in to work because I enjoy being here. And my heart is to help people. (Participant H)

Another person shared that an internal driving force was a catalyst when working in the community.

That's what keeps me coming back to the job. It keeps me wanting to be here is because in an atmosphere, in an area like this you still have the ability to help someone and be hopeful – to be hopeful, that they don't have to remain here. (Participant I)

Theme 3: Navigating Systems

HSPs described how they assist homeless women in navigating systems at the individual and structural-level; in particular, the following was mentioned: (a) system barriers and

resources, (b) shelter accommodations, (c) limited contract time, (d) healthcare facilities, and (e) documentation needs. HSPs described challenges regarding helping individuals navigate systems. One HSP mentioned,

There [are] just so many barriers within various systems when you're trying to help navigate a client through them. Or not enough resources or different systems that aren't knowledgeable about mental health or health issues... (Participant F)

HSPs described uncertainty with some shelter accommodations despite trying to provide adequate space for individual's needs. One person shared,

...The hospital will send people, send people to us right, and they're not able to climb like we have bunk beds. And most of the time we only have top beds. Then we have somebody in a wheelchair, cane, walker, whatever that can't get on a bunk, on the top bunk. So now we don't have any place for them to sleep. So then we got to put them on a cot for tonight and see what happens tomorrow. Maybe we have a lower bed, maybe not. (Participant B)

Furthermore, HSPs described doing their best to manage care for those with varied levels of acuity. In particular, one shared,

Somebody landed on our doorstep; we've had blind people land on our doorstep. We're going to take them in and then we're going to work from there, trying to find them other housing options and things like that. (Participant B)

HSPs described challenges for homeless women exiting correctional institutions. In particular, contracts may limit services and substance use treatment. One person shared,

Now with AB109, it's less supervision. It's no, no services. And you have 90-day transitional housing which doesn't cover treatment. It's just housing. And they have to be willing to participate in it. We can't make them because it's not covering treatment. And so that's one thing. And most of these people are still, still need services, still need treatment, still need the help but it's not covered because they're under AB109. (Participant J)

Furthermore, some providers shared that even 90 days in treatment may not be enough time to manage specific problems. HSPs also described the need for more advanced healthcare; in particular, HSPs mentioned that those who need skilled nursing facilities obtain the needed care due to the need to being referred from the hospital. One HSP provider noted,

There is an effort for sure but I still feel like there's never enough resources. Skilled nursing facilities, it's not like you can call them up and say hey, we have this gal who needs help. It's – they have a process where they have to be discharged from the hospital into a skilled nursing facility. So it's really you know, when we have an individual or woman, an older adult woman whose obvious – obviously has health needs, perhaps she comes through the clinic, we can't just refer to a skilled nursing facility. (Participant F)

Across the focus groups, HSPs noted the difficulties with documentation and the length of the process to obtain basic documents (e.g., birth certificate, identification). One person shared,

You know, they don't have ID, birth certificate, ... And it takes time to get all that so they can... be a part of society and get ready for to move back into the larger community. And... they have to deal with the issues that kept them in the same, in the same spiral of life of doing the same thing, revolving door, the same thing over and over. (Participant K)

Another structural-level challenge included transportation which is a key element to managing health conditions. In fact, one HSP noted,

There's just more accessible transportation to get people to and from the doctor, to and from like better food options, to and from any kind of preventative care, managed care... (Participant L)

HSPs also described that there were **existing structures of support** for women in the neighborhood which included medical staff and additional programs. One described the following:

You know there's array of services down there that they offer to women and they have a ...different writing club that gives ... women back their self-worth and their self-esteem... (Participant A)

Theme 4: Targeted Outreach

At the individual-level, HSPs described a number of qualities and characteristics which may necessitate targeted outreach which include the following: (a) gender and trauma-specific, (b) physical and mental healthcare, and (c) age-related needs. HSPs described the need for more gender-specific outreach for women.

...And I think that more outreach should be down here towards women. There should be more you know medical teams and more mental health outreach workers in the stuff that's down here, to engage people and just don't leave it to let people like me ...to do that. Because I mean we are professional in what we do because that's what we were trained to do as far as negotiating and dealing with people here. But when it comes to that professional part of like the mental illness or medical things, that's beyond us. And it's not enough of that down here to engage these women to help get them off the streets. (Participant M)

HSPs described gender-related issues related to women's health needs and being more sensitive as compared with men. One HSP shared,

It's easier for men to bounce back than it is for women. Over the years, I've seen a lot of guys come in here very broke down and very torn down and they stay here for a year. They put on a suit. They walk back out on the streets like nothing ever happened. Women bear scars of things that happen to them. (Participant M)

Across the focus groups, HSPs described trauma and violence which may have been in combination with physical and chronic health conditions. In particular, one HSP shared,

Trauma, trauma and violence, women experiencing that. Chronic mental health issues, physical health issues, poverty, lack of affordable housing, incarcerations, a hard time finding a job. (Participant E)

Another person shared,

...Housing has been available to them... But, because of certain issues or things that happened in the past, traumas, stuff like that, they don't want to live by themselves. (Participant M)

Across the focus groups, HSPs described the need for physical and mental health care outreach in the community which was more accessible. Some shared that it was difficult to have accessible healthcare and recommended setting up free clinics. Others described the need for mental health counseling, group or one-on-one sessions. Other areas of need included sex education, pap smears, birth control, mammograms, dental and vision care. Another described the need to have access to a rape kit outside of the hospital walls. One provider shared,

And in the various clinics I feel like rape kits could be more accessible. We've certainly seen that here. You know, rather than just being sent to the ER or the ER's that have the rape kits that type of thing. (Participant E)

HSPs discussed age-related needs among older women versus younger women. In particular, HSPs described that many elderly may feel a sense of loneliness and isolation. One shared,

It's different in dealing with a woman say in her 30s and dealing with a woman in her 60s. Because you're talking two different kind of physical needs for one thing. And it's, let's say, some of the seniors, women, a lot of these women are like kind of like set in their ways in a way. And even if you're offering services to them there's trust issues there, there's trust issues because of past abuse. (Participant M)

Theme 5: Program Design Recommendations

HSPs recommended individual-level program recommendations for future development which included: (a) a health buddy or patient navigator, (b) HSP cultural competence training, and (c) life skills classes. HSPs described having a health buddy to help homeless women navigate complex health care appointments, transportation and other structures. Another woman shared that women may not follow through appointments because they do not trust HSPs. One woman shared,

It's just like, there's a long wait and it's complicated and often times because there's so many different doctors and nurses, it's hard to decipher the advice that they're being given. So, to have some sort ... a buddy or a liaison or somebody that ...could...help them through the process I think would be helpful. And sometimes case managers can do that but it just kind of depends on the case management program and if it's even offered. (Participant F)

Furthermore, the health buddy would serve as an added support person who would allow individuals to have company especially if someone is older, have mobility or mental health co-occurring issues. Another woman described the need for cultural-competence training in homelessness. She said,

...Being culturally competent and not just in ethnicity but also in like the culture of homelessness and folks with ...co-occurring disorders and having an understanding

of what that assessment needs to look like is super important... And then sensitive–increased sensitivity about you know, what these folks are experiencing and not taking it personally. (Participant L)

Another HSP noted,

I think that people need to be specially trained with a homeless community. And because ... you're having people...that live normal lives...[try] to reach these people... they don't get it. Do you get what I'm saying? (Participant N)

Some HSPs described the need for life skills classes which would include money management and budgeting assistance to help homeless women learn how to shop for healthy foods and pay bills. One HSP mentioned,

And maybe you need some money management, some budgeting, how to shop for ...healthy foods or how to manage your money and pay your bills.(Participant A)

Across the focus groups, HSPs described the need for employment preparation classes (e.g., life skills, communication skills, resume building, interview prep classes, job readiness classes). HSPs described that the location of the intervention should be in common location in order to meet the population where they were.

Structural-level provider program recommendations included: (a) shelter accessibility, (b) housing access, (c) federal entitlement benefits, and (d) healthy eating options. Some described the fact that there are limited shelter accommodations for women and children.

...And it would help out if they opened their doors to accept a certain amount of mothers with children...And most of them don't even take single women either. It's just a men only. So we're very limited to where we can send women and mothers with children. And it's unfair. (Participant B)

HSPs recommended opening shelter doors for at least five to 10 families on any given night. HSPs described the need for stable, permanent housing and its relationship with health and safety. Furthermore, one HSP mentioned that it was important to have housing available.

I mean, when you don't have a stable living environment your health may not be your top priority. You're just trying to survive and you know, where am I going to sleep tonight? How am I going to stay safe? (Participant F)

Likewise, HSPs described that the younger generation may not respect the older generation; therefore, housing should be age-specific. One HSP described:

A lot of young people around elderly people, they don't mix. They don't mix sometimes. They're not on the same page. The elderly person that's been there, they done a lot already, so sometimes the younger generation don't respect where they're are. So it should be centered more around their age ...for housing... (Participant A)

HSPs described that federal entitlement benefits (e.g., general relief) do not reflect the cost of living. In fact, the funding matrix needs to reflect the location and cost of living. One provider stated,

General relief is \$221 for the month and...it's like nearly impossible to live on that. And they haven't upped the GR in like 30 years, 20 years, something like that? So, but that's more at a policy level. I would love to see that increase. (Participant F)

Further, they continued,

Whatever funding matrix they use needs to match the location and actual real cost-of-living data by location. Otherwise again you're setting people up to fail. You're telling them they have to get off the streets and do whatever it is but they physically cannot. There's not enough money. Certainly \$221 a month is not going to get you anything. (Participant L)

HSPs also described that it was challenging to eat healthy due to the available options in the community. Furthermore, oftentimes, healthier options are more expensive when compared to less healthy options. One shared,

...So it's kind of like okay, well I'm not going to spend seven dollars on a salad when I can get a hamburger meal for four [dollars]. So it's kind of like, it's hard to incorporate healthy habits when all you see is you know, junk food. (Participant C)

Furthermore, the stores in the communities have less nutritious options available. One person described:

The corner stores, it's all junk food and that's like the-- but they accept EBT cards. So if you have your food stamps or EBT card and that's where you are you know, able to go buy like Ho Ho's, dingdongs, Twinkies and soda... (Participant D)

However, across the focus groups, HSPs described that they held health education, workshops, diabetes, exercise and nutrition workshops. Furthermore, they have access to breakfast and lunch which are healthy.

Discussion

HSPs are on the frontlines helping guide women experiencing homelessness out of the state of homelessness. The purpose of this qualitative study was to understand HSP accounts and perspectives working with homeless women, and opportunities for intervention development and integration. Main themes generated from these focus groups included: (a) seeking to establish a therapeutic relationship, (b) internal and external drivers of change, (c) navigating systems, (d) targeted outreach, and (e) program design recommendations. Within these themes, individual-level provider and structural-level characteristics emerged. Figure 1 depicts major themes and elements of major themes.

HSPs described challenges which included seeking to establish trust with clients and how it took a great deal of time to establish rapport. Other studies have found the critical importance of building trust between providers and homeless populations (Biederman & Nichols, 2014); in fact, one author describes that caring for the most vulnerable necessitates building trust (Bharel, 2015) to develop health promoting relationships. Predictors of provider trust among 260 homeless veterans found that continuity and satisfaction with providers were significant positive predictors of trust (van den Berk-Clark & McGuire,

2014). Without doubt, establishing trust is a critical ingredient and needs to be established among this population.

Other challenges which providers described included managing hostility and anger when working with the population. Given that HSPs absorb a range of emotions and hear a range of life experiences, it is important for providers to care for themselves and seek out ways to self-care given that secondary traumatic stress (STS; Bride, 2007) may be experienced at higher than normal rates when compared with community-dwelling populations. In particular, STS is an adverse outcome when working with trauma survivors (Jenkins & Baird, 2002). While the trauma survivor may develop PTSD, the service provider may develop STS disorder (Jenkins & Baird, 2002). Given that homelessness is a traumatic experience and homeless populations experience a great deal of trauma (Hopper, Bassuk, & Olivet, 2010), HSPs are at risk for vicarious trauma (VT) and STS and should engage in self-care activities.

HSPs also described individual-level facilitators which aided them when working with the population and included helping to build empowerment by providing a positive and encouraging attitude. Furthermore, HSPs described that it was a myth that some believed that the homeless did not have internal motivation, because many are motivated and proactive to make a change. Interestingly, HSPs described how they felt fulfilled and satisfied with their job and how that was an important ingredient. HSPs also described a number of structural-level challenges which made it more difficult to help someone experiencing homelessness. HSPs noted that while shelter accommodations were limited for homeless women who had a high degree of need, HSPs did their best to help assist those in need.

Another challenge included individuals exiting jail on specific AB109 contracts; HSPs described the limited supervision and number of days that an individual on this type of contract had at specific facilities. For many who are reentering the community, having limited opportunity to have housing and support may challenge successful reintegration especially after exiting jail. Other challenges which were described by HSPs included documentation, the length of time to obtain documentation and its level of importance.

Individual-level provider recommendations included integrating several features into future intervention development which included having a health buddy or patient navigator to help HW navigate through complex appointments, provide support, and supplemental information related to chronic disease. In particular, it is plausible that the patient navigator could provide TIC by encouraging participants to attend class delivered by them, going to appointments with them (as needed), and providing more diet-specific chronic disease information, along with guidelines for healthy eating on a budget. Others have documented use of a patient navigator to increase compliance with colorectal cancer screening in an urban neighborhood (Jandorf, Gutierrez, Lopez, Christie, & Itzkowitz, 2005). It is also important to note as the population may fit the criteria of being prefrail or frail, health buddies could be assigned to them to help them navigate the complexities of homelessness.

Likewise, developing an HSP training would assist with developing cultural competence in working with the homeless population. This is an interesting finding and warrants further development and investigation. Next, providers described developing life skills classes which included communication skills, resume building, interview preparation classes, and job readiness classes. Likewise, HSPs described the need for more gender-based outreach which included facilities for women. Another area of need was in terms of healthcare; in particular, skilled nursing facilities were areas of need for some; however, many HSPs were unable to make referrals directly to skilled nursing facilities. Due to the high level of health care need among the homeless population (Cimino et al., 2015; Garibaldi, Conde-Martel, & O'Toole, 2005), it is plausible that having accessible skilled nursing facilities could assist in helping to address a higher level of acuity among prefrail and frail HW.

HSPs also described health outreach as an area of need; specifically, they mentioned sex education, pap smears, birth control, mammograms, dental and vision care. Interestingly, a qualitative study among 20 middle-aged and older prefrail and frail homeless women found that areas of need included vision, dental care, managing pain, and having comprehensive, holistic care which included diagnostics and specialist providers (Salem & Ma-Pham, 2015). Structural-level provider recommendations included having more shelters for women and children, more housing which would enable a stable living environment, federal entitlement benefits which reflected the cost of living and the location of living.

HSPs provided a unique vantage which helps us to gain a greater understanding of areas of need when working with women experiencing homelessness. This study has several limitations which are important to note; first, this was a convenience sample of women aged 27 to 58 serving four homeless shelters in Los Angeles. Second, we sampled a heterogeneous range of HSPs in various positions. Thus, our findings are not generalizable outside of this scope.

Despite these study limitations, these findings are informative for nurse researchers and multidisciplinary providers. In particular, it is critical to integrate TIC in program development and delivery. Utilizing a health buddy or patient navigator is an important and supportive role which will aid in health and social service delivery navigation. Likewise, for HSP working with the population, self-care should be integrated into systems.

At the provider-level, integrating culturally-competent training for all providers working with homeless populations (e.g., healthcare, social workers, case managers) is a program development need. For policy makers, expanding shelter accommodations for women and access to facilities which can provide a higher level of health care access (e.g., skilled nursing facilities) is needed. Further, providing those with AB109 contracts with greater support will aid in successful reintegration. Future research aims not only develop individual-level provider programs but also address structural-level policies which influence shelter accommodations, federal entitlement benefits, and increase housing access with the goal of helping women experiencing homelessness navigate out of homelessness.

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Figure 1.
Homeless Service Provider (HSP) Major Themes

Table 1

Sociodemographics of Homeless Service Providers (N=19)

	N	%
Gender		
Male	3	15.0
Female	16	84.2
Birthplace		
United States	19	100
Race or Ethnicity		
African American/Black	9	47.4
Mexican American	6	31.6
Anglo/White/Caucasian	3	15.8
South Asian	1	5.3
Marital Status		
Legally Married	7	36.8
Divorced	5	26.3
Never Married or Unmarried	4	21.1
Single	2	10.5
Separated	1	5.3
Children		
Yes	12	63.2
No	7	36.8
	N	%
Occupation		
Case Manager	6	31.6
Social Worker	3	15.8
Dorm Coordinator	2	10.5
Demonstrator/Counselor	1	5.3
Courtyard Outreach	1	5.3
Intake Assistant	1	5.3
Volunteer Supervisor	1	5.3
Mental Health Outreach	1	5.3
Management Coordinator	1	5.3
Administrator	1	5.3
Medical Assistant	1	5.3
Number of Agencies Worked With		
At Least One Agency	12	63.2
More than One Agency	7	36.8